Medical Necessity Guidelines: Spinal Cord Stimulator (SCS) Insertion

Effective: December 16, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products

☒Tufts Health Plan Commercial products; Fax: 617.972.9409

☒Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

To obtain InterQual® SmartSheets™:

- **Tufts Health Plan Commercial Plan products and Tufts Health Freedom Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider website. If you are not a Tufts Health Plan provider please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404.
- **Tufts Health Public Plans products:** InterQual SmartSheet(s) available as part of the prior authorization process.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Tufts Health Plan requires the use of an InterQual SmartSheet to obtain prior authorization for Spinal Cord Stimulator insertion.

Tufts Health Plan may cover dorsal root ganglion stimulation (DRG) when member has confirmed diagnosis of complex regional pain syndrome (CRPS) affecting the trunk and/or limbs **AND** InterQual criteria for Spinal Cord Stimulation Insertion are met.

In order to obtain prior authorization for procedure(s), choose appropriate InterQual SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number listed above, according to Plan.

- **Spinal Cord Stimulator (SCS) Insertion**

LIMITATIONS

The following are noncovered services as they are considered investigational. Refer to Medical Necessity Guidelines: Noncovered Investigational Services:

- Positional adaptive spinal cord stimulation
- Burst -frequency spinal cord stimulation
- Freedom Spinal Cord Stimulator (SCS) System

CODES

PROCEDURES REQUIRING PRIOR AUTHORIZATION:
Tufts Health Plan will be using InterQual SmartSheet(s) for the following procedure code(s).

SPINAL CORD STIMULATOR (SCS) INSERTION/DORSAL ROOT GANGLION STIMULATION

The following CPT code(s) require prior authorization:

Code	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
The following CPT code requires prior authorization only when submitted with listed ICD10 codes applicable to failed back syndrome, chronic regional pain syndrome and refractory angina.	
95972	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements);with complex spinal cord, or peripheral nerve, sacral nerve, neurostimulator pulse generator/transmitter, programming by physician or other qualified health care professional
ICD10	**CODE DESCRIPTION**
Failed back syndrome	
G89.28	Other chronic postprocedural pain
G89.29	Other chronic pain
Complex regional pain syndrome	
G90.511	Complex regional pain syndrome I of right upper limb
G90.512	Complex regional pain syndrome I of left upper limb
G90.513	Complex regional pain syndrome I of upper limb, bilateral
G90.519	Complex regional pain syndrome I of unspecified upper limb
G90.521	Complex regional pain syndrome I of right lower limb
G90.522	Complex regional pain syndrome I of left lower limb
G90.523	Complex regional pain syndrome I of lower limb, bilateral
G90.529	Complex regional pain syndrome I of unspecified lower limb
G90.59	Complex regional pain syndrome I of other specified site
G57.70	Causalgia of unspecified lower limb
G57.71	Causalgia of right lower limb
G57.72	Causalgia of left lower limb
G57.73	Causalgia of bilateral lower limbs
G56.40	Causalgia of unspecified upper limb
G56.41	Causalgia of right upper limb
G56.42	Causalgia of left upper limb
G56.43	Causalgia of bilateral upper limbs
Refractory angina	
I20.8	Other forms of angina pectoris
I20.9	Angina pectoris, unspecified

REFERENCES

1. Hayes, Inc. Spinal Cord Stimulation for Relief of Neuropathic Pain: Hayes Medical Technology Directory; December 21, 2018. Accessed at www.hayesinc.com on December 24, 2018.
2. Dorsal Root Ganglion Stimulation for the Treatment of Complex Regional Pain Syndrome. Hayes inc.com/login [via subscription only]. Published December 12, 2017. Updated April 9, 2020. Accessed November 9, 2020.
3. Levy RM, Mekhail N, Kramer J, Poree L, et. al. Therapy Habituation at 12 Months: Spinal Cord Stimulation Versus Dorsal Root Ganglion Stimulation for Complex Regional Pain Syndrome Type I and II. J Pain. 2020 Mar - Apr;21(3-4):399-408. doi: 10.1016/j.jpain.2019.08.005.
4. Deer TR, Levy RM, Kramer J, et al. Dorsal root ganglion stimulation yielded higher treatment success rate for complex regional pain syndrome and causalgia at 3 and 12 months: a randomized comparative trial. *Pain*. 2017;158(4):669-681. doi:10.1097/j.pain.0000000000000814

APPROVAL HISTORY

September 15, 2006: Reviewed by the Clinical Coverage Criteria Committee. New criteria.

Subsequent endorsement date(s) and changes made:

- April 25, 2007: Reviewed and renewed, without changes
- April 30, 2008: The following CPT Codes were added to the MNG, 95972, 95973
- May 4, 2009: Reviewed and renewed, without changes
- May 2010: Reviewed at MSPAC, no changes
- December 2010: Reviewed at MSPAC, no changes
- December 14, 2011: Reviewed by MSPAC – Integrated Medical Policy Advisory Committee, no changes
- April 11, 2012: Reviewed at IMPAC (Integrated Medical Policy Advisory Committee), changes made to criteria wording; trial requirement clarified
- September 11, 2013: Reviewed by IMPAC, criteria change to InterQual® SmartSheet™ with effective date of April 1, 2014. CPT code 63663 added.
- December 10, 2014: Reviewed by IMPAC, renewed without changes
- January 1, 2015: Instructions for Tufts Health Plan – Network Health products included in this document.
- July 23, 2015: Reviewed by IMPAC, renewed without changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 31, 2015: Coding updated. Per AMA CPT®, effective December 31, 2015 the following code(s) deleted: 95973.
- July 20, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- July 20, 2017: Reviewed by IMPAC. Effective January 1, 2018, CPT code 63655 added.
- October 10, 208: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- November 14, 2018: Reviewed by IMPAC. For effective date April 1, 2019, dorsal root ganglion stimulation is not covered and is added as MNG limitation.
- December 3, 2018: 2018.2 Interqual upgrade for Tufts Health Commercial products including Tufts Health Freedom Plan. Effective December 17, 2018, Interqual upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, Interqual upgrade effective for Tufts Health RITogether.
- December 31, 2018: For effective date January 1, 2019 code description of CPT 95972 updated per AMA CPT®
- April 17, 2019: Reviewed at IMPAC. Effective April 17, 2019, positional adaptive spinal cord stimulation and burst-frequency spinal cord stimulation are not covered as these are considered investigational.
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- January 15, 2020: Reviewed at IMPAC. Effective March 9, 2020 CPT 95972 requires prior authorization only when submitted with ICD10 codes applicable to SCS insertion diagnoses: failed back syndrome, CRPS and refractory angina
- February 19, 2020: Reviewed at IMPAC. Freedom Spinal Cord Stimulator (SCS) System added to limitations section
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 10, 2020: Fax number for Unify updated
- December 16, 2020: Reviewed at IMPAC. Dorsal root ganglion stimulation covered for CRPS diagnosis affecting trunk/limbs when InterQual criteria for SCS insertion are met

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government

agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.