Epilepsy Treatment

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☐ *Oregon* ☐ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Focal epilepsy is a neurological disorder characterized by recurrent, seizures originating from a local region of the brain. Management typically begins with antileptic medications; however, some patients develop drug-resistant focal epilepsy with persistent seizures despite appropriate pharmacological therapy. For these cases, advanced interventions may be considered, such as deep brain stimulation, laser interstitial thermal therapy (LITT) or Responsive Neurostimulation (RNS).

I. **Deep brain stimulation** – Implantable neurostimulation device which delivers targeted electrical stimulation to specific brain regions to modulate abnormal severity.

II. **Vagus Nerve Stimulation (VNS)** – Implantable neurostimulation device which delivers intermittent electrical stimulation to the vagus nerve to modulate brain networks and reduce seizure frequency.

III. **Laser interstitial thermal therapy** (LITT) – Minimally invasive surgical procedure which uses Magnetic Resonance Imaging (MRI)-guided thermal energy to ablate epileptogenic brain tissue and reduce seizure activity.

IV. **Responsive Neurostimulation** – Implantable neurostimulation device which detects abnormal electrical activity and delivers responsive stimulation to disrupt seizures at their focal onset.

Criteria

Commercial

Prior authorization is required.

I. Deep Brain Stimulation

A. PacificSource considers deep brain stimulation for the treatment of epilepsy medically necessary when MCG criteria: Neurosurgery or Procedure GRG: SG-NS (ISC GRG) is met.

Note: See Brain, Spinal Cord, and Peripheral Nerve Stimulators for other deep brain stimulation indication criteria.

II. Vagus Nerve Stimulation

A. PacificSource considers vagus nerve stimulation (VNS) medically necessary when MCG criteria: Vagus Nerve Stimulation, Implantable ACG: A-0424 (AC) is met.

III. Laser Interstitial Thermal Therapy

A. PacificSource considers Laser Interstitial Thermal Therapy to be medically necessary when **ALL** of the following criteria is met:

1. Diagnosis of drug-resistant focal epilepsy, including but not limited to mesial temporal lobe epilepsy (MTLE)
2. Documented seizure activity refractory to at least two (2) anti-epileptic drugs
3. Member **DOES NOT** have either of the following contraindications:
    a. An implanted device that contraindicates MRI
    b. Progressive brain lesions and/or tumors not associated with epilepsy

IV. Responsive Neurostimulation

A. PacificSource considers Responsive Neurostimulation (e.g., cortical stimulation, NeuroPace RNS System) to be medically necessary when **ALL** of the following criteria is met:

1. Member is 18 years of age or older
2. Diagnosis of focal epilepsy, with no more than two localized epileptogenic foci
3. Member experiences 3 or more seizures per month within 3 months prior to procedure
4. Seizure activity refractory to 2 or more antiepileptic drugs

V. Revision or Replacement of Responsive Neurostimulation

PacificSource considers revision or replacement of an implanted Responsive Neurostimulator to be medically necessary when the insertion criteria above is met.

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage, limitations, and exclusions outlined in OARs 410-141-3820, 410-141-3825, and 410-120-1200. Relevant coverage guidance, including but not limited to Guideline Notes 14 and 237 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services; as well as any applicable Oregon Administrative Rules (OARs) may be used to determine coverage of Epilepsy treatment.

PCS follows the “Unlisted and Unspecified Procedure Codes” policy for requests for unlisted codes.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0000 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance, including but not limited to Guideline Note 14 and 237, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow commercial criteria above for determination of coverage for coverage for epilepsy treatment.

Experimental/Investigational/Unproven

PacificSource considers Laser Interstitial Thermal Therapy to be experimental, investigational, or unproven for any neurological indication not listed above and including, but not limited to the following:

- Treatment of primary or metastatic brain tumors
- Radiation necrosis of the brain

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

61736 Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion

61737 Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)

61850 Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical

61860 Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, 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

61868 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, Globus pallidum, subthalami nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)

61880 Revision or removal of intracranial neurostimulator electrodes

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

61889 Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)

61891 Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)

61892 Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed

64553 Percutaneous implantation of neurostimulator electrode array; cranial nerve

64568 Open implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator

64569 Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator

64999 Unlisted procedure, nervous system

L8679 Implantable neurostimulator, pulse generator, any type

L8680 Implantable neurostimulator electrode, each

L8681 Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

L8682 Implantable neurostimulator radiofrequency receiver

L8683 Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver

L8685 Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver

L8686 Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension

L8687 Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension

L8688 Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

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

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

Definitions

Drug-Resistant Epilepsy - Failure of adequate trials of two (2) appropriately selected and tolerated anti-epileptic medications (whether as monotherapy or in combination) to achieve sustained seizure freedom.

Epilepsy - A chronic neurological disorder characterized by a predisposition to generate recurrent, unprovoked seizures due to abnormal electrical activity in the brain.

Epileptogenic Focus - A discreate region of brain tissue identified as the origin of seizure activity and considered a target for surgical or neuromodulator intervention.

Focal Epilepsy - A form of epilepsy in which seizures originate within networks limited to one hemisphere of the brain; the seizure focus may be localized to a specific brain region.

Mesial temporal lobe epilepsy (MTLE) - A subtype of focal epilepsy arising from the medial structures of the temporal lobe (e.g., hippocampus, amygdala), often associated with structural abnormalities such as mesial temporal sclerosis.

Related Policies

Brain, Spinal Cord, and Peripheral Nerve Stimulators

Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Thalamotomy

Unlisted and Unspecified Procedure Codes

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Appendix

Policy Number:

Effective: 2/1/2021 **Next review:** 8/1/2027

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): 42 CFR § 422.101(b-c); OARs 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0000 through 410-151-0003OARs 410-120-1320, 410-141-3820 to 3830,410-151-0000 through 0003

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