BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Occipital Nerve Stimulation
Corporate Medical Policy

File Name: Occipital Nerve Stimulation
File Code: 7.01.VT125
Origination: 2011
Last Review: 06/2025
Next Review: 06/2026
Effective Date: 09/01/2025

Description/Summary

Occipital nerve stimulation (ONS) 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. The scientific evidence is insufficient to determine that the ONS results in improvement in net health outcomes in individuals who have migraine or non-migraine headaches refractory to preventive medical management.

Policy

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

Coding Information
Click the links below for attachments, coding tables & instructions.
Attachment I- CPT® & HCPCS Code Table & Instructions

Reference Resources

1. Blue Cross and Blue Shield Association. Occipital Nerve Stimulation. MPRM#7.01.125. Last reviewed 05/2024. Accessed 05/2025.

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the

extent that there may be any conflict between medical policy and contract language, the member's contract language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required for services as outlined in this policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

2011	New policy
11/2015	Adoption of BCBSA MPRM# 7.01.125. Code table updates.
11/2017	Updated policy/references from BCBSA MPRM# 7.01.125. Policy statements remain unchanged. Added descriptor to code L8689 added to PA list.

06/2018	Updated policy/references from BCBSA MPRM# 7.01.125. Policy statements remain unchanged.
05/2021	Policy reviewed policy statement remains unchanged.
06/2022	Policy Reviewed. Added summative statement re lack of sufficient medical evidence. Policy statement unchanged. Updated reference. Code 64568 Code description changed effective 01/01/2022. Code range L8680-L8688 require prior approval.
06/2023	Policy reviewed. Updated reference. Policy statement unchanged.
06/2024	Policy reviewed. Updated reference. Policy statement unchanged.
06/2025	Policy reviewed. No change to policy statement. Reference updated.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Director(s)

Tom Weigel, MD, MBA
Vice President & Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I
CPT® & HCPCS Code Table & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be denied as Not Medically Necessary, Contract Exclusions or Investigational.			
CPT®	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	Prior Approval Required
CPT®	61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	Prior Approval Required

CPT®	64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	Prior Approval Required
CPT®	64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior Approval Required
CPT®	64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Prior Approval Required
CPT®	64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior Approval Required
HCPCS	L8680	Implantable neurostimulator electrode, each	Prior Approval Required
HCPCS	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	Prior Approval Required
HCPCS	L8682	Implantable neurostimulator radiofrequency receiver	Prior Approval Required
HCPCS	L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Prior Approval Required
HCPCS	L8684	Auditory osseointegrated device, transducer/actuator, replacement only, each	Prior Approval Required
HCPCS	L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	Prior Approval Required
HCPCS	L8686	Implantable neurostimulator pulse generator, single array, nonchargeable, includes extension	Prior Approval Required
HCPCS	L8687	Implantable neurostimulator pulse generator, dual, array, rechargeable, includes extension	Prior Approval Required

HCPCS	L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension	Prior Approval Required
HCPCS	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	Prior Approval Required
The following code is unlisted and requires clinical documentation at time of claims submission. Clinical documentation will be reviewed, and coverage determination will be made by a medical director.			
CPT®	64999	Unlisted procedure, nervous system	Clinical documentation is required at time of claims submission for medical review.