

Implanted Electrical Stimulator for Spinal Cord (for Ohio Only)

Policy Number: CS061OH.R – P
Effective Date: February 1, 2023

[➔ Instructions for Use](#)

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Related Policies
• Bariatric Surgery (for Ohio Only)
• Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Ohio Only)
• Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Ohio Only)
• Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for Ohio Only)

Application

This Medical Policy only applies to the state of Ohio.

Coverage Rationale

Implanted electrical spinal cord stimulators, including high-frequency spinal cord stimulators and burst spinal cord stimulators, are proven and medically necessary for treating the following indications:

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

Implanted electrical spinal cord stimulators are unproven and not medically necessary for treating the following indications:

- Diabetic neuropathy
- Refractory angina pectoris

For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Spinal Cord Stimulator (SCS) Insertion.

Click [here](#) to view the InterQual® criteria.

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, refer to the Medical Policy titled [Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation \(for Ohio Only\)](#).

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 federal, state, or contractual requirements 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 Guidelines may apply.

CPT Code	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
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

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HCPCS Code	Description
C1767	Generator, neurostimulator (implantable), nonrechargeable
C1778	Lead, neurostimulator (implantable)
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	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
C1897	Lead, neurostimulator test kit (implantable)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8682	Implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
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>. (Accessed May 12, 2021)

Policy History/Revision Information

Date	Summary of Changes
02/01/2023	<ul style="list-style-type: none">Created state-specific policy version
08/01/2021	<p>Coverage Rationale</p> <ul style="list-style-type: none">Replaced references to “implanted electrical stimulators <i>for spinal cord</i>” with “implanted electrical <i>spinal cord</i> stimulators”Replaced language indicating “implanted electrical stimulators for spinal cord, including high-frequency <i>dorsal column</i> stimulators (<i>also known as BurstDR</i> spinal cord stimulators), are proven and medically necessary for treating the [listed] indications” with “implanted electrical spinal cord stimulators, including high-frequency spinal cord stimulators <i>and burst</i> spinal cord stimulators, are proven and medically necessary for treating the [listed] indications” <p>Supporting Information</p> <ul style="list-style-type: none">Archived previous policy version CS061.Q

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. The 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.