REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Policy Name		Policy Number	Effective Date
Implantable Spinal Cord Stimulator		PY-1074	10/01/2020
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Implantable Spinal Cord Stimulator

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Nearly 84% of adults experience back pain during their lifetime. Long term outcomes are largely favorable for most patients, but a small percentage of patient's symptoms are categorized as chronic. Chronic pain is defined by the International Association for the Study of Pain as: "pain that persists beyond normal tissue healing time, which is assumed to be three months".

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

C. Definitions

- **Implantable Spinal Cord Stimulator** - Spinal cord (dorsal column) stimulation (SCS) is a pain relief technique that delivers a low-voltage electrical current to the spinal cord to block the sensation of pain.

D. Policy

I. Implantable Spinal Cord Stimulator
   A. Prior authorization (PA) is required for all implantable spinal cord stimulators, including short-term trial placement and permanent placement.
      1. Prior authorizations are not required for the following services:
         a. Removal/revision of implanted device
         b. Electronic analysis/studies post implantation
   B. Short term and permanent Implantable Spinal Cord Stimulators are considered

medically necessary according to the criteria found in the Implantable Spinal Cord Stimulator Medical policy MM-0076.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

Implantable Spinal Cord Stimulator MM-0076

G. Review/Revision History

	DATE	ACTION
Date Issued	07/26/2016	
Date Revised	05/13/2020	Added Codes: L8682
Date Effective	10/01/2020	
Date Archived		

H. References

1. CMS Physician's Fee Schedule. Retrieved on April 22, 2020 from www.cms.gov
2. CMS Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule. Retreived on March 4, 2020 from www.cms.gov

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

IN-MCD-P-165112 Date Issued 07/26/2016 OMPP Approved 07/15/2020