Minuteman Health

Clinical Review Criteria Related to Spinal Cord Stimulation

I.Criteria for Approval

A. Minuteman Health Insurance (MHI) covers spinal cord stimulation (SCS) or dorsal column stimulation for the treatment of severe chronic pain due to any of the following indications when the criteria listed below are met:

1. Failed back surgery syndrome with low back pain and significant radicular pain; *or*
2. Complex regional pain syndrome (also known as reflex sympathetic dystrophy); *or*
3. Inoperable chronic ischemic limb pain secondary to peripheral vascular disease; *or*
4. Last resort treatment of moderate to severe chronic neuropathic pain of certain origins (i.e., lumbosacral arachnoiditis and radiculopathies, phantom limb/stump pain, peripheral neuropathy, post-herpetic neuralgia, intercostal neuralgia, cauda equina 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).

B. The member must meet all of the following criteria:

1. Member does not have any untreated drug addiction problems (per American Society of Addiction Medicine (ASAM) guidelines); and
2. Member has obtained psychiatric clearance; and
3. The treatment is a last resort when the pain is refractory to all other therapies (pharmacologic, surgical, psychological, and physical, when appropriate) or the therapies are considered unsuitable or contraindicated; and
4. There is documented pathology, i.e., an objective basis for the pain complaint; and
5. Member experienced significant pain reduction (50% or more) with a 3- to 7-day trial of percutaneous spinal stimulation. (A trial of percutaneous spinal stimulation is considered medically necessary for members who meet the above-

listed criteria, in order to predict whether a dorsal column stimulator will induce significant pain relief.)

II. Required Documentation

Letter of medical necessity or office notes documenting clinical indications.

III.What is Not Covered

A. MHI will not cover Spinal Cord Stimulation when the following conditions are present:

1. Uncontrolled bleeding disorder, ongoing anticoagulant therapy, local or systemic sepsis

2. Presence of a demand pacemaker or implanted defibrillator

3. Immunosuppression

4. Failure of percutaneous trial of stimulation

5. MHI considers SCS **experimental and investigational** for the treatment of members with cervical trauma, disc herniation, failed cervical spine surgery syndrome presenting with arm pain, neck pain and/or cervicogenic headache, gliomas, migraine, radiation-induced brain injury, because its effectiveness for these indications has not been established.

6. High- frequency spinal cord stimulators (Senza)

IV.CPT/ ICD-10/ HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

CPT Codes

63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver

HCPCS Codes

L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator
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, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension

V.References

NCQA Standard, UM2, Clinical Criteria for Utilization Management Decisions, Element A

Turner, J.A., Loeser, J.D., Bell, K.G. Spinal Cord Stimulation for Chronic Low Back Pain: A Systemic Literature Synthesis. Neurosurgery, 1995;37(6) 1088-1095 https://www.ncbi.nlm.nih.gov/books/NBK66393/ (Last Accessed 12/29/16)

Cameron, T., Safety and Efficacy of Spinal Cord Stimulation for the Treatment of Chronic Pain: A 20 Year Literature Review. J Neurosurg, 2004;100 (3 Suppl Spine): 254-267 https://www.ncbi.nlm.nih.gov/pubmed/15029914

(Last Accessed 12/29/16)

Bernstein, Clifford A. MD, Spinal Cord Stimulation Advantages and Risks. http://www.spine-health.com/treatment/back-surgery/spinal-cord-stimulation-advantages-and-risks

(Last Accessed 12/29/16)

WebMD: Electrical Nerve Stimulation for Chronic Pain, http://www.webmd.com/back-pain/spinal-cord-stimulation-for-low-back-pain

(Last Accessed 12/29/16)

CMS-160.7 http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=240&ncdver=1&DocID=160.7&bc=gAAAABAAAAAA& National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7)

(Last Accessed 12/29/16)

VI.Summary of Changes

4/13/2017

- New criteria under I., Criteria for Approval:
  A.
  1. Failed back surgery syndrome with low back pain and significant radicular pain; *or*
  2. Complex regional pain syndrome (also known as reflex sympathetic dystrophy); *or*
  3. Inoperable chronic ischemic limb pain secondary to peripheral vascular disease; *or*
  4. Last resort treatment of moderate to severe chronic neuropathic pain of certain origins (i.e., lumbosacral arachnoiditis and radiculopathies, phantom limb/stump pain, peripheral neuropathy, post-herpetic neuralgia, intercostal neuralgia, cauda equina 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).

B.

4. There is documented pathology, i.e., an objective basis for the pain complaint;

- Clarification on III., What is Not Covered:
  A.

5. MHI considers SCS experimental and investigational for the treatment of members with cervical trauma, disc herniation, failed cervical spine surgery syndrome presenting with arm pain, neck pain and/or cervicogenic headache, gliomas, migraine, radiation-induced brain injury, because its effectiveness for these indications has not been established.

6. High-frequency spinal cord stimulators (Senza) added the disclaimer.

VII.Review Dates

HNE Review Dates: 4/9/13, 4/8/14, 4/14/15, 4/12/16, 04/04/2017
MHI Review Dates: 01/01/2014, 10/23/2014, 07/02/2015, 4/21/2016, 04/13/2017