



An Independent Licensee of the Blue Cross and Blue Shield Association.

## Occipital Nerve Stimulation Corporate Medical Policy

File Name: Occipital Nerve Stimulation  
File Code: 7.01.VT125  
Origination: 2011  
Last Review: 06/2021  
Next Review: 06/2022  
Effective Date: 07/01/2021

### Description/Summary

Occipital nerve stimulation (ONS) delivers a small electrical charge to the occipital nerve in an attempt to prevent migraines and other headaches in patients who have not responded to medications. The device consists of a subcutaneously implanted pulse generator (in the chest wall or abdomen) attached to extension leads that are tunneled to join electrodes placed across 1 or both occipital nerves at the base of the skull. Continuous or intermittent stimulation may be used.

### Policy

Occipital nerve stimulation is considered **investigational** for all indications.

### Coding Information

Click the links below for attachments, coding tables & instructions.

[Attachment I- CPT® & HCPCS Code Table & Instructions](#)

### Reference Resources

1. Blue Cross and Blue Shield Association. Occipital Nerve Stimulation. MPRM#7.01.125. Last review May 2021.

### Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member's contract language takes precedence.

## Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

## Administrative and Contractual Guidance

### Benefit Determination Guidance

Prior approval is required for services as outlined in this policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

### Policy Implementation/Update information

|         |   |
|---------|---|
| 2011    | New policy  |
| 11/2015 | Adoption of BCBSA MPRM# 7.01.125. Code table updates.   |
| 11/2017 | Updated policy/references from BCBSA MPRM# 7.01.125. Policy statements remain unchanged. Added descriptor to code L8689 added to PA list. |
| 06/2018 | Updated policy/references from BCBSA MPRM# 7.01.125. Policy statements remain unchanged.  |

|         |   |
|---------|---|
| 05/2021 | Policy reviewed policy statement remains unchanged. |
|---------|---|

**Eligible providers**

Qualified healthcare professionals practicing within the scope of their license(s).

**Approved by BCBSVT Medical Director(s)**                      **Date Approved**

Joshua Plavin, MD, MPH, MBA  
Chief Medical Officer

Kate McIntosh, MD, MBA, FAAP  
Senior Medical Director

Attachment I  
CPT® & HCPCS Code Table & Instructions

| Code Type   | Number | Description  | Policy Instructions     |
|---|--------|--|-------------------------|
| <b>The following codes will be denied as Not Medically Necessary, Contract Exclusions or Investigational.</b> |        |  |                         |
| CPT®  | 61885  | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array   | Prior Approval Required |
| CPT®  | 61886  | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays | Prior Approval Required |
| CPT®  | 64553  | Percutaneous implantation of neurostimulator electrode array; cranial nerve  | Prior Approval Required |

|       |       |  |  |
|-------|-------|--|--|
| CPT®  | 64568 | Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator                             | Prior Approval Required  |
| CPT®  | 64569 | Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator | Prior Approval Required  |
| CPT®  | 64570 | Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator   | Prior Approval Required  |
| HCPCS | L8680 | Implantable neurostimulator electrode, each  | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS | L8681 | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only                        | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS | L8682 | Implantable neurostimulator radiofrequency receiver  | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS | L8683 | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver                                       | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS | L8685 | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension  | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |

|  |       |  |  |
|--|-------|--|--|
| HCPCS  | L8686 | Implantable neurostimulator pulse generator, single array, nonchargeable, includes extension                 | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS  | L8687 | Implantable neurostimulator pulse generator, dual, array, rechargeable, includes extension                   | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS  | L8688 | Implantable neurostimulator pulse generator, dual array, norechargeable, includes extension                  | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| HCPCS  | L8689 | External recharging system for battery (internal) for use with implantable neurostimulator, replacement only | Prior Approval Required. This code is Investigational for occipital nerve stimulation. |
| <b>The following code is unlisted and requires clinical documentation at time of claims submission. Clinical documentation will be reviewed and coverage determination will be made by a medical director.</b> |       |  |  |
| CPT  | 64999 | Unlisted procedure, nervous system   | Clinical documentation is required at time of claims submission for medical review.    |