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1.0 Description of the Procedure

Stereotactic pallidotomy is a surgical technique used in the treatment of severe Parkinson's disease. Pallidotomy is defined as the surgical creation of a lesion in a globus pallidus in the basal ganglia.

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

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.

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****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/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure 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, see **Section 2.0** of this policy.

3.1 Specific Criteria

Stereotactic pallidotomy is covered when all of the following coverage criteria are met:

a. The recipient has typical paralysis agitans.
b. The recipient exhibits rigidity and bradykinesia.
c. The recipient has a history of optimal response to levodopa.
d. The recipient has become refractory to medical therapy **or** has developed intolerance to medication.
e. The recipient is alert, cooperative, and in general good health.
f. The recipient has a history of active disease for more than five years.

4.0 When the Procedure 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, see **Section 2.0** of this policy.

4.1 Specific Criteria

a. Stereotactic pallidotomy is not covered when performed with radiation. This is considered investigational and is therefore noncovered by Medicaid.
b. Bilateral pallidotomy on the same date of service is not covered.
c. Stereotactic pallidotomy is not covered when any of the following conditions exist:
   1. Advanced cerebral atrophy, focal lesion, or lacuna of the basal ganglia
   2. Advanced disease **or** other conditions that could explain the neurological symptoms
   3. Atypical parkinson's disorder
   4. Dementia, cerebral atrophy, or confused state

5.0 Requirements for and Limitations on Coverage

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, see **Section 2.0** of this policy.

5.1 Prior Approval and Documentation

Prior approval is required. The following medical documentation must be submitted with the prior approval request:

a. documentation of the recipient's response to levodopa;
b. documentation that the recipient is alert, cooperative and in general good health;
c. documentation that the recipient has a history of the active disease for more than five years;
d. documentation that the recipient exhibits rigidity and bradykinesia;
e. documentation that the recipient has typical paralysis agitans;
f. neurological evaluation that indicates the recipient has become refractory to medical therapy or has developed intolerance to medication; and
g. documentation through MRI or CT of the absence of advanced cerebral atrophy, focal lesion, or lacuna of the basal ganglia.

6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this surgery may bill for this service.

7.0 Additional Requirements

There are no additional requirements.

8.0 Billing Guidelines

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

8.1 Claim Type

Providers bill professional physician services on the CMS-1500 claim form.

8.2 Diagnosis Codes

The ICD-9-CM diagnosis code that supports medical necessity is 332.0.

8.3 Procedure Codes

The CPT procedure code that is covered by the N.C. Medicaid program is 61720.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 2000

Revision Information:

Date	Section Updated	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA’s EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age