

Clinical Policy: Diaphragmatic/Phrenic Nerve Stimulation

Reference Number: CP.MP.203

Last Review Date: 12/20

[Coding Implications](#)

[Revision Log](#)

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Description

Diaphragmatic/phrenic nerve stimulation, also referred to as diaphragm pacing, is a treatment option used to eliminate or reduce the need for ventilator support in those with chronic ventilatory insufficiency due to bilateral paralysis or severe paresis of the diaphragm.

Diaphragmatic/phrenic nerve stimulation uses the phrenic nerves to signal the diaphragm muscles to contract and produce breathing through electrical stimulation.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that *diaphragmatic/phrenic nerve stimulation with the Mark IV™ Breathing Pacemaker System* is **medically necessary** when all of the following are met:
 - A. Stimulation is used as an alternative to mechanical ventilation for an individual with severe, chronic respiratory failure due to one of the following:
 1. Upper cervical spinal cord injury (at or above the C3 vertebral level);
 2. Central alveolar hypoventilation disorder;
 - B. Diaphragm movement with stimulation is visible under fluoroscopy;
 - C. Intact and sufficient function in the phrenic nerve, lungs, and diaphragm;
 - D. Stimulation of the diaphragm either directly or through the phrenic nerve results in sufficient muscle activity to accommodate independent breathing without the support of a ventilator;
 - E. Normal chest anatomy, a normal level of consciousness, and the ability to participate in and complete the training and rehabilitation associated with the use of the device.

- II. It is the policy of health plans affiliated with Centene Corporation[®] that *diaphragmatic/phrenic nerve stimulation with the NeuRX DPS™ RA/4 Respiratory Stimulation System* is **medically necessary** when provided in accordance with the Humanitarian Device Exemption (HDE) specifications of the U.S Food and Drug Administration when the following criteria is met:
 - A. Stimulation is used as an alternative to mechanical ventilation for an individual with severe, chronic respiratory failure due to one of the following:
 1. Amyotrophic lateral sclerosis (ALS);
 - a. Age 21 years or older;
 - b. Experiencing chronic hypoventilation but not progressed to FVC (forced vital capacity) less than 45% predicted;
 - c. Diaphragm movement with stimulation is visible under fluoroscopy;
 - d. Intact and sufficient function in the phrenic nerve, lungs, and diaphragm.
 2. Upper cervical spinal cord injury (at or above the C3 vertebral level);
 - a. Age 18 years or older;
 - b. Diaphragm movement with stimulation is visible under fluoroscopy;

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- c. Stimulation of the diaphragm will allow the individual to breathe without the assistance of a mechanical ventilator for at least four continuous hours a day;
- d. Intact and sufficient function in the phrenic nerve, lungs, and diaphragm.

III. It is the policy of health plans affiliated with Centene Corporation[®] that *diaphragmatic/phrenic nerve stimulation* is considered **investigational** for any other conditions, including but not limited to, *central sleep apnea*, because the evidence supporting its safety and efficacy is limited.

Background

Diaphragmatic/phrenic nerve stimulator devices are indicated for certain ventilator-dependent individuals who lack voluntary control of their diaphragm muscles to enable independent breathing without the assistance of a mechanical ventilator.

NeuRx DPS RA/4 Respiratory Stimulation System (Synapse Biomedical, Inc.)

FDA approval for distribution of the NeuRx DPS[™] RA/4 Respiratory Stimulation System (Synapse Biomedical, Inc., Oberlin, OH) was granted under a Humanitarian Device Exemption (HDE) on June 17, 2008. The FDA-approved indications are: For use in patients with stable, high spinal cord injuries with stimulatable diaphragms, but lack control of their diaphragms. The device is indicated to allow the patients to breathe without the assistance of a mechanical ventilator for at least 4 continuous hours a day and is for use only in patients 18 years of age or older. This FDA approval is subject to the manufacturer developing an acceptable method of tracking device implantation to individual patient recipients.⁶

In 2011 the FDA approved the NeuRx DPS[™] RA/4 Respiratory Stimulation System as a humanitarian-use device (HUD) in amyotrophic lateral sclerosis (ALS) following the submission of a humanitarian device exemption (HDE) application. The FDA approved indications are: “For use in amyotrophic lateral sclerosis (ALS) patients with a stimulatable diaphragm (both right and left portions) as demonstrated by voluntary contraction or phrenic nerve conduction studies, and who are experiencing chronic hypoventilation (CH), but not progressed to an FVC less than 45% predicted. For use only in patients 21 years of age or older”.⁷

Mark IV[™] Breathing Pacemaker System (Avery Biomedical Device, Inc.)

The Avery Breathing Pacemaker System (i.e., the Mark IV[™] Avery Biomedical Device, Inc., Commack, NY) is the only other diaphragmatic/phrenic stimulator system approved for use by the FDA in the United States. The pacemaker is classified as a Class III neurologic therapeutic device requiring premarket approval (PMA). The device is approved "For persons who require chronic ventilatory support because of upper motor neuron respiratory muscle paralysis (RMP) or because of central alveolar hypoventilation (CAH) and whose remaining phrenic nerve, lung, and diaphragm function is sufficient to accommodate electrical stimulation".⁸

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

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informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT®* Codes | Description |
|------------------------------|---|
| 64575 | Incision for implantation of neurostimulator electrode array; peripheral nerve, (excludes sacral nerve) |
| 64595 | Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver |

| HCPCS®* Codes | Description |
|--------------------------------|---|
| C1778 | Lead, neurostimulator (implantable) |
| C1816 | Receiver and/or transmitter, neurostimulator (implantable) |
| L8681 | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only |
| L8689 | External recharging system for battery (internal) for use with implantable neurostimulator, replacement only |

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

| ICD-10 Code | Description |
|--------------------|--|
| G12.20 | Motor neuron disease, unspecified |
| G12.21 | Amyotrophic lateral sclerosis |
| G12.22 | Progressive bulbar palsy |
| G12.23 | Primary lateral sclerosis |
| G12.24 | Familial motor neuron disease |
| G12.25 | Progressive spinal muscle atrophy |
| G12.29 | Other motor neuron disease |
| G47.35 | Congenital central alveolar hypoventilation syndrome |
| G82.50 | Quadriplegia, unspecified |
| G82.51 | Quadriplegia, C1-C4 complete |
| G82.52 | Quadriplegia, C1-C4 incomplete |
| G83.89 | Paralytic syndrome, unspecified |
| J96.10 | Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia |
| J96.11 | Chronic respiratory failure with hypoxia |
| J96.12 | Chronic respiratory failure with hypercapnia |
| J96.20 | Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia |
| J96.21 | Acute and chronic respiratory failure with hypoxia |
| J96.22 | Acute and chronic respiratory failure with hypercapnia |
| R06.81 | Apnea, not elsewhere classified |
| Z99.11 | Dependence on respirator [ventilator] status |

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| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|-------|---------------|
| Approved by MPC. No changes. (Original approval date 08/11) | 04/16 | 04/16 |
| Approved by MPC. No changes. | 04/17 | 04/17 |
| Approved by MPC. No changes. | 03/18 | 03/18 |
| Approved by MPC. No changes. | 03/19 | 03/19 |
| Approved by MPC. No changes. | 04/20 | 04/20 |
| Integrated diaphragmatic pacing criteria from CP.MP.107 DME and Legacy WellCare Diaphragmatic Phrenic Nerve Stimulation HS-185 policy. Removed ICD-10-PCS codes and replaced with ICD-10-CM codes. Separated criteria by FDA approved device. Added medical necessity criteria for amyotrophic lateral sclerosis (ALS), additional verbiage changes made with no clinical significance. Specialist reviewed. Background and references reviewed and updated. Replaced “member” with “member/enrollee” in all instances. | 11/20 | 12/20 |

References

1. National coverage determination for phrenic nerve stimulator (160.19). Centers for Medicare and Medicaid Services Web site. <http://www.cms.hhs.gov/mcd/search.asp>. Accessed November 2, 2020.
2. Marion DW. Pacing the diaphragm: Patient selection, evaluation, implantation and complications. In: UpToDate, Shefner JM (Ed), UpToDate, Waltham, MA. Accessed October 30, 2020.
3. Le Pimpec-Barthes F, Legras A, Arame A, et al. Diaphragm pacing: the state of the art. J Thorac Dis. 2016;8(Suppl 4):S376-S386. doi:10.21037/jtd.2016.03.97
4. Onders RP, Elmo M, Khansarinia S, et al. Complete worldwide operative experience in laparoscopic diaphragm pacing: results and differences in spinal cord injured patients and amyotrophic lateral sclerosis patients. Surg Endosc. 2009;23(7):1433-1440. doi:10.1007/s00464-008-0223-3
5. McDermott CJ, Bradburn MJ, Maguire C, et al. DiPALS: Diaphragm Pacing in patients with Amyotrophic Lateral Sclerosis – a randomised controlled trial. Southampton (UK): NIHR Journals Library; 2016 Jun. (Health Technology Assessment, No. 20.45.) Scientific summary. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK368508/>.
6. Premarket Notification Database: NeuRx DPS™ RA/4 Respiratory Stimulation System. Summary of Safety and Probable Benefit. U.S. Food and Drug Administration Center for Devices and Radiological Health Web site. https://www.accessdata.fda.gov/cdrh_docs/pdf7/H070003B.pdf Published June 17, 2008. Accessed November 2, 2020.
7. Premarket Approvals for the NeuRx DPS™ Diaphragm Pacing System. Summary of Safety and Probable Benefit. U.S. Food and Drug Administration Center for Devices and Radiological Health Website. https://www.accessdata.fda.gov/cdrh_docs/pdf10/H100006b.pdf Published September 28, 2011. Accessed November 2, 2020.
8. Premarket Approvals for the Avery Breathing Pacemaker System Mark IV™ (Avery Biomedical Device, Inc., Commack, NY). Summary of Safety and Effectiveness. U.S. Food

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and Drug Administration Center for Devices and Radiological Health Web site.
https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma_template.cfm?id=p860026.
Published 2019. Accessed November 2, 2020.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited.

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Providers, member/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to member/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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