

Corporate Medical Policy

Spinal Cord Stimulation

File Name:	spinal_cord_stimulation
Origination:	3/1980
Last CAP Review:	11/2011
Next CAP Review:	11/2012
Last Review:	11/2011

Description of Procedure or Service

Spinal cord stimulation (SCS) delivers low voltage electrical stimulation to the dorsal columns of the spinal cord to block the sensation of pain. Spinal cord stimulation devices either have a power source (battery) that is surgically implanted or else the power source is worn externally and only the radiofrequency receiver is implanted.

Spinal cord stimulation devices consist of several components: 1.) the lead that delivers the electrical stimulation to the spinal cord; 2.) an extension wire that conducts the electrical stimulation from the power source to the lead, and 3.) a power source that generates the electrical stimulation. The lead may incorporate from 4 to 8 electrodes, with 8 electrodes more commonly used for complex pain patterns, such as bilateral pain or pain extending from the limbs to the trunk. There are two basic types of power source. In one type the power source (battery) can be surgically implanted. In the other a radiofrequency receiver is implanted, and the power source is worn externally with an antenna over the receiver. Totally implantable systems are most commonly used.

The patient's pain distribution pattern dictates at what level in the spinal cord the stimulation lead is placed. The pain pattern may influence the type of device used; for example, a lead with 8 electrodes may be selected for those with complex pain patterns or bilateral pain. Implantation of the spinal cord stimulator is typically a 2-step process. Initially, the electrode is temporarily implanted in the epidural space, allowing a trial period of stimulation. Once treatment effectiveness is confirmed (defined as at least 50% reduction in pain), the electrodes and radio-receiver/transducer are permanently implanted. Successful spinal cord stimulation may require extensive programming of the neurostimulators to identify the optimal electrode combinations and stimulation channels. Computer-controlled programs are often used to assist the physician in studying the millions of programming options when complex systems are used.

A number of total implanted spinal cord stimulators have received U.S. Food and Drug Administration (FDA) premarket approval (PMA). The Cordis programmable neurostimulator from Cordis, Corp. was approved in 1981 and the Itrel(R) manufactured by Medtronic was approved in 1984. In April 2004, Advanced Bionics received PMA for its Precision spinal cord stimulator as an aid in management of chronic, intractable trunk and limb pain. All are fully implanted devices

Related Policies:

Deep Brain Stimulation

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

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Policy

BCBSNC will provide coverage for Spinal Cord Stimulation when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Spinal Cord Stimulation is covered

- A. A trial treatment of spinal cord stimulation using a temporary stimulator may be considered medically necessary when all of the following criteria are met:
 - 1. The patient has severe and chronic neuropathic pain of the trunk or limbs resulting from actual damage to peripheral nerves; and
 - 2. Other pain management modalities (pharmacologic, surgical, psychological, and physical therapies) have been tried and failed, or judged to be unsuitable or contraindicated; and
 - 3. The patient has undergone careful screening, evaluation and diagnosis by a multi-disciplinary pain management team (including psychological as well as physical evaluation); and
 - 4. No untreated drug habituation exists.
- B. Placement of a permanent spinal cord stimulator may be considered medically necessary and eligible for coverage when the above medical necessity criteria for a trial treatment of spinal cord stimulation are met, the trial is performed, and the patient has demonstrated pain relief of at least 50% for a minimum of 48 hours with the temporarily implanted electrode as documented in the medical record.

When Spinal Cord Stimulation is not covered

- A. Spinal cord stimulation for neuropathic pain of the trunk or limbs, resulting from damage to the peripheral nerves, is considered not medically necessary when the above criteria are not met.
- B. Spinal cord stimulation is considered investigational for all other indications including but not limited to the following:
 - 1. treatment of critical limb ischemia as a technique to forestall amputation
 - 2. treatment of refractory angina pectoris
 - 3. treatment of nociceptive pain (pain resulting from irritation rather than damage to the nerves)
 - 4. treatment of visceral pain
 - 5. treatment of central deafferentation pain (pain related to central nervous system damage from stroke or spinal cord surgery).

Policy Guidelines

Nociceptive pain arises from stimulation of pain receptors within tissue that has been damaged or involved in an inflammatory process.

Neuropathic pain results from damage to or dysfunction of the peripheral or central nervous system,

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rather than stimulation of pain receptors. Diagnosis is suggested by pain out of proportion to tissue injury, dysesthesia (e.g., burning, tingling), and signs of nerve injury detected during neurologic examination.

Common indications for spinal cord stimulation include, but are not limited to, failed back syndrome, complex regional pain syndrome (i.e., reflex sympathetic dystrophy), arachnoiditis, radiculopathies, phantom limb/stump pain, and peripheral neuropathy. Spinal cord stimulation is generally not effective in treating nociceptive pain and central deafferentation pain.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 95970, 95971, 95972, 95973, L8680, L8681, L8682, L8683, L8685, L8686, L8687, L8688, L8689.

Medical documentation must include:

- All other treatment modalities used, including pharmacologic agents, surgeries, physical, or psychological, transcutaneous and percutaneous electrical nerve stimulation, if appropriate) and the results of these treatments
- Supporting documentation of the screening, evaluation, and diagnosis by a multidisciplinary team
- Evidence that all the facilities, equipment, professional and support personnel required for the proper diagnosis, treatment and follow-up of the patient are available.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual - 3/96

Plan Consultant - 8/95

BCBSA Medical Policy Reference Manual - 11/15/98; 7.01.25

Medical Policy Advisory Group - 1/99

Medical Policy Advisory Group - 12/99

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group - 10/2000

Specialty Matched Consultant Advisory Panel - 7/2002

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.25, 4/29/2003.

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Specialty Matched Consultant Advisory Panel - 6/2004

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.25, 8/17/2005.

Specialty Matched Consultant Advisory Panel - 5/2006

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.25, 3/13/08.

Specialty Matched Consultant Advisory Panel - 5/2008

Senior Medical Director Review - 2/2009

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.25, 1/14/10.

Medical Director - 8/2010

Specialty Matched Consultant Advisory Panel – 11/2010

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.25, 1/13/11.

Specialty Matched Consultant Advisory Panel – 11/2011

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.25, 1/12/12

Policy Implementation/Update Information

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| 3/80 | Original policy: Generally accepted medical practice for treating chronic intractable pain |
| 6/83 | Reaffirmed |
| 6/84 | Reaffirmed |
| 12/85 | Revised: Investigational for treating motor function disorders |
| 8/88 | Reviewed: Eligible for coverage for severe, chronic pain. Investigational for all other neurological diseases. |
| 7/96 | Reaffirmed: National Association reviewed 3/96. No changes. Combined Local and National by adding list of codes from Local policy. |
| 1/99 | Reaffirm. Medical Policy Advisory Group |
| 12/99 | Medical Policy Advisory Group |
| 10/00 | Specialty Matched Consultant Advisory Panel review. Changed criteria under "When Spinal Cord and Deep Brain Stimulation is covered" to say, "4. The patient demonstrates pain relief for one week with a temporarily implanted electrode preceding permanent implantation." 10/00 System coding changes. Medical Policy Advisory Group. No further changes to criteria. Approve. |
| 6/01 | 63690, 63691 deleted from coding section. 95970-95973 added to coding section. |

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- 8/02 Specialty Matched Consultant Advisory Panel review 7/12/2002. Revised statement under the "when it is not covered" section for clarity. Changed title from Spinal Cord and Deep Brain Stimulation. Billing/Coding section revised. CPT codes 61855 and 61865 deleted and replaced with 61862. HCPCS codes E0751 and E0753 deleted and added E0752 and E0754. Reference added to Scientific References.
- 7/29/04 Specialty Matched Consultant Advisory Panel review 6/22/2004. Description updated. In the section When Spinal Cord Stimulation is Covered, added the word "neuropathic in the first sentence. Under section When Spinal Cord Stimulation is not covered added statement "Spinal Cord Simulation is investigational as treatment of critical limb ischemia. BCBSNC does not provide coverage for investigational procedures". Updated Benefit Application and Billing Coding section format for consistency. Deleted HCPCS code E0754 and CPT codes 61862 and 61875 as they do not apply to this policy. References added. Notification given 7/29/2004. Effective date 10/14/2004.
- 1/6/05 Deleted HCPCS code E0752 from "Billing/Coding" section.
- 6/5/06 Specialty Matched Consultant Advisory Panel review 5/3/2006. No changes to policy statement. Policy number added to "Key Words" section. References added.
- 1/17/07 Added HCPCS codes L8680, L8681, L8682, L8683, L8685, L8686, L8687, L8688 and L8689 to "Billing/Coding" section.
- 7/14/08 Specialty Matched Consultant Advisory Panel review 5/29/08. Added the statement; "The most recent studied indication is for patients with refractory chest pain who are not candidates for surgical revascularization." to "Description" section. Changed the first sentence under the "When Covered" section from "For the treatment of" to "A trial treatment of spinal cord stimulation using a temporary stimulator may be considered medically necessary for severe and chronic neuropathic pain when all of the following criteria are met:" The last paragraph in the "When Covered" section was clarified to indicate; "It is anticipated that if the patient demonstrates pain relief of at least 50% for one week with a temporarily implanted electrode a permanent spinal cord stimulator will be implanted. References added.
- 3/16/09 Medical policy reviewed by Senior Medical Director 2/6/09. Reformatted the "When Covered" section for ease of administration. Changed wording in "B. Placement of a permanent spinal cord stimulator may be considered medically necessary and eligible for coverage when the above medical necessity criteria for a trial treatment of spinal cord stimulation are met, the trial is performed, and the patient has demonstrated pain relief of at least 50% for one week at least 48 hours with the temporarily implanted electrode as documented in the medical record." Reformatted the "When Not Covered" section and added additional indications determined to be investigational as follows: "treatment of refractory angina, treatment of nociceptive pain (pain resulting from irritation rather than damage to the nerves), treatment of visceral pain, and treatment of central deafferentation pain (pain related to central nervous system damage from stroke or spinal cord surgery)." No change in policy statement or intent of policy. "Policy Guidelines" added. References added. (btw)
- 1/5/10 Added new CPT codes: 63661, 63662, 63663, and 63664 to "Billing/Coding" section. Removed deleted CPT code 63660. (btw)
- 6/22/10 Policy Number(s) removed (amw)
- 8/31/10 Medical Director review 8/5/2010. "Description" section revised. Added to the "When

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Covered” section, 1.“that has been refractory to all other pain therapies.” and “5. No untreated drug habituation exists”. Removed the following criteria statements; “Treatment is consistent with the multidisciplinary evaluation findings and management recommendations; **and** The patient is capable and willing to comply with the treatment plan.” Changed statement in “B” from “the patient has demonstrated pain relief of at least 50% for **at least** 48 hours” to “the patient has demonstrated pain relief of at least 50% for a **minimum** of 48 hours with the temporarily implanted electrode with the temporarily implanted electrode No change to policy intent. References added. (btw)

12/21/10 Specialty Matched Consultant Advisory Panel review 11/29/2010. No change to policy. (btw)

3/29/11 References updated. (btw)

1/10/12 Specialty Matched Consultant Advisory Panel review 11/30/11. “Description” section revised. No change to policy statement. (btw)

3/30/12 Reference added. (btw)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.