**A close up of a sign

Description generated with very high confidence**

**HE&R NEUROMODULATION**

Sample Letter or Medical Necessity Template: Prior Auth for SCS Trial

**Prior Authorization for Spinal Cord Stimulation (SCS) Trial**

For independent consideration and review, please make any and all changes that you believe appropriate or disregard these suggestions in their entirety. The customer is ultimately responsible for the accuracy and completeness of all claims submitted to third-party payers. Nothing in this document should be construed as a guarantee by Abbott regarding coverage or payment at any specific level, and Abbott does not advocate or warrant the appropriateness of the use of any particular code. This form letter is intended for prior authorization/appeals purposes, not for promotional purposes. Please see the FDA-approved label for information relevant to any prescribing decisions.

**Instructions for completing the sample appeal letter:**

1. Please customize the appeal letter template based on the medical appropriateness of the Spinal Column Stimulator System for your patient. Fields required for customization are **highlighted in yellow**.
2. It is important to provide the most complete information to assist with the appeal of a prior authorization denial.
3. After you have customized the appeal letter, please make sure to delete any specific instructions for completion that are highlighted throughout the letter, so the health plan does not misinterpret the information.

**Disclaimer:**

This document and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal, reimbursement, business, clinical, or other advice. Furthermore, it is not intended to and does not constitute a representation or guarantee of reimbursement, payment, or charge, or that reimbursement or other payment will be received. It is not intended to increase or maximize payment by any payer. Similarly, nothing in this document should be viewed as instructions for selecting any particular code, and Abbott does not advocate or warrant the appropriateness of the use of any particular code. The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently, and, therefore, the customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial, coding, or reimbursement specialist for any questions related to coding, billing, reimbursement or any related issues. This material reproduces information for reference purposes only. It is not provided or authorized for marketing use.

[Physician Letterhead]

Date: [\_\_\_\_\_\_\_\_\_\_]

Attention: Appeals Department

Reference number: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

[Payer contact name]

[Payer contact title]

[Street address]

[City, State, zip code]

[Fax]

**Re: Request for Prior Authorization of Spinal Cord Stimulation (SCS) therapy**

Patient Name: [First and Last Name]

Policy Holder Name: [First and Last Name]

Date of Birth: [XX/XX/XXXX]

SS#: [XXX-XX-XXXX]

Insurance Patient ID #: [XXXXXXXXXX]

Group # [XXXXXXXXXX]

Claim #: [XXXXXXXXXX]

Phone #: [XXX-XXX-XXXX]

To Whom It May Concern:

Please consider this prior authorization request for the above patient to have a trial procedure of spinal column stimulation (SCS) therapy.

Unlike other pain management procedures, the benefit of SCS therapy to the patient can be assessed from the trial procedure, which is prior to the system implant. During the trial procedure, temporary leads are placed in the epidural space at the spinal levels corresponding to the areas of pain and are attached to an external power source to validate therapy effectiveness. The trial procedure allows patients to temporarily experience neurostimulation and the effect it has on controlling their pain, in order to make an informed choice about pursuing the therapy.

I am referring this patient for SCS because the patient has tried and failed other pain therapies. At this time, I believe [Patient Name] may be a candidate for Spinal Cord Stimulation.

|  |
| --- |
| **SCS *may* be indicated when the following criteria[[1]](#footnote-1) are met:** |

|  |  |
| --- | --- |
| Description | Provide background information: |
| Pain present for at least 6 months  (List ICD-10 Diagnosis Code) |  |
| Conservative therapies tried & failed  (List Medications & other attempted therapies) |  |
| Pain causes functional deficit |  |
| Patient has undergone a psychological evaluation |  |
| Patient is not a surgical candidate |  |

[PLEASE ADD ADDITIONAL INFO IF NEEDED]

The patient has undergone a careful screening evaluation and diagnosis by multiple prior physicians. The SCS therapy I recommend has several distinct advantages for this patient. SCS therapy has been proven clinically effective[[2]](#footnote-2) and offers the prospect of enabling chronic pain patients to return to activities of daily living and potentially discontinue or reduce the use of narcotics[[3]](#footnote-3).

Because of [patient’s name] worsening conditions, please expedite your response. Thank you for your review of this information and for your coverage consideration. If you have any questions, please feel free to contact me.

Sincerely,

[Physician’s name and credentials]

[Title]

[Name of practice]

[Street address]

[City, State, zip code]

[Email address]

[Phone number]

Enclosures:

[Patient medical records/chart notes]

# Appendix

Cameron T, Safety and efficacy of spinal cord stimulation for the treatment of chronic pain: a 20-year literature review. J. Neurosurgery: Spine, March 2004, 254-267

Kemler MA, Barendse GA, van Kleef M, de Vet HC, et al. Spinal cord stimulation in patients with reflex sympathetic dystrophy. NEJM 2000; 343: 618-624.

North RB, Kidd DH, Lee MS, Piantodosi S. A prospective, randomized study of spinal cord stimulation versus reoperation for failed back syndrome: Initial results. Stereotactic Functional Neurosurgery 1994; 62:267-72.

Taylor RS, Taylor RJ, Van Buyten, Buchser E, North R, Baylis S. The cost effectiveness of spinal cord stimulation in the treatment of pain: a systematic review of the literature. J Pain Symptom Manage April 2004:370-378

National Institute for Health and Care Excellence (NICE). *Spinal Cord Stimulation for Chronic Pain of Neuropathic or Ischemic Origin.* 2008. https://www.nice.org.uk/guidance/ta159/chapter/1-Guidance.

**Rx Only**

**Brief Summary:**

Prior to using these devices, please review the User’s Guide for a complete listing of indications, contraindications, warnings, precautions, potential adverse events, and directions for use. The system is intended to be used with leads and associated extensions that are compatible with the system.

**Indications for Use**:  Spinal cord stimulation as an aid in the management of chronic, intractable pain of the trunk and/or limbs, including unilateral or bilateral pain associated with the following: failed back surgery syndrome and intractable low back and leg pain.

**Contraindications**: Patients who are unable to operate the system or who have failed to receive effective pain relief during trial stimulation

**Warnings/Precautions**: Diathermy therapy, implanted cardiac systems or other active implanted devices, magnetic resonance imaging (MRI), electrosurgery, explosive and flammable gases, theft detectors and metal screening devices, lead movement, operation of machinery, equipment and vehicles, pediatric use, pregnancy, and case damage. Patients who are poor surgical risks, with multiple illnesses, or with active general infections should not be implanted.

**Adverse Effects**: Unpleasant sensations, undesirable changes in stimulation, stimulation in unwanted places, lead or implant migration, epidural hemorrhage, hematoma, infection, spinal cord compression, or paralysis from placement of a lead in the epidural space, cerebrospinal fluid leakage, paralysis, weakness, clumsiness, numbness, sensory loss, or pain below the level of the implant, pain at the electrode or IPG site, seroma at IPG site, allergic or rejection response, battery failure. User’s Guide must be reviewed for detailed disclosure.

Icon

Description automatically generatedInformation contained herein for DISTRIBUTION in the U.S. ONLY**.**

**Abbott**

One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 2000

™ Indicates a trademark of the Abbott group of companies.

‡ Indicates a third-party trademark, which is property of its respective owner.

[www.neuromodulation.abbott](http://www.neuromodulation.abbott)

©2022 Abbott. All rights reserved. MAT-2201860 v1.0

1. SCS coverage criteria adapted from [NCD 160.7 conditions for coverage](https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240), [LCD L36204](https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=36204&ver=22) coverage guidance and North American Spine Society (NASS) Spinal Cord Stimulation Coverage Policy recommendations, 2017 [↑](#footnote-ref-1)
2. Sdrulla, Andrei & Guan, Yun & Raja, Srinivasa. (2018). Spinal Cord Stimulation: Clinical Efficacy and Potential Mechanisms. Pain Practice. 18. 10.1111/papr.12692. [↑](#footnote-ref-2)
3. Vu T, Khunsriraksakul C, Vorobeychik Y, et al. Association of Spinal Cord Stimulator Implantation With Persistent Opioid Use in Patients With Postlaminectomy Syndrome. JAMA Netw Open. 2022;5(1):e2145876. doi:10.1001/jamanetworkopen.2021.45876 [↑](#footnote-ref-3)