

CENTRAL NERVOUS SYSTEM STIMULATION

Issue Date: March 12, 1985

Authority: [32 CFR 199.4\(b\)\(2\)](#), [\(c\)\(2\)](#), and [\(g\)\(15\)](#)

I. PROCEDURE CODE RANGE

61850 - 61888, 63650 - 63688, 95970, 95971

II. DESCRIPTION

A. Central nervous system is that portion of the nervous system consisting of the brain and spinal cord.

B. Deep brain (intracranial) stimulation is the electrical stimulation through implanted electrodes of specific regions of the deep brain i.e., thalamic and periaqueductal gray matter.

C. Spinal cord stimulation is the electrical stimulation through implanted electrodes of specific regions of the spinal column.

III. POLICY

Benefits are authorized for both spinal cord and deep brain stimulation in the treatment of chronic intractable pain.

IV. POLICY CONSIDERATIONS

A. No payment may be made for the implantation of dorsal column or deep brain stimulators or services and supplies related to such implantation, unless all of the conditions listed below have been met.

1. The treatment is used only as a late resort (if not a last resort) for patients with chronic intractable pain.

2. With respect to paragraph a, above, other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient.

3. Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation.)

4. Demonstration of the effectiveness of the treatment must be demonstrated with the use of a temporarily implanted electrode before implantation of a permanent electrode. If relief is not documented, implantation of a permanent device will not be authorized.

B. All claims must have documentation of having met the criteria in paragraphs 1 - 4 above and subjected to medical review before authorization of benefits will be allowed.

C. Benefits are also authorized for the following:

1. Accessories necessary for the effective functioning of the covered device.
2. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

V. EXCLUSIONS

A. Benefits will not be authorized for transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders. (See [Chapter 8, Section 14.1](#))

B. Benefits will not be allowed for deep brain neurostimulation in the treatment of insomnia, depression, anxiety, substance abuse, or any condition other than chronic intractable pain.

VI. EFFECTIVE DATE December 1, 1979.

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