MEDICAL POLICY	Peripheral Nerve Stimulation for Chronic Pain (Medicare Only)	
Effective Date: 12/1/2020  12/1/2020 Medical Officer Date	Section: MED	Policy No: 434
	Medical Policy Committee Approved Date: 8/19; 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
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

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

64575	Incision for 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.

REFERENCES

1. Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Peripheral Nerve Stimulation (L37360). 2018 https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=37360. Accessed 10/30/2020.
2. Centers for Medicare & Medicaid. Local Coverage Article: Billing and Coding: Peripheral Nerve Stimulation (A55531). 2018; https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=55531&ver=7&LCDId=37360. Accessed 10/30/2020.