Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: All Indiana Health Coverage Programs Physicians and Acute Care Hospitals

Subject: Phrenic Nerve Stimulator (Breathing Pacemaker)

Note: The information in this bulletin regarding prior authorization, payment methodology, and max fees may vary for practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

Indiana Health Coverage Programs (IHCP) began covering the phrenic nerve stimulator (breathing pacemaker) effective for claims with dates of service of October 26, 2000. Specific coverage criteria have been developed and must be met for reimbursement to be made. This bulletin provides coverage and billing information to allow providers to submit claims for this device.

This device is an electrophrenic pacemaker for pacing of the diaphragm. It consists of an external radio frequency transmitter, an antenna, a subcutaneous radio receiver, and a bipolar platinum nerve electrode. Diaphragmatic pacing (intermittent electrical stimulation of the phrenic nerves) offers patients who need long-term ventilation, and have a functionally intact phrenic nerve and chest wall stability, freedom from mechanical ventilation.

Prior Authorization

Prior authorization (PA) is required for this device and its implantation whether implanted as an inpatient or an outpatient. One or more of the following *ICD-9-CM* diagnosis codes must be used when submitting

requests for PA. Members with these diagnoses who are ventilator dependent and have a tracheostomy due to partial or complete respiratory insufficiency are considered candidates for this device subject to review.

- 344.0-344.9 includes quadriplegia and quadraparesis of all types
- 780.51 and 780.53—nonobstructive sleep apnea
- 786.09—congenital respiratory abnormalities, other

Coding and Billing Instructions

For inpatient billing of the **implantation of the device**, the appropriate diagnosis-related grouping (DRG) will be used. The claim for the **device** must be submitted as a durable medical equipment (DME) item on a HCFA-1500 claim form. When the device is implanted as an outpatient procedure, the **revenue code 360** with **CPT code 33282** should be used on the UB-92 claim form and the device billed as a DME item on a HCFA-1500 claim form. The decision for either outpatient or inpatient status is made by the physician and determined by the assessment of complicating factors and their severity at the time the procedure is planned. The hospital providing the equipment for implantation must have a DME provider number.

Table 1.1 provides the CPT codes and description information to use when submitting claims either as an inpatient or outpatient.

Table 1.1 – CPT Codes for Inpatient and Outpatient Claims

CPT/HCPCS Code	Description	Current Pricing
64577	Incision for implantation of neurostimulator electrodes; autonomic nerve	RBRVS-**$207.72** ASC 1-**$337.08**
64585	Revision or removal of peripheral neurostimulator electrodes	RBRVS-**$83.62** ASC A-**$348.20**
95970	Initial programming	Included in initial fee
95974	Intraoperative or subsequent programming, first hour	Included in initial fee, provided by manufacturer at the time of implant then per telephone for life of the power source at no cost to the member.

(Continued)

Table 1.1 – CPT Codes for Inpatient and Outpatient Claims

CPT/HCPCS Code	Description	Current Pricing
Z5108	Implantable neurostimulator pulse generator	Max Fee $58,299
Z5109	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Max Fee $37,967

Coverage Issues

Patient Selection

The primary objective of implanting the phrenic nerve stimulator is to allow the member to return to a home environment from a skilled nursing facility and be more independent. Therefore the following criteria are mandatory for prospective candidates requesting this device:

- Functional lungs and diaphragm muscle
- Absence of infection
- A clear and adequate upper airway (including nasopharynx, pharynx, larynx)
- Family support that includes an unpaid, physical care giver of adequate quality and the availability of nursing and medical care

Medical Review Documentation

Prior authorization for medical necessity is required for this device and its implantation. The equipment is costly and requires preoperative testing of the components and thorough education of the member and his or her caregivers concerning its use.

Medical Policy Criteria

1. Members who qualify for this device will demonstrate life-threatening oxygen depletion when respiration is unassisted.
2. For stable, non-acute quadriplegics and other spinal cord or brain stem injured members [ICD-9-CM 344(00-09) diagnosis codes] all of the following criteria must be met:

- Patient is oriented to name, date, and place.
- Patient's mobility will be improved. Patient will be able to be out of bed and be mobile per wheelchair, which may include employment or attending school. Increased mobility will allow the patient to function without interference of large equipment.
- Patient's skin integrity will be better maintained because of increased mobility.
- Patient has capacity to be productive. He or she will more easily perform cognitive tasks within physical limitations.
- Patient will be better able to eat and swallow.

3. For nonobstructive (or central) sleep apnea (ICD-9-CM 780.51, 780.53 diagnosis codes) only when other treatments have failed, and the following criteria must be met:
   - The requesting physician will present sleep studies demonstrating life- threatening respiratory cycles when the patient is asleep.
   - The member must have a diagnosis of central sleep apnea and have failed to maintain an appropriate PO_2 level (oxygen partial pressure) with continuous positive air pressure (CPAP) and bi-level continuous positive airway pressure (BiPAP) treatments.
   - Documentation by a specialist in otolaryngology or pulmonology of treatment attempts will accompany the prior authorization request.
   - The breathing pacemaker should **never** be recommended for treatment of obstructive sleep apnea.
4. Documentation indicating medical necessity for the appropriate diagnosis will be submitted **prior to** surgical implantation of the stimulator wires.

Device Monitoring

Medical device tracking regulations of the U.S. Food and Drug Administration require that the manufacturer of the device be notified when the following occurs:

- Diaphragm pacing system is implanted,
- Diaphragm pacing receiver or electrode is explanted, (date, name, mailing address, and telephone number of the explanting physician are to be included)
- Diaphragm pacing patient dies,
- Diaphragm pacing device is returned

- Diaphragm pacing device is permanently retired from use or otherwise permanently discarded.

Additional Information

Please direct any questions regarding this bulletin and policy to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500. Direct questions about billing procedures provided in this bulletin to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.