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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare Guidelines</th>
</tr>
</thead>
</table>
| Peripheral nerve stimulation for chronic pain| • Local Coverage Determination (LCD): Peripheral Nerve Stimulation ([L37360]^{1})
• Local Coverage Article (LCA): Billing and Coding: Peripheral Nerve Stimulation ([A55531]^{2}) |

HCPCS CODES

<table>
<thead>
<tr>
<th>Medicare Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>64555 Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
</tr>
</tbody>
</table>
### 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