



## Spinal Cord Stimulation

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### A. Documentation Required:

To facilitate the authorization process referral requests must include the following:

1. Documentation of the patient's diagnosis, medical history and physical exam;
2. Documentation of the patient's pain severity and impact on activities of daily living;
3. Documentation of previous treatments including pharmacotherapies, physical therapy and surgeries;
4. Documentation of multidisciplinary pain team evaluation (including physical and psychological evaluation);
5. Documentation from Orthopedic Surgeon, Neurosurgeon, or other applicable specialist including review of diagnostic exams indicating the need for spinal cord stimulator.

### B. Criteria for Medical Necessity:

Requests for a **TEMPORARILY** implanted FDA approved epidural spinal cord stimulator must meet **ALL** the following General Criteria in addition to the condition specific criteria outlined below.

#### General Criteria:

- a. The patient is  $\geq 18$  years of age; **AND**
- b. The patient has chronic (e.g.  $\geq 6$  months except failed back surgery syndrome which is 12 months), intractable pain that interferes with the patient's abilities to perform activities of daily living; **AND**
- c. The patient has undergone psychologic evaluation and all active psychiatric and addiction illnesses are being adequately treated; **AND**
- d. Spinal cord stimulation is a last resort after all other treatment modalities have been tried and failed; **AND**
- e. Patient has undergone a physical evaluation and is deemed a suitable candidate for the placement of a permanent device; **AND**
- f. Patient has a life expectancy of at least 6 months.

**Note:** In certain situations, the 6 months of pain can be waived at the discretion of the Medical Director if there is acute need (e.g., continued hospitalization for severe pain, worsening pain and dysfunction despite multiple treatment modalities). The remainder of the criteria must be met.

#### Condition Specific Criteria:

##### 1. Failed Back Surgery Syndrome (FBSS)

Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. The patient meets **ALL** the general criteria outlined above; **AND**
- b. Chronic, intractable, neuropathic low back pain is of  $\geq 12$  months duration after previous spinal surgery; **AND**
- c. The patient continues to have chronic neuropathic low back pain despite other treatment modalities including **ALL** the following:
  - i) At least 3 trials of pharmacotherapy from at least 3 classes of medications or documented contraindications to drug therapy; **AND**

- ii) Physical Therapy or chiropractor evaluation and treatment; **AND**
- iii) At least 3 months in a multidisciplinary pain management program (including psychological and physical evaluations).

## 2. **Complex Regional Pain Syndrome (CRPS)**

Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. The patient meets **ALL** the general criteria outlined above; **AND**
- b. The patient has a diagnosis of Complex Regional Pain Syndrome (CRPS) with chronic, intractable neuropathic pain of > 6 months duration; **AND**
- c. The patient continues to have chronic neuropathic pain despite other treatment modalities including **ALL** the following:
  - i) At least 3 trials of pharmacotherapy from at least 3 classes of medications or documented contraindication to drug therapy; **AND**
  - ii) Physical Therapy evaluation and treatment; **AND**
  - iii) At least 3 months in a multidisciplinary pain management program (including psychological and physical evaluation); **AND**
- d. Undergone surgical evaluation for alternative treatment considerations.

## 3. **Inoperable chronic ischemic limb pain secondary to peripheral vascular disease (PVD).** Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. Patient meets **ALL** the General Criteria outlined above; **AND**
- b. Patient has chronic, intractable, ischemic limb rest pain of > 6 months duration due to peripheral vascular disease that's been documented by Ankle-Brachial Index (ABI) or angiogram; **AND**
- c. Patient cannot undergo revascularization or revascularization has failed to relieve painful symptoms; **AND**
- d. Patient has failed pharmacotherapy with at least 2 different medications unless there is documented contraindication to drug therapy; **AND**
- e. Patient has failed a supervised walking or exercise program; **AND**
- f. A Vascular surgeon involved in the patient's care has determined that all other reasonable treatment modalities have been tried and failed.

## 4. **Diabetic Peripheral Neuropathy in the lower extremities.** Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. The patient meets **ALL** the General Criteria outlined above; **AND**
- b. Patient has had attempts to optimize diabetes glycemic control through diet and medications; **AND**
- c. The patient continues to have chronic neuropathic pain despite other treatment modalities including at least 3 trials of pharmacotherapy from at least 3 classes of medications including tricyclic antidepressants, serotonin noradrenaline re-uptake inhibitors (SNRI), anticonvulsants, opioids, capsaicin cream, or documented contraindication to drug therapy.

## 5. **Chronic neuropathic pain of certain origins to include phantom limb pain, post herpetic neuralgia (PHN), and intercostal neuralgia.** Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. The patient meets **ALL** the General Criteria outlined above; **AND**

- b. The patient has chronic intractable neuropathic pain of > 6 months duration due to one of the conditions above; **AND**
- c. The patient continues to have chronic neuropathic pain despite other nonsurgical treatment modalities including **BOTH** of the following:
  - i. At least 3 trials of pharmacotherapy from at least 3 classes of medications including NSAIDs, tricyclic antidepressants and anticonvulsant medications used for chronic pain or documented contraindication to drug therapy; **AND**
  - ii. Physical Therapy evaluation and treatment; **AND**.
- d. Patient has undergone careful screening, evaluation and diagnosis by a multidisciplinary pain management team prior to implantation (Note: screening must include psychological as well as physical evaluations); **AND**
- e. There is documented pathology (e.g., an objective basis for the pain complaint).

#### 6. Chronic Angina Resistant to Therapy (CART)

Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. The patient meets **ALL** the General Criteria outlined above; **AND**
- b. Patient has **refractory angina defined as severe angina due to** angiogram- documented coronary artery disease and is not a suitable candidate for revascularization procedures such as coronary artery bypass grafting (CABG) or percutaneous transluminal coronary angioplasty (PTCA); **AND**
- c. Patient has had optimal pharmacotherapy for at least one month. Optimal pharmacotherapy includes the maximal tolerated dosages of at least 2 of the following anti-anginal medications: long-acting nitrates, beta-adrenergic blockers, ranolazine, or calcium channel antagonists; **AND**
- d. Patient's angina pectoris is New York Heart Association (NYHA) Functional Class III (patients are comfortable at rest; less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain) or Class IV (symptoms of cardiac insufficiency or angina are present at rest; symptoms are increased with physical activity); **AND**
- e. Reversible ischemia is documented by symptom-limited treadmill exercise test; **AND**
- f. A Cardiologist involved in the patient's care has determined that all other reasonable treatment modalities have been tried and failed and that the patient is an acceptable candidate for spinal cord stimulator trial/placement.

#### 7. Idiopathic Small Fiber Neuropathy (those cases with no identifiable etiology or alternative treatment).

Spinal Cord Stimulation (SCS) is considered medically necessary when **ALL** the following criteria are met:

- a. The patient meets **ALL** the General Criteria outlined above; **AND**
- b. The patient has chronic intractable neuropathic pain of > 6 months duration; **AND**
- c. Possible treatable etiologies including thyroid disease, vitamin B12 deficiency and paraproteinemia/monoclonal gammopathy have been excluded; **AND**
- d. Skin biopsy of the affected area/limb is diagnostic for small fiber neuropathy; **AND**
- e. The patient continues to have chronic neuropathic pain despite at least 3 trials of pharmacotherapy from at least 3 classes of medications including tricyclic antidepressants, SNRI, Anticonvulsants, topical lidocaine, opioids or documented contraindication to drug therapy; **AND**
- f. Patient has undergone careful screening, evaluation and diagnosis by a multidisciplinary pain team prior to SCS trial (screening must include both psychological and physical evaluations).

**C. A PERMANENTLY** implanted FDA approved epidural spinal cord stimulator is considered medically necessary for the conditions noted in section B1-B7 above when **BOTH** of the following are met:

1. The patient met all the medical necessity criteria for trial of a temporarily implanted epidural spinal cord stimulator; **AND**
2. The patient has undergone a successful 5-day trial of a temporary epidural spinal cord stimulator within the past 3 months with a documented reduction in chronic neuropathic pain of at least 50%.

**D. Indications Considered Experimental, Investigational or not Medically Necessary:** (Not an all-inclusive list)

**Experimental/Investigational:**

- a. Any pain syndrome other than those specifically outlined in the criteria above;
- b. Non-FDA approved devices;
- c. Less than 18 years of age.

**Not Medically Necessary:**

- d. Replacement of an existing, functional spinal cord stimulator device with a High frequency/HD device.
- e. Patient life expectancy of 6 months or less.

**CPT CODES:**

63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

**REFERENCES:**

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Mailis A, Taenzer P. Evidence-based guideline for neuropathic pain interventional treatments: Spinal cord stimulation, intravenous infusions, epidural injections and nerve blocks. Pain Res Manag. 2012;17(3):150-158.

Slangen, Rachel, Schaper, Nicholaas, Faber, Catharina G, et al. Spinal Cord Stimulation and Pain Relief in Painful Diabetic Peripheral Neuropathy: A Prospective Two-Center Randomized Controlled Trial, Diabetes Care 2014; 37: 3016 – 3024.

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Forward Health WI Medicaid; Dorsal Column or Spinal Stimulator Surgeries; Topic #15557 Prior Authorization Guidelines.