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1.0 Description of the Procedure, Product, or Service

Spinal cord stimulation (SCS), also known as a dorsal column stimulator, is an implantable medical device used to treat chronic intractable neuropathic pain. A small wire (called a lead) connected to a power source is surgically implanted under the skin. Low-level electrical signals are then transmitted through the lead to the spinal cord or to specific nerves to block pain signals from reaching the brain. Using a remote control, a patient can turn the current on and off, or adjust the intensity. The sensations, or paresthesias, derived from the stimulator are different for everyone. Most patients describe it as a pleasant tingling sensation, subsequently altering the perception of pain and providing analgesia.

Implantation of the spinal cord stimulator is typically a two-step process. Initially, the electrode is temporarily implanted in the epidural space, allowing a trial period of stimulation. Once treatment effectiveness is confirmed, defined as at least 50% reduction in pain, the electrodes and radio receiver/transducer are permanently implanted. This is a reversible therapy and results in no intended neuroablation, or nerve destruction.

When covered, SCS must be provided using an FDA-approved device for FDA-approved indications.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

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EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.

b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide,* sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/basicmed/

EPSDT provider page: http://www.ncdhhs.gov/dma/provider/epsdt/

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Permanent placement of a spinal cord stimulator for intractable pain is covered when all of the following criteria are met:

a. The recipient has a diagnosis of severe and intractable chronic pain (greater than 6 months' duration) of the trunk or limbs, other than critical limb ischemia, that is refractory to all other pain therapies.
b. The recipient has undergone careful screening, evaluation, and diagnosis prior to implantation. This includes psychological evaluation.
c. The treatment is used only as a last resort; other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and failed or have been judged to be unsuitable or contraindicated for the recipient.
d. The recipient has demonstrated pain relief of at least 50% improvement with a temporarily (minimum 48 hours) implanted electrode that preceded permanent implantation.
e. The facilities, equipment, and professional and support personnel required are available for the proper treatment, training, and follow-up of the recipient.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

N.C. Medicaid does not cover procedures, products, and services related to this policy when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
c. the procedure, product, or service duplicates another provider's procedure; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

SCS is not covered and may be considered investigational for all other indications, including treatment of the following:

a. Critical limb ischemia as a technique to forestall amputation
b. Visceral pain
c. Drug-refractory chronic cluster headaches
d. Nociceptive pain (resulting from irritation, not damage to the nerves)

e. Central deafferentation pain (related to central nervous system damage from a stroke or spinal cord injury)
f. Pregnant recipients
g. Chronic refractory angina pectoris

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is required for both the trial and the permanent SCS. Refer to the Basic Medicaid Billing Guide, Section 6 (Prior Approval) for submission requirements and Medical record documentation supporting the criteria listed in **Section 3.0.** The Billing Guide is located at http://www.ncdhhs.gov/dma/basicmed/.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for procedures, products, and services related to this policy when they are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws; regulations; and agreements, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation and Update Information

Original Effective Date: January 1, 1975

Revision Information:

Date	Section Updated	Change
1/1/2010	Throughout	Initial promulgation of current coverage.
1/1/2010	Attachment A	CPT code 63660 deleted, and CPT codes 63661, 63662,63663,63664 added in CPT update

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Medicaid covers the following procedure codes relative to spinal neurostimulators:

CPT Code	Description	Prior Approval Required?
63650	Percutaneous implantation of neurostimulator electrode array, epidural	Yes
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	Yes
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	Yes
63661	Removal of spinal neurostimulator electrode percutaneous array(s) , including fluoroscopy, when performed	No
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	No
63663	Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s) , including fluoroscopy, when performed	No
63664	Revision, including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	No
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	No
95970	Electronic analysis of implanted neurostimulator pulse generator system (eg, 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 (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	No

CPT Code	Description	Prior Approval Required?
95971	Electronic analysis of implanted neurostimulator pulse generator system (eg, 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 (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	No
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, 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	No
95973	Electronic analysis of implanted neurostimulator pulse generator system (eg, 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)	No

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

Providers may bill one unit per date of service for the above procedure codes.

F. Place of Service

Inpatient, outpatient

95970 through 95973 may also be billed in the office setting.

G. Co-payments

Co-payments are required for spinal cord stimulation.

H. Reimbursement Rate

Providers shall bill their usual and customary charges.