Chapter 4 Section 20.1

Nervous System

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1.0 CPT[1] PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

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 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 is covered. Battery replacement is also covered.

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.

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2.5 The Guglielmi Detachable Coil (GDC) 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 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.

2.7 Non-pulsed Radiofrequency (RF) denervation (CPT[2] procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

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

2.7.2 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

2.7.3 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

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

2.7.5 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).

2.8 Endoscopic laminotomy (CPT[2] procedure code 63030) is covered for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved.

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.

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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 Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

3.6 Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

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

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

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

3.10 Stereotactic cingulotomy is unproven.

3.11 Sacral nerve neurostimulator (CPT[3] procedure codes 64561, 64581, 64585, and 64590). See Section 14.1 for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

3.12 Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT[3] procedure codes 63050 and 63051).

3.13 Balloon angioplasty, intracranial, percutaneous (CPT[3] procedure code 61630) is unproven.

3.14 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.

3.15 Balloon dilation of intracranial vasospasm, initial vessel (CPT[3] procedure code 61640) each additional vessel in same family (CPT[3] procedure code 61641) or different vascular family (CPT[3] procedure code 61642) is unproven.

3.16 Endoscopic thoracic sympathectomy.

3.17 Trigger point injection for migraine headaches.

3.18 Botox (chemodenervation), surgical denervation, and muscle resection for migraine headaches are unproven.

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3.19 Sphenopalatine ganglion block (CPT[4] procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

3.20 RF denervation (CPT[4] procedure codes 64626, 64627) for the treatment of thoracic facet pain is unproven. Pulsed Radiofrequency Ablation (RFA) for spinal pain is unproven.

3.21 Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

3.22 Cryoablation of Occipital Nerve (CPT[4] procedure code 64640) for the treatment of chronic intractable headache is unproven.

3.23 Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

3.24 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.

3.25 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.)**

4.0 EFFECTIVE DATES

4.1 January 1, 1989, for PAVM.

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

4.3 July 14, 1997, for GDC.

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

4.5 June 1, 2004, for Magnetoencephalography.

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

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

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

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