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Robert Mandel, MD, MBA
President
Carelton Medical Benefits Management
8600 W. Bryn Mawr Ave.
S. Tower, Ste. 80
Chicago, IL, 60631
robert.mandel@carelon.com

Subject: Appropriate Use Criteria for Spinal Cord Stimulation (SCS) in Non-Surgical Low Back Pain

Dear. Dr. Mandel,

We are writing on behalf of the 70,000+ members represented by our undersigned medical societies. Our members include anesthesiologists, interventional radiologists, neurologists, neurosurgeons, orthopedic surgeons, physiatrists, psychologists, engineers, scientists, and health care professionals. Collectively, we are dedicated to improving access to treatment for patients suffering with debilitating pain.

We are strongly concerned about Carelon's recent policy decision to deny coverage for spinal cord stimulation (SCS) in patients with non-surgical low back pain. We find this decision troubling, as it fails to reflect both current clinical standards and the latest high-quality evidence.

We respectfully raise the following issues with the current policy:

1. Surgeon Determination Requirement

The requirement that a surgeon must first evaluate and rule out surgical pathology prior to approving SCS is clinically inappropriate and unnecessarily restrictive. Many patients suffering from chronic low back pain do not have a surgical indication and may not benefit from a surgical consultation. These individuals are often managed by board-certified pain specialists who are well equipped to evaluate and treat chronic pain using multimodal approaches, including SCS. Mandating a formal surgical evaluation may cause unnecessary delays in care given the limited availability of spine surgeons for nonurgent appointments for patients without an obvious surgical indication. Under your current policy, many suitable non-surgical patients are denied access to a proven and effective treatment.

2. Limiting SCS as a "Last Resort"

Designating SCS only as a final-line therapy is inconsistent with modern pain management principles. The last 15 years have clearly demonstrated the limitations of pharmacological therapy (especially opioids) for chronic pain. The COVID-19 pandemic revealed the consequences of delayed interventional care, with studies showing that only 3% of chronic pain patients experienced spontaneous resolution of their disabling symptoms. Further, delayed treatment is associated with long term decreased quality of life, increased psychological distress, functional decline, delayed

return to work, and increased healthcare costs. Moreover, multiple studies have shown that a longer duration of chronic pain reduces the chance of success of SCS. Multispecialty publications have almost uniformly favored moving SCS up in the chronic pain treatment continuum. Forcing patients to continue on less successful pathways and treating SCS as a therapy of last resort risks unnecessary patient suffering and broader socioeconomic consequences.

3. Selective Use of Outdated Literature

We are particularly concerned that the references cited in the policy do not include the most recent, high-quality literature published since 2022. Multiple recent robust studies demonstrate the superiority of SCS compared to conventional medical management in reducing pain in patients with chronic back pain and no indication for spinal surgery. The exclusion of these high-level scientific studies suggests a selective and outdated interpretation of the evidence. This undermines the credibility of the policy and raises questions about its objectivity and commitment to evidence-based care.

4. Lack of Alternatives in Non-Surgical Patients

In carefully selected non-surgical back pain patients, denying access to SCS leaves few viable alternatives. These patients are often left with opioid therapy or other potentially harmful or ineffective treatments—precisely the scenario that modern interventional pain management aims to avoid. The irony is that a therapy shown to reduce opioid reliance and improve function is being denied while less effective or higher-risk treatments remain accessible.

In summary, we urge Carelton to reconsider its position and to revise this policy to be in alignment with current evidence and expert clinical consensus. Board-certified pain medicine specialists are trained to determine appropriateness of care in patients with chronic pain. More importantly, patients should not be denied access to a well-studied, cost-effective, and life-changing therapy based on restrictive criteria and outdated references.

We welcome the opportunity to collaborate on creating a more patient-centered and evidence-driven policy that reflects the current state of pain medicine.

Sincerely,

American Academy of Physical Medicine and Rehabilitation

American College of Radiology

American Society of Spine Radiology

International Pain and Spine Intervention Society

North American Neuromodulation Society

Society for Interventional Radiology

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