MEDICAL POLICY

Excellus
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Medical Policy Title	**Deep Brain Stimulation**
Policy Number	**7.01.23**
Current Effective Date	**April 16, 2026**
Next Review Date	**April 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

This medical policy does not address occipital nerve stimulation for chronic migraines or occipital neuralgia.

POLICY STATEMENT(S)

I. Unilateral or bilateral deep brain stimulation of the ventral intermediate nucleus (VIM) thalamus is a **medically appropriate** treatment option in the management of disabling, medically unresponsive essential tremor or tremor due to Parkinson's disease when **BOTH** of the following criteria are met (Disabling, medically unresponsive tremor is defined as both of the following):

   A. Tremor causing significant limitation in daily activities; **and**

   B. Inadequate control with maximal dosage of medication for at least three (3) months before implant.

II. Conventional bilateral deep brain stimulation of the subthalamic nucleus (STN) or globus pallidus interna (GPi) is a **medically appropriate** treatment option for Parkinson's disease when **ALL** of the following criteria are met:

   A. The patient has a good response to levodopa;

   B. Motor complications are not controlled by pharmacologic therapy; **and**

   C. **ONE** of the following:

      1. a minimum score of 30 points on the motor portion of the Unified Parkinson Disease Rating Scale (UPDRS) when the individual has been without medication for approximately 12 hours; **or**

      2. Parkinson's disease for at least four (4) years.

III. Conventional unilateral or bilateral deep brain stimulation of the STN or GPi is **medically appropriate** when **BOTH** of the following criteria are met:

   A. Individual is seven (7) years of age or older;

   B. Individual has chronic, intractable primary dystonia, including **any** of following indications:

      1. generalized or segmental dystonia,

      2. hemidystonia; **or**

3. cervical dystonia (torticollis).

IV. Unilateral or bilateral deep brain stimulation of the anterior nucleus of the thalamus (ANT) is **medically appropriate** when **ALL** of the following criteria are met:

A. A confirmed diagnosis of epilepsy;

B. 18 years of age or older;

C. Focal partial onset seizures with or without generalized seizure;

D. Refractory to medical therapy defined as failure to adequately control seizures after two (2) (or more) appropriate and adequately dosed anti-seizure medications or intolerance to anti-seizure medications;

E. Currently having an average of three (3) or more disabling seizures (e.g., motor partial seizures, complex partial seizures, or secondary generalized seizures) per month over the most recent three (3) months; **and**

F. Absence of progressive neurological conditions such as neurodegenerative disease.

V. Deep brain stimulation is contraindicated and therefore, **not medically necessary** for **ANY** individuals in the following situations:

A. Not a good surgical candidate due to unstable medical conditions;

B. Presence of a cardiac pacemaker;

C. A medical condition that requires repeated magnetic resonance imaging (MRI);

D. Presence of dementia that may interfere with the ability to cooperate; **or**

E. Recent treatment with botulinum toxin injections within the last six (6) months.

Device Repair

VI. Repair of a medically necessary DBS System or components not under warranty will be considered **medically appropriate** when the following criteria are met:

A. Physician documentation includes **ALL** of the following:

1. date of device implantation/initiation;

2. manufacturer warranty information, if applicable;

3. attestation that the patient has been compliant with the use of device and will continue to benefit from the use of device;

B. The device is no longer functioning adequately; and **BOTH** of the following criteria are met:

1. inadequate function interferes with activities of daily living; **and**

2. repair is expected to make the equipment fully functional (as defined by manufacturer).

C. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance,

etc.) is **ineligible for coverage**.

Device Replacement

VII. Replacement of a medically necessary DBS System or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

A. The device is no longer functioning adequately and has been determined to be non-repairable or the cost of the repair is in excess of the replacement cost; **or**

B. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.

VIII. The replacement of a properly functioning DBS System, its components or accessories is considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or in order to make the device more aesthetically pleasing.

IX. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

X. Accessories or components for DBS System that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

XI. Directional deep brain stimulation (e.g., St. Jude Medical Infinity DBS System and Vercise DBS System) is **investigational** for all indications.

XII. Conventional deep brain stimulation is **investigational** for all conditions not specifically identified in Policy Statements I through IV, including, but not limited to, the following conditions:

A. Multiple sclerosis tremor;

B. Post-traumatic dyskinesia;

C. All other movement disorders;

D. Chronic pain syndromes, including cluster headache;

E. Tardive dyskinesia;

F. Tourette syndrome;

G. Dementias, including Alzheimer's disease;

H. Eating disorders, including anorexia nervosa;

I. Alcohol addiction;

J. Treatment-resistant depression;

K. Treatment-resistant obsessive-compulsive disorder.

RELATED POLICIES

Corporate Medical Policy

07.01.103 Responsive Neurostimulation for the Treatment of Refractory Focal Epilepsy

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. Bilateral stimulators may be implanted simultaneously or in staged procedures.

DESCRIPTION

Deep brain stimulation (DBS) has been investigated as an alternative to permanent neuro-ablative procedures, such as thalamotomy and pallidotomy. The procedure involves the stereotactic placement of an electrode into a targeted region of the brain. The electrode is then attached, via a cable/wire, to a programmable stimulator implanted subcutaneously. DBS is designed to turn off overactive brain regions without destroying them. The immediate advantage of DBS over conventional destructive surgery is that the lesions are titratable and, hence, reversible. After implantation, noninvasive programming of the neurostimulator can be adjusted to the individual's symptoms.

The effect of DBS depends on where the electrodes are placed. The three common target sites are the VIM thalamus, STN and GPi. Whereas unilateral/bilateral DBS of the thalamus is utilized to treat essential tremor or tremors of advanced Parkinson's disease, DBS of the STN or of the GPi is used for treatment of the entire constellation of Parkinsonian symptoms (e.g., tremor, rigidity, and bradykinesia). DBS is performed at specialty centers.

DBS has also been investigated for the treatment of primary dystonia, defined as a neurological movement disorder characterized by involuntary and painful muscle contractions and contortions. Dystonia can be classified according to cause and the bodily distribution of symptoms. Primary or idiopathic dystonia is not associated with any other pathology, whereas secondary dystonia is caused by a known insult (e.g., trauma, infarct, stroke) to the basal ganglia. Generalized dystonia affects a wide range of body areas, while focal dystonia affects specific body parts (e.g., spasmodic torticollis/cervical dystonia, blepharospasm). Dystonia is the third most common movement disorder, behind Parkinson's disease and essential tremor. Unless contraindicated, DBS of either the STN or GPi requires a bilateral procedure.

In addition to essential tremors, Parkinson's disease, and primary dystonia, DBS is also being investigated for disorders such as major depression, cluster headaches, chronic pain syndromes, Tourette syndrome, epilepsy, and obsessive-compulsive disorder.

Unified Parkinson's Disease Rating Scale (UPDRS)

The Unified Parkinson's Disease Rating Scale (UPDRS) is the most widely applied rating instrument for the evaluation of a person with Parkinson's Disease to determine disease severity. The total UPDRS score includes 31 items contributing to three (3) subscales: (I) Mentation, Behavior and Mood; (II) Activities of Daily Living; and (III) Motor Examination. The UPDRS does not assess general cardiovascular fitness and provides only limited information on functional performance relative to

daily activities.

Conventional DBS

Conventional DBS systems use ring-shaped electrodes, which generate an approximately spherical electrical field. In these systems, programming of polarity and stimulation pulse parameters allows only limited control of the shape of the volume of tissue activated. While physicians try to target a very specific area of the brain with conventional DBS, there is a risk of stimulating neighboring regions as they cannot steer the stimulation precisely.

Directional DBS

Directional DBS systems use novel lead designs with segmented, multi-contact electrodes that allow for the activation of individual electrode contacts which also allow the physician to specify the exact amount of current needed for every contact of the electrode. By activating specific electrode contacts and defining the amount of stimulation for each contact, stimulation precision is significantly increased. More precise stimulation is thought to reduce side effects of DBS, such as muscle contractions, dysarthria, and cognitive or behavioral disturbances sometimes seen in conventional DBS.

SUPPORTIVE LITERATURE

Unilateral Stimulation of the Thalamus

Schuurman et al (2008) reported on 5-year follow-up of 68 patients comparing thalamic stimulation with thalamotomy for the treatment of tremor due to Parkinson's disease (n=45 patients), essential tremor (n=13 patients), and multiple sclerosis (MS; n=10 patients). Forty-eight (71%) patients were assessed at five years: 32 with Parkinson's disease, 10 with essential tremor, and 6 with MS. The Frenchay Activities Index, the primary study outcome measure, was used to assess change in functional status. Secondary measures included tremor severity, complication frequency, and patient-assessed outcomes. The mean difference between interventions, as measured on the Frenchay Activities Index, favored thalamic stimulation at all time points: 4.4 (95% confidence interval [CI], 1.1 to 7.7) at 6 months, 3.3 (95% CI, -0.03 to 6.6) at 2 years, and 4.0 (95% CI, 0.3 to 7.7) at 5 years. The procedures had similar efficacy for suppressing tremors. The effect of thalamic stimulation diminished in half of the patients with essential tremor and MS. Neurologic adverse effects were higher after thalamotomy. Subjective assessments favored stimulation.

Hariz et al (2008) evaluated outcomes of thalamic deep brain stimulation in patients with tremor-predominant Parkinson's disease who participated in a multicenter European study. The authors reported that at 6 years post-surgery, tremor was still effectively controlled and appendicular rigidity and akinesia remained stable compared with baseline.

Bilateral Stimulation

Jost et al (2023) conducted an observational study of the long-term effect of bilateral DBS on the subthalamus nucleus and its effects on quality of life, motor functions, and medication requirements for patients with advanced Parkinson's. The final analysis included 108 patients with 62 receiving DBS and 46 receiving medications matched to a sub cohort of 25 patients per group. At the five years

follow up, the Parkinson's Disease Questionnaire 8 (PDQ-8) and ADL scores worsened only in the medication group, while remaining stable in the DBS group. The group that received DBS also experienced favorable effects on motor complications.

Epilepsy

Results of Medtronic's Stimulation of the Anterior Nuclei of Thalamus for Epilepsy (SANTÉ) trial (Fisher 2010) showed promising outcomes on the adjunct use of DBS of the ANT over placebo stimulation for patients suffering from severe, refractory, partial-onset seizures. All subjects underwent DBS implantation followed by three months of randomized and blinded active stimulation (n=54) or no stimulation (n=55), then followed by nine months of active stimulation for all subjects. Two years after implantation of the device, seizures were reduced by a median 56% compared with baseline, and 14 patients (12.7%) became seizure-free for at least six months. Longer-term studies were needed to better define its safety and efficacy, as well as the subset of patients who would benefit most from this treatment.

Salanova and others published a long-term follow-up study of the SANTÉ trial in 2015. Beginning 13 months following device implantation, 105 subjects receiving active stimulation were followed for an additional four years. The authors reported that for subjects with at least 70 diary entries recorded at one (1) year (n=99), median change for seizure frequency from baseline decreased by 41% ($p < 0.001$), and by 69% at five (5) years (n=59; $p < 0.001$). For the same population, reduction in the most severe type of seizure was 39% at one year ($p < 0.001$) and 75% at five years ($p < 0.001$). During the 5-year study, 17 of 109 subjects (16%) reported a 6-month seizure-free interval. A 2-year seizure-free interval was reported for 6 of 109 subjects (5.5%). Mean improvement in the Liverpool Seizure Severity Score (LSSS) was 13.4 at one year and 18.3 at five years ($p < 0.001$ for both). Similarly, results from the Quality of Life in Epilepsy-31 (QOLIE-31) tool improved from baseline by 5.0 points at one (1) year and 6.1 points at (5) five years ($p < 0.001$ for both). A change of 5 points on this measure is considered clinically significant and was experienced by 46% and 48% of subjects at one and five years. Device-related adverse events included site infection, leads not within the target area, depression and memory impairment. This study demonstrated significant long-term benefit from DBS for individuals with epilepsy, although the study was relatively small and unblinded.

On April 27, 2018, the FDA approved the Medtronic DBS System for Epilepsy for bilateral stimulation of the anterior nucleus of the thalamus (ANT) based on the SANTÉ trials as an adjunctive therapy for reducing the frequency of seizures in individuals 18 years of age or older who are diagnosed with epilepsy characterized by partial-onset seizures, with or without secondary generalization, that are refractory to three or more antiepileptic medications. The FDA indicated that the Medtronic DBS System for Epilepsy has demonstrated safety and effectiveness for patients who average six (6) or more seizures per month over the three (3) most recent months prior to implantation of the DBS system (with no more than 30 days between seizures). The Medtronic DBS System for Epilepsy has not been evaluated in patients with less-frequent seizures.

The effect of deep brain stimulation of the anterior nuclei of the thalamus (ANT-DBS) after implantation has been reported as approximately 50% seizure frequency reduction in approximately 60% of patients (Herrman 2019) and the seizure frequency reduction increased over the following ten years (Salanova 2018 and Salanova 2021). Multiple literature reviews of randomized and blinded

clinical trials and case series with high-quality data support the use of DBS for the treatment of medically refractory epilepsy.

Other Indications

Published clinical trials have not provided evidence to support the efficacy and safety of DBS for other conditions, including, but not limited to multiple sclerosis, post-traumatic dyskinesia, treatment-resistant depression, Alzheimer's disease, and Tourette syndrome; or for bilateral DBS of the VIM thalamus. Studies of DBS for the treatment of chronic pain have not provided evidence that DBS is an effective treatment method over already-established treatment methods.

PROFESSIONAL GUIDELINE(S)

In 2003, the National Institute for Health and Care Excellence (NICE) published guidance on DBS for Parkinson's Disease stating that the evidence on the safety and efficacy of deep brain stimulation for treatment of Parkinson's disease "appears adequate to support the use of the procedure." The guidance noted that deep brain stimulation should only be offered when Parkinson's disease is refractory to best medical treatment.

The American Academy of Neurology (AAN) 2011 updated its guidelines on the treatment of essential tremor, which were reaffirmed in 2022. The guidelines stated that bilateral DBS of the thalamic nucleus may be used to treat medically refractory limb tremors in both upper limbs (level C, possibly effective) but that there were insufficient data on the risk/benefit ratio of bilateral versus unilateral deep brain stimulation in the treatment of limb tremor. There was insufficient evidence to make recommendations on the use of thalamic deep brain stimulation for head or voice tremors (level U, treatment is unproven).

In December of 2021, the American Society of Stereotactic and Functional Neurosurgery (ASSFN) published the following position statement: "Deep brain stimulation (DBS) of the bilateral anterior nucleus of the thalamus (ANT) is a Food and Drug Administration (FDA)-approved, safe, and efficacious treatment option for patients with refractory focal epilepsy" who meet specific criteria.

REGULATORY STATUS

The FDA first approved Medtronic's Activa Tremor Control System for DBS in 1997 for the unilateral treatment of tremors. This approval was expanded in 2002 to include bilateral implantation for individuals with advanced Parkinson's disease whose symptoms were inadequately managed with medication. In 2016, the FDA further broadened the indication to include patients who had been diagnosed with Parkinson's disease for at least four years and who had developed motor complications not sufficiently controlled by drug therapy. This expanded indication was supported by findings from the EARLYSTIM trial (Schuepbach WM et al., 2013), which demonstrated a 26 percent improvement in quality of life for patients treated with DBS in combination with best medical therapy, compared with a 20 percent improvement among those receiving medical therapy alone.

In April 2003, the FDA gave Humanitarian Device Exemption (HDE) approval to the Activa Therapy System for the unilateral or bilateral stimulation of the internal STN or GPi, to aid in the management of chronic, intractable (drug-resistant) primary dystonia, including generalized and/or segmental

dystonia, hemidystonia, and cervical dystonia in individuals seven years of age or older. In 2016, the FDA identified that the HDE for the Activa Therapy System remained appropriately approved for pediatric use. In 2018, the Activa deep brain stimulation system received FDA approval with an expanded indication as an adjunctive therapy for epilepsy.

The Brio Neuromodulation System (St. Jude Medical) received FDA approval in June 2015 for use in deep brain stimulation therapy. The system is indicated for bilateral stimulation of the subthalamic nucleus (STN) to reduce symptoms of advanced, levodopa-responsive Parkinson's disease that are insufficiently controlled with medication, as well as for unilateral or bilateral stimulation of the VIM of the thalamus to manage disabling upper extremity tremor in adults with essential tremor. A key distinction from Medtronic's Activa system is that the Brio device delivers stimulation using constant current rather than constant voltage. FDA approval was supported by two clinical trials involving patients with Parkinson's disease and essential tremor whose symptoms were not adequately managed with medication. "Both groups showed statistically significant improvement on their primary effectiveness endpoints when the device was turned on compared to when it was turned off," the statement notes.

Clinical studies support that deep brain stimulation (DBS) is a safe and effective treatment for several movement disorders. Unilateral DBS targeting the ventral intermediate nucleus (VIM) of the thalamus is highly effective for essential tremor and tremor associated with Parkinson's disease, producing complete or clinically meaningful tremor reduction in approximately 82–91% of patients, with sustained benefits and minimal adverse effects. When tremors recur, symptoms can often be effectively managed through adjustments to stimulation settings. Although long-term outcome data remain limited, bilateral DBS of the STN or GPi has been shown to significantly improve neurological function in individuals with advanced Parkinson's disease. Evidence from studies evaluating DBS for dystonia indicates substantial improvements in motor function and activities of daily living among patients with primary dystonia, whereas patients with secondary dystonia experience limited benefit.

Directional DBS

The St. Jude Medical Infinity DBS System was the first FDA-approved deep brain stimulation system to use directional leads, allowing more precise targeting of brain areas to reduce stimulation-related side effects. It received FDA approval on September 19, 2016, as a design and component update to the previously approved Brio Neurostimulation System. The Infinity system is indicated for bilateral stimulation of the STN to treat advanced, levodopa-responsive Parkinson's disease not adequately controlled by medication, and for unilateral or bilateral stimulation of the VIM of the thalamus to suppress disabling upper extremity tremor in adults with essential tremor. Although the system's 8-channel directional leads were recalled in 2018 due to manufacturing issues, the recall was terminated in September 2020.

In January 2020, Abbott received FDA approval to expand indications for the Infinity DBS system to include targeting the internal GPi for treating Parkinson's disease symptoms not adequately controlled by medication. The Infinity system uses directional leads to optimize stimulation and reduce side effects.

Boston Scientific's Vercise DBS systems were FDA approved between 2019 and 2021, including the

Vercise PC, Vercise Gevia, and Vercise Genus systems. These systems are indicated for bilateral stimulation of the STN or GPi for moderate to advanced levodopa-responsive Parkinson's disease, and unilateral stimulation of the VIM of the thalamus to control disabling tremor in essential tremor or parkinsonian tremor. The Vercise systems feature current steering across eight contacts per lead to enable precise and customizable stimulation.

Obsessive Compulsive Disorder (OCD)

In February 2009, the FDA granted a Humanitarian Device Exemption (HDE) to Medtronic's ReClaim Deep Brain Stimulator, making it the first DBS device approved to treat obsessive-compulsive disorder (OCD). The device is indicated for bilateral stimulation of the anterior limb of the internal capsule (AIC) as an adjunct to medication and an alternative to anterior capsulotomy for adults with chronic, severe, treatment-resistant OCD who have failed at least three SSRIs. Approval was based on a small study of 26 patients, which showed an average 40% reduction in symptoms after 12 months. However, study limitations included lack of full blinding, raising concerns about placebo effects. As of 2021, the World Society for Stereotactic and Functional Neurosurgery considered DBS for OCD to be an emerging but unproven treatment, noting that larger, well-designed studies are needed to establish long-term safety and effectiveness.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
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	each additional array
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	each additional array
61880	Revision or removal of intracranial neurostimulator electrodes

Code	Description
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	with connection to two or more electrode arrays
61888	Revision or removal of cranial neurostimulator pulse generator or receiver
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact groups[s], interleaving, amplitude, pulse width, frequency [HZ], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional
95984	each additional 15 minutes face-to-face time with physician or other qualified health care professional (list separately in addition to code for primary procedure)

HCPCS Codes

Code	Description
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1787	Patient programmer; neurostimulator
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1822	Generator, neurostimulator (implantable), high frequency with rechargeable battery and charging system
L8679	Implantable neurostimulator pulse generator, any type

Code	Description
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non- rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only

ICD10 Codes

Code	Description
G20.A1-G20.C	Parkinson's disease (code range)
G21.11-G21.9	Secondary Parkinsonism (code range)
G24.1-G24.3	Dystonia (code range)
G24.8	Other dystonia
G24.9	Dystonia, unspecified
G25.0	Essential tremor
G40.0-G40.919	Epilepsy and recurrent seizures (intractable) (code range)
Investigational Codes:	
All other ICD10 diagnosis codes are considered investigational.	

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Deep Brain Stimulation (NCD 160.24) [accessed 2026 Mar 19]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

09/16/99, 07/19/01, 05/16/02, 03/20/03, 03/18/04, 03/17/05, 01/19/06, 01/18/07, 11/15/07, 11/20/08, 10/29/09, 10/28/10, 09/15/11, 08/16/12, 07/18/13, 06/19/14, 05/29/15, 06/16/16, 05/18/17, 04/19/18, 03/21/19, 02/20/20, 02/18/21, 02/17/22, 04/20/23, 04/18/24, 04/17/25, 04/16/26

Date	Summary of Changes
04/16/26	• Annual review; policy intent unchanged.
04/17/25	• Annual review. Policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
09/16/99	• Original effective date