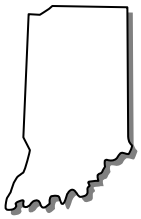

PROVIDER BULLETIN

BT200828 JUNE 12, 2008

To: All Providers

Subject: Prior Authorization Criteria for Spinal Cord Stimulators

Overview

This bulletin announces changes to the Indiana Health Coverage Programs (IHCP) billing requirements and prior authorization (PA) criteria for spinal cord stimulators (SCS). SCS is used to treat chronic pain syndromes intractable to other treatment modalities. SCS is frequently used to treat failed back surgery, complex regional pain syndromes, peripheral neuropathies, angina, peripheral vascular disease, post-herpetic neuralgia, occipital neuralgia, and chronic pelvic pain. This treatment is considered a last resort for individuals who have failed other treatment options for the management of intractable, chronic pain. SCS is a covered service for all IHCP programs.

Spinal Cord Stimulation Prior Authorization Criteria

SCS treatment must be evaluated in a three- or seven-day trial stimulation period prior to permanent implantation. Providers must request PA for both the trial and permanent phases of this service. The IHCP will only cover SCS services with the appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes listed in Table 1, the Current Procedural Terminology (CPT[1]) codes listed in Table 2, and the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 3. All other diagnoses of chronic, non-malignant, neuropathic pain will be considered for approval on a case-by-case basis by a pain management consultant if all other PA criteria are met.

Three- to Seven-Day Trial Stimulation Period

The first phase of SCS must be evaluated prior to a permanent SCS implantation. Providers must meet the following criteria for the three- to seven-day trial stimulation period:

1. The implantation of the stimulator is used only as a treatment of last resort for patients with chronic intractable, non-malignant pain.
2. There must be documentation of failure of at least six months of conservative treatment, including at least three of the following therapies: pharmacological, surgical, physical, and psychological.

1 Current Procedural Terminology (CPT) is copyright 2007 American Medical Association. All Rights Reserved.

3. The member must not be a candidate for further surgical interventions.
4. An evaluation must be performed by a physician experienced in treating chronic pain, which includes documentation of a psychological evaluation, as well as a consultation from another pain specialist, that indicates the member would benefit from SCS.
5. The member must not have any existing, untreated drug addictions.

Permanent SCS Implantation

Following the trial stimulation period, PA will be approved for permanent implantation after the following criteria have been met. These criteria meet medical necessity for permanent implantation:

1. All five criteria for a three- to seven-day trial implantation period must be met.
2. Once the trial implantation has been performed, providers must submit documentation of successful treatment showing a 50 percent reduction in pain for at least two days to receive approval for permanent implantation.

IHCP providers are directed to use the Multidimensional Affect and Pain Scale, the Brief Pain Inventory, and/or the Faces Pain Scale to measure pain levels. Providers are responsible for deciding which pain measurement scale is appropriate for each member.

Table 1 – Recommended ICD-9 CM Diagnosis Codes for SCS

Diagnosis Code	Description
036.0	Meningococcal meningitis
250.6x	Diabetes with neurological manifestations
337.2x	Reflex sympathetic dystrophy
353.0	Brachial plexus lesions
353.1	Lumbosacral plexus lesions
353.6	Phantom limb (syndrome)
353.8	Other nerve root and plexus disorders
353.9	Unspecified nerve root and plexus disorder
354.4	Causalgia of upper limb
354.8	Other mononeuritis of upper limb
354.9	Mononeuritis of upper limb, unspecified
355.71	Causalgia of lower limb
355.79	Other mononeurits of lower limb
355.8	Mononeuritis of lower limb, unspecified
413.9	Other and unspecified angina pectoris
440.22	Atherosclerosis of the extremities with rest pain
443.9	Peripheral vascular disease, unspecified
722.81	Postlaminectomy syndrome, cervical region
722.82	Postlaminectomy syndrome, thoracic region

Diagnosis Code	Description
722.83	Postlaminectomy syndrome, lumbar region
723.4	Brachial neuritis or radiculitis NOS
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.9	Other unspecified back disorders
952.xx	Spinal cord injury without evidence of spinal bone injury
953.x	Injury to nerve roots and spinal plexus

Table 2 – CPT codes for SCS

CPT Code	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
95970	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 heritor/transmitter, with reprogramming
95971	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 spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
95972	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); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour
95973	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); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)

Table 3-HCPCS Codes for Spinal Cord Stimulation Equipment

HCPCS Code	Description
L8680	Implantable neurostimulator electrode, each
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, non-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

Intractable Angina

The IHCP also covers SCS for the treatment of intractable angina, for members who are not surgical candidates and whose pain is unresponsive to standard therapy. This treatment also requires PA. Providers are instructed to use the appropriate ICD-9-CM diagnosis codes in Table 1 and the CPT and HCPCS codes in Tables 2 and 3. The following criteria must be met for the treatment of intractable angina:

1. Angiography documents significant coronary artery disease and the patient is not a candidate for precutaneous transluminal coronary angiography (PTCA) or coronary artery bypass grafting (CABG).
2. The angina pectoris is New York Heart Association Functional Class III or IV.
3. Reversible ischemia is documented by symptom-limited treadmill exercise tests.
4. The member has had optimal pharmacotherapy for at least one month. Optimal pharmacotherapy includes the maximum tolerated doses of at least two of the following medications: long-acting nitrates, beta-adrenergic blockers, or calcium channel blockers.
5. There is documentation of successful trial spinal cord stimulator implantation showing a 50 percent reduction in pain for at least two days.

Billing Requirements

Following PA approval, providers must bill using the appropriate ICD-9-CM, CPT, and HCPCS codes for SCS services. Effective January 1, 2006, separate outpatient reimbursement for the SCS implantable device is covered.

Please refer to Table 3 for the spinal cord stimulation equipment effective January 1, 2006. Providers are reminded that separate outpatient reimbursement is also subject to medical necessity and PA guidelines.