MEDICAL POLICY	Back: Implantable Spinal Cord and Dorsal Root Ganglion Stimulation (Medicare Only)	
Effective Date: 1/1/2021  1/1/2021 Medical Officer Date	Section: SUR	Policy No: 134
	Technology Assessment Committee Approved Date: 9/05; 2/07; 10/10; 3/16 Medical Policy Committee Approved Date: 10/91; 5/95; 2/97; 3/98; 3/99; 3/00; 11/00; 12/01; 12/02; 2/04; 3/06; 3/09; 1/2010 ;10/10; 12/10; 12/11; 8/12; 1/13; 1/14; 3/14; 4/15; 12/15; 2/16; 4/17; 8/17; 1/18; 2/18; 12/18; 5/19; 8/2020; 11/2020	

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
Electric Nerve Stimulators	• National Coverage Determination (NCD) for Electric Nerve Stimulators (106.7)[1]
Spinal Cord Stimulators for Chronic Pain	• Local Coverage Determination (LCD): Spinal Cord Stimulators for Chronic Pain (L36204)[2] • Local Coverage Article: Spinal Cord Stimulators for Chronic Pain (A57792)[3]

Per the Medicare Policy Manual commercial medical policies may be applied to Medicare coverage determinations in the absence of an appropriate NCD, LCD, LCA, or CMS Coverage Manual. Therefore, the commercial medical policy, **Back: Implantable Spinal Cord and Dorsal Root Ganglion Stimulation (All Lines of Business Except Medicare),** *applies to the following services:*

- Dorsal Root Ganglion Stimulation
- Burst Spinal Cord Stimulation

BILLING GUIDELINES

For complete billing guidelines, refer to the LCA: Billing and Coding: Spinal Cord Stimulators for Chronic Pain (A57792).[3]

63650 - Two temporary spinal cord stimulator trials per anatomic spinal region (two per DOS) or (four units) per patient per lifetime (with exceptions allowed for technical limitations for the initial trials or for use of different modalities of stimulation, including new technology), in place of service office, ASC, out-patient hospital, or hospital. Since permanent neurostimulator arrays can also be placed percutaneously, code 63650 can be covered more often in place of service ASC, out-patient hospital, or hospital.

63655 - One permanent spinal cord stimulator per patient per lifetime and must be performed in an ASC, out-patient hospital or hospital.

63663 - Will not be reimbursed in the office setting since they are included in 63650.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1816	Receiver and/or transmitter, neurostimulator (implantable)
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads
C1883	Adapter/extension, pacing lead or neurostimulator lead (implantable)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
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
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
L8695	External recharging system for battery (external) for use with implantable neurostimulator, replacement only
No Prior Authorization Required	
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
Unlisted Codes	

All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
64999	Unlisted procedure, nervous system

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.

REFERENCES

1. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7). Effective date. 8/7/1995. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=240. Accessed 9/18/2020.
2. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Spinal Cord Stimulators for Chronic Pain (L36204). Effective date. 12/01/2019 https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36204. Accessed 9/18/2020.
3. Centers for Medicare & Medicaid Services. Local Coverage Article. Billing and coding. Spinal cord stimulators for chronic pain (A57792). Effective date: 12/01/2019. https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57792. Accessed 9/18/2020.