

Neurologic Services and Procedures

Policy Number: MMP061.11
Last Committee Approval Date: June 11, 2025
Effective Date: July 1, 2025

[Instructions for Use](#)

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Related Commercial Policies
<ul style="list-style-type: none"> Transcranial Magnetic Stimulation for Treating Physical Health Conditions Vagus and External Trigeminal Nerve Stimulation

Coverage Rationale

Magnetoencephalography (MEG)

Medicare does not have a National Coverage Determination (NCD) for magnetoencephalography (MEG). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Imaging, Imaging, Brain.

[Click here to view the InterQual® criteria.](#)

Motor Function Mapping Using Non-Invasive Navigated Transcranial Magnetic Stimulation (nTMS)

Medicare does not have an NCD for motor function mapping using non-invasive navigated transcranial magnetic stimulation (nTMS). LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Transcranial Magnetic Stimulation for Treating Physical Health Conditions](#).

Vagus Nerve Stimulation for Strokes

Medicare does not have an NCD for vagus nerve stimulation for strokes. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Vagus and External Trigeminal Nerve Stimulation](#).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Magnetoencephalography (MEG)	
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)
Motor Function Mapping Using Non-Invasive Navigated Transcranial Magnetic Stimulation (nTMS)	
64999	Unlisted procedure, nervous system
Vagus Nerve Stimulation for Strokes	
64568	Open implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator

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HCPCS Code	Description
Vagus Nerve Stimulation for Strokes	
C1827	Generator, neurostimulator (implantable), nonrechargeable, with implantable stimulation lead and external paired stimulation controller

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the [Medicare Coverage Database](#), if no NCD, LCD, or LCA is found, refer to the criteria as noted in the [Coverage Rationale](#) section above.

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	States/Territories
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers.	
**For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

MLN Matters

[MLN Connects, 11-02-2023 MLNC: Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827](#)

Policy History/Revision Information

Date	Summary of Changes
02/01/2026	Related Policies <ul style="list-style-type: none"> Updated reference link to reflect the current policy title for <i>Transcranial Magnetic Stimulation for Treating Physical Health Conditions</i>
07/01/2025	Centers for Medicare and Medicaid Services (CMS) Related Documents <ul style="list-style-type: none"> Added reference link to the <i>MLN Connects Newsletter, 2023-11-02-MLNC, Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827</i>

Date	Summary of Changes
	<p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version MMP061.10

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.