

Vagus and External Trigeminal Nerve Stimulation (for North Carolina Only)

Policy Number: CSNCT0101.07
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[➔ Instructions for Use](#)

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Related Policies
• Bariatric Surgery (for North Carolina Only)
• Deep Brain and Cortical Stimulation (for North Carolina Only)
• Implanted Electrical Stimulator for the Spinal Cord (for North Carolina Only)
• Transcranial Magnetic Stimulation for Treating Physical Health Conditions (for North Carolina Only)

Application

This Medical Policy only applies to the state of North Carolina.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the [North Carolina Medicaid \(Division of Health Benefits\) Clinical Coverage Policy, Physician: 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures](#).

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

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. Benefit coverage for health services is determined by federal, state, or contractual requirements 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
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

CPT Code	Description
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
64570	Removal of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator

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HCPCS Code	Description
*E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified
E1399	Durable medical equipment, miscellaneous
*L8679	Implantable neurostimulator, pulse generator, any type
*L8680	Implantable neurostimulator electrode, each
*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, non-rechargeable, includes extension
*L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
*L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

Codes labeled with an asterisk (*) are not on the State of North Carolina Medicaid Fee Schedule and therefore may not be covered by the State of North Carolina Medicaid Program.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Implantable Vagus Nerve Stimulators

The FDA has approved a number of Implantable Vagus Nerve Stimulator devices. Refer to the following website for more information (use product codes LYJ, MUZ and QPY): <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm>. (Accessed October 1, 2024)

Transcutaneous (Non-Implantable) Vagus Nerve Stimulation Devices

The FDA has approved a number of devices used for Transcutaneous (Non-Implantable) Vagus Nerve Stimulation. Refer to the following website for more information (use product codes PKR and QAK) <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmnm.cfm>. (Accessed October 1, 2024)

External or Transcutaneous Trigeminal Nerve Stimulation

The FDA has approved a number of devices used for External or Transcutaneous Trigeminal Nerve Stimulation. Refer to the following website for more information <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (use product codes PCC and QGL). (Accessed October 1, 2024)

To locate marketing clearance information for a specific device or manufacturer, search the Center for Devices and Radiological Health (CDRH) [510\(k\) database](#) or the [Premarket Approval \(PMA\) database](#) by product and/or manufacturer name.

References

North Carolina Medicaid, Division of Health Benefits, Physician Clinical Coverage Policies, Vagus Nerve Stimulation, No: 1A-33. <https://medicaid.ncdhhs.gov/1a-33-vagus-nerve-stimulation-treatment-seizures/download?attachment>. Accessed October 20, 2025.

Policy History/Revision Information

Date	Summary of Changes
04/01/2026	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 (for North Carolina Only)</i>
12/01/2025	Medical Records Documentation Used for Reviews <ul style="list-style-type: none">Added language to indicate:<ul style="list-style-type: none">Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific serviceMedical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requestedThe patient's medical record must contain documentation that fully supports the medical necessity for the requested servicesThis documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or proceduresDocumentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.