IMPLANTED ELECTRICAL STIMULATOR FOR SPINAL CORD

Policy Number: PAIN 022.13 T2  
Effective Date: April 1, 2019

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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

(Does not apply to non-gatekeeper products)

No

Authorization Required

(Precertification always required for inpatient admission)

Yes

Precertification with Medical Director Review Required

No

Applicable Site(s) of Service

(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, 23rd edition, 2019, 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.

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.

Required Clinical Information

Implanted Electrical Stimulator for Spinal Cord

Medical notes documenting all of the following:

- Specific device to be implanted including all documentation
- Indicate if this request is for a trial or permanent placement
- Physician office notes including:
**Required Clinical Information**

### Implantated Electrical Stimulator for Spinal Cord

- Condition requiring procedure
- Physical examination
- Treatments tried and failed including:
  - Spine surgery
  - Physical therapy
  - Medications
  - Injections
- Documentation of psychological evaluation
- For permanent placement, include documentation of pain relief with temporary implant
- Physician Plan of Care

### 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

### 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<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>
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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<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), non-rechargeable, 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>
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*CPT® is a registered trademark of the American Medical Association*
HCPCS Code | Description
--- | ---
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](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm). (Accessed January 3, 2019)

**POLICY HISTORY/REVISION INFORMATION**

<table>
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<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>08/01/2019</td>
<td><strong>Template Update</strong></td>
</tr>
<tr>
<td></td>
<td>• Added Documentation Requirements section</td>
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<tr>
<td>04/01/2019</td>
<td>• Revised coverage rationale:</td>
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<tr>
<td></td>
<td>○ Replaced reference to “MCG™ Care Guidelines, 22nd edition, 2018” with “MCG™ Care Guidelines, 23rd edition, 2019”; refer to 23rd edition for complete details on applicable updates to the MCG™ Care Guidelines</td>
</tr>
<tr>
<td></td>
<td>• Updated list of applicable HCPCS codes; added C1823</td>
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<td>• Archived previous policy version PAIN 022.12 T2</td>
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**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.