MEDICAL POLICY	Peripheral Nerve Stimulation for Chronic Pain (Medicare Only)
Effective Date: 1/1/2022  1/1/2022 Medical Officer Date	Medical Policy Number: 18 Medical Policy Committee Approved Date: 8/19; 6/2020; 11/2020; 11/2021

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Initial placement of peripheral nerve stimulation for chronic pain	• Local Coverage Determination (LCD): Peripheral Nerve Stimulation (L37360)
Removal, revision, and replacement	For ***removal only*** of previously placed devices: • Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare **Note**: Even if initial placement of a device did not meet medical necessity coverage criteria and the complication or subsequent medical condition is the result of a prior non-covered service, coverage may be allowed in certain circumstances for the removal of the device. For ***revision/replacement*** requests of previously placed devices:

	• Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §120 - Prosthetic Devices, D. Supplies, Repairs, Adjustments, and Replacement **Note**: A procedure or device that did **not** meet medical necessity criteria when initially placed would have been non-covered, thus any revision or replacement to allow for the continued use of the non-covered device would not meet Medicare's general requirements for coverage. Replacement of previously placed medically necessary devices or their components that are nonfunctioning and irreparable (e.g., device malfunction, etc.) may be considered medically necessary in accordance with the above Medicare reference if the stimulator continues to be medically indicated and is no longer under manufacturer warranty or if the component is not included under the warranty. *(See "Policy Guidelines" below)*

POLICY GUIDELINES

While implantation of nerve stimulators involves the implantation of a "device," they are not considered durable medical equipment (DME). Implanted nerve stimulators are considered to be "prosthetic devices" under the Medicare Program.[1] Therefore, similar guidelines regarding the *replacement* of protheses would also apply to implanted electrical nerve stimulation devices. This includes consideration of whether the device itself continues to be medically reasonable and necessary for the individual, as well as confirming the device is no longer under manufacturer warranty.[2]

BILLING GUIDELINES

See associated local coverage articles (LCAs) for additional coding and billing guidance:

- Local Coverage Article (LCA): Billing and Coding: Peripheral Nerve Stimulation (A55531)

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

REFERENCES

1. National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7); Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240 [Cited 10/21/2021]
2. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §40.4 - Items Covered Under Warranty; Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf [Last Cited 10/21/2021]