Implanted Electrical Stimulator for Spinal Cord (for Tennessee Only)

Policy Number: CS061TN.P
Effective Date: July 1, 2021

Instructions for Use

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Related Community Plan Policies

- Bariatric Surgery (for Tennessee Only)
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Commercial Policy

- Implanted Electrical Stimulator for Spinal Cord

Medicare Advantage Coverage Summary

- Stimulators: Electrical and Spinal Cord Stimulators

Application

This Medical Policy applies to Medicaid only plans in the state of Tennessee.

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. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, 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, please refer to the Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Tennessee 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 January 19, 2020)

Policy History/Revision Information

Date	Summary of Changes
07/01/2021	Coverage Rationale • Replaced reference to "InterQual® 2020" with "InterQual® 2021" Supporting Information • Archived previous policy version CS061TN.O

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.