Deep Brain Stimulation

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Effective Date	6/2001
Next Review Date	5/15/2024
Coverage Policy	Surgical 74
Version	4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Deep Brain Stimulation.

Description & Definitions:

Deep brain stimulation is the use of implanted electrodes to regulate involuntary tremors or movements in an individual.

Criteria:

Deep Brain Stimulation is considered medically necessary in individuals with **1 of the following**:

- Parkinson's Disease with **all of the following**:
  - Individual has idiopathic Parkinson's Disease
  - Individual has significant disability affecting safety, functional status or quality of life due to **1 or more of the following**:
    - Bradykinesia
    - Tremor
    - Rigidity
    - Levodopa-induced dyskinesia
  - Individual has had a favorable response in the past to administration of levodopa
  - Individual has current signs or symptoms refractory to standard medication for Parkinson's disease
  - Individual has no significant cognitive impairment
  - If individual has depression or mood disorders, they are adequately controlled with medicine
  - Individual has no intracranial pathology on imaging studies that would contraindicate or complicate deep brain stimulation
  - Individual does not have coagulopathy
- Essential Tremor and **all of the following**:
  - Individual has significant disability of one or more limbs from resting, positional, or kinetic tremor that affects safety, functional status, or quality of life

    - Individual has tremor refractory to at least one year of standard medication
    - Individual has no significant cognitive impairment
    - If individual has depression or mood disorders, they are adequately controlled with medicine
    - Individual has no intracranial pathology on imaging studies that would contraindicate or complicate deep brain stimulation
    - Individual does not have coagulopathy
- Primary Dystonia with **all of the following:**
    - Individual is seven (7) years of age or older
    - Individual has severe impairment in daily activities despite optimal medical management
    - Individual has no intracranial pathology on imaging studies that would contraindicate or complicate deep brain stimulation
    - Individual does not have coagulopathy
- Partial onset seizures with **all of the following**:
    - Individual is eighteen (18) years of age or older
    - Individual has undergone diagnostic testing that localized no more than two (2) epileptogenic foci
    - Individual is refractory to two or more antiepileptic medications
    - Individual is currently having an average of three (3) or more disabling seizures (for example, motor partial seizures, complex partial seizures, or secondary generalized seizures) per month over the most recent three months
- Replacement/revision of a cranial neurostimulator pulse generator or receiver or electrodes is considered medically necessary for **all of the following**:
    - Individual meets ALL of the criteria for initial placement of cranial neurostimulator pulse generator or receiver or electrodes
    - Existing cranial neurostimulator pulse generator or receiver or electrodes are no longer under warranty
    - Existing cranial neurostimulator pulse generator or receiver or electrodes are damaged or not functioning properly and cannot be repaired

Deep Brain Stimulation is considered **not medically necessary** considered not medically necessary for any use other than those indicated in clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)

61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)
61880	Revision or removal of intracranial neurostimulator electrodes
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
61888	Revision or removal of cranial neurostimulator pulse generator or receiver

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: May
- 2020: June
- 2019: October
- 2014: May, August
- 2013: May
- 2010: April
- 2009: March
- 2008: March, April
- 2004: November
- 2003: April
- 2002: February

Reviewed Dates:

- 2023: May
- 2019: June
- 2018: March
- 2017: February, May
- 2015: May
- 2012: May
- 2011: May
- 2010: March
- 2008: April
- 2007: December
- 2005: November

- 2004: April
- 2003: February

Effective Date:

- June 2001

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Parkinson's Disease, SHP Deep Brain Stimulation, SHP Surgical 74, Essential Tremor, dystonia, seizures, tremors, involuntary movements, epilepsy