

Table of Contents

| | | |
|--|---|---|
| 1.0 | Description of the Procedure, Product, or Service | 1 |
| 2.0 | Eligible Recipients | 1 |
| 2.1 | General Provisions | 1 |
| 2.2 | EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age | 1 |
| 3.0 | When the Procedure, Product, or Service Is Covered | 2 |
| 3.1 | General Criteria | 2 |
| 3.2 | Specific Criteria | 2 |
| 4.0 | When the Procedure, Product, or Service Is Not Covered | 3 |
| 4.1 | General Criteria | 3 |
| 4.2 | Specific Criteria | 3 |
| 5.0 | Requirements for and Limitations on Coverage | 4 |
| 5.1 | Prior Approval | 4 |
| 6.0 | Providers Eligible to Bill for the Procedure, Product, or Service | 4 |
| 7.0 | Additional Requirements | 4 |
| 7.1 | Compliance | 4 |
| 8.0 | Policy Implementation and Update Information | 4 |
| Attachment A: Claims-Related Information | | 5 |
| A. | Claim Type | 5 |
| B. | Diagnosis Codes | 5 |
| C. | Procedure Code(s) | 5 |
| D. | Modifiers | 7 |
| E. | Billing Units | 7 |
| F. | Place of Service | 7 |
| G. | Co-Payments | 7 |
| H. | Reimbursement Rate | 7 |

1.0 Description of the Procedure, Product, or Service

Deep brain stimulation (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 patient'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.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient'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**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

The use of deep brain stimulation with a Humanitarian Device Exemption (HDE) or for other indications will be considered on a case by case basis under extraordinary circumstances. Placement of a deep brain stimulator is covered when all of the following criteria are met:

- a. The recipient has one of the diagnoses listed in **Attachment A, Claims-Related Information.**

- b. The recipient 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 recipient.
- d. The facilities, equipment, and professional and support personnel required for the proper treatment, training, and follow-up of the recipient are available.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

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 recipient'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.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is not required; however, diagnosis editing does apply. Refer to **Attachment A, Claims-Related Information**, letter B.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; 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.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation and Update Information

Original Effective Date: January 1, 1985

Revision Information

| Date | Section Updated | Change |
|------------|-----------------|---|
| 03/01/2010 | Throughout | Initial promulgation of current coverage. |
| | | |
| | | |

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity. The following are the only diagnosis codes currently allowed.

| ICD-9-CM Code | Description |
|---------------|--|
| 332.0 | Paralysis agitans |
| 333.1 | Essential and other specified forms of tremor |
| 333.6 | Genetic torsion dystonia |
| 333.71 | Athetoid cerebral palsy |
| 333.79 | Other acquired torsion dystonia |
| 333.83 | Spasmodic torticollis |
| 333.90 | Unspecified extrapyramidal disease and abnormal movement disorder |
| 996.2 | Mechanical complication of nervous system device, implant, and graft |

C. Procedure Code(s)

Medicaid covers the following procedure codes relative to DBS:

| CPT Code | 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 |

| CPT Code | Description |
|----------|--|
| +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) |
| 61870 | Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical |
| 61875 | Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical |
| 61880 | Revision or removal of intracranial neurostimulator electrodes. Use diagnosis code 996.2. |
| 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 two or more electrode arrays |
| 61888 | Revision or removal of cranial neurostimulator pulse generator or receiver. Use diagnosis code 996.2. |
| 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 physician attendance |
| +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 physician attendance (List separately in addition to code for primary procedure) |
| 95970 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming |
| 95974 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour |
| +95975 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) |

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

Codes 61850, 61860, 61863, 61867, 61870, 61875, 61880, 61885, 61886, 61888, 95961, 95970, 95974, and 95975 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.

F. Place of Service

Inpatient, outpatient

G. Co-Payments

Reimbursement may be subject to a co-payment calculation.

H. Reimbursement Rate

Providers must bill their usual and customary charges.