American Society *of* Interventional Pain Physicians®

"The Voice of Interventional Pain Management"

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Subject: Multiple issues related to denial of spinal cord stimulation to Medicare Advantage patients by Humana

Dear Mr. Rechtin and Dr. Goodrich:

On behalf of American Society of Interventional Pain Physicians (ASIPP), 48 state societies and membership, we are writing this letter to express our concern on Humana coverage policies. These policies contradict Medicare LCDs and create numerous access issues, including double copays and major inconvenience, all of this is without accepted evidence base, causing substantial harm to Medicare Advantage recipients. It is well known that Medicare Advantage recipients are already suffering significant hardship, along with all other recipients who are supplementing Medicare Advantage. The literature shows that Medicare spends over $100 billion more a year on Medicare Advantage compared to Medicare fee-for-service. Further, Medicare fee-for-service individuals, as well as Medicare Advantage, also pay a premium to support Medicare Advantage of $198 or $13 billion over a period of one year.

Based on the Medicare policy, Medicare Advantage shall follow LCDs and use the medical necessity criteria and frequency of the procedures as described in the LCDs. When there is no LCD, Medicare Advantage shall use similar criteria based on evidence base and what Medicare is applying.

The Medicare Managed Care Manual reinforces this obligation, stating that any adverse medical necessity determination must be conducted by a licensed professional with expertise in Medicare criteria and that coverage policies **must be no more restrictive than Original Medicare**.

Medicare Advantage (MA) plans are legally required to follow the coverage guidelines established by traditional Medicare, as mandated under federal law and reinforced by the Centers for Medicare & Medicaid Services (CMS). Specifically, under **42 U.S.C. § 1395w-22(a)(1)(A)**, MA plans must provide coverage that is at least actuarially equivalent to the benefits offered under Original Medicare Parts A and B. Additionally, **CMS Medicare Managed Care Manual, Chapter 4, Section 10.1** explicitly states that Medicare Advantage plans are obligated to "provide all Part A and Part B covered services," and must adhere to the national and local coverage determinations (NCDs and LCDs) established by CMS and the Medicare Administrative Contractors (MACs). Furthermore, **42 C.F.R. § 422.101(b)** mandates that MA plans must follow CMS's national coverage determinations and may not apply coverage rules that are more restrictive than those established under Original Medicare. Deviating from these standards can undermine

health equity by creating disparities in access to medically necessary care, especially for vulnerable populations who rely on consistent, evidence-based national coverage criteria. Inconsistent application of benefits across plans can result in delays, denials, or administrative barriers that disproportionately affect individuals from underserved communities, thereby perpetuating systemic health inequities and contradicting CMS's own stated commitment to promoting equity in healthcare delivery.

Interventional pain management is defined as, "the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment".
(http://www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf)

Interventional pain management techniques are defined as, "minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain".
(https://permanent.fdlp.gov/lps21261/dec2001PainManagement.pdf)

Humana has consistently applied restrictive internal medical necessity criteria—such as requiring radicular pain or a history of spine surgery—that are neither part of National Coverage Determination (NCD) 160.7 nor any relevant Local Coverage Determination. These practices are expressly prohibited under Title 42 CFR § 422.101, which requires Medicare Advantage Organizations to provide coverage for all services covered under Medicare Parts A and B. CMS has further clarified in the Federal Register that the only time an MA plan may rely on internal coverage criteria is when no applicable federal statute, regulation, NCD, or LCD exists. In the case of spinal cord stimulation, NCD 160.7 clearly governs coverage and shall be followed.

Further, the internal criteria used by Humana are unsupported by scientific evidence and current clinical practices. In Humana's latest policy update the following language was added "While the LCDs Spinal Cord Stimulators for Chronic Pain (L35136, L36204, L37632 [JE, JF, JJ, JM]) indicate that spinal cord stimulators are best suited for neuropathic pain, they do not provide what evidence-based conditions/diagnoses are considered medically reasonable and necessary. Therefore, for all jurisdictions, Humana and subsidiaries may consider the following to interpret or supplement such criteria in order to determine medical necessity consistently." (HUM – 1215- 005) Within this language Humana is acknowledging that the current recommendations from CMS and the MACs is that SCS is an effective, scientific backed treatment option for patients with chronic neuropathic pain but is choosing to disregard this, instead deciding they know better than the Medical Directors and physicians who created and supported these policies. This suggests that, despite recognizing the efficacy of SCS for neuropathic pain as indicated in the LCDs, Humana has opted to implement additional criteria that may not align with the broader guidance provided by CMS and the Medicare Administrative Contractors (MACs).

We are concerned that Humana cites that the LCD's "they do not provide what evidence-based conditions/diagnoses are considered medically reasonable and necessary," yet as a Medicare Advantage plan administrator, we would expect that the policy makers at Humana to be educated on the purposes of LCD's vs Billing Articles. Article A57791, titled "Billing and Coding: Spinal Cord Stimulators for Chronic Pain," has an entire section dedicated to, "ICD-10-CM Codes that Support Medical Necessity."

Furthermore, the body of literature validating SCS for chronic low back pain in non-surgical patients continues to emerge. In one randomized study, researchers concluded that "back pain intensity was reduced by 66.4% at 12 months in patients treated with high-frequency SCS, compared with only 38.9% in the control group." (1, Kapural et al) Another investigation found that "SCS provided significant and sustained improvements in pain, functional status, and quality of life in patients without prior spine surgery." (2, North et al) In a third trial, it was observed that "even in the absence of radicular symptoms or surgical intervention, patients experienced meaningful relief with neurostimulation therapy." (3, De Andres et al) A meta-analysis further noted that "spinal cord stimulation resulted in clinically significant pain reduction and improved functional outcomes in patients with chronic, non-surgical axial low back pain." (4, Gill et al)

To date, 3 randomized controlled trials have compared SCS to conventional medical management (CMM). (Deer, Kapural 2022, Kallewaard) All the trials found SCS to be superior to CMM for the outcomes evaluated, including pain intensity, physical function, and health-related quality of life. A greater proportion of patients that received SCS reported reduction or discontinuation of opioid use compared to CMM. Further, 2 of the trials observed increase in opioid use in patients randomized to CMM. (Kailewaard 2024 and Kapural 2024)

The evidence supports the use of SCS in appropriately selected patients regardless of surgical history. Continued denials based on non-existent Medicare requirements reflect a systemic failure to honor both regulatory and ethical responsibilities. These actions delay medically necessary treatment, contribute to prolonged disability, increase opioid dependence, and ultimately harm patients who would otherwise benefit from timely, guideline-concordant care.

We respectfully request that Humana immediately cease applying unsupported supplemental coverage criteria, ensure full compliance with NCD 160.7.

We trust Humana will act swiftly to correct this deviation and uphold its obligations to beneficiaries and the Medicare program.

Sincerely,

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