# Deep Brain and Responsive Cortical Stimulation

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➲ Instructions for Use

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**Related Medicare Advantage Medical Policies**

- Electrical Stimulators
- Spinal Cord Simulators for Chronic Pain

**Related Commercial Policy**

- Deep Brain and Cortical Stimulation

## Coverage Rationale

### Deep Brain Stimulation

#### *Essential Tremor and Parkinson's Disease*

Medicare has a National Coverage Determination (NCD) for unilateral or bilateral thalamic ventralis intermedius nucleus (VIM) deep brain stimulation (DBS) for the treatment of essential tremor (ET) and/or Parkinsonian tremor and unilateral or bilateral subthalamic nucleus (STN) or globus pallidus interna (GPi) DBS for the treatment of Parkinson's disease (PD). Refer to the NCD Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24) for coverage guidelines. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

#### *All Other DBS Indications (e.g., Dystonia, Refractory Epilepsy for a Partial or Focal Seizure Disorder, Obsessive-Compulsive Disorder)*

Medicare does not have an NCD for DBS for other indications besides those listed above (e.g., dystonia, refractory epilepsy for a partial or focal seizure disorder, obsessive-compulsive disorder). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Deep Brain and Cortical Stimulation.

### Responsive Cortical Stimulation

Medicare does not have an NCD for responsive cortical stimulation. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Deep Brain and Cortical Stimulation.

## 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 policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. 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.


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| CPT Code | Description |
|---|---|
| 61850 | Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical |
| 61863 | Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array |
| 61864 | Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure) |
| 61867 | Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array |
| 61868 | Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure) |
| 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 |
| 64999 | Unlisted procedure, nervous system |

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| HCPCS Code | Description |
|---|---|
| L8680 | Implantable neurostimulator electrode, each (Non-Covered) |
| L8682 | Implantable neurostimulator radiofrequency receiver |
| L8685 | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension (Non-Covered) |
| L8686 | Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension (Non-Covered) |
| L8687 | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension (Non-Covered) |
| L8688 | Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension (Non-Covered) |

# Description of Services

## Deep Brain Stimulation

Deep brain stimulation (DBS) delivers electrical pulses to select areas of the brain (e.g., internal globus pallidus interna, subthalamic nucleus, ventral intermediate nucleus of the thalamus) via surgically implanted electrodes. The mechanism of action is not completely understood, but the goal of DBS is to interrupt the pathways responsible for the abnormal movements that are associated with movement disorders such as Parkinson disease and essential tremor. The exact location of electrodes depends on the type of disorder being treated, and unlike standard surgical ablation, which causes permanent destruction of the targeted area, DBS is reversible and adjustable. The DBS device consists of an implantable pulse generator or neurostimulator, implantable lead with electrodes, and connecting wire. The neurostimulator is approximately the size of a stopwatch and is similar to a cardiac pacemaker. Subcutaneous extension wires connect the lead(s) to the neurostimulator, which is implanted near the clavicle or, in the case of younger individuals with primary dystonia, in the abdomen.

## Responsive Cortical Stimulation (Closed-Loop Implantable Neurostimulator).

The RNS® System (NeuroPace, Inc.) is intended to detect abnormal electrical brain signals that precede seizures and deliver electrical stimulation in response to try to normalize electrical brain activity and prevent seizures before they fully develop. The device includes a neurostimulator that is placed in the skull and leads that are placed in the seizure-


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originating areas of the brain. The system's intended benefits include seizure prevention, fewer adverse events than other neurostimulation methods, and data transmission from the individual's home to clinicians.

## Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

| NCD | LCD | LCA | Contractor Type | Contractor Name |
|---|---|---|---|---|
| Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (NCD 160.24) | N/A | N/A | N/A | N/A |

| Medicare Administrative Contractor (MAC) With Corresponding States/Territories | |
|---|---|
| **MAC Name (Abbreviation)** | **States/Territories** |
| CGS Administrators, LLC (CGS) | KY, OH |
| First Coast Service Options, Inc. (First Coast) | FL, PR, VI |
| Noridian Healthcare Solutions, LLC (Noridian) | AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY |
| Novitas Solutions, Inc. (Novitas) | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA** |
| Palmetto GBA (Palmetto) | AL, GA, NC, SC, TN, VA**, WV |
| Wellpoint Federal (Wellpoint) | CT, IL, ME, MA, MN, NH, NY, RI, VT, WI |
| Wisconsin Physicians Service Insurance Corporation (WPS)* | IA, IN, KS, MI, MO, NE |
| **Notes** | |
| *Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers.<br>**For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction. | |

### CMS Benefit Policy Manual

Chapter 14; § 10, Coverage of Medical Devices

### CMS Claims Processing Manual

Chapter 32; § 50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease

### CMS Transmittal(s)

Transmittal 12440, Change Request 13391, Dated 01/03/2024 (International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) – April 2024 Update – CR 2 of 2)
Transmittal 2902, Change Request 8645, Dated 03/11/2014 (April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule)
Transmittal 2836, Change Request 8531, Dated 12/13/2013 (CY 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule)

### Others

Treatment of Motor Function Disorders with Electric Nerve Stimulation (NCD 160.2)
Electrical Nerve Stimulators (NCD 160.7)
Vagus Nerve Stimulation (VNS) (NCD 160.18)


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# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 09/01/2026 | **Supporting Information**<br>• Replaced references to "National Government Services (NGS)" with "Wellpoint Federal (Wellpoint)" (no change to policy guidelines)<br>• Archived previous policy version MMP395.01 |

# Instructions for Use

The Medicare Advantage Medical Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

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

Medicare Advantage Medical Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Medical Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. 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 this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Medical Policies 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 Medical Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Medical Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Medical Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Medical Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Medical Policies 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 members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.


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