Spinal cord stimulator (SCS)

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan will be used to determine your coverage.

Administrative Process

Prior authorization is required for both the trial insertion and permanent placement of a spinal cord stimulator.

Coverage

Peripheral nerve stimulation is not addressed in this coverage policy.

Spinal cord stimulation to treat intractable chronic neuropathic pain that is refractory to other treatment modalities is generally covered as described below, and per your plan documents.

The patient is to be offered patient decision support. The following are recommendations for a robust informed consent discussion between physician and patient:

1. Provide information about treatment options and their probabilities for success in sufficient detail for decision making.
2. Present probabilities of outcomes in an unbiased and understandable way.
3. Include methods for clarifying and expressing patients’ values.

Indications that are covered

Spinal cord stimulation is covered to treat intractable chronic neuropathic pain that is:

1. Refractory to other treatment modalities (see “Criteria for a trial insertion ” item #1); and
2. The result of one of the following:
   A. Failed back surgery syndrome with intractable radicular pain refractory to medical management. NOTE: Medical management for this condition must include Physical Therapy (PT). In addition, an Oswestry disability index (ODI) is required; OR
   B. Complex regional pain syndrome, including upper or lower extremity pain. OR
   C. Diabetic peripheral neuropathy

Criteria for a trial insertion

Documentation submitted by the operating physician demonstrating compliance with all of the following criteria:

1. The treatment is recommended after all other patient-appropriate therapies have been tried and proven ineffective, including but not limited to pharmacological management, injection therapies, physical therapy, surgery and psychological treatment if indicated. Documentation for failed back surgery syndrome must include Oswestry Disability Index (ODI) scores from the first and last therapy visits prior to implantation of SCS that demonstrate less than 30% improvement.
2. Preoperative psychiatric/psychological evaluation conducted by a licensed psychiatrist, psychologist or other licensed mental health professional who has a working knowledge of the psychological issues involved in chronic pain syndromes. The goals of this assessment are to rule out major psychiatric comorbidities or major substance abuse issues that would be strong predictors of poor outcomes and to select motivated patients who would be more likely to adhere to a follow-up plan.
3. Documentation of severe pain and disability.
   A. For low back pain, the most recent pre-trial ODI is equal to or greater than 40% disability.
   B. For complex regional pain syndrome an ODI is not required.

Conservative therapy must include physical therapy (PT) and may include activity modification, weight loss, and drug therapy. Documentation must correspond to the current episode of pain (within 6 months).

Formal physical therapy, at least four visits over a six week course, including active muscle conditioning is REQUIRED. OR there must be an explicit statement in the clinical documents that explains why such physical therapy is contraindicated. The requirement for physical therapy will not be met if there is a failure to complete prescribed physical therapy for non-clinical reasons. Documentation of formal physical therapy would be the therapist’s notes. If a patient is unable to complete physical therapy (PT) due to progressively, worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer. Documentation in the physical therapist’s notes demonstrating this must be submitted.
Criteria for Permanent Placement

1. All of the criteria listed above AND
2. A trial insertion of a minimum of three days (preceding permanent implantation) leads to ≥50% pain relief and improvement in function.

Indications that are not covered

Use of SCS is considered experimental and investigational for the following conditions, including but not limited to:

1. Chronic pain from malignancy (cancer);
2. Other chronic non-malignant pain, including but not limited to, cephalgia, headache, inguinal pain, intercostal neuralgia, occipital neuralgia, phantom limb syndrome, post-herpetic neuralgia, and trigeminal neuralgia;
4. For cervical spinal cord stimulation: cervical trauma, disc herniation, or failed cervical spine surgery syndrome, presenting with arm pain, neck pain, or cervicogenic headache;
5. Any conditions not listed as covered.

Definitions

Spinal Cord Stimulation (SCS) involves electrical stimulation of spinal nerves using electrodes implanted in the epidural space of the spinal column. The goal of spinal cord stimulation is to suppress pain in specific areas for patients with a variety of chronic pain disorders, including chronic, refractory, neuropathic pain.

SCS implantation is a two-phase procedure:
• Temporary Percutaneous Electrode Placement
• Permanent Electrode Placement and Implantation of the Pulse Generator

Alternative names or also known as: Dorsal column stimulator (DCS)

Codes

If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrode array, epidural</td>
</tr>
<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural</td>
</tr>
<tr>
<td>63661</td>
<td>Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63663</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63664</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>63688</td>
<td>Revision or removal of implanted spinal neurostimulator pulse generator or receiver</td>
</tr>
<tr>
<td>95970</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming</td>
</tr>
<tr>
<td>95972</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour</td>
</tr>
<tr>
<td>95973</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or</td>
</tr>
</tbody>
</table>
peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

L8679  Implantable neurostimulator, pulse generator, any type
L8680  Implantable neurostimulator electrode, each
L8681  Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8682  Implantable neurostimulator radiofrequency receiver
L8683  Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685  Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686  Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
L8687  Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688  Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension
L8689  External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
C1767  Generator, neurostimulator (implantable), nonrechargeable
C1778  Lead, neurostimulator (implantable)
C1787  Patient programmer, neurostimulator
C1816  Receiver and/or transmitter, neurostimulator (implantable)
C1820  Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1883  Adaptor/extension, pacing lead or neurostimulator lead (implantable)
C1897  Lead, neurostimulator test kit (implantable)

References

Products
This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.

Number S004-04; Approved Medical Director Committee 2/28/11. Revised 7/28/11, 6/12/2012, 8/22/14, 6/21/16, 1/24/2017; Annual review 6/2012, 6/2013, 7/2014, 7/2015, 2/2016, 1/2017