Chapter 4 Section 20.1

Nervous System

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1.0 CPT[1] PROCEDURE CODES

61000 - 61626, 61680 - 62264, 62268 - 62284, 62290 - 63048, 63050, 63051, 63055 - 64484, 64505 - 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95979, 95983, 95984

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 (CPT[1] 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, and battery replacement, may be covered for the following indications:

- 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.

- As therapy for children 12 years of age or younger who have a diagnosis of medically refractory Lennox-Gastaut Syndrome (LGS) (a rare disease).

- Effective July 27, 2012, as adjunctive therapy in reducing the frequency of seizures that are refractory to anti-epileptic medications in beneficiaries under the age of 12.

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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.

2.5 Endovascular coil occlusion 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.

2.6 FDA approved Flow Diverter Devices (FDDs) may be cost-shared.

2.7 Thoracic epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniations may be considered for cost-sharing when a patient meets all of the following criteria:

- Pain is radicular; and
- Pain is unresponsive to conservative treatment.

2.8 Non-pulsed Radiofrequency (RF) denervation (CPT[2] procedure codes 64633-64636) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

2.8.1 No prior spinal fusion surgery in the vertebral level being treated, and

2.8.2 Low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; and the pain is not radicular, and

2.8.3 Pain has failed to respond to three months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program, and

2.8.4 A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and

2.8.5 If there has been a prior successful RF denervation, a minimum time of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

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2.9 Endoscopic laminotomy (CPT[3] procedure code 63030) is covered for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved.

2.10 Sacral Nerve Stimulation (SNS) for the treatment of chronic fecal incontinence is covered for patients who have failed or are not candidates for more conservative treatment, and who have a weak but structurally intact anal sphincter refractory to conservative measures. See Section 14.1 for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

2.11 Intracranial angioplasty (CPT[3] procedure code 61630) may be covered when medically necessary and appropriate.

2.12 Deep Brain Stimulation (DBS) for the treatment of Parkinson's Disease (PD) and Essential Tremor (ET) is proven when using an FDA approved device, according to FDA indications.

2.13 Cervical laminoplasty (CPT[3] procedure codes 63050 and 63051) may be covered when medically necessary and appropriate.

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

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

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

3.8 Stereotactic cingulotomy is unproven.

3.9 Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT[3] procedure code 61635) is unproven. See Chapter 1, Section 3.1 for coverage policy regarding treatment of pseudotumor cerebri.

3.10 Balloon dilation of intracranial vasospasm, initial vessel (CPT[4] procedure code 61640) each additional vessel in same family (CPT[4] procedure code 61641) or different vascular family (CPT[4] procedure code 61642) is unproven.

3.11 Endoscopic thoracic sympathectomy.

3.12 The following treatments for chronic intractable headache or migraine pain are unproven:

- Trigger point injection
- Sphenopalatine ganglion block (CPT[4] procedure code 64505)
- Cryoablation of Occipital Nerve (CPT[4] procedure code 64640)
- Deep brain neurostimulation
- Spinal cord neurostimulation
- Implantation of Occipital Nerve Stimulator

3.13 Sphenopalatine ganglion block (CPT[4] procedure code 64505) for the treatment of neck pain is unproven.

3.14 RF denervation (CPT[4] procedure codes 64633, 64634) for the treatment of thoracic facet pain is unproven. Pulsed Radiofrequency Ablation (RFA) for spinal pain is unproven.

3.15 Thermal Intradiscal Procedures (TIPs) (CPT[4] procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous RF thermomodulation or Percutaneous Plasma Diskectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

3.16 Laser ablation of paravertebral facet joint nerves (CPT[4] procedure codes 64622 and 64623) is unproven. **(This applies only to laser ablation and should not be applied to RFA.)**

3.17 Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

3.18 RFA of the genicular nerves of the knee for the treatment of osteoarthritis (OA) is unproven.

3.19 RFA for sacroiliac joint (SIJ) denervation for the treatment of low back pain is unproven.

3.20 Transcutaneous Electrical Nerve Stimulation (TENS) for the treatment of acute, subacute, and chronic low back pain (LBP) is excluded from coverage.

4.0 EFFECTIVE DATES

4.1 January 1, 1989, for PAVM.

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

4.3 July 14, 1997, for GDC.

4.4 February 16, 2011, for endovascular coil occlusion for embolizing intracranial aneurysms.

4.5 December 24, 2012, for FDD treatment of intracranial aneurysms.

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

4.7 June 1, 2004, for Magnetoencephalography.

4.8 June 10, 2008, for thoracic epidural steroid injections.

4.9 January 1, 2009, for non-pulsed RF denervation for the treatment of chronic cervical and lumbar facet pain.

4.10 January 1, 2009, for endoscopic laminotomy for the treatment of lumbar spinal stenosis.

4.11 October 1, 2011, for vagus nerve stimulator for treatment of LGS in children 12 years of age or younger.

4.12 March 14, 2011, for SNS for the treatment of chronic fecal incontinence in patients who have failed or are not candidates for more conservative treatment, and who have a weak but structurally intact anal sphincter refractory to conservative measures.

4.13 Effective July 27, 2012, for implantation of a FDA approved vagus nerve stimulator and battery replacement as adjunctive therapy in reducing the frequency of seizures that are refractory to anti-epileptic medications in beneficiaries under the age of 12.

4.14 August 9, 2012, for intracranial angioplasty.

4.15 February 2, 2014, for DBS for the treatment of PD and ET.

4.16 September 3, 2016, for cervical laminoplasty.

4.17 June 1, 2020, for the exclusion of TENS for the treatment of acute, subacute, and chronic LBP.

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