

Subject: Implantable Neurostimulators

Background: Implantable neurostimulators are micro-electronic devices that deliver stimulation to the nervous system and offer various therapeutic treatment options. Deep brain stimulation (DBS) involves constant, high-frequency electrical stimulation of specific sites in the brain with implanted electrodes as a means to reduce the symptoms of movement disorders such as essential tremor and Parkinson’s disease. Gastric electrical stimulation (GES) therapy is a treatment for individuals with chronic gastroparesis, a gastrointestinal motility disorder characterized by delayed gastric emptying without evidence of physical obstruction. The implanted stimulator delivers electrical impulses to the gastric muscles to stimulate gastric myoelectric activity, which improves stomach emptying and reduces the frequency and severity of symptoms.

Sacral nerve stimulation has been recently introduced as an alternative, minimally invasive treatment option for individuals with chronic, severe fecal incontinence who fail first-line conservative therapies or who are not appropriate candidates for such therapies, and who are considering a more invasive surgical option. Spinal cord stimulation (SCS) involves the electrical stimulation of spinal nerves using electrodes implanted in the epidural space of the spinal column. The goal of SCS is to suppress pain in specific areas for individuals with chronic pain, including chronic, refractory, neuropathic pain. Vagus nerve stimulation (VNS) is a therapy for treatment-resistant major depression and bipolar disorder in which an implanted generator, the neurocybernetic prosthesis, delivers electrical pulses to the cervical portion of the vagus nerve. The goal of VNS is to reduce the severity and/or duration of a depressive period.

Authorization:

Prior authorization is required for covered implantable stimulators provided to members enrolled in commercial (HMO, POS, and PPO) products.

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation and/or color photographs may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation —via HPHConnect Clinical Upload or secure fax (800-232-0816)
- Photographs— HPHConnect Clinical Upload function, email (utilization_requests@harvardpilgrim.org), or mail (Utilization Management, 1600 Crown Colony Dr., Quincy, MA 02169). Please note that photographs should not be faxed as faxed photos cannot be utilized in making a medical necessity determination.

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Resources and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the [instructions here](#).) Members may access these materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

Policy and Coverage Criteria:

I.A Gastric Stimulation InterQual Subset	CODES The following codes require prior authorization:
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<ul style="list-style-type: none"> Gastric Stimulation 	<table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>43647</td> <td>Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum</td> </tr> <tr> <td>43881</td> <td>Implantation or replacement of gastric neurostimulator electrodes, antrum, open</td> </tr> <tr> <td>64590</td> <td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td> </tr> </tbody> </table>	Code	Description	43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling																
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I.C. Spinal Cord Stimulator Insertion InterQual Subset <ul style="list-style-type: none"> • Spinal Cord Temporary Electrode Trial • Spinal Cord Stimulator Insertion 	CODES	
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	63650	Percutaneous implantation of neurostimulator electrode array, epidural
	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	

In addition, The Plan requires the following criteria:

The Plan considers implantable neurostimulators as reasonable and medically necessary with a request from an accredited provider with appropriate state licensure and when documentation confirms specific criteria for ANY of the following devices:

II. A Sacral Nerve Stimulators for Urinary Incontinence: Temporary Trial	Coverage Guidelines	
	Temporary trial of Sacral Nerve Stimulators with an external stimulator for either percutaneous nerve evaluation or an implanted lead is considered reasonable and medically necessary when documentation confirms member has urinary incontinence or frequency, and confirms ALL the following: <ul style="list-style-type: none"> • Diagnosis of urinary urgency with or without incontinence, urinary urgency associated with frequency and/or nocturia in the absence of infection or other pathology, OR non-obstructive urinary retention unrelated to a neurologic condition; AND • Documented failure of, or symptoms refractory to, at least two types of conservative therapies, (e.g. behavioral interventions, dietary modifications, bladder training, trial of anticholinergic or beta agonist medications); AND • Urinary incontinence is experienced for a minimum of 12 months and is not related to other neurologic conditions that is associated with secondary manifestations of urinary urge incontinence, urgency, frequency or non-obstructive urinary retention. 	
	Codes	
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	Code	Description
	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
	64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)

<p>II. B Sacral Nerve Stimulators for Urinary Incontinence: Permanent</p>	<p>Coverage Guidelines Permanent Sacral Nerve Stimulators are considered reasonable and medically necessary when documentation confirms member meets criteria for temporary trial of sacral nerve stimulators for urinary incontinence and has undergone a successful trial based on ALL the following:</p> <ul style="list-style-type: none"> • Member has at least a 50% reduction in catheter volume/catheterization; • Member has at least 50% reduction in ONE of the following: <ul style="list-style-type: none"> ○ Daily incontinence episodes, OR ○ Severity of the episodes or the number of pads/diapers used per day • Member has at least 50% improvement in ONE of the following: <ul style="list-style-type: none"> ○ Number of voids daily, OR ○ Volume per void, OR ○ Frequency per void <p>Codes The following codes require prior authorization</p> <table border="1" data-bbox="602 808 1453 1003"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>64561</td> <td>Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed</td> </tr> <tr> <td>64581</td> <td>Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)</td> </tr> </tbody> </table>	Code	Description	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
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<p>II. C Sacral Nerve Stimulators for Fecal Incontinence: Temporary Trial</p>	<p>Coverage Guidelines Temporary trial of Sacral Nerve Stimulators is considered reasonable and medically necessary when documentation confirms member has fecal incontinence, and confirms ALL the following:</p> <ul style="list-style-type: none"> • More than 2 episodes of fecal incontinence per week for 6 consecutive months, or for 12 consecutive months following vaginal childbirth; AND • Incontinence is not related to another neurologic condition (e.g. peripheral neuropathy, spinal cord injury) • Documented failure of conservative therapies for at least 12 months, (e.g. medication, dietary modification), or symptoms or refractory to conservative therapies. <p>Codes The following codes require prior authorization</p> <table border="1" data-bbox="602 1518 1453 1711"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>64561</td> <td>Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed</td> </tr> <tr> <td>64581</td> <td>Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)</td> </tr> </tbody> </table>	Code	Description	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
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<p>II. D Sacral Nerve Stimulators for Fecal Incontinence: Permanent</p>	<p>Coverage Guidelines Permanent Sacral Nerve Stimulators are considered reasonable and medically necessary when documentation confirms member meets criteria for temporary trial of sacral nerve stimulators for fecal incontinence and has undergone a successful trial of at least 50% improvement in symptoms.</p> <p>Codes The following codes require prior authorization</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>64561</td> <td>Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed</td> </tr> <tr> <td>64581</td> <td>Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)</td> </tr> </tbody> </table>	Code	Description	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)						
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<p>II. E Vagus Nerve Stimulator</p>	<p>Coverage Guidelines Vagal Nerve Stimulators are considered reasonable and medically necessary when documentation confirms ALL the following:</p> <ul style="list-style-type: none"> Member with refractory seizures experiences persistent seizures and/or intolerable side effects after trials of 2 or more antiepileptic medications; AND Member has failed, or is not a candidate for, resective surgery <p>Codes The following codes require prior authorization</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>61885</td> <td>Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array</td> </tr> <tr> <td>61886</td> <td>Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays</td> </tr> <tr> <td>61888</td> <td>Revision or removal of cranial neurostimulator pulse generator or receiver</td> </tr> <tr> <td>64553</td> <td>Percutaneous implantation of neurostimulator electrode array; cranial nerve</td> </tr> <tr> <td>64568</td> <td>Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td> </tr> </tbody> </table>	Code	Description	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	61888	Revision or removal of cranial neurostimulator pulse generator or receiver	64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
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Note: For non-implantable percutaneous tibial nerve stimulation for voiding dysfunction please see the Percutaneous Tibial Nerve Stimulation for Voiding Dysfunction Medical Necessity Guideline

Exclusions:

HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members' unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.

The Plan considers Implantable Neurostimulators as not medically necessary for all other indications. In addition, The Plan does not cover:

- Subcortical/Cortical Electrodes and Deep Brain stimulation for conditions including, but not limited to:
 - Chronic Cluster headache
 - Degenerative disorders
 - Depression
 - Drug-induced movement disorder (e.g., Tardive Dyskinesia)
 - Multiple Sclerosis (MS)
 - Obsessive-Compulsive Disorder (OCD)
 - Tourette Syndrome
 - Trauma
- Gastric stimulation for any other indication, including obesity
- Sacral nerve stimulation for conditions including, but not limited to:
 - Anorectal malformation
 - Chronic inflammatory bowel disease
 - Chronic pelvic pain
 - Constipation;
 - Fecal incontinence following non-cancer related rectal surgery within the past 12 months, or cancer-related rectal surgery within the past 24 months;
 - Stress incontinence or other chronic voiding dysfunction due to neurologic conditions (e.g., spinal cord injury, diabetic neuropathy, MS)
 - Urge incontinence due to a neurologic condition (e.g., detrusor hyperreflexia)
- Spinal nerve stimulation for conditions including, but not limited to:
 - Refractory Canadian Class III or IV Angina
 - Pain associated with malignancy
 - Treatment of critical limb ischemia
 - Cancer-related pain
 - Heart failure
 - Diabetic Neuropathy
 - Chronic Intractable Back Pain with Prior Spine Surgery
- Vagus stimulation for conditions including, but not limited to:
 - Addictions
 - Alzheimer's disease
 - Anxiety disorder
 - Asthma
 - Autism spectrum disorder
 - Back and neck pain
 - Bipolar disorder
 - Bulimia
 - Cerebral palsy
 - Crohn's Disease
 - Chronic pain syndrome
 - Cluster headaches
 - Depression
 - Essential tremor
 - Fibromyalgia
 - Heart failure
 - Migraines
 - Morbid obesity
 - Narcolepsy

- Obsessive-compulsive disorder
- Paralysis agitans
- Sleep disorders
- Tinnitus
- Traumatic brain injury
- Tourette's syndrome
- Cerebellar stimulation/pacing for any indication
- Occipital nerve stimulation for any indication
- gammaCore®
- Peripheral Nerve Stimulation

Billing Guidelines:

Member's medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

References:

1. Abdi, S. Prevention and management of complex regional pain syndrome in adults. UpToDate.com/login [via subscription only]. Accessed April 19, 2021..
2. Chronic migraine. UpToDate.com/login [via subscription only]. Accessed April 19, 2021..
3. DBS Epilepsy Fact Sheet. Medtronic Inc.; 2018. Accessed April 19, 2021..
4. Deep Brain Stimulation for Parkinson's Disease. National Institute for Health and Care Excellence (NICE); 2017. Available at: <https://www.nice.org.uk/guidance/ipg19/resources/deep-brain-stimulation-for-parkinsons-disease-pdf-52773986491333>. Accessed April 19, 2021..
5. Deep brain stimulation for treatment of obsessive-compulsive disorder. UpToDate.com/login [via subscription only]. Accessed April 19, 2021..
6. Deep Brain Stimulation for Treatment-Resistant Depression. Hayesinc.com/subscribers [via subscription only]. Accessed April 19, 2021..
7. Depression in adults: Overview of neuromodulation procedures. UpToDate.com/login [via subscription only]. Accessed April 19, 2021..
8. Epilepsy Bibliography. Medtronic Inc.; 2018. Accessed April 19, 2021..
9. Evaluation and management of drug-resistant epilepsy. UpToDate.com/login [via subscription only]. Accessed April 19, 2021.
10. Fecal incontinence in adults: Management. UpToDate.com/login [via subscription only]. Accessed April 19, 2021.
11. Gormley, EA., Lightner, DJ., Faraday, M., et al. Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline amendment. J Urol. 2015; 193(5): 1572.
12. Implantable Sacral Nerve Stimulation for Urinary Voiding Dysfunction. Hayesinc.com/subscribers [via subscription only]. Accessed April 19, 2021.
13. Management of Gastroparesis. Giorg. 2013. Available at: <https://gi.org/guideline/management-of-gastroparesis/>. Accessed April 19, 2021..
14. Medical Technology Directory. Gastric electrical stimulation for gastroparesis. Hayesinc.com/subscribers [via subscription only]. Accessed April 19, 2021..
15. Medtronic DBS Therapy for Epilepsy. U.S. Food and Drug Administration; 2018. Accessed April 19, 2021.
16. National Coverage Determination (NCD) for Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24). <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=279&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&>

17. National Coverage Determination (NCD) for Sacral Nerve Stimulation for Urinary Incontinence (230.18)
<https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=249&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&>
18. National Coverage Determination (NCD) for Vagus Nerve Stimulation (VNS) (1670.18).
<https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=230&ncdver=2&bc=AAAAgAAAAAAAAA%3d%3d&>
19. Occipital Nerve Stimulation for Chronic Cluster Headache and Chronic Migraine. Hayesinc.com/subscribers [via subscription only]. Accessed May 4, 2020.
20. Overview of the treatment of chronic pain. UpToDate.com/login [via subscription only]. Accessed April 19, 2021.
21. Panebianco M, Zavanone C, Dupont S, Restivo D, Pavone A. Vagus nerve stimulation therapy in partial epilepsy: a review. Acta Neurologica Belgica. 2016;116(3):241-248. doi:10.1007/s13760-016-0616-3.
22. Spinal Cord Stimulation for Relief of Neuropathic Pain. Hayesinc.com/subscribers [via subscription only]. Accessed April 19, 2021..
23. Stewart, F., Gameiro, OL., El Dib, R., et al. Electrical stimulation with non-implanted electrodes for overactive bladder in adults. Cochrane Database Syst Rev. 2016; 4: CD010098.
24. Summary of Safety and Effectiveness Data (SSED). U.S. Food and Drug Administration; 2018. Accessed April 19, 2021.
25. Surgical treatment of essential tremor. UpToDate.com/login [via subscription only]. April 19, 2021..
26. Surgical treatment of Parkinson disease. UpToDate.com/login [via subscription only]. Accessed April 19, 2021.
27. Treatment of dystonia. UpToDate.com/login [via subscription only]. Accessed April 19, 2021..
28. Treatment of urinary incontinence in women. UpToDate.com/login [via subscription only]. Accessed April 19, 2021..
29. Vagus Nerve Stimulation for Depression. Hayesinc.com/subscribers [via subscription only]. Accessed April 19, 2021.
30. Vagus Nerve Stimulation for Epilepsy. Hayesinc.com/subscribers [via subscription only]. Accessed April 19, 2021..
31. Vagus nerve stimulation therapy for the treatment of epilepsy. UpToDate.com/login [via subscription only]. Accessed April 19, 2021.
32. Zesiewicz T, Elble R, Louis E et al. Evidence-based guideline update: Treatment of essential tremor: Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2011;77(19):1752-1755. doi:10.1212/wnl.0b013e318236f0fd.

Summary of Changes

Date	Change
6/23	Coding updated
10/22	Criteria updated for Integration with Tufts Health Plan (THP)
7/22	Annual review; no changes
5/21	Annual review; criteria and coding updated
6/20	Annual review; adoption of IQ criteria, coding updated
6/19	Annual review; no changes
3/18	Background and references updated; policy coverage criteria refined
3/17	Updated coding to reflect deleted code
8/16	Updated references. Minor formatting changes.

Approved by Medical Policy Committee: 6/21/23

Approved by Clinical Policy Operational Committee: 2/15; 8/16; 3/17; 3/18; 6/19; 8/20; 5/21; 8/22; 11/22; 7/23

Policy Effective Date: 08/01/2023

Initiated: 7/1/15