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Spinal Cord and Dorsal Root Ganglion (DRG) Stimulation For Treatment of Pain MP9430

Covered Service:	Yes
Prior Authorization Required:	Yes, for both spinal cord stimulation trial and permanent implantation, including reoperation. Prior authorization is not required for removal without intended reoperation/implantation.
Additional Information:	None
Medicare Policy:	Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Medicare Cost (Dean Care Gold) and Medicare Supplement (Select) when this service is provided by participating providers. Prior authorization is required if a member has Medicare primary and Dean Health Plan secondary coverage. This policy is not applicable to our Medicare Replacement products.
BadgerCare Plus Policy:	Dean Health Plan covers this benefit when BadgerCare Plus also covers the benefit. Please refer to Forward Health: https://www.forwardhealth.wi.gov/WIPortal/Default.aspx

Dean Health Plan Medical Policy:

Spinal Cord Stimulation

1.0 Trial spinal cord stimulation (SCS) **require** prior authorization through the Health Services Division and is considered medically necessary when **ALL** of the following criteria are met:

- 1.1 Spinal cord stimulator system has received final FDA approval. Examples of FDA approved devices include, but are not limited to:
  - 1.1.1 Eon® Neurostimulation Systems (St. Jude Medical)
  - 1.1.2 Precision™ Spinal Cord Stimulation Systems, now marketed as Precision Plus SCS System (Boston Scientific)
  - 1.1.3 Protégé System (St. Jude Medical)
  - 1.1.4 Restore™ Systems (Medtronic)
  - 1.1.5 Senza Spinal Cord Stimulation System (Nevro Corp.); **AND**
- 1.2 Member has a diagnosis of **one of the following** chronic neuropathic pain conditions of the trunk or limbs:

1.2.1 Complex regional pain syndrome (also known as reflex sympathetic dystrophy, algoneurodystrophy/algodystrophy, causalgia syndrome); **OR**

1.2.2 Failed back surgery syndrome (FBSS); **OR**

1.2.3 Moderate to severe diabetic peripheral neuropathy, when **all** of the following criteria have been met:

1.2.3.1 Pain scale intensity rating of 50% or higher using a standard pain relief inventory assessment tool (e.g., Visual Analog Scale, Numeric Rating Scale, Verbal Rating Scale); **AND**

1.2.3.2 Neuropathic pain refractory to a minimum of twelve months of conservative therapy, including **all** of the following therapies:

1.2.3.2.1. Non-steroidal anti-inflammatory drug (NSAIDS); **AND**

1.2.3.2.2. Antidepressant; **AND**

1.2.3.2.3. Anticonvulsant; **AND**

1.3 Documentation of **ALL** of the following:

1.3.1 Intractable pain for a minimum of twelve months duration; **AND**

1.3.2 Failure of standard therapy (e.g., conservative management, standard surgical intervention) or unsuitability of standard therapies; **AND**

1.3.3 Comprehensive physical examination, including pain evaluation; **AND**

1.4 Psychiatric/psychological evaluation has been conducted, and **ALL** of the following apply:

1.4.1 Evaluation has been completed within the past 12 months; **AND**

1.4.2 Continued optimal management of any previously diagnosed (greater than twelve months) mental or neurobehavioral condition(s); **AND**

1.5 **None of the following** contraindications are present:

1.5.1 Implanted cardiac pacemaker or defibrillator

1.5.2 Coagulation disorder (e.g., coagulopathy, severe thrombocytopenia)

1.5.3 Current or chronic infection

1.5.4 Malignancy-derived pain

1.5.5 Vascular claudication.

2.0 Permanent spinal cord stimulation implantation **requires** prior authorization through the Health Services Division and is considered medically necessary when **ALL** of the following criteria are met:

2.1 Medical necessity criteria is consistent with (1.1) to (1.5) above; **AND**

2.2 Member has completed a trial using either percutaneous leads or surgically implanted leads with documentation of **ALL** of the following:

2.2.1 Trial duration of a minimum of three days; **AND**

2.2.2 Greater than or equal to 50% reduction in pain using a standard pain relief inventory assessment tool (e.g., Visual Analog Scale, Numeric Rating Scale, Verbal Rating Scale).

3.0 Spinal cord stimulation **reoperation requires** prior authorization through the Health Services Division and is considered medically necessary when **ONE** of the following are met:

3.1 Development of fibrosis surrounding the electrode tip

3.2 Electrode misalignment or migration has occurred

3.3 Infection necessitating removal of the stimulation system

3.4 Spinal cord stimulator and/or the battery are no longer operational

4.0 Dorsal root ganglion stimulation for the treatment of pain is considered **experimental and investigational**, and therefore not medically necessary.

5.0 Spinal cord stimulation of the dorsal column for the treatment of intractable pain is considered **experimental and investigational**, and therefore not medically necessary, for any indications not addressed in this policy, including but not limited to:

5.1 Angina pectoris/myocardial ischemia

5.2 Arachnoiditis

5.3 Cancer associated pain

5.4 Chronic visceral abdominal pain

5.5 Custer/migraine headache

5.6 Intercostal neuralgia

5.7 Lower limb ischemia (chronic/critical)

5.8 Non-diabetic peripheral neuropathy

5.9 Phantom limb syndrome

5.10 Post herpetic neuralgia

5.11 Post-cervical spine surgery

5.12 Spinal cord injury

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