Implanted Electrical Stimulator for Spinal Cord

Guideline Number: MMG064.L
Effective Date: April 1, 2020

Instructions for Use

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Related Medical Management Guidelines

- Bariatric Surgery
- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
- Gastrointestinal Motility Disorders, Diagnosis and Treatment
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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, 24th edition, 2020, Implanted Electrical Stimulator, Spinal Cord ACG: A-0243 (AC)

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 Management Guideline 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:
  ○ Condition requiring procedure
  ○ Physical examination
  ○ Treatments tried and failed including:
  ▪ Spine surgery
  ▪ Physical therapy

Required Clinical Information
Implanted Electrical Stimulator for Spinal Cord

- 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 guideline 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 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

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)

HCPCS Code	Description
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, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, 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 January 19, 2020)

Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	Template Update • Reformatted policy; transferred content to new template
04/01/2020	Coverage Rationale • Replaced reference to "MCG™ Care Guidelines, *23rd* edition*, 2019*" with "MCG™ Care Guidelines, *24th* edition*, 2020*" Supporting Information • Archived previous policy version MMG064.K

Instructions for Use

This Medical Management Guideline 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 guideline, 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 Management Guideline is provided for informational purposes. It does not constitute medical advice.

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

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.