SPINAL CORD STIMULATIONS (SCS)

Description

Implantable Spinal Cord Stimulation maybe considered appropriate medical treatment under certain conditions. These conditions include failed back surgery syndrome with low back pain and significant radicular pain. Complex regional pain syndrome (reflex sympathetic dystrophy). Inoperable chronic ischemic limb pain secondary to peripheral vascular disease. Last resort treatment of moderate to severe (5 or more on a 10 point VAS scale) chronic neuropathic pain of certain origins (i.e. Lumbosacral arachnoiditis (documented by high levels of proteins in the CSF and/or by myelography or MRI), radiculopathies, phantom limb/stump pain, peripheral neuropathy, post-herpetic neuralgia, intercostals neuralgia, cauda equine injury, incomplete spinal cord injury, or plexopathy) that is refractory to 12 or more months of standard therapy (including non-steroidal anti inflammatory drugs, tricyclic antidepressants, and anticonvulsants). To treat intractable angina in members who are not surgical candidates and whose pain is unresponsive to all standard therapies.

Spinal cord stimulation consists of an implantable medical device used to treat chronic pain which has 2 phases. In the first phase a trial of 3-7 days of percutaneous spinal stimulation is completed and member must experience a significant pain reduction (50%) or more then permanent placement can be made after certain criteria is met.

THC considers requests for Spinal Cord Stimulation on a case-by-case basis when supporting documentation demonstrates medical necessity and clinical decision criteria is met. THC utilizes criteria derived from evidenced based medicine and nationally accepted Standards of Care from recognized sources such as Centers for Medicare and Medicaid, Blue Cross Blue Shield, and well established managed care organizations.

Additional factors taken into consideration during the clinical review process include (not all inclusive): 

- Age
- Pertinent past and current medical history
- Current treatment and progress
- Individual need
- Local Delivery System
- Psychological factors/home environment (if/when applicable)
**Decision Criteria**

**Administrative**
1. Referral from Primary Care Physician is required along with appropriate supporting medical documentation
2. Services must be performed by a Total Health Care affiliated or contracted physician, hospital, or other provider
3. Prior authorization is required by Plan’s Medical Director
4. Affected member must have current eligibility at time of request

**Implantable Spinal Cord Stimulator Decision Criteria – Chronic Intractable Pain**

**Clinical**
**Phase 1 – Trial**

1. Documentation does not indicate any untreated existing drug addiction problems.
2. Documentation shows the failure of 6-12 months of conservative treatment modalities including but not limited to; non-steroidal anti inflammatory drugs, tricyclic antidepressants, anticonvulsants, further surgical intervention is not indicated or contraindicated, physical therapy.
3. Psychological evaluation has been obtained and there is documentation clearly indicating the pain is not psychologic in origin.
4. No contraindications to implantation exists
5. There is documented objective pathology for the pain complaint.
6. The Implantation of the stimulator is used only as a late resort for patients with chronic retractable pain.

**Phase 2 – Permanent Placement**

1. Documentation of at least 50% reduction in pain for at least 3 days.
2. Improvement in function documented in the medical record.

**Implantable Spinal Cord Stimulator Decision Criteria – Intractable Angina**

1. Documentation supports member is not a surgical candidate.
2. There is documentation to support pain is unresponsive to all standard therapies.
3. Member had significant pain reduction (50% or more) with a 3 to 7 day trial of percutaneous spinal stimulation.
4. Member has angiographically documented significant coronary artery disease and not a candidate for revascularization procedures.
5. Member has optimal pharmacotherapy for at least a month
6. Angina pectoris is considered Functional Class III or Class IV.
7. Reversible ischemia is documented by symptom-limited treadmill exercise test.
Exclusions\textsuperscript{1}

1. Total Health Care does not cover spinal cord stimulation for the treatment of members with cervical trauma, disc herniation, failed cervical spine surgery syndrome presenting with arm pain, neck pain, and/or cervicogenic headache, radiation-induced brain injury, or stroke, and all other indications in relation to chronic pain and intractable angina that do not meet all the applicable criteria listed, because it is considered experimental, investigational, or unproven.

Bibliography

\textsuperscript{1} Centers for Medicare and Medicaid Services LCD L32753 revised 11/19/2012 Spinal Cord Stimulation (Dorsal Column Stimulation) Pages 1-8, Blue Cross Blue Shield of CA, Policy 00060, Posted 11/8/2012, Implantable Spinal Cord Stimulators (SCS) Pages 1-6

\textsuperscript{1} Centers for Medicare and Medicaid Services LCD L32753 revised 11/19/2012 Spinal Cord Stimulation (Dorsal Column Stimulation) Pages 1-8, Blue Cross Blue Shield of CA, Policy 00060, Posted 11/8/2012, Implantable Spinal Cord Stimulators (SCS) Pages 1-6

\textsuperscript{1} Centers for Medicare and Medicaid Services, Blue Cross Blue Shield of Massachusetts, Policy 157, Posted 12/09/05, Fracture Healing Devices (Electric Bone Growth Stimulation and Ultrasound-Accelerated Healing), Pages 1-15

\textsuperscript{1} Centers for Medicare and Medicaid Services, Blue Cross Blue Shield of Massachusetts, Policy 157, Posted 12/09/05, Fracture Healing Devices (Electric Bone Growth Stimulation and Ultrasound-Accelerated Healing), Pages 1-15

\textsuperscript{2} Standards and Guidelines for the Accreditation of MCO’s, 2006, NCQA, National Committee for Quality Assurance, 2000 L Street, NW, Suite 500, Washington, DC, 20036