Care N' Care Insurance Company of North Carolina, Inc. d/b/a/ HealthTeam Advantge Policy

Medical Policy Spinal Cord Stimulator Replacement			
Department Responsible Utilization Management	**Policy Code** 9.90	**Effective Date** 03/10/2021	**Next Review Date** 6/2024
Title of Person Responsible Medical Director	**Approval Council** HTA Medical Management Committee		**Approved Date** 03/10/2021

PURPOSE

This policy describes Care N' Care Insurance Company of North Carolina, ("CNC-NC") Inc to support medical necessity coverage guidelines, including documentation requirements for Spinal Cord Stimulator and replacement requests. HealthTeam Advantage (HTA) follows medical guidelines such as the national coverage determinations, local coverage determinations, and other manuals for the purpose of determining coverage. This guideline is not a replacement for medical source materials but meant to provide healthplan applications of such.

DEFINITIONS, INITIALS, ACONYMS

Spinal Cord Stimulator Replacement - SCS

POLICY

OVERVIEW

Coverage Indications, Limitations, and/or Medical Necessity

Background

The implantation of spinal cord stimulators (SCS) may be covered as therapies for the relief of chronic intractable pain. SCS is best suited for neuropathic pain, but may have some limited value in other types of nociceptive severe, intractable pain. Therapy consists of a short trial with a percutaneous implantation of neurostimulator electrode(s) in the epidural space for assessing a patient's suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. Performance and documentation of an effective trial is a prerequisite for permanent nerve stimulation.

Selection of patients for implantation of SCS is critical to success of this therapy. SCS therapy should be considered as a late option after more conservative attempts, such as medications, physical therapy, psychological therapy or other modalities have been tried.

Patients must have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation(such screening must include psychological, as well as physical evaluation). Documentation of the history and careful screening must be available in the patient chart if requested.

Many experts recommend that the temporary neurostimulator be placed in an Ambulatory Surgical Center (ASC) or outpatient hospital setting. However, the temporary neurostimulator trial can be done in an office setting if all the sterility, equipment, professional training and support personnel required for the proper surgery, and follow up of the patient are available. Permanent neurostimulators must be placed in an ASC or hospital. Physicians performing SCS trials in the office setting must have like privileges at a local hospital or ASC, or the providers must be subspecialty boarded in Pain Medicine by the American Board of Anesthesiology.

It is preferable that physicians performing the SCS trial will also perform the permanent implant. If the physician implanting the trial neurostimulator does not or cannot implant the permanent neurostimulator, the patient should be informed of this in writing and given the name of the referral surgeon, who will implant the permanent neurostimulator(s). It is expected that accurate patient selection will lead to most patients going on to receive permanent implants.

Only patients who experience a positive response to a trial should proceed to a permanent implantation. All trials which proceed to permanent implant must have adequate documentation in the chart to support that decision. A successful trial should be associated with at least a 50% reduction of target pain, or 50% reduction of analgesic medications, and show some element of functional improvement. (Patients with reflex sympathetic dystrophy may show lower levels of improvement, since it takes longer periods for improvement than the typical 1 to 2 week trial). Physician judgment and experience will also be taken into account. Physicians with a low trial to permanent implant ratio (less than 50%) may/can/will be subject to post-payment review and may be asked to submit documentation as to the patient selection criteria, the radiologic imaging demonstrating proper lead placement, and the medical necessity of the trials. Failure to provide this documentation will be cause for post-payment denial and recoupment of reimbursement. It is understood that all patients may not have a favorable result of the trial implant; but careful selection should find the most appropriate patients.
CPT/HCPCS Codes
Group 1 Paragraph: N/A
Group 1 Codes: 63650 Implant neuroelectrodes

GUIDELINE

This A/B MAC will reimburse for placement of a maximum of two leads or sixteen contacts, and for two SPINAL CORD STIMULATOR (SCS) trials per anatomic SPINAL region 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).

If a trial fails, a repeat trial is not appropriate unless there are extenuating circumstances that lead to trial failure. Appropriate medical documentation to support a repeat trial can be sent on appeal. Generally, electronic analysis services (CPT® codes 95970, 95971 and 95972) are not considered medically necessary when provided at a frequency more often than once every thirty days. More frequent analysis may be necessary in the first month after implantation.

CPT® code 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, outpatient hospital, or hospital.
The HCPCS/CPT® code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

REPLACEMENT

Replacement of a cervical, lumbar or thoracic dorsal column stimulator or battery/generator is considered medically necessary for individuals who meet medical necessity criteria for dosal column stimulation and the existing stimulator or battery/generator are no longer under warranty and cannot be repaired. Note: Lead and electrode replacement are not generally required at the time of generator replacement due to end of battery life.

Code	Description
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 laminectome 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
95970	Alys npgt w/o programming
95971	Alys smpl sp/pn npgt w/prgrm
95972	Alys cplx sp/pn npgt w/prgrm

RESPONIBILITIES

The HTA Utilization Management Department has day-to-day responsibility for the operationalization policy and procedures associated with organization determinations for non-emergent out-of-network services, and to ensure that the policy is consistently applied in a uniform manner.

The HTA Medical Management and Quality Council is responsible to ensure that appropriate medical management and quality standards are established and adhered to promote effective and compliant member care.

The HTA Board of Directors have overarching responsibility for review and approval of this policy, and it complies with all applicable federal and state laws, regulations and sub-regulatory guidance.

REFERENCE DOCUMENTS/LINKS

Medicare Managed Care Manual 1/1/2020 Parts C and D Enrollee Grievances, Organization / Coverage Determinations and Appeals Guidance
Medicare Coverage Database L37632 and A56876
Code of Federal Regulations: 42 CFR 422.570 and 422.566(b)(3)
Spinal Cord Stimulation: Clinical Efficacy and Potential Mechanisms, Sdrulla, AD et al, Pain Pract. 2018 November; 18(8): 1048-1067

PREVIOUS REVISION/REVIEW DATES

Date	Reviewed	Revised	Notes
02/26/2021	N/A	N/A	New policy
06/09/2021	X	X	CPT codes 6XXXX descriptions updated to mirror MCR LCD
5/11/2022	X		Reviewed and no changes made

06/30/2023	X		Reviewed and no changes. No NCD or LCD