Instructions for use
The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT® five digit codes, nomenclature and other data are copyright 2015 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in the CPT® book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.

©Copyright 2015 eviCore healthcare
CMM-211~Spinal Cord Stimulators

CMM-211.1 Definitions

Spinal cord stimulation, also known as dorsal column stimulation, is a reversible therapy applied for neuropathic pain with techniques that include multi-output implanted pulse generators and a choice of electrodes, some of which can be placed percutaneously. The technical goal of this therapy is to achieve stimulation of paresthesia of spinal nerve root(s) at a subjectively comfortable level, overlapping an individual’s topography of pain. The procedure initially involves a short-term, trial (e.g., three to seven [3–7] days) of percutaneous (temporary) spinal cord stimulation, prior to the subcutaneous (permanent) implantation of the spinal cord stimulation device, to determine whether the spinal cord stimulator device will induce sufficient pain relief to render it medically necessary.

CMM-211.2 Indications and Non-Indications

Dorsal Column Spinal Cord Stimulator

A dorsal column spinal cord stimulator (SCS) with up to two leads and no more than a total of 16 contact/electrodes is considered medically necessary for any of the indications listed below when the associated criteria are met:

✓ A short-term trial (e.g., three to seven [3–7] days) of a dorsal column spinal cord stimulator (SCS) is considered medically necessary for the treatment of chronic, intractable pain secondary to EITHER of the following indications:

• Failed back syndrome (FBS) with intractable neuropathic leg pain
• Complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy (RSD)

And when ALL of the following criteria are met:

• Failure of at least six consecutive months of physician-supervised conservative medical management (e.g., pharmacotherapy, physical therapy, cognitive therapy, and activity lifestyle modification)
• Surgical intervention is not indicated
• An evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug
dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement.

✓ Permanent implantation of a dorsal column spinal cord stimulator (SCS) is considered medically necessary for the treatment of chronic, intractable pain secondary to EITHER of the following indications:

- Failed back syndrome (FBS) with intractable neuropathic leg pain
- Complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy (RSD)

**And when ALL of the following criteria are met:**

- Failure of at least six consecutive months of physician-supervised conservative medical management (e.g., pharmacotherapy, physical therapy, cognitive therapy, activity lifestyle modification)
- Surgical intervention is not indicated
- An evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement
- At least a 50% reduction in pain has been demonstrated during a short-term trial of SCS.

**Chronic Critical Limb Ischemia (CLI)**

✓ A short-term trial (e.g., three to seven [3–7] days) of a dorsal column spinal cord stimulator (SCS) is considered medically necessary for the treatment of chronic, intractable pain secondary to chronic critical limb ischemia (CLI) when BOTH of the following criteria are met:

- Failure of available conventional multidisciplinary medical (e.g., pharmacological, physical therapy) and surgical management (e.g., revascularization)
- An evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement.
Permanent implantation of a dorsal column spinal cord stimulator (SCS) is considered medically necessary for the treatment of chronic, intractable pain secondary to chronic critical limb ischemia (CLI) when all of the following criteria are met:

- Failure of available conventional multidisciplinary medical (e.g., pharmacological, physical therapy) and surgical management (e.g., revascularization)
- An evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement
- Beneficial clinical response from a temporarily implanted electrode has been demonstrated prior to consideration of permanent implantation.

**Chronic Stable Angina Pectoris**

A short-term trial (e.g., three to seven [3–7] days) of a dorsal column spinal cord stimulator (SCS) is considered medically necessary for the treatment of chronic, intractable pain secondary to chronic stable angina pectoris as medically necessary for myocardial ischemia when all of the following criteria are met:

- angina pectoris is Canadian Cardiovascular Society (CCS) functional class III or class IV (see Appendix A)
- individual has documented significant coronary artery disease (CAD) and is not a suitable candidate for a revascularization procedure
- optimal pharmacological treatment using anti-anginal medications (e.g., long-acting nitrates, beta-adrenergic blockers, or calcium-channel antagonists) has failed to adequately improve anginal symptoms
- an evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement.

Permanent implantation of a dorsal column spinal cord stimulator (SCS) is considered medically necessary for the treatment of chronic, intractable pain secondary to chronic stable angina pectoris as medically necessary for myocardial ischemia when all of the following criteria are met:
• Angina pectoris is Canadian Cardiovascular Society (CCS) functional class III or class IV (see Appendix A)
• The individual has documented significant coronary artery disease (CAD) and is not a suitable candidate for a revascularization procedure
• Optimal pharmacological treatment using anti-angina medications (e.g., long-acting nitrates, beta-adrenergic blockers, or calcium-channel antagonists) has failed to adequately improve anginal symptoms
• An evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement
• Beneficial clinical response from a temporarily implanted electrode has been demonstrated prior to consideration of permanent implantation.

**Dorsal Column Spinal Cord Stimulator Replacement**

✓ The replacement of a dorsal column spinal cord stimulator (SCS) and/or battery/generator is considered medically necessary for an individual who meets ALL of the above criteria and the existing stimulator and/or battery/generator replacement are/is no longer under warranty and cannot be repaired.

**Dorsal Column Spinal Cord Stimulator Not Covered Services**

✓ A dorsal column spinal cord stimulator (SCS) is considered experimental, investigational or unproven for any other indication including but not limited to:
  o Post-amputation pain (phantom limb pain)
  o Post-herpetic neuralgia
  o Peripheral neuropathy
  o Dysesthesias involving the lower extremities secondary to spinal cord injury.

✓ Implantation of a dorsal column spinal cord stimulator (SCS) with more than two leads and/or more than a total of 16 contacts/electrodes is considered experimental, investigational or unproven for any indication.

**Implanted Peripheral Nerve Stimulation**

✓ Implantation of a peripheral nerve stimulator for any indication, including chronic pain, is considered experimental, investigational or unproven.
# Appendix A

## New York Heart Association and Canadian Cardiovascular Society Functional Classifications

<table>
<thead>
<tr>
<th>Class</th>
<th>New York Heart Association Functional Classification</th>
<th>Canadian Cardiovascular Society Functional Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.</td>
<td>Ordinary physical activity does not cause angina, such as walking and climbing stairs. Angina occurs with strenuous or rapid or prolonged exertion at work or recreation.</td>
</tr>
<tr>
<td>II</td>
<td>Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.</td>
<td>Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or under emotional stress, or only during the few hours after awakening. Walking more than two blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.</td>
</tr>
<tr>
<td>III</td>
<td>Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.</td>
<td>Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing one flight in normal conditions and at a normal pace.</td>
</tr>
<tr>
<td>IV</td>
<td>Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.</td>
<td>Inability to carry on any physical activity without discomfort—anginal syndrome may be present at rest.</td>
</tr>
</tbody>
</table>

(Heart Failure Society of America [HFSA], 2006; Gibbons, et al., 2002; American Heart Association [AHA], 1994; Canadian Cardiovascular Society [CCS], 1976).
### CMM-211.4 Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<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>63661</td>
<td>Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63663</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63664</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) place via laminectomy, including fluoroscopy, when performed</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>
</tr>
<tr>
<td>95970</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse, amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming</td>
</tr>
<tr>
<td>95971</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurement(s); simple spinal cord, or peripheral (i.e., peripheral nerve, automatic nerve, neuromuscular) neurostimulator pulse generation/transmitter, with intraoperative or subsequent programming</td>
</tr>
<tr>
<td>95972</td>
<td>Electrode analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurement(s); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.
CMM-211.5 References


