COVERAGE RATIONALE

Implanted electrical stimulators for spinal cord, including high-frequency dorsal column stimulators (also known as BurstDR spinal cord stimulators), are proven and medically necessary.


Click here to view the MCG™ Care Guidelines.

Note:
- Coverage of a replacement battery/generator for a previously implanted electrical stimulator is appropriate when the individual’s existing battery/generator is malfunctioning, cannot be repaired, and is no longer under warranty.
- For Dorsal Root Ganglion (DRG) stimulation, please refer to the Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

DOCUMENTATION REQUIREMENTS

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT/HCPCS Codes* | Required Clinical Information
--- | ---
63650 | Medical notes documenting all of the following:
63655 | - Specific device to be implanted including all documentation
63661 | - Indicate if this request is for a trial or permanent placement
63662 | - Physician office notes including:
63663 |   - Condition requiring procedure
63664 |   - Physical examination
63685 |   - Treatments tried and failed including:
63688 |     - Spine surgery
63688 |     - Physical therapy
L8680 |     - Medications
L8682 |     - Injections
L8685 |   - Documentation of psychological evaluation
L8686 |   - For permanent placement, include documentation of pain relief with temporary implant
CPT/HCPCS Codes* | Required Clinical Information
---|---
### Implantable Electrical Stimulator for Spinal Cord

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8687</td>
<td>Physician Plan of Care</td>
</tr>
<tr>
<td>L8688</td>
<td></td>
</tr>
</tbody>
</table>

**For Revision or Removal**

- Specific device to be implanted including all documentation
- Indicate if this request is for a trial or permanent placement
- Physician office notes including:
  - Condition requiring procedure
  - Physical examination
  - Treatments tried and failed including:
    - Spine surgery
    - Physical therapy
    - Medications
    - Injections
- Documentation of psychological evaluation
- Documentation that device has failed and cannot be modified and or repaired
- For permanent placement, include documentation of pain relief with prior implant
- Physician Plan of Care

*For code descriptions, see the Applicable Codes section.*

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrode array, epidural</td>
</tr>
<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural</td>
</tr>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>63688</td>
<td>Revision or removal of implanted spinal neurostimulator pulse generator or receiver</td>
</tr>
</tbody>
</table>

*CPT® is a registered trademark of the American Medical Association*

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1767</td>
<td>Generator, neurostimulator (implantable), nonrechargeable</td>
</tr>
<tr>
<td>C1778</td>
<td>Lead, neurostimulator (implantable)</td>
</tr>
<tr>
<td>C1816</td>
<td>Receiver and/or transmitter, neurostimulator (implantable)</td>
</tr>
<tr>
<td>C1820</td>
<td>Generator, neurostimulator (implantable), with rechargeable battery and charging system</td>
</tr>
<tr>
<td>C1822</td>
<td>Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system</td>
</tr>
<tr>
<td>C1823</td>
<td>Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads</td>
</tr>
<tr>
<td>C1883</td>
<td>Adaptor/extension, pacing lead or neurostimulator lead (implantable)</td>
</tr>
<tr>
<td>C1897</td>
<td>Lead, neurostimulator test kit (implantable)</td>
</tr>
<tr>
<td>L8679</td>
<td>Implantable neurostimulator, pulse generator, any type</td>
</tr>
<tr>
<td>L8680</td>
<td>Implantable neurostimulator electrode, each</td>
</tr>
<tr>
<td>L8682</td>
<td>Implantable neurostimulator radiofrequency receiver</td>
</tr>
<tr>
<td>L8685</td>
<td>Implantable neurostimulator pulse generator, single array, rechargeable, includes extension</td>
</tr>
<tr>
<td>L8686</td>
<td>Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension</td>
</tr>
</tbody>
</table>
**HCPCS Code | Description**
---|---
L8687 | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688 | Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension
L8695 | External recharging system for battery (external) for use with implantable neurostimulator, replacement only

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Totally implantable spinal cord stimulation systems for pain relief are regulated by the FDA as Class III devices and are approved through the Premarket Approval (PMA) process. See the following website for more information (use product code LGW): [http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm). (Accessed January 19, 2020)

**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Medicare covers implantable electrical stimulators for the spinal cord when coverage criteria are met. Refer to the National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7). Local Coverage Determinations (LCDs) exist; see the LCDs for Spinal Cord Stimulation (Dorsal Column Stimulation) and Spinal Cord Stimulators for Chronic Pain.

Medicare does not have an NCD specifically for high-frequency dorsal column stimulators with BurstDR™ stimulation technology. LCDs that specifically address BurstDR™ stimulation technology do not exist at this time. (Accessed January 21, 2020)

**POLICY HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
</table>
| 04/01/2020 | **Coverage Rationale**  
**Supporting Information**  
- Archived previous policy version 2019T0567M |

**INSTRUCTIONS FOR USE**

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.