Clinical Policy: Deep Brain Stimulation

Reference Number: WNC.CP.201 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy discusses the medical necessity criteria for deep brain stimulation (DBS).

Policy/Criteria[1]

I. Placement of a deep brain stimulator is covered by WellCare of North Carolina® when **all** of the following criteria are met:
- **A.** The member has one of the diagnoses listed in this policy (see *ICD-10-CM Diagnosis Codes that Support Coverage Criteria)*
- **B.** The member has undergone careful screening, evaluation, and diagnosis prior to implantation.
- **C.** All other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and proven unsatisfactory or have been determined to be unsuitable or contraindicated for the member.
- **D.** The facilities, equipment, and professional and support personnel required for the proper treatment, training, and follow-up of the member are available.

II. DBS is **contraindicated** when **any** of the following are true:
- **A.** Medical, surgical, neurologic, or orthopedic co-morbidities exist contraindicating DBS surgery or stimulation.
- **B.** One or more medical conditions exist that require repeated magnetic resonance imaging (MRI). MRI can be safely performed under specialized protocols.
- **C.** Cognitive impairment, dementia, or depression would be worsened by or would interfere with the member's ability to benefit from DBS.
- **D.** Botulinum toxin injections have been given within the last 4 months.
- **E.** Diathermy will be used in the future.

III. The use of deep brain stimulation with a Humanitarian Device Exemption (HDE) or for other indications shall be considered on a case-by-case basis under extraordinary circumstances.

Background[1]

DBS consists of electrical stimulation of specific sites in the brain with implanted electrodes to reduce the symptoms of movement disorders such as Parkinson's disease and Essential Tremor. DBS can be done on one or both sides of the brain, depending on the disorder and the member's symptoms.

Once implanted, noninvasive programming of the stimulator can be adjusted to the patient's symptoms. This is an important feature for patients, whose disease may progress over time, requiring different stimulation parameters. Setting the best stimulation parameters may involve the balance between optimal symptom control and the appearance of side effects of stimulation, such as dysarthria, disequilibrium, or involuntary movements.

Coding Implications

CPT®* Codes	Description	Unit Billing
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	bill only 1 unit per date of service
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	bill only 1 unit per date of service
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	bill only 1 unit per date of service
+61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	bill 2 units per date of service
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in	bill only 1 unit per date of service

CPT®* Codes	Description	Unit Billing
	subcortical site (e.g., 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 (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	bill 2 units per date of service
61880	Revision or removal of intracranial neurostimulator electrodes	bill only 1 unit per date of service
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	bill only 1 unit per date of service
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	bill only 1 unit per date of service
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	bill only 1 unit per date of service
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	bill only 1 unit per date of service
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	bill only 1 unit per date of service
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	bill only 1 unit per date of service
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	bill only 1 unit per date of service
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)	bill only 1 unit per date of service
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	bill only 1 unit per date of service
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	bill only 1 unit per date of service

CPT®* Codes	Description	Unit Billing
+95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	billed up to an additional 7 units per date of service when billed with the primary procedure
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	bill only 1 unit per date of service
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	bill only 1 unit per date of service
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	bill only 1 unit per date of service

Place of Service Inpatient, Outpatient, and Independent Diagnostic Testing Facilities (IDTF). CPT codes 95970, 95976 and 95977 may be billed in the office setting. CPT codes 95976 and 95977 may be billed in IDTF Centers.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
G20	Parkinson's disease
G20.A	Parkinson's disease without dyskinesia
G20.A1	Parkinson's disease without dyskinesia, without mention of fluctuations
G20.A2	Parkinson's disease without dyskinesia, with fluctuations
G20.B	Parkinson's disease with dyskinesia
G20.B1	Parkinson's disease with dyskinesia, without mention of fluctuations
G20.B2	Parkinson's disease with dyskinesia, with fluctuations
G20.C	Parkinsonism, unspecified
G21.11	Neuroleptic induced parkinsonism
G21.19	Other drug induced secondary parkinsonism
G21.2	Secondary parkinsonism due to other external agents
G21.3	Postencephalitic parkinsonism
G21.4	Vascular parkinsonism
G21.8	Other secondary parkinsonism
G21.9	Secondary parkinsonism, unspecified
G24.1	Genetic torsion dystonia
G24.2	Idiopathic nonfamilial dystonia
G24.3	Spasmodic torticollis
G24.4	Idiopathic orofacial dystonia
G24.8	Other dystonia
G24.9	Dystonia, unspecified
G25.0	Essential tremor
G25.1	Drug-induced tremor
G25.2	Other specified forms of tremor
G25.9	Extrapyramidal and movement disorder, unspecified
G80.3	Athetoid cerebral palsy
T85.01xA	Breakdown (mechanical) of ventricular intracranial (communicating) shunt, initial encounter
T85.02xA	Displacement of ventricular intracranial (communicating) shunt, initial encounter
T85.03xA	Leakage of ventricular intracranial (communicating) shunt, initial encounter
T85.110A	Breakdown (mechanical) of implanted electronic neurostimulator of brain electrode (lead), initial encounter
T85.111A	Breakdown (mechanical) of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
T85.112A	Breakdown (mechanical) of implanted electronic neurostimulator of spinal cord electrode (lead), initial encounter
T85.118A	Breakdown (mechanical) of other implanted electronic stimulator of nervous system, initial encounter
T85.120A	Displacement of implanted electronic neurostimulator of brain electrode (lead), initial encounter

ICD-10-CM Code	Description
T85.121A	Displacement of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
T85.122A	Displacement of implanted electronic neurostimulator of spinal cord electrode (lead), initial encounter
T85.128A	Displacement of other implanted electronic stimulator of nervous system, initial encounter
T85.190A	Other mechanical complication of implanted electronic neurostimulator of brain electrode (lead), initial encounter
T85.191A	Other mechanical complication of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
T85.192A	Other mechanical complication of implanted electronic neurostimulator of spinal cord electrode (lead), initial encounter
T85.199A	Other mechanical complication of other implanted electronic stimulator of nervous system, initial encounter

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	04/21	05/21
CPT and ICD-10-CM codes reviewed.	07/21	08/21
Removed CPT codes that do not require prior authorization.	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. CPT and ICD-10-CM codes reviewed.	08/23	08/23
Criteria II.D. Added "Botulinum toxin injections have been given within the last 4 months." ICD-10-CM Code Added G20A, G20A1, G20A2, G20B, G20B1, G20B2, G20C. Codes 61850, 61860, 61863, 61867, 61870, 61880, 61885, 61886, 61888, 95961, 95970, 95976 and 95977 may bill only 1 unit per date of service. Codes 61864 and 61868 may bill 2 units per date of service. Code 95962 may be billed up to an additional 7 units per date of service when billed with the primary procedure.	11/23	11/23
Annual Review. Added CPT codes 61889, 61891, 61892, 64596, 64597, 64598. HCPCS code table removed.		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy. No: 1A-26 Deep Brain Stimulation (DBS). Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2024. Accessed April 18, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer

to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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