SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral nerve stimulation for chronic pain</td>
<td>Local Coverage Determination (LCD): Peripheral Nerve Stimulation ([L37360]1)</td>
</tr>
</tbody>
</table>

DOCUMENTATION REQUIREMENTS

The patient’s medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (Please see "Coverage Indications, Limitations and/or Medical Necessity.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The clinical record should include elements leading to the diagnosis and the therapies tried before the decision to use PNS. When the documentation does not meet the criteria for the service rendered or the
documentation does not establish the medical necessity for the service, such services will be denied as not reasonable and necessary.

**UTILIZATION GUIDELINES**

Noridian expects no more than two services of 64555-(Percutaneous implantation of neurostimulator electrodes; peripheral nerve [excludes sacral nerve]) be billed per 365 days.

Trials will be limited to four leads with maximum of 16 contacts.

**HCPCS CODES**

<table>
<thead>
<tr>
<th>Medicare Only</th>
<th>Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>64555</td>
<td>Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
</tr>
<tr>
<td>64575</td>
<td>Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
</tr>
<tr>
<td>64585</td>
<td>Revision or removal of peripheral neurostimulator electrode array</td>
</tr>
<tr>
<td>64590</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>64595</td>
<td>Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver</td>
</tr>
</tbody>
</table>

**INSTRUCTIONS FOR USE**

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.
MEDICAL POLICY

Peripheral Nerve Stimulation for Chronic Pain
(Medicare Only)

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

REFERENCES