Priority Health

MEDICAL POLICY
No. 91635-R0

SPINAL CORD/DORSAL COLUMN AND DORSAL ROOT GANGLION STIMULATION

Effective Date: February 22, 2023	**Review Dates: 2/23, 2/24**
Date Of Origin: February 22, 2023	**Status: Current**

RELATED MEDICAL POLICIES:

For the peripheral nerve stimulation (including transcutaneous electrical nerve stimulators (TENS), percutaneous electrical nerve stimulators (PENS), and implanted peripheral nerve stimulators (PNS), see ***Priority Health Medical Policy No. 91634 – Peripheral Nerve Stimulation.***

For hypoglossal nerve and other stimulation for the treatment of obstructive sleep apnea, see ***Priority Health Medical Policy No. 91333 – Obstructive Sleep Apnea.***

For gastric pacing (gastric pacemaker) and gastric electrical stimulation for treatment of gastroparesis, see ***Priority Health Medical Policy No. 91572 – Gastroparesis Testing and Treatment.***

For transcranial magnetic stimulation for treatment of depression, see ***Priority Health Medical Policy No. 91563 – Transcranial Magnetic Stimulation for Depression.***

For transcutaneous electrical acupoint stimulation for treatment of hyperemesis gravidarum, see ***Priority Health Medical Policy No. 91576 – Transcutaneous Electrical Acustimulation (TEAS) for Hyperemesis Gravidarum.***

For all other stimulation therapies and devices, see ***Priority Health Medical Policy No. 91468 – Stimulation Therapy and Devices.***

I. POLICY/CRITERIA

A. Spinal cord/dorsal column: Priority Health may consider spinal cord or dorsal column stimulator insertion medically necessary when applicable **InterQual®** criteria are met for the following indications:

- Complex regional pain syndrome (CRPS)
- Failed back surgery syndrome

B. Dorsal root ganglion: Priority Health may consider dorsal root ganglion stimulator insertion medically necessary when applicable **InterQual®** criteria are met.

C. Exclusions:

- Dorsal column stimulation for the management of chronic malignant pain

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the***

Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IV. BACKGROUND

Spinal cord/dorsal column stimulation/stimulators. Spinal cord stimulation (SCS), dorsal column stimulation (DCS), also known as neuromodulation, 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 from the dorsal horn of the spinal cord at a subjectively comfortable level, overlapping an individual's topography of pain.

The procedure initially involves a short-term trial (i.e., greater than 48 hours) of percutaneous (temporary) spinal cord stimulation, prior to the subcutaneous (permanent) 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.

Dorsal root ganglion stimulation/stimulators. Dorsal root ganglion (DRG) stimulation is an emerging method of treatment for neuropathic pain. With DRG stimulation leads are placed percutaneously into the epidural space under fluoroscopic guidance directly over the targeted dorsal root ganglion within the lumbar or sacral region of the spine.

Patients should be considered non-responders to conservative treatment modalities (e.g., pharmacological, physical, psychological) prior to considering spinal cord stimulation (SCS).

InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have

been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders. (Source: Change Healthcare LLC)

V. CODING INFORMATION

ICD-10 Codes that may apply:

G54.1	Lumbosacral plexus disorders
G54.9	Nerve root and plexus disorder, unspecified
G56.40 – G56.42	Causalgia of upper limb
G56.80 – G56.92	Mononeuropathies of upper limb
G57.70 – G57.92	Mononeuropathies of lower limb
G89.0	Central pain syndrome
G89.29	Other chronic pain
G89.4	Chronic pain syndrome
G90.511 –	Complex regional pain syndrome
I20.1 – 120.9	Angina pectoris
I25.111 - I25.119	Atherosclerotic heart disease with angina pectoris
I25.701 – I25.799	Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris
M51.14 – M51.17	Intervertebral disc disorder with radiculopathy
M54.10 – M54.18	Radiculopathy
M96.1	Post laminectomy syndrome, not elsewhere classified

CPT/HCPCS Codes:

63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural *(DCS/SCS only)*
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed ***(No Auth)***
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed ***(No Auth)***
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed ***(No Auth)***
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed ***(No Auth)***
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver (*DCS/SCS only)*
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array ***(No Auth)***

95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming ***(No Auth)***
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional ***(No Auth)***
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional ***(No Auth)***

C1767	Generator, neurostimulator (implantable), nonrechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
C1883	Adapter/ extension, pacing lead or neurostimulator lead
C1897	Lead, neurostimulator 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
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator

(L codes not separately paid under APC payment arrangements)

VI. REFERENCES

1. Musculoskeletal Spinal Cord and Dorsal Root Ganglion Stimulation. Cigna Medical Coverage Policy/eviCore healthcare CMM-211.
2. Deer TR, 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 Apr;158(4):669-681.
3. Kapural L, Yu C, Doust MW, et.al. Novel 10-kHz High-frequency Therapy (HF10 Therapy) Is Superior to Traditional Low-frequency Spinal Cord Stimulation for the Treatment of Chronic Back and Leg Pain: The SENZA-RCT Randomized Controlled Trial. *Anesthesiology*. 2015 Oct;123(4):851-60.
4. Hayes, Inc. Spinal Cord Stimulation for Relief of Neuropathic Pain. August 2013
5. Hayes, Inc. Spinal Cord Stimulation for the Treatment of Intractable Angina Pectoris", Updated Search August 2002.
6. Hayes, Inc. Spinal Cord Stimulation for the Treatment of Pain, September 2000
7. Spinal Cord Stimulator (SCS) Insertion. InterQual® CP: Procedures Subset.