

Nervous System

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Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

1.0 CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

2.0 POLICY

2.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the nervous system are covered.

2.2 Therapeutic embolization (CPT¹ procedure code 61624) may be covered for the following indications. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

- Cerebral Arteriovenous Malformations (AVMs).
- Vein of Galen Aneurysm.
- Inoperable or High-Risk Intracranial Aneurysms.
- Dural Arteriovenous Fistulas.
- Meningioma.
- Pulmonary Arteriovenous Malformations (PAVMs).

2.3 Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

2.4 Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

2.4.1 The accessories necessary for the effective functioning of the covered device.

2.4.2 Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

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2.5 The Guglielmi Detachable Coil (GDC) may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

2.5.1 Very high risk for management by traditional operative techniques; or

2.5.2 Inoperable; or

2.5.3 For embolizing other vascular malformation such as AVMs and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

3.0 EXCLUSIONS

3.1 N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

3.2 Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

3.3 Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

3.4 Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

3.5 Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

3.6 Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

3.7 Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

3.8 Epidural steroid injections for thoracic pain are unproven.

3.9 Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

3.10 Neuromuscular Electrical Stimulation (NMES) for the treatment of denervated muscles is unproven.

3.11 Stereotactic cingulotomy is unproven.

3.12 Sacral nerve neurostimulator (CPT² procedure codes 64561, 64581, 64585, and 64590). See [Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

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3.13 Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

3.14 Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven.

3.15 Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT³ procedure code 61635) is unproven.

3.16 Balloon dilation of intracranial vasospasm, initial vessel (CPT³ procedure code 61640) each additional vessel in same family (CPT³ procedure code 61641) or different vascular family (CPT³ procedure code 61642) is unproven.

3.17 Endoscopic thoracic sympathectomy.

3.18 Trigger point injection for migraine headaches.

3.19 Botox (chemodenervation), surgical denervation, and muscle resection for migraine headaches are unproven.

3.20 Sphenopalatine ganglion block (CPT³ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

3.21 Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT³ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

3.22 Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

3.23 Cryoablation of Occipital Nerve (CPT³ procedure code 64640) for the treatment of chronic intractable headache is unproven.

3.24 Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

4.0 EFFECTIVE DATES

4.1 January 1, 1989, for PAVM.

4.2 April 1, 1994, for therapeutic embolization for treatment of meningioma.

4.3 July 14, 1997, for GDC.

4.4 The date of FDA approval of the embolization device for all other embolization procedures.

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Chapter 4, Section 20.1

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4.5 June 1, 2004, for Magnetoencephalography.

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