Medica Central Utilization Management Policy

Policy Name:	**Vagus Nerve Stimulation (VNS), Implantable MP9232 (III-DEV.24)**
Effective Date:	**September 19, 2025**

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, The Health Plan uses MCG™ Care Guidelines, 29th edition, 2025: *ACG: A-0424 (AC), Vagus Nerve Stimulation, Implantable.*

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for *initial* implantation of a vagus nerve stimulator. Please see the prior authorization list for product specific prior authorization requirements.
2. Prior authorization is **not required** for *reoperation/revision* following implantation of a vagus nerve stimulator.
3. Implantable vagus nerve stimulation *is investigative and therefore, not covered* for all other indications not addressed in this policy, including but not limited to: Alzheimer's disease, anxiety

disorders, autism, bipolar disorders, bulimia, cerebral palsy, cluster headaches, depression, essential tremor, multiple sclerosis, fibromyalgia, heart failure, migraines, obesity, obsessive-compulsive disorder, post-traumatic stress disorder, sleep disorders, Tourette's syndrome and traumatic brain injury.

4. Non-implantable transcutaneous vagus nerve stimulation (e.g., gammaCore®) is investigative and therefore not covered for all indications.
5. Coverage may vary according to the terms of the member's plan document.
6. If the Medical Necessity Criteria and Benefit Considerations are met, The Health Plan will authorize benefits within the limits in the member's plan document.
7. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Provider Administrative Manual.

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	Committee/Source	Date(s)
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