

MEDICA®

UTILIZATION MANAGEMENT POLICY

TITLE: IMPLANTABLE DEEP BRAIN STIMULATION

EFFECTIVE DATE: August 20, 2018

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member's plan document for specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage.

With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless these programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica UM policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of implantable deep brain stimulation. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, Medica uses MCG™ Care Guidelines, 21st edition, 2017: ACG: A-0403 (AC), *Deep Brain Stimulation (DBS)*.

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for Implantable Deep Brain Stimulation. Please see the prior authorization list for product specific prior authorization requirements.
2. Reprogramming of implantable deep brain stimulation devices does not require prior authorization.
3. These criteria do not apply to implantable deep brain stimulators that have an approved humanitarian device exemption. The Reclaim™ Deep Brain Stimulation device has been granted an HDE for treatment of Obsessive Compulsive Disorder, for patients who meet device exemption indications. Refer to the Utilization Management: *Humanitarian Device Exemption* policy for details on coverage and criteria.
4. Deep Brain Stimulation, for all other indications, including but not limited to treatment of depression, epilepsy, cluster headaches, multiple sclerosis, neuropathic pain *is investigative and therefore not eligible for coverage*.
5. Coverage is limited to devices that have FDA approval for the intended use.
6. Coverage may vary according to the terms of the member's plan document.
7. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's plan document.
8. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed

by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Medica Provider Administrative Manual.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: <http://www.cms.hhs.gov/mcd/search.asp?>

DOCUMENT HISTORY

Original Effective Date	July 1, 2010
MPC Endorsement Date(s)	04/2011, 04/2012, 04/2013, 04/2014, 04/2015
Began use of MCG™ Care Guidelines	05/01/2016 (19 th edition)
MCG Care Guidelines Edition Updates (<i>Medica Effective Date</i>)	20 th edition: 10/10/2016, 21 st edition: 08/31/2017, 21 st edition reaffirmed: 8/20/2018
Administrative update(s)	05/01/2017