MEDICAL MUTUAL®

Medical Policy

Policy:	**200602**		
SUBJECT:	**Temporary (Trial) Spinal Cord Stimulation for Chronic Pain**	**Initial Effective Date:**	**10/20/2006**
		Annual Review Date:	**08/02/2024**
		Last Revised Date:	**08/02/2024**

Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.

Definition: Spinal cord stimulation (SCS), also known as dorsal column stimulation, is most used to treat chronic pain. It involves the surgical implantation of an electrode array, sometimes referred to as a lead, in the epidural space of the spinal cord. The electrode array is attached to an extension cable which in turn is attached to a pulse generator, also referred to as a neurostimulator. An electrical impulse generated by the device travels to the lead at the spinal cord and generates a tingling sensation that alters the perception of pain.

Implantation/insertion of a SCS system is performed in two stages. The first stage is a trial stimulation to determine if the patient is a suitable candidate. A successful trial is defined as the patient experiencing and recording ≥50% pain relief during the trial. This should occur with stable or reduced pain medications, in particular opioids, and with at least stable or improved levels of daily activity. Only patients who are deemed suitable will go on to permanent implantation/insertion of the SCS system.

Medical Necessity:

I. Temporary Trial: The Company considers temporary (trial) spinal cord stimulation **medically necessary** and eligible for reimbursement providing that ***all*** of the following medical criteria are met:

- Chronic neuropathic or ischemic pain, including **1 or more** of the following:

  1. Complex regional pain syndrome (previously referred to as reflex sympathetic dystrophy)
  2. Failed back surgery syndrome
  3. Lower extremity pain at rest due to critical limb ischemia

- Failed conservative management, including **1 or more** of the following:

  1. For limb ischemia, failed surgical or endovascular revascularization, or inoperable vascular disease
  2. For neuropathic pain, stellate ganglion or lumbar sympathetic block

3. Pharmacotherapy
4. Physical therapy
5. Psychotherapy or cognitive behavioral therapy

- Favorable psychological evaluation, absence of untreated psychiatric comorbidity, or current treatment in multidisciplinary pain management program; and
- Patient capable of operating stimulating device; and
- No coagulopathy, anticoagulant or antiplatelet therapy or thrombocytopenia (ie, platelet count of less than 75,000/mm^3 (75 x10^9/L)); and
- No current or chronic infection

II. Permanent Implantation: The Company considers permanent implantation of a spinal cord stimulator **medically necessary** and eligible for reimbursement. Medical Mutual uses MCG Care Guidelines (A-0243) to guide medical necessity determination for implanted electrical stimulation of the spine.

NOTE: Spinal cord stimulators using high-frequency spinal cord stimulation (Senza) or burst stimulation (BurstDR) have been determined to be equally effective alternatives to standard stimulators for the medically necessary indications listed above and in MCG Care Guidelines (A-0243).

NOTE: Dorsal root ganglion stimulators (e.g. Axium Neurostimulator System) are considered medically necessary to treat complex regional pain syndrome when the other medically necessary indications listed above and in MCG Care Guidelines (A-0243) are met.

III. Replacement: The Company considers replacement/upgrade of leads (e.g., lead migration is a frequent complication of spinal cord stimulation and requires revision surgery), implantable pulse generator, external recharger, and patient programmer **medically necessary** and eligible for reimbursement providing medical criteria for permanent implantation of a spinal cord stimulator are met and existing equipment is not under manufacturer warranty.

NOTE: Replacement/upgrade of a functioning SCS to a burst or high-frequency spinal cord stimulator is considered not medically necessary.

IV. Removal: The Company considers removal (without revision or replacement) of leads and/or pulse generator **medically necessary** and eligible for reimbursement.

V. Investigational Procedures or Devices: The Company considers the following spinal cord stimulation procedures or devices **investigational** and **not** eligible for reimbursement:

- Spinal nerve stimulation for ***all*** other indications (e.g., treatment of cancer related pain, pain secondary to inoperable critical limb ischemia, chronic angina resistant to therapy, pain due to diabetic peripheral neuropathy)

- Spinal cord stimulation using more than 16 electrodes/contacts or more than two percutaneous leads
- Spinal nerve stimulation using the Stimwave Freedom Spinal Cord Stimulation System (Stimwave Technologies Inc.) or a similar system powered by an external radiofrequency transmitter coupled to an implanted receiver

Benefits for investigational services are subject to each specific benefit plan.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Prior approval is required for CPT Codes L8678, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688

Sources of Information:

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Applicable Code(s):	
CPT:	**63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688**
HCPCS:	**C1767, C1778, C1820, C1897, L8678, L8679, L8680, L8681, L8682, L8683, L8685, L8686, L8687, L8688, L8689, L8695**
ICD10 Procedure:	**00HU0MZ, 00HU3MZ, 00HU4MZ, 00HV0MZ, 00HV3MZ and 00HV4MZ**