Medicare Advantage Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Vagus Nerve Stimulation – Medicare Advantage

Medicare Advantage Plan
☒ Medicare Plus Blue℠
☒ BCN Advantage℠

Current Policy Effective Date: 10/16/2026
(See policy history boxes for previous effective dates)

Description

Vagus nerve stimulation (VNS) is a therapeutic modality that uses a pulse generator or similar stimulation device to deliver controlled electrical signals to the vagus nerve. VNS may be delivered through surgically implanted systems or through non-implanted, external devices. Implanted systems generally include components such as a pulse generator, lead, and electrode that are surgically placed and programmed to deliver stimulation at selected intervals. Non-implanted or noninvasive devices deliver stimulation externally without surgical placement of device components. Devices may vary in design, method of stimulation, programming capabilities, and intended clinical use.

Related Medical Coverage Policies

- Percutaneous Electrical Nerve Stimulation (PENS), Percutaneous Neuromodulation Therapy (PNT) and Restorative Neurostimulation Therapy – Medicare Advantage
- Implantable Peripheral Nerve Stimulation and Peripheral Subcutaneous Field Stimulation Devices for the Treatment of Chronic Pain – Medicare Advantage
- Obstructive Sleep Apnea and Snoring-Surgical Treatment – Medicare Advantage

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare & Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other sub-regulatory guidance establish the coverage criteria and requirements used for coverage determinations, payment integrity activities, and other functions governed by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCDs/LCAs outside the service area or research from independent medical research repositories (i.e., Hayes) for coverage policies consistent with 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at https://www.bcbsm.com/providers/mpradmin/ by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCDs, LCDs, and LCAs should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCDs/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

CMS Guidance	Additional Guidance
NCD with Coverage with Evidence Development (CED): CAG-00313R2, *Vagus Nerve Stimulation (VNS) for Treatment of Resistant Depression (TRD)* VNS for treatment-resistant depression is noncovered when furnished outside of a CMS-approved CED study. To access the list of studies that meet CMS requirements for CED coverage, please visit the CMS Coverage with Evidence Development webpage at: https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/ **National Coverage Determinations** 160.18 – Vagus Nerve Stimulation 310.1 – Routine Costs in Clinical Trials For additional information regarding clinical trials evaluating VNS, please visit ClinicalTrials.gov. **Local Coverage Determinations and Articles** None	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: *Vagus Nerve Stimulation* To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.

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	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)

Code	Description
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, 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
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, 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 simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, 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 complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
C1827	Generator, neurostimulator (implantable), nonrechargeable, with implantable stimulation lead and external paired stimulation controller
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified
E0735	Noninvasive vagus nerve stimulator
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
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, 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
0908T	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed
0909T	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed
0910T	Removal of integrated neurostimulation system, vagus nerve

Code	Description
0911T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; without programming by physician or other qualified health care professional
0912T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; with simple programming by physician or other qualified health care professional

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).
HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare & Medicaid Services (CMS).

The information contained in this policy is current as of the review date. CMS coverage policies, guidance documents, and related coverage determinations are subject to periodic updates and revisions; therefore, the most current CMS information may not be reflected in this document.

Please refer to the Medicare Coverage Database at CMS.gov for the most current NCDs, LCDs, LCAs, and CMS Online Manual System Transmittals. For any code associated with a product or service determined to be noncovered by policy (either CMS or health plan policy if CMS is silent) medical record review, including prior authorization, will not be required.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc.	FL, PR, US VI
Noridian Healthcare Solutions, LLC Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto GBA	AL, GA, TN, NC, SC, VA, WV
Wellpoint Federal - Previously known as National Government Services, Inc. (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
DME MAC Jurisdictions	
CGS Administrators, LLC Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, US Virgin Islands, WI, WV
Noridian Healthcare Solutions, LLC Jurisdictions JA and JD	AK, American Samoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical Policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN's Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN's Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to, applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee clinical results, outcomes, or payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide for their patients. Identification of selected brand names of devices, tests, and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established
N/A	N/A	Medicare Advantage policy retired effective 03/21/2025 because services were managed by TurningPoint under an approved TurningPoint policy.
10/16/2026	09/16/2026	Annual review completed. Policy reinstated because TurningPoint manages some services using the BCBSM/BCN policy for certain codes. Guidance and code tables were reformatted. JUMP policy updates were adopted, and Coverage with Evidence Development (CED) guidance for Vagus Nerve Stimulation (VNS) for Treatment of Resistant Depression (TRD) was added.