# IMPLANTED ELECTRICAL STIMULATOR FOR SPINAL CORD

**Policy Number**: PAIN 022.12 T2 **Effective Date**: January 1, 2019

Instructions for Use

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**Related Policies**

- Bariatric Surgery
- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
- Gastrointestinal Motility Disorders, Diagnosis and Treatment
- Occipital Neuralgia and Headache Treatment

## CONDITIONS OF COVERAGE

| | |
|---|---|
| Applicable Lines of Business/Products | This policy applies to Oxford Commercial plan membership. |
| Benefit Type | General Benefits Package |
| Referral Required<br>(Does not apply to non-gatekeeper products) | No |
| Authorization Required<br>(Precertification always required for inpatient admission) | Yes |
| Precertification with Medical Director Review Required | No |
| Applicable Site(s) of Service<br>(If site of service is not listed, Medical Director review is required) | Inpatient, Outpatient |

## 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, see MCG™ Care Guidelines, 22nd edition, 2018, Implanted Electrical Stimulator, Spinal Cord ACG: A-0243 (AC).

**Notes:**

- 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 policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

## 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 may apply.

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

| CPT Code | Description |
|---|---|
| 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 |
| 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)

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 August 21, 2018)

## POLICY HISTORY/REVISION INFORMATION

| Date | Action/Description |
|---|---|
| 01/01/2019 | • Reorganized policy template:<br>  ○ Simplified and relocated *Instructions for Use*<br>  ○ Removed *Benefit Considerations* section<br>• Revised coverage rationale:<br>  ○ Replaced language indicating "implanted electrical stimulator for spinal cord is proven *and/or* medically necessary *in certain circumstances*" with "implanted electrical stimulators for spinal cord*, including high-frequency dorsal column stimulators (also known as BurstDR spinal cord stimulators),* are proven *and* medically necessary"<br>  ○ Modified language to clarify the listed MCG™ Care Guidelines should be referenced for *medical necessity* clinical coverage criteria<br>  ○ Added notation to indicate 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<br>• Updated list of applicable CPT codes; added 63688<br>• Archived previous policy version PAIN 022.11 T2 |

## INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical 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.