GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Spinal cord stimulators (SCS), also known as dorsal column stimulators (DCS), are most commonly used for the management of failed back surgery syndrome. The use of SCS for controlling chronic low back pain is a non-destructive, reversible procedure, and it is therefore an attractive alternative for patients who may be facing or have already experienced neuroablative procedures, or habituating opioid medications. This procedure has also been shown to be effective in the treatment of patients with angina pectoris who fail to respond to standard pharmacotherapies and are not candidates for surgical interventions.

SCS involves the use of low-level electrical stimulation of spinal nerves using electrodes implanted in the epidural space of the spinal column. The stimulation overrides, or masks, the original pain sensation with paresthesia. The objectives of treatment are to minimize the frequency, intensity and duration of pain; enhance physical activity; and decrease the need for pain medication. There is some evidence from studies of low to moderate quality that SCS can reduce chronic, refractory, neuropathic pain, and may improve quality of life in patients with failed back surgery syndrome, and complex regional pain syndrome.

POLICY

HMO, PPO, Individual Marketplace & Advantage
Spinal Cord Stimulation (63650, 63655, & 63685) neurostimulator electrode initial implantation requires prior authorization. Additionally, effective 10/1/2019 neurostimulator electrode revision (63663 & 63664) requires prior authorization.

Elite
Spinal Cord Stimulation (63650, 63655, & 63685) neurostimulator electrode initial implantation requires prior authorization. Additionally, effective 01/01/2020 neurostimulator electrode revision (63663 & 63664) requires prior authorization.

HMO, PPO, Individual Marketplace, Elite, Advantage
A spinal cord stimulator trial period will be initiated first, when criteria below is met, to determine whether the pain is effectively relieved (reduction in pain of at least 50% or more), assessment to determine the appropriate type of SCS technology needed and to evaluate different stimulation settings and programs.

- trial period is ≥ 3 days,
- documented pain reduction ≥ 50% and
- demonstrated understanding of use of stimulator during trial.

Member Spinal Cord Stimulators (SCS) criteria:
- Has undergone careful screening, evaluation, diagnosis and clearance, by a multidisciplinary team (psychological indicating the pain is not psychologic in origin and physical evaluations) prior to implantation; and
- No untreated existing drug addiction problems (per American Society of Addiction Medicine (ASAM) guidelines; and
- Spinal cord compression excluded by history and physical examination and imaging; and
- Other more conservative methods of pain management have been tried and failed for a minimum of 6 months; and
  - All of the following:
    - Sympathetic block
    - Home exercise or occupational therapy or physical therapy
    - Antidepressant or antiepileptic drugs
- Pain is not associated with malignancy; **and**
- No pacemaker or other medical contraindications (i.e. sepsis or coagulopathy); **and**
- There is documented pathology, spinal cord stimulators (SCS) are medically indicated for members with chronic pain whom met any of the following indications;
  - Failed back surgery syndrome (FBSS) with low back pain and significant radicular pain: **or**
    - One of the following:
      - ≥ 2 prior surgeries at same level
      - ≥ 1 prior surgery at > 1 level
      - Prior spinal fusion surgery
  - Complex regional pain syndrome (CRPS); **or**
    - With two of the following
      - Swelling or tenderness
      - Cyanotic or red or pale digit or extremity
      - Increased sweating
      - Alteration of temperature
      - Trophic skin changes
      - Flexion contractures
- Arachnoiditis (usually documented by the presence of high levels of proteins in the cerebrospinal fluid and/or by myelography or MRI); **or**
- Inoperable chronic ischemic limb pain secondary to peripheral vascular disease; **or**
- Last resort treatment of moderate to severe (5 or more on a 10-point VAS scale) chronic neuropathic pain of certain origins (i.e., lumbosacral arachnoiditis, phantom limb/stump pain, peripheral neuropathy, post-herpetic neuralgia, intercostal neuralgia, cauda equine injury, incomplete spinal cord injury, or plexopathy) that is refractory to 12 or more months of standard therapy (including non-steroidal anti-inflammatory drugs, tricyclic antidepressants, and anticonvulsants).

Spinal cord stimulators (SCS) are medically indicated for management of intractable angina in members who are not surgical candidates and whose pain is unresponsive to all standard therapies and whom met any of the following indications;
- Documentation supports angiographic coronary artery disease and is not candidate for revascularization procedures; **and**
- Optimal pharmacology therapy for at least one month; **and**
- Member’s angina pectoris is New York Heart Association (NYHA) Functional Class III (patients are comfortable at rest; less than ordinary physical activity causes fatigue, palpitation, dyspnea, or angina pain) or Class IV (symptoms of cardiac insufficiency or angina are present at rest; symptoms are increased with physical activity), **and**
- Reversible ischemia is documented by symptom-limited treadmill exercise test.

**Replacement** of standard or high-frequency spinal cord stimulator and/or battery/generator may be considered medically necessary for an individual that meets the above medical necessity criteria and the existing stimulator and/or battery/generator are/is no longer under warranty and cannot be repaired. Replacement of a functioning standard spinal cord stimulator (SCS) device with a high-frequency spinal cord stimulator (SCS) device is considered not medically necessary.

The **removal or revision** of a standard or high frequency spinal cord stimulator device may be considered medically necessary for migration of the lead(s), loss of effectiveness, and intolerance by the individual, infection, painful generator site, development of neurological deficits or the need for an MRI study.

The use of cervical spinal cord stimulation for the treatment of patients with cervical trauma, disc herniation, essential tremor, or failed cervical spine surgery syndrome, presenting with arm pain, neck pain, cervicogenic headache, gliomas, migraine, radiation-induced brain injury, stroke, trigeminal neuropathy, or any other indication is experimental and investigational because its effectiveness for these indications has not been established.

Spinal cord stimulation, for the treatment of pain associated with conditions/diseases including, but not limited to, the following are considered **investigational** medical indications for this technology:
- Cancer related pain
- Peripheral vascular disease
- Plexus lesions caused by trauma or malignancy
- Multiple sclerosis and spasticity disorders
- Paraplegia and other spinal cord lesions
- Peripheral nerve injuries or deafferentation, which includes neuropathy due to injuries, surgery, entrapment or scars
- Postamputation pain
- Post herpetic neuralgia
- Heart failure
- Fibromyalgia

Paramount utilizes InterQual® criteria sets for medical necessity determinations for spinal cord stimulation in the treatment of failed back surgery syndrome, complex regional pain syndrome and refractory angina.

Per the Ohio Department of Medicaid (ODM), providers can request prior authorization to exceed coverage or benefit limits for members under age 21.

**CODING/BILLING INFORMATION**

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

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L8689  External recharging system for implanted neurostimulator (replacement only)
L8695  External recharging system for battery (external) for use with implantable neurostimulator (replacement only)

REVISION HISTORY EXPLANATION
10/24/14: Removed deleted code 63660. Added codes 63661, 63662, 63663, 63664, C1767, & C1816. SCS (63650, 63655) will now require prior authorization following InterQual criteria for HMO, Individual Marketplace, Elite, & Advantage. Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).
1/22/16: Prior authorization now required for PPO. Added code 63685 to require prior authorization for all product lines. Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).
1/27/17: Removed deleted code 95973 effective 12/31/16. Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).
8/14/19: Specific coverage criteria documentation added to the policy, InterQual® criteria sets. Procedures 63663 and 63664 added to the procedures requiring a prior authorization for all product lines, except Elite, effective 10/1/2019.
12/01/19: Medical Policy revised to include the Elite Product requiring a prior authorization as of 1/1/2020.

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.