

Policy: MP234

Section: Medical Benefit Policy

Subject: Occipital Nerve Stimulation

I. Policy: Occipital Nerve Stimulation

II. Purpose/Objective:

To provide a policy of coverage regarding Occipital Nerve Stimulation

III. Responsibility:

A. Medical Directors

B. Medical Management Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community;
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.

- (iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:

Occipital nerve stimulation has been proposed for the treatment of patients with intractable headache that cannot be managed by alternative treatments. It involves the use of a neurostimulator to deliver low-voltage electrical impulses via insulated lead wires that run under the skin and up to the occipital nerve.

MEDICARE BUSINESS SEGMENT: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR

Per CMS NCD 160.7, payment may be made under the prosthetic device benefit for implanted peripheral nerve stimulators.

EXCLUSIONS: The Plan does **NOT** provide coverage for occipital nerve stimulation as a treatment for any indication including but not limited to intractable headache because it is considered **experimental, investigational or unproven**. The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in **MP 15 - Experimental Investigational or Unproven Services or Treatment**.

CODING ASSOCIATED WITH: Occipital Nerve Stimulation

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

- 61885 insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
- 61886 insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays
- 64553 Percutaneous implantation of neurostimulator electrodes; cranial nerve
- 64555 Percutaneous implantation of neurostimulator electrodes; peripheral nerve
- 64575 Incision for implantation of neurostimulator electrodes; peripheral nerve
- 64590 Insertion or replacement of peripheral or gastric neurostimulator, pulse generator or receiver, direct or inductive coupling
- 95970 Electronic analysis in implanted Neurostimulator pulse generator system (eg, rate, pulse amplitude and duration configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) Neurostimulator pulse generator/transmitter, without reprogramming
- 95975 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour
- 95978 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour
- 95979 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour
- L8679 Implantable neurostimulator, pulse generator, any type
- L8680 Implantable neurostimulator electrode, each
- L8681 patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
- L8682 implantable neurostimulator radiofrequency receiver

L8683 radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685 Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686 Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687 implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688 implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension
L8689 external recharging system for battery (internal) for use with implantable neurostimulator, replacement only
C1767 generator neurostimulator (implantable) non-rechargeable
C1778 lead, neurostimulator
C1787 patient programmer, neurostimulator
C1816 receiver and/or transmitter neurostimulator (implantable)
C1820 generator, neurostimulator (implantable), non high-frequency with rechargeable battery and charging system
C1822 generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
C1897 lead neurostimulator test kit (implantable)
Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 08/2009

Revised: 7/17 (clarified Medicare/Medicaid coverage)

Reviewed: 9/10, 8/11, 8/12, 8/13, 8/14; 8/15; 7/16, 6/18