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

Medica 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

	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Health Services Division	February 20, 2019
Revised:	Medical Policy Committee/Health Services Division	August 21, 2019
	Medical Policy Committee/Health Services Division	August 19, 2020
	Medical Policy Committee/Health Services Division	April 21, 2021
	Medical Policy Committee/Health Services Division	June 16, 2021
	Medical Policy Committee/Health Services Division	January 18, 2023
	Medical Policy Committee/Health Services Division	September 20, 2023
Reviewed:	Medical Policy Committee/Health Services Division	August 21, 2019
	Medical Policy Committee/Health Services Division	August 19, 2020
	Medical Policy Committee/Health Services Division	April 21, 2021
	Medical Policy Committee/Health Services Division	June 16, 2021
	Medical Policy Committee/Health Services Division	January 18, 2023
	Medical Policy Committee/Health Services Division	September 20, 2023

Published: 10/01/2023
Effective: 01/01/2024