Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP021

Section: Medical Benefit Policy

Subject: Dorsal Column Stimulation

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Dorsal Column Stimulation

II. Purpose/Objective:

To provide a policy of coverage regarding Dorsal Column Stimulation

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:
Spinal cord stimulation, also known as dorsal column stimulation, blocks pain conduction pathways to the brain. The neurostimulator electrodes used for this purpose are implanted percutaneously in the epidural space via a special needle. Some members may require an open laminectomy for electrode placement. After the electrodes are implanted, the member is provided with an external neurostimulator on a trial basis for up to 4 weeks. If during the trial, it is determined that the stimulation is not effective or is unacceptable to the member, the electrodes are removed. If the trial proves successful, a spinal neurostimulator and pulse generator that are activated through a radiofrequency device, are inserted subcutaneously and are connected to the implanted electrodes.

INDICATIONS: REQUIRES PRIOR PLAN AUTHORIZATION. The authorization must be requested and approved prior to the implantation of the electrodes for the trial period.

Relief of chronic intractable lumbar or thoracic pain under the following circumstances:

- Lumbosacral arachnoiditis that has not responded to medical management including physical therapy. (Presence of arachnoiditis is usually documented by presence of high levels of proteins in the CSF and/or by myelography or MRI.)
- Nerve root injuries, post-surgical or post traumatic including that of post laminectomy syndrome (failed back syndrome)
- Complex regional pain syndrome I & II (upper or lower extremities)
- Diabetic peripheral neuropathy (DPN)
- Phantom limb syndrome that has not responded to medical management
- End stage peripheral vascular disease, when the member cannot undergo revascularization or when revascularization has failed to relieve painful symptoms and the pain has not responded to medical management
- Post- herpetic neuralgia
- Plexopathy
- Intercostal neuralgia that did not respond to medical management and nerve blocks
- Cauda equina injury
- Incomplete spinal cord injury.

CRITERIA FOR COVERAGE: All must be met

- The implantation of the stimulator is used only as a late resort (if not a last resort) for members with chronic intractable pain and;
- Documented failure or contraindication to physical therapy or chiropractic care (if clinically applicable). There must be documentation of a minimum of 4 weeks of physical therapy or chiropractic care at least 2 times per week for the four weeks (minimum of 8 visits) within one year of the request for dorsal column stim trial/implantation. A home exercise program is not an adequate substitute for formal physical therapy or chiropractic care. If the provider indicates the member cannot do physical therapy or chiropractic care due to pain, the provider must submit documentation from an evaluating physical therapist or chiropractor dated within 4 weeks of the request indicating the member cannot tolerate therapy services. Please also note that completion of less than the minimum number of therapy or chiropractor visits due to non-compliance is not an acceptable alternative to this requirement in the absence of documentation the member was unable to tolerate therapy services; and
- Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes; and
- Documented failure of more conservative invasive methods, such as epidural steroid injections or facet injections, if applicable; and
- The member has completed a spine evaluation and surgical intervention is recommended by the spine evaluator and;
- All facilities, equipment, and personnel required for the proper diagnosis, treatment, training, and follow-up of the members must be available and;
- Demonstration of pain relief with a temporarily implanted electrode must precede permanent implantation.

LIMITATIONS:
For PA Medicaid: Dorsal Column Stimulation for the treatment of chronic stable angina pectoris may be considered through a Program Exception on a per case basis

Please note both the trial and permanent implantation require prior authorization. The permanent implantation cannot be prior authorized until the trial has been completed and response as noted above has been documented.
For permanent implantation, there must be documented improvement of at least 50% or greater in symptoms with a trial.

EXCLUSIONS:
Spinal Cord Stimulation for the treatment of members with cervical trauma, disc herniation, or failed cervical spine surgery syndrome, presenting with arm pain, neck pain, or cervicogenic headache, chronic pain associated with malignancy, is considered **experimental, investigational or unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

For Commercial and Medicare Business Segments:
Spinal Cord Stimulation as a treatment for chronic stable angina pectoris is considered **experimental, investigational or unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in **MP 15 - Experimental Investigational or Unproven Services or Treatment.**

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

CODING ASSOCIATED WITH: Dorsal Column Stimulation
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

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 percutaneous 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

63664 Revision including replacement, when performed of spinal neurostimulator electrode percutaneous plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

63685 Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

63688 revision or removal of implanted spinal neurostimulator pulse generator or receiver

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95972 complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

0784T Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed

0785T Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator

0788T Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters

0789T Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters

C1767 generator neurostimulator (implantor) non-rechargeable

C1778 lead, neurostimulator

C1787 patient programmer, neurostimulator

C1816 receiver and/or transmitter neurostimulator (implantable)

C1820 generator, neurostimulator (implantable), non-frequency, with rechargeable battery and charging system

C1822 generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

C1897 lead neurostimulato test kit (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, nonrechargeable, includes extension

L8687 implantable neurostimulator pulse generator, dual array, rechargeable, includes extension

L8688 implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

L8989 external recharging system for battery (internal) for use with implantable neurostimulator, replacement only

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 9/03

Revised: 9/04: 9/05;9/06, 11/09, 11/10, 11/12, 2/15 (criteria); 3/15, 10/16, 10/17 (clarified Medicaid coverage for angina), 1/20 (Removed Coverage for DME statement); 8/22 (add DPN indication);4/24 (revise auth requirement for reimplantation); 8/24 (clarify CRPS Indication)

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CMS UM Oversight Committee Approval: 12/23, 07/24; 11/8/24

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at https://www.geisinger.org/health-plan/providers/ghp-clinical-policies