

# Phrenic Nerve Stimulator (NCD 160.19)

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[Terms and Conditions](#)

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- Related Medicare Advantage Policy Guideline
  - [Electrical Nerve Stimulators \(NCD 160.7\)](#)
- Related Medicare Advantage Coverage Summary
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## Policy Summary

[See Purpose](#)

### Overview

The phrenic nerve stimulator provides electrical stimulation of the patient's phrenic nerve to contract the diaphragm rhythmically and produce breathing in patients who have hypoventilation (a state in which an abnormally low amount of air enters the lungs). The phrenic nerve stimulator is intended to be an alternative to management of patients with respiratory insufficiency who are dependent upon the usual therapy of intermittent or permanent use of a mechanical ventilator as well as maintenance of a permanent tracheotomy stoma.

The device has been used successfully to treat hypoventilation caused by a variety of conditions, including chronic pulmonary disease with ventilatory insufficiency and respiratory paralysis resulting from lesions of the brain stem and cervical spinal cord. An implanted phrenic nerve stimulator can be effective only if the patient has an intact phrenic nerve and diaphragm. Also, nerve injury may occur during the surgical procedure and if sufficient injury is incurred, the device will not prove useful to the patient. Consequently, it is possible for such a device to be indicated for a patient but, due to injury sustained during implant, fail to assist the patient, resulting in a return to the use of mechanical ventilation.

### Guidelines

Implantation of a phrenic nerve stimulator is covered for selected patients with partial or complete respiratory insufficiency.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: The below HCPCS codes may be submitted for phrenic nerve stimulators. These codes are also related to other NCDs and diagnoses.

HCPCS Code	Description
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each (Invalid)
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension (Invalid)
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension (Invalid)
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension (Invalid)
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension (Invalid)
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
L8695	External recharging system for battery (external) for use with implantable neurostimulator, replacement only

## References

### CMS National Coverage Determinations (NCDs)

[NCD 160.19 Phrenic Nerve Stimulator](#)

Reference NCD: [NCD 160.7 Electrical Nerve Stimulators](#)

### CMS Transmittal(s)

[Transmittal 2836, Change Request 8531, Dated 12/13/2013 \(CY 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies \(DMEPOS\) Fee Schedule\)](#)

[Transmittal 2902, Change Request 8645, Dated 3/11/2014 \(April Quarterly for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Fee Schedule\)](#)

### MLN Matters

[Article SE20001, Incorrect Billing of HCPCS L8679 – Implantable Neurostimulator, Pulse Generator, Any Type](#)

### Other(s)

[July 2020 DMEPOS Fee Schedule Update](#)

[March 2014 HCPCS Quarterly Update \(For L8680- See “Other Codes Effective July 1, 2014”\)](#)

[Medicare National Coverage Determinations Manual Chapter 1, Part 2 \(Sections 90 – 160.26\) Coverage Determinations](#)

## Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	<b>Template Update</b> <ul style="list-style-type: none"> <li>Reformatted policy; transferred content to new template</li> </ul>
09/09/2020	<b>Related Policies</b> <ul style="list-style-type: none"> <li>Added reference link to the Medicare Advantage Policy Guideline titled <i>Electrical Nerve Stimulators (NCD 160.7)</i></li> </ul> <b>Policy Summary</b> <i>Overview</i>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>Updated language to clarify the phrenic nerve stimulator provides electrical stimulation of the patient's phrenic nerve to contract the diaphragm rhythmically and produce breathing in patients who have hypoventilation (<i>a state in which an abnormally low amount of air enters the lungs</i>)</li> </ul> <p><b>Applicable Codes</b></p> <ul style="list-style-type: none"> <li>Updated notation to indicate HCPCS codes L8680, L8685, L8686, L8687, and L8688 are “invalid”</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Updated <i>References</i> section to reflect the most current information</li> <li>Archived previous policy version MPG247.05</li> </ul>

## Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

## Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document\* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and

Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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\*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).