



## Peripheral Nerve Stimulation

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P&P # C.5.31

### Policy

The Medical Management Department reviews referral requests for authorization of implanted peripheral nerve stimulation.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

### Procedure

#### **A. Documentation Required:**

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

1. Order from a Pain Management or Physical Medicine and Rehabilitation specialist;
2. Documentation of medical condition causing chronic intractable pain and treatment to date (e.g., analgesics, physical therapy, local injection, surgery);
3. Documentation of prior or current issues with opioid addiction;
4. Documentation of any psychological issues related to peripheral nerve stimulation;
5. Documentation of previous mental health evaluation performed and the lack of an active, uncontrolled psychiatric disorder.
6. Documentation of transcutaneous electrical nerve stimulation treatment.

#### **B. Criteria for Medical Necessity:**

Implantation of an FDA approved peripheral nerve stimulator is considered medically necessary to alleviate chronic intractable neurogenic pain **if ALL** the following criteria are met:

1. Patient has six months of chronic intractable pain, refractory to other methods of treatment (analgesics, physical therapy, local injection, surgery); **AND**
2. Patient does not have current opioid addiction; **AND**
3. No psychological contraindications to peripheral nerve stimulation; **AND**
4. There is objective evidence of pathology (e.g., electromyography); **AND**
5. A one-month trial of transcutaneous electrical nerve stimulation was successful (resulting in at least a 50% reduction in pain) prior to the final implant.

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

1. Patients with active systemic infection.
2. Patients with inadequately controlled psychiatric/psychological problems.
3. Patients who are cognitively unable to participate in their care.

4. Patients with active malignancy who will be receiving chemotherapy and/or radiation therapy for treatment purposes.
5. Occipital Nerve Stimulation for Chronic Cluster Headache and Chronic Migraine Headache.
6. Peripheral nerve stimulation for low back pain.
7. Indication of post-herpetic neuralgia.

**CPT/HCPCS CODES:**

64555	Peripheral nerve (excludes sacral nerve)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8682	Implantable neurostimulator radiofrequency receiver

**References:**

CMS Pub.100-03 National Coverage Determination; Manual Section Number 160.7 Electrical Nerve Stimulators and 160.7.1 Assessing Patients Suitability for Electrical Nerve Stimulation Therapy. Available at [https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=240&ncdver=1&TAId=6&MEDCACId=9&NCAId=55&NcaName=Neuromuscular+Electrical+Stimulation+\(NMES\)+for+Spinal+Cord+Injury&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=STI&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAACAAAA&](https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=240&ncdver=1&TAId=6&MEDCACId=9&NCAId=55&NcaName=Neuromuscular+Electrical+Stimulation+(NMES)+for+Spinal+Cord+Injury&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=STI&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAACAAAA&) Accessed March 8, 2019.

Deer TR, et al. The Neurostimulation Appropriateness Consensus Committee (NACC) Recommendations for Infection Prevention and Management. *Neuromodulation*. 2017; 20:31-50.

Deer TR et al. for the Neuromodulation Appropriateness Consensus Committee. The appropriate use of neurostimulator: new and evolving neurostimulator therapies and applicable treatment for chronic pain and selected disease states. *Neuromodulation Appropriateness Consensus Committee*. *Neuromodulation*. 2014 Aug;17(6):599-615.

Elsabe S, Buchner E, Duarte RV. Complications of Spinal Cord Stimulation and Peripheral Nerve Stimulation Techniques: A Review of the Literature. *Pain Medicine*. 2016;17(2):325-336.

Hayes, Inc. Health Technology Brief. Percutaneous electrical nerve stimulation for treatment of low back pain. Publication date: February 9, 2017. Annual Review January 10, 2019. Accessed March 8, 2019.

Hayes, Inc. Search & Summary. SPRINT PNS System (SPR Therapeutics) for chronic pain. Publication date January 21, 2019. Accessed March 8, 2019.

Stuart, R. Morgan et al. Neurostimulation Techniques for Painful Peripheral Nerve Disorders; *Neurosurgery Clinics*, 2009;20(1):111-120.