

Dear Provider:

Boston Scientific is committed to supporting providers when recommending Spinal Cord Stimulation as a treatment option to the indicated patients diagnosed with chronic pain of trunk and limb. This support includes resources when navigating insurance for patient access.

You may use the sample template which is included for your patients specific medical necessity submission for Spinal Cord

Stimulation therapy.

Should you have additional questions, please contact your Regional Reimbursement and Sales Managers. Thank you,

BSC Health Economics and Market Access (HEMA) Team

**Indications for Use**. The Boston Scientific Spinal Cord Stimulator Systems are indicated 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, Complex Regional Pain Syndrome (CRPS) Types I and II, Diabetic Peripheral Neuropathy of the lower extremities, intractable low back pain and leg pain, radicular pain syndrome, radiculopathies resulting in pain secondary to failed back syndrome or herniated disc, epidural fibrosis, degenerative disc disease (herniated disc pain refractory to conservative and surgical interventions), arachnoiditis, multiple back surgeries. The Boston Scientific Spectra WaveWriter™, WaveWriter Alpha™ and WaveWriter Alpha™ Prime SCS Systems are also indicated as an aid in the management of chronic intractable unilateral or bilateral low back and leg pain without prior back surgery. Contraindications, warnings, precautions, side effects. The SCS Systems are contraindicated for patients who: are unable to operate the SCS System, have failed trial stimulation by failing to receive effective pain relief, are poor surgical candidates, or are pregnant. Refer to the Instructions for Use provided with the SCS System or Pain.com for potential adverse effects, warnings, and precautions prior to using this product. Warning: Stimulation modes. Only paresthesia-based stimulation mode has been evaluated for effectiveness in the diabetic peripheral neuropathy (DPN) population.

Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

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**Spinal Cord Stimulation Appeal Template (INSERT PHYSICIAN LETTERHEAD)**

Insurance Company Name Attn: Appeals Department Street Address

City, State, Zip

Patient Name:

ID Number:

Group Number:

Date of Birth:

Procedure Codes: Specify Trial or Implant Code(s)

63650 Percutaneous implantation of neurostimulator array, epidural

63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

Principle Diagnosis: (Insert DX here) To Whom It May Concern:

This letter is in response to your recent denial of coverage for spinal cord stimulation (SCS) therapy for my patient (Patient Name) and is a request for reconsideration for the implantation of a spinal cord stimulator. Attached is a copy of your denial notice, dated (insert date of denial letter), where you stipulate that the request does not meet medical necessity criteria.

Rationale for non-coverage communicated by the health plan states (insert non-coverage rationale). The health plan’s coverage policy (insert policy number and link) requires (insert summary criteria). It is my professional medical opinion that SCS is the best treatment option for my patient to treat (FBSS, CRPS, Diabetic Peripheral Neuropathy, Non-Surgical Back Pain.) who has been unresponsive to conservative care.

(Summary restatement of the H&P, dose/duration in tolerability of the therapeutics, why patient may be less responsive or contraindicated for specific options. Include date and disposition of the psychological evaluation; and surgical consult or clearance if required, or neurological evaluation).

The patient meets coverage criteria of the health plan. It is my clinical determination (he/she) requires implantation of a spinal cord stimulator to address chronic pain symptoms, having tried and failed conservative interventions denoted above.

I am requesting immediate approval for SCS therapy for your beneficiary, (Patient Name) and appreciate your expedited response for coverage.

Please contact me directly if you require additional information or if you would like to discuss the specifics of this case. I can be reached at PHONE # or by email at EMAIL ADDRESS.

Thank you in advance for your consideration of this request. Sincerely,

Physician Name Facility Name Full Address Phone

Attachments: (copy of H&P, copy of psychological evaluation, copy of neurological evaluation)

<https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240>