1. **Purpose**
   The purpose of this policy is to establish the criteria for the medical necessity of spinal cord stimulators.

2. **Definitions**
   Spinal cord stimulation, also known as dorsal column stimulation, is a reversible therapy applied for neuropathic pain with techniques that include multi-output implanted pulse generators and a choice of electrodes, some of which can be placed percutaneously. The technical goal of this therapy is to achieve stimulation of paresthesia of spinal nerve root(s) at a subjectively comfortable level, overlapping a patient’s topography of pain. The procedure initially involves a trial of three to seven (3-7) days of percutaneous spinal cord stimulation, prior to the subcutaneous implantation of the spinal cord stimulation device, to determine whether the spinal cord stimulator device will induce sufficient pain relief to render it medically necessary.

3. **Statement of Policy**
   3.1. The determination of medical necessity for the use of spinal cord stimulators is always made on a case-by-case basis.

   3.2. The use of spinal cord stimulators may be considered medically necessary for a patient with chronic neuropathic pain including, but not limited to:
   - Failed back surgery syndrome with low back pain and radicular pain
   - Complex regional pain syndrome (also known as reflex sympathetic dystrophy)
   - Chronic ischemic limb pain secondary to peripheral vascular disease
   - Post-amputation pain (phantom limb pain)
   - Post-herpetic neuralgia
   - Peripheral neuropathy
   - Pain associated with ischemic cardiac disease
   - Dysestheiasias involving the lower extremities secondary to spinal cord injury.

   3.3 A trial of percutaneous spinal cord stimulation may be considered medically necessary when the following criteria have been met:
   - There is documented pathology (i.e., an objective basis for the pain complaint); and
The patient has demonstrated a sufficient trial of all reasonable treatment options for pain management, which could have provided benefit with a reasonable expectation that the treatment could possibly render the need for the spinal cord stimulator medically unnecessary; and

- The patient has participated in a reasonable trial of aggressive active rehabilitative exercises; and
- The patient has received appropriate psychiatric care and has obtained psychiatric clearance; and
- The patient has predominantly radiating extremity pain with the exception of patients with pain associated with ischemic cardiac disease.

3.4 A subcutaneous spinal cord stimulator is considered medically necessary if the patient met the criteria in section 3.3 and experienced at least a 50% reduction in pain during a three to seven (3-7) day trial of percutaneous spinal cord stimulation.

4. References

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding spinal cord stimulators and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


• NICE (National Institute for Health and Clinical Excellence). Pain (chronic neuropathic or ischaemic) - spinal cord stimulation: final appraisal determination. 01 September 2008.


4.2. Related Triad Medical Policies:

- **TMMP 18 – Medical Necessity**

**CPT Codes**

This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrode array, epidural.</td>
</tr>
<tr>
<td>63661</td>
<td>Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed.</td>
</tr>
<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed.</td>
</tr>
<tr>
<td>63663</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed.</td>
</tr>
<tr>
<td>63664</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) place via laminotomy or laminectomy, including fluoroscopy, when performed.</td>
</tr>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling.</td>
</tr>
<tr>
<td>63688</td>
<td>Revision or removal of implanted spinal neurostimulator pulse generator or receiver.</td>
</tr>
<tr>
<td>95970</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and pulse duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming.</td>
</tr>
<tr>
<td>95971</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and pulse duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generation/transmitter, with intraoperative or subsequent programming.</td>
</tr>
<tr>
<td>95972</td>
<td>Electrode analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and pulse duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generation/transmitter, with intraoperative or subsequent programming.</td>
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</tbody>
</table>
status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements; complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, up to 1 hour.

95973  
Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling impedance and patient compliance measurements); complex spinal cord or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition for code for primary procedure).

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

### Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/20/2015</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Minor change in CPT Code 95972 description: “…with intraoperative or subsequent programming, up to 1 hour.”</td>
</tr>
<tr>
<td>02/19/2014</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>03/03/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>03/27/2012</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Added CPT code table.</td>
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<tr>
<td>03/09/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review: no changes</td>
</tr>
<tr>
<td>03/18/2010</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>02/18/2009</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
</tr>
</tbody>
</table>

Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.