blue of california

Medical Policy

Spinal Cord Stimulation	
Type: Medical Necessity and Investigational / Experimental	**Policy Specific Section:** Surgery
Original Policy Date: October 1, 2010	**Effective Date:** October 29, 2010

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Spinal cord stimulation delivers low voltage electrical stimulation to the dorsal columns of the spinal cord to block the sensation of pain.

Spinal cord stimulation has been used in a wide variety of chronic refractory pain conditions, including pain associated with cancer, failed back pain syndromes, arachnoiditis, and complex

regional pain syndrome. There has also been interest in spinal cord stimulation as a treatment of critical limb ischemia, primarily in patients who are poor candidates for revascularization, and in patients with refractory chest pain.

Policy

Spinal cord stimulation is considered **medically necessary** for the treatment of severe and chronic pain when **all** of the following criteria are met:

- Prior failure of all other pain therapies (e.g., pharmacological, surgical, psychological, or physical) unless unsuitable or contraindicated
- No serious untreated drug habituation exists
- Demonstration of at least 50% pain relief with a temporarily implanted electrode
- Pain is neuropathic in nature; resulting from actual damage to the peripheral nerves

Spinal cord stimulation is considered **investigational** for treatment of the following conditions:

- Critical limb ischemia to forestall amputation
- Refractory angina pectoris

Policy Guideline

Common neuropathic pain indications include:

- Failed back syndrome
- Complex regional pain syndrome (i.e., chronic reflex sympathetic dystrophy)
- Arachnoiditis
- Radiculopathies
- Phantom limb/stump pain
- Peripheral neuropathy

Spinal cord stimulation is generally not effective in treating nociceptive pain (resulting from irritation, not damage to the nerves) and central deafferentation pain (related to central nervous system damage from a stroke or spinal cord injury).

Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

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Documentation Required for Clinical Review
• History and physical including: previous treatment plan and response • Multidisciplinary evaluation • Results of temporary implanted electrode trial Post Service • Operative report(s)

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available

Click here to view the appendix for this policy

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