

Policy: MP094

Section: Medical Benefit Policy

Subject: Unilateral Pallidotomy

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

I. Policy: Unilateral Pallidotomy

II. Purpose/Objective:

To provide a policy of coverage regarding Unilateral Pallidotomy

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking

into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:

Unilateral pallidotomy is a stereotactic surgical procedure used for the treatment of intractable, disabling Parkinson's disease. The goal is to obliterate or damage the area of the brain that controls the symptoms of the disease.

INDICATIONS:

All of the following criteria must be met:

- A diagnosis of idiopathic Parkinson's disease has been established
- The disease was previously responsive to levodopa therapy but is now medically intractable
- Physician documentation of severe levodopa-induced dyskinesia or disease
- No evidence of dementia

Unilateral magnetic resonance guided focused ultrasound thalamotomy; **See MP316 High Intensity Focused Ultrasound**

EXCLUSIONS:

Unilateral pallidotomy will not be covered if:

- Inclusion criteria are not met
- If used for any diagnosis other than idiopathic Parkinson's disease

There is insufficient evidence in the published peer-reviewed medical literature to support the safety and efficacy of pallidotomy for any indication other than idiopathic Parkinson's disease. The Plan does **NOT** provide coverage for pallidotomy for any indication other than idiopathic Parkinson's disease because it is considered **experimental, investigational or unproven.**

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH:

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

CPT/HCPCS Codes:

- 61720 Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus
- 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
- 64999 Unlisted procedure, nervous system

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

- Geisinger Clinic Technology Assessment Committee, "Unilateral Pallidotomy for Parkinson's Disease", Oct. 23, 1996
- Hayes, Inc. Online, "Pallidotomy for Treatment of Parkinson's Disease" April 7, 1999. Updated April 22, 2005 Accessed at <http://www.hayesinonline.com>
- Technology Evaluation Center, TEC Assessment, "Stereotactic Radiofrequency Pallidotomy with Microelectrode Mapping for Treatment of Parkinson's Disease", 11(18), Nov. 1996
- Lin JJ, Lin SZ, Lin GY, Chang DC, Lee CC. Treatment for intractable generalized dystonia by bilateral posterioventral pallidotomy – one year results. *Zhonghua Yi Xue Za Zhi.* 64(4):231-238. Apr. 2001.
- Bronte-Stewart H. Surgical therapy for dystonia. *Current Neurology & Neuroscience Report.* 3(4):296-305. Jul 2003.
- Lin JJ, Lin GY, Shih C, Lin SZ, Chang DC, Lee CC. Benefit of bilateral pallidotomy in the treatment of generalized dystonia. Case report. *Journal of neurosurgery.* 90(5):974-976. May 1999.
- Favre J, Burchiel KJ, Taha JM, Hammerstad J. Outcome of unilateral and bilateral pallidotomy for Parkinson's disease: patient assessment. *Neurosurgery.* 2000 Feb;46(2):344-53;

This policy will be revised as necessary and reviewed no less than annually.

Devised: 10/23/96

Revised: 1/97, 3/98, 02/03(format, criteria); 2/04 (references), 2/10 (removed auth); 2/20 (add cross reference)

Reviewed: 2/05, 2/06; 2/07, 2/08, 2/09. 2/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/21, 2/22, 2/23, 2/24

CMS UM Oversight Committee Approval: 12/23

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.