REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Implantable Spinal Cord Stimulator		PY-1076	01/01/2021-05/31/2021
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.

Table of Contents

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, permanent placement and removal and revision of the implanted device.
      1. Prior authorizations for implantable spinal cord stimulator services are not required for the following:
         a. Implantable device and device components are considered part of the procedure and does not require a separate PA.

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.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

Implantable Spinal Cord Stimulator Codes	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs

95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower
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
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
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
L8679	Implantable neurostimulator, pulse generator, any type
L8682	Implantable neurostimulator radiofrequency receiver
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code
C1767	Generator, neurostimulator (implantable), nonrechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1816	Receiver and/or transmitter, neurostimulator (implantable)
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
C1823	External recharging system for battery (external) for use with implantable neurostimulator, replacement only
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)

C1897	Lead, neurostimulator test kit (implantable)

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 08/26/2020	Added Codes: L8682 PA is now required for removal/revision of the device.
Date Effective	01/01/2021	
Date Archived	05/31/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

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.