

7.01.125 Occipital Nerve Stimulation	
Original Policy Date: January 7, 2011	Effective Date: June 1, 2024
Section: 7.0 Surgery	Page: Page 1 of 13

Policy Statement

I. Occipital nerve stimulation is considered **investigational** for all indications.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Coding
See the [Codes table](#) for details.

Description

Occipital nerve stimulation delivers a small electrical charge to the occipital nerve intended to prevent migraines and other headaches in patients who have not responded to medications. The device consists of a subcutaneously implanted pulse generator (in the chest wall or abdomen) attached to extension leads that are tunneled to join electrodes placed across one or both occipital nerves at the base of the skull. Continuous or intermittent stimulation may be used.

Related Policies

- Spinal Cord and Dorsal Root Ganglion Stimulation

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

The U.S. Food and Drug Administration (FDA) has not cleared or approved any occipital nerve stimulation device for treatment of headache. In 1999, the Synergy™ IPG device (Medtronic), an implantable pulse generator, was approved by the FDA through the premarket approval process for management of chronic, intractable pain of the trunk or limbs, and off-label use for headache is described in the literature. The Genesis™ Neuromodulation System (St. Jude Medical) was approved by the FDA for spinal cord stimulation, and the Eon™ stimulator has received CE mark approval in Europe for the treatment of chronic migraines.

An independent member of the Blue Shield Association

Rationale

Background

Headache

There are 4 types of headache: vascular, muscle contraction (tension), traction, and inflammatory. Primary (not the result of another condition) chronic headache is defined as headache occurring more than 15 days of the month for at least 3 consecutive months. An estimated 45 million Americans experience chronic headaches. For at least half of these people, the problem is severe and sometimes disabling. Herein, we only discuss types of vascular headache, including migraine, hemicrania continua, and cluster.

Migraine

Migraine is the most common type of vascular headache. Migraine headaches are usually characterized by severe pain on one or both sides of the head, an upset stomach, and, at times, disturbed vision. One year prevalence of migraine ranges from 6% to 15% in adult men and from 14% to 35% in adult women. Migraine headaches may last a day or more, and can strike as often as several times a week or as rarely as once every few years.

Treatment of Migraine

Drug therapy for migraine is often combined with biofeedback and relaxation training. Sumatriptan and other triptans are commonly used for relief of symptoms. Drugs used to prevent migraine include amitriptyline, propranolol and other β -blockers, topiramate and other antiepileptic drugs, and verapamil.

Hemicrania Continua

Hemicrania continua causes moderate and occasionally severe pain on only one side of the head. At least one of the following symptoms must also occur: conjunctival injection and/or lacrimation, nasal congestion and/or rhinorrhea, or ptosis, and/or miosis. Headache occurs daily and is continuous with no pain-free periods. Hemicrania continua occurs mainly in women, and its true prevalence is not known.

Treatment of Hemicrania Continua

Indomethacin usually provides rapid relief of symptoms. Other nonsteroidal anti-inflammatory drugs, including ibuprofen, celecoxib, and naproxen, can provide some relief of symptoms. Amitriptyline and other tricyclic antidepressants are effective in some patients.

Cluster Headache

Cluster headache occurs in cyclical patterns or clusters of severe or very severe unilateral orbital or supraorbital and/or temporal pain. The headache is accompanied by at least one of the following autonomic symptoms: ptosis, conjunctival injection, lacrimation, rhinorrhea, and, less commonly, facial blushing, swelling, or sweating. Bouts of 1 headache every other day up to 8 attacks per day may last from weeks to months, usually followed by remission periods when the headache attacks stop completely. The pattern varies by person, but most people have 1 or 2 cluster periods a year. During remission, no headaches occur for months, and sometimes even years. The intense pain is caused by the dilation of blood vessels, which creates pressure on the trigeminal nerve. While this process is the immediate cause of the pain, the etiology is not fully understood. It is more common in men than in woman. One-year prevalence is estimated to be 0 to 1 in 1000.

Treatment of Cluster Headache

Management of cluster headache consists of abortive and preventive treatment. Abortive treatments include subcutaneous injection of sumatriptan, topical anesthetics sprayed into the nasal cavity, and strong coffee. Some patients respond to rapidly inhaled pure oxygen. A variety of other

pharmacologic and behavioral methods of aborting and preventing attacks have been reported with wide variation in patient response.

Peripheral Nerve Stimulators

Implanted peripheral nerve stimulators have been used to treat refractory pain for many years, but have only recently been proposed to manage craniofacial pain. Occipital, supraorbital, and infraorbital stimulation have been reported in the literature.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Migraine Headache

Clinical Context and Therapy Purpose

Migraine is the most common type of vascular headache. Migraine headaches are usually characterized by severe pain on one or both sides of the head, an upset stomach, and, at times, disturbed vision. One-year prevalence of migraine ranges from 6% to 15% in adult men and from 14% to 35% in adult women. Migraine headaches may last a day or more, and can strike as often as several times a week or as rarely as once every few years.

The purpose of occipital nerve stimulation in individuals who have migraines is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with migraine headache.

Interventions

The therapy being considered is occipital nerve stimulation.

Occipital nerve stimulation delivers a small electrical charge to the occipital nerve intended to prevent migraines and other headaches in individuals who have not responded to medications. The

device consists of a subcutaneously implanted pulse generator (in the chest wall or abdomen) attached to extension leads that are tunneled to join electrodes placed across one or both occipital nerves at the base of the skull. Continuous or intermittent stimulation may be used.

Comparators

Comparators of interest include medication and self-management (e.g., relaxation, exercise).

Outcomes

The general outcomes of interest are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Based on the available literature, follow-up of 12 weeks to 1 year is recommended.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

1. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
2. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
3. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
4. Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Systematic Reviews

Two systematic reviews of the literature on occipital nerve stimulation have been published, both including RCTs and observational studies. Chen et al (2015) identified 5 RCTs and 7 case series with at least 10 patients.¹ Three of the RCTs were industry-sponsored, multicenter, parallel-group trials and 2 were single-center crossover trials. All 5 included a sham control group and one also included a medication management group. Risk of bias was judged to be high or unclear for all trials. Meta-analyses were performed on 2 outcomes. A pooled analysis of 2 trials did not find a significant difference in response rates between active and sham stimulation (relative risk [RR], 2.07; 95% confidence interval [CI], 0.50 to 8.55; $p=0.31$) and a pooled analysis of 3 trials showed a significantly greater reduction in the number of days with prolonged moderate-to-severe headache (mean difference, 2.59; 95% CI, 0.91 to 4.27; $p=0.003$).

Yang et al (2016)² identified the same 5 RCTs as Chen in their systematic review. The Yang review only included studies conducted with patients who had migraines for at least 6 months in duration who did not respond to oral medications. In addition to the RCTs, 5 case series met the inclusion criteria. Yang did not pool study findings. The definition of response rate varied across studies and could include frequency and/or severity of headaches. Response rates in 3 case series with self-reported efficacy were 100% in each, and response rates in the other 2 series were 50% and 89%, respectively. Complication rates in the series ranged from 40% to 100%. Reviewers noted that the case series were subject to biases (e.g., inability to control for the placebo effect), that RCT evidence was limited, and that complication rates were high. The most common complications were lead migration (21% of patients) and infection (7% of patients).

Randomized Controlled Trials

The 2 parallel-group RCTs published as full-text journal articles are detailed next. Saper et al (2011) reported on the Occipital Nerve Stimulation for the Treatment of Intractable Chronic Migraine Headache trial, which was a multicenter, randomized feasibility study of occipital nerve stimulation for treatment of intractable chronic migraine headache refractory to preventive medical management.³ The trial evaluated study design and had no primary endpoint. One hundred ten patients were enrolled, and patients who had a positive response to a short-acting occipital nerve block were randomized as follows: 33 to adjustable stimulation, 17 to preset stimulation of 1 min/d, and 17 to medical management. At the 3-month evaluation, the response rate (percentage of

patients who achieved $\geq 50\%$ reduction in number of headache days per month or a ≥ 3 -point reduction in average overall pain intensity vs. baseline) was 39% in the adjustable stimulation group, 6% in the preset stimulation group, and 0% in the medical management group. Twelve (24%) of 51 subjects who had successful occipital nerve stimulation device implantation experienced lead migration and 3 (6%) of the 51 subjects were hospitalized for adverse events (infection, lead migration, nausea). Trial limitations included a short observation period and ineffective blinding of subjects and investigators to treatment groups.

Silberstein et al (2012) reported on an industry-sponsored, double-blind trial, regulated by U.S. Food and Drug Administration (FDA) that randomized 157 patients with chronic migraine refractory to preventive medical management in a 2:1 ratio to active or sham stimulation.⁴ Intention-to-treat (ITT) analysis revealed no significant differences between groups in the percentage of patients who achieved 50% or greater reduction in visual analog scale scores for pain at 12 weeks (active, 17.1%; control, 13.5%). More patients in the occipital nerve stimulation group had fewer days with headache, less migraine-related disability, and greater pain relief, although benefits were modest. The most common adverse event was persistent implant site pain. Dodick et al (2015) published results from the 52-week open-label extension of this trial.⁵ Results were reported for the ITT population and for the 125 patients who met selection criteria for intractable chronic migraine. Twenty-four patients were excluded from analysis due to explantation of the occipital nerve stimulation system (n=18) or loss to follow-up. Mean headache days at baseline were 21.6 for the ITT population and 24.2 for the intractable chronic migraine group. In the ITT population, headache days were reduced by 6.7 days, and a reduction of 50% or more in the number of headache days and/or pain intensity was observed in 47.8% of this group. Seventy percent of patients experienced at least 1 of 183 device-related adverse events, of which 8.6% of events required hospitalization and 40.7% of events required surgical intervention. Eighteen percent of patients had persistent pain and/or numbness with the device.

Section Summary: Migraine Headache

Two systematic reviews (2015, 2016) each identified 5 sham-controlled randomized trials. One of the systematic reviews also identified 5 case series. Findings from pooled analyses of RCTs were mixed. For example, compared with sham stimulation, response rates (ie, $\geq 50\%$ reduction in visual analog scale score) for occipital nerve stimulation did not differ significantly, but the number of days with prolonged moderate-to-severe headache was reduced. Occipital nerve stimulation was also associated with a substantial number of minor and serious adverse events.

Non-Migraine Headaches

Clinical Context and Therapy Purpose

The non-migraine headaches included in this evidence review are hemicrania continua and cluster headache. Hemicrania continua causes moderate and occasionally severe pain on only one side of the head. At least one of the following symptoms must also occur: conjunctival injection and/or lacrimation, nasal congestion and/or rhinorrhea, or ptosis, and/or miosis. Headache occurs daily and is continuous with no pain-free periods. Hemicrania continua occurs mainly in women, and its true prevalence is not known.

Cluster headache occurs in cyclical patterns or clusters of severe or very severe unilateral orbital or supraorbital and/or temporal pain. The headache is accompanied by at least one of the following autonomic symptoms: ptosis, conjunctival injection, lacrimation, rhinorrhea, and, less commonly, facial blushing, swelling, or sweating. Bouts of one headache every other day up to 8 attacks per day may last from weeks to months, usually followed by remission periods when the headache attacks stop completely. The pattern varies by person, but most people have 1 or 2 cluster periods a year. During remission, no headaches occur for months, and sometimes even years. The intense pain is caused by the dilation of blood vessels, which creates pressure on the trigeminal nerve. While this process is the immediate cause of the pain, the etiology is not fully understood. It is more common in men than in women. One-year prevalence is estimated to be 0 to 1 in 1000.

The purpose of occipital nerve stimulation in individuals who have non-migraine headache is to provide a treatment option that is an alternative to or an improvement on existing therapies. The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with non-migraine headache.

Interventions

The therapy being considered is occipital nerve stimulation.

Occipital nerve stimulation delivers a small electrical charge to the occipital nerve intended to prevent migraines and other headaches in individuals who have not responded to medications. The device consists of a subcutaneously implanted pulse generator (in the chest wall or abdomen) attached to extension leads that are tunneled to join electrodes placed across one or both occipital nerves at the base of the skull. Continuous or intermittent stimulation may be used.

Comparators

Comparators of interest include medication and self-management (e.g., relaxation, exercise).

Outcomes

The general outcomes of interest are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Based on the available literature, follow-up of 12 weeks to 1 year is recommended.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Case Series

Hemicrania Continua

The evidence evaluating the use of occipital nerve stimulation for hemicrania continua consists of a small crossover study. Burns et al (2008) reported on the efficacy of continuous unilateral occipital nerve stimulation in 6 patients.⁶ Pain on a 10-point scale was recorded hourly in patient diaries, and the Migraine Disability Assessment was administered at each follow-up visit. Four of 6 patients reported substantially less pain (range, 80%-95% less), one reported 30% less pain, and one reported 20% worse pain. Adverse events were mild and associated with transient overstimulation.

Cluster Headache

Numerous case series assessing cluster headache were identified, with sample sizes ranging from 10 to 105 patients.^{7,8,9,10,11,12} The largest of these case series included 105 patients with refractory cluster headache in a French occipital nerve stimulation database.¹³ Mean follow-up was 3.7 years; the number of patients with follow-up data ranged from 60 to 93, depending on the outcome. The primary outcome was change in attack frequency. At last follow-up, 69% (64/93) of patients had a reduction of $\geq 50\%$ in attack frequency, and 73% (68/93) reported at least a 30% reduction in frequency. Overall response rate was 77% (72/93); including 59% of patients who reported excellent response to treatment and 18% who reported mild response; 23% were nonresponders. Statistically significant improvements from baseline were also reported for quality of life measures. Adverse events were common, occurring in 64% (67/105) of patients, including need for reoperation in 28% (29/105).

Leone et al (2017) published a case series on use of occipital nerve stimulation in 35 patients with chronic cluster headache.¹¹ This series had the longest follow-up (median, 6.1 years; range, 1.6-10.7 years). Selection criteria included daily or almost daily cluster headache attacks in the past year and resistance of prophylactic drugs. Twenty (66.7%) of the 30 patients in the per protocol analysis had 50% or more reduction in number of headaches per day and were considered responders. In 12 (40%) patients, improvement was considered stable (i.e., ≤ 3 headache attacks per month).

Limitations of the series reporting on cluster headaches included lack of blinding and comparison groups.

Headache Associated With Chiari Malformation

Vadivelu et al (2012) reported on a series of 22 patients with Chiari malformation and persistent occipital headaches.¹⁴ Of the 22, 15 (68%) had a successful occipital neurostimulator trial and underwent permanent implantation. At a mean follow-up of 18.9 months (range, 6-51 months), 13 (87%) of the 15 patients reported pain relief greater than 50%. Forty percent of patients reported device-related complications requiring additional surgery (lead migration, uncomfortable position of generator, wound infection) during follow-up.

Occipital Neuralgia

A systematic review by Sweet et al (2015) identified 9 small case series (<15 patients each) assessing the efficacy of occipital nerve stimulation for treating medically refractory occipital neuralgia.¹⁵ Reviewers did not pool study findings. Conclusions cannot be drawn on the impact of occipital nerve stimulation on occipital neuralgia due to the lack of RCTs or other controlled studies.

Section Summary: Non-Migraine Headaches

The evidence on occipital nerve stimulation for treatment of non-migraine headaches consists of case series; no RCTs or nonrandomized comparative studies were identified. Many of the case series were small; series with over 25 patients were available only for treatment of cluster headache. Although case series tended to find that a substantial number of patients improved after occipital nerve stimulation, the studies lacked blinding and comparison groups. RCTs are needed to assess outcomes between occipital nerve stimulation and comparators (e.g., to control for a potential placebo effect).

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Congress of Neurological Surgeons

In 2015, the Congress of Neurological Surgeons released an evidence-based guideline that stated, "the use of occipital nerve stimulators is a treatment option for patients with medically refractory occipital neuralgia."¹⁵ The guideline was jointly funded by Congress of Neurological Surgeons and the Joint Section on Pain of the American Association of Neurological Surgeons/Congress of Neurological Surgeon. The statement had a level III recommendation based on a systematic review of literature (see Rationale section) that only identified case series. An update of the review was published in 2023.¹⁶ The update included a new systematic review of the relevant literature, but the new studies did 'not result in modification of the prior recommendations'.

Department of Veterans Affairs and Department of Defense

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) released a Clinical Practice Guideline for Management of Headache in 2023.¹⁷ The guideline recommendations were based on a systematic review and included strength of recommendation ratings. The guidelines stated that 'There is insufficient evidence to recommend for or against any form of neuromodulation for the treatment and/or prevention of migraine' including external combined occipital and trigeminal neurostimulation systems.

National Institute for Health and Care Excellence

In 2013, the National Institute for Health and Care Excellence issued a guidance informed by a systematic review noting that the evidence on occipital nerve stimulation for intractable chronic migraine showed "some efficacy in the short term but very little evidence about long-term outcomes. With regard to safety, there is a risk of complications, needing further surgery."¹⁸

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT05023460	Treatment of Chronic Cluster Headache (Horton's Headache) With Transcutaneous Electrical Nerve Stimulation and Occipital Nerve Stimulation	40	Jul 2024
NCT05804396	The SP-303 PERL Study - Combined Occipital and Trigeminal Nerve Stimulation (eCOT-NS) for Preventive Treatment of Migraine	57	Aug 2024
NCT01842763	French Database of Occipital Nerves Stimulation in the Treatment of Refractory Chronic Headache Disorders	240	Jul 2026
NCT04937010	Efficacy and Safety of Occipital Nerve Stimulation in Trigeminal Autonomic Cephalalgias: A Double-blind, Phase II, Randomized, Controlled Trial	20	Sep 2026
<i>Unpublished</i>			
NCT03475797	Evaluation of Occipital Nerve Stimulation in Intractable Occipital Neuralgia: A Multicentric, Controlled, Randomized Study	22 (actual)	Sept 2021

NCT: national clinical trial.

References

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2. Yang Y, Song M, Fan Y, et al. Occipital Nerve Stimulation for Migraine: A Systematic Review. *Pain Pract*. Apr 2016; 16(4): 509-17. PMID 25865962
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 11. Leone M, Proietti Cecchini A, Messina G, et al. Long-term occipital nerve stimulation for drug-resistant chronic cluster headache. *Cephalalgia*. Jul 2017; 37(8): 756-763. PMID 27250232
 12. Miller S, Watkins L, Matharu M. Treatment of intractable chronic cluster headache by occipital nerve stimulation: a cohort of 51 patients. *Eur J Neurol*. Feb 2017; 24(2): 381-390. PMID 27995704
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 14. Vadivelu S, Bolognese P, Milhorat TH, et al. Occipital nerve stimulation for refractory headache in the Chiari malformation population. *Neurosurgery*. Jun 2012; 70(6): 1430-6; discussion 1436-7. PMID 22418582
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 17. VA/DoD Clinical Practice Guideline. (2023). Management of Headache Work Group. Washington, DC: U.S. Government Printing Office.
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Documentation for Clinical Review

- No records required

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
	61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays
	64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
	64568	Open implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator
	64569	Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
	64570	Removal of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator
	64999	Unlisted procedure, nervous system
HCPCS	L8680	Implantable neurostimulator electrode, each
	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
	L8682	Implantable neurostimulator radiofrequency receiver
	L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
	L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
	L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
	L8686	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
	L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension
	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/07/2011	BCBSA Medical Policy adoption
04/08/2015	Coding update
05/29/2015	Coding update
10/30/2015	Policy revision without position change
02/01/2016	Coding update
07/01/2016	Policy revision without position change
06/01/2017	Policy revision without position change
06/01/2018	Policy revision without position change
06/01/2019	Policy revision without position change
06/01/2023	Policy reactivated. Previously archived from 06/01/2020 to 05/31/2023.
06/01/2024	Annual review. No change to policy statement. Policy guidelines and literature review updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>Occipital Nerve Stimulation 7.01.125</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Occipital nerve stimulation is considered investigational for all indications. 	<p>Occipital Nerve Stimulation 7.01.125</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Occipital nerve stimulation is considered investigational for all indications.