Medica Coverage Policy

<table>
<thead>
<tr>
<th>Policy Name:</th>
<th>Implantable Deep Brain Stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date:</td>
<td>7/17/2019</td>
</tr>
</tbody>
</table>

Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica coverage policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

Coverage Policy

Deep brain stimulation COVERED when used for the following FDA approved indications:

1. Thalamic stimulation for the suppression of tremor in the upper extremity in patients who are diagnosed with essential tremor or Parkinsonian tremor not adequately controlled by medication and where the tremor constitutes a significant functional disability, or
2. Stimulation of the internal globus pallidus (GPI) or the subthalamic nucleus (STN) as an adjunctive therapy in reducing some of the symptoms of advanced, levodopa-responsive Parkinson’s diseases that are not adequately controlled with medication.

Deep brain stimulation is investigative and therefore NOT COVERED for all other conditions, including, but not limited to: depression, epilepsy, cluster headaches, multiple sclerosis, and neuropathic pain. There is insufficient reliable evidence in the form of high quality peer-reviewed medical literature to establish the safety and efficacy or effects on health care outcomes.

The investigative determination does not apply to HDE approved devices. The following HDE approved devices are covered for the following:

1. The Reclaim™ Deep Brain Stimulation device for obsessive compulsive disorder (OCD)
2. The Activa® Dystonia Therapy device for treatment of primary dystonia.

Description

Deep brain stimulation consists of electrode(s) implanted into the targeted brain structure (e.g., thalamus, subthalamic nucleus, or globus pallidus). Unilateral or bilateral electrodes are connected to an implantable pulse generator power source and is generally implanted in the subclavicular region of the chest cavity. The electrodes, through a battery-operated neurostimulator, carry a high frequency electrical signal that interferes with the neural activity at the placement site and is thought to inhibit the activity in that region of the brain. The electrode(s) and the generator are connected by an extension wire that is tunneled down the neck under the skin. The device can be turned on and off by the patient using a hand held magnet.
FDA Approval
Multiple devices have been approved for unilateral and/or bilateral deep brain stimulation for suppression of upper extremity tremor not adequately controlled by medication and where the tremor constitutes a significant functional disability, including but not limited to:
1. Activa® Tremor Control System (Medtronic)
2. Brio™ Neurostimulation System (St. Jude Medical)
3. Infinity™ Deep Brain Stimulation System (St. Jude Medical).

Multiple devices have been approved for bilateral deep brain stimulation as an adjunctive therapy in reducing symptoms of advanced, levodopa-responsive Parkinson’s diseases that are not adequately controlled with medication, including but not limited to:
1. Activa® Tremor Control System (Medtronic)
2. Brio™ Neurostimulation System (St. Jude Medical)

Prior Authorization
Prior authorization is not required. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Coding Considerations
Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT Codes:
- **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)
- **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
Medica Coverage Policy

Original Effective Date Coverage Policy: 1/1/2004
Re-Review Date(s) Coverage Policy: 3/1/2007
                                            3/1/2010
                                            7/17/2019

Original Effective Date UM Policy: 7/1/2010
Re-Review Date(s) UM Policy: 4/1/2011
                                            4/1/2012
                                            4/1/2013
                                            4/1/2014
                                            4/1/2015
                                            4/1/2016
                                            4/1/2017
                                            4/1/2018
                                            2/17/2020 – administrative update; format

© 2004-2020 Medica. Medica® is a registered service mark of Medica Health Plans. “Medica” refers to the family of health services companies that includes Medica Health Plans, Medica Community Health Plan, Medica Insurance Company, Medica Self-Insured, MMSI, Inc. d/b/a Medica Health Plan Solutions, Medica Health Management, LLC and the Medica Foundation.