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LCD DL29547 - Nerve Conduction Studies and ElectromyographyPrint

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Contractor Information

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Novitas Solutions, Inc.

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LCD Information

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LCD Title

Nerve Conduction Studies and Electromyography

Contractor's Determination Number

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AMA CPT/ADA CDT Copyright Statement



Primary Geographic Jurisdiction

Pennsylvania, Maryland, Delaware, District of Columbia, New Jersey

Oversight Region

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Original Determination Effective Date

For services performed on or after N/A

Original Determination Ending Date

N/A

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N/A

CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

CMS Internet-Only Manual (IOM), Publication 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Section 160.23 concludes after reconsideration (2004) that there continues to be insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test as reasonable and necessary within the meaning of section 1862(a)(1)(A) of the law.

Program Memorandum B-01-28 dated April 19, 2001, Medicare Carriers Manual Change Request 1756, dated September 27, 2001

42 CFR Section 410.32

Federal Register Vol. 62, 59047

CMS IOM Publication 100-2. Chapter 15, Section 80

Indications and Limitations of Coverage and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

Electromyography (EMG) is the study and recording of intrinsic electrical properties of skeletal muscles. This is carried out with a needle electrode. Generally, the needles are of two types: monopolar or concentric. There is a requirement for ongoing real-time clinical diagnostic evaluation, especially during EMG examination.; Also, EMG examination is invasive. Needle placement in the exact muscle of interest is essential. It requires needle exploration near vital structures as the pleurfa, femoral neurovascular bundle, peritoneum, intraspinal spaces, carotid artery, orbit and brachial plexus. Risk of infection from AIDS, Hepatitis B-E, Creutzfeldt-Jakob encephalopathy, and hemorrhage from anticoagulation can be managed by proper techniques.

Nerve conduction studies (NCS) are used to measure action potentials resulting from peripheral nerve stimulation which are recordable over the nerve or from an innervated muscle. With this technique, responses are measured between two sites of stimulation, or between a stimulus and a recording site.

Nerve conduction studies are of two general types: sensory and motor. Either surface or needle electrodes can be used to stimulate the nerve or record the response. Axonal damage or dysfunction generally results in loss of nerve or muscle potential response amplitude; whereas, demyelination leads to prolongation of conduction time and slowing of conduction velocity.

Obtaining and interpreting NCS results requires extensive interaction between the performing qualified health care professional and patient, and is most effective when both obtaining raw data and interpretation are performed concurrently on a real-time basis.

Results of the NCS reflect on the integrity and function of:

the myelin sheath (Schwann cell derived insulation covering an axon), and

the axon (an extension of neuronal cell body) of a nerve.

Interruption of axon and dysfunction of myelin will both affect NCS results.

EMG is undertaken together with nerve conduction studies (NCS). Unlike NCS, however, EMG testing relies on both auditory and visual feedback to the electromyographer. This testing is also invasive in that it requires needle electrode insertion and adjustment at multiple sites, and at times, anatomically critical sites. As in NCS, during EMG studies, the electromyographer depends on ongoing real-time interpretation based knowledge of the clinical diagnoses being evaluated to decide whether to continue, modify, or conclude a test. This process requires knowledge of anatomy, physiology, and neuromuscular diseases.

There may be instances where questions about an indication, or need for a study, will arise. The clinical history and examination, carried out before the study, must always describe and document clearly and comprehensibly the need for the planned test. A "rule-out" diagnosis is typically not acceptable. The Contractor is cognizant of the fact that patients are not always referred with a definite diagnosis in mind. Often, pain, paresthesia, or weakness in an extremity is the reason for an NCS or EMG. These common symptoms result not only from axonal and myelin dysfunction but also from systemic, non-neurological illnesses. EMG and NCV may help in making this distinction. Therefore, symptom-based diagnoses such as "pain in limb," weakness, disturbance in skin sensation or "paresthesia" are acceptable provided the clinical assessment unequivocally supports the need for a study. To cite but one example of many, an EMG or NCS is irrelevant as a first order diagnostic test for limb pain resulting from immediate antecedent trauma or acute bone injury.

Both EMGs and NCSs are required for a clinical diagnosis of peripheral nervous system disorders. EMG results reflect on the integrity of the functioning connection between a nerve and its innervated muscle and also on the integrity of a muscle itself. Performance of one does not eliminate the need for the

other. The intensity and extent of testing with EMG and NCS are matters of clinical judgment developed after the initial pre-test evaluation, and later modified during the testing procedure.

The electrodiagnostic evaluation is actually an extension of the neurologic portion of the physical examination. Both require a detailed knowledge of a patient and his/her disease. Training in the performance of electrodiagnostic procedures, in isolation without awareness and ability to diagnose and manage neuromuscular diseases, is not always adequate for electrodiagnostic consultation. Recognition and experience in the management of disparate diseases that produce common electrodiagnostic findings may be necessary. For example, EMG-NCS findings may overlap in the following pairs of disorders: inflammatory myopathies and ALS, ALS and multi-level radiculopathies, myotonia of channelopathies (periodic paralyses) and myotonic dystrophies, focal neuropathies as Carpal Tunnel Syndrome and proximal plexopathies. Other instances where knowledge of disease behavior is crucial are Chronic Inflammatory Demyelinating Neuropathy (CIDP) and Multifocal Motor Neuropathy. These entities display electrodiagnostic features that resemble generalized polyneuropathies. Neuromuscular transmission disorders require separation based on clinical presentation and electrical features. Treatment will depend on differentiating among them. Without awareness of the disease spectrum, diagnosis solely by EMG-NCS findings may be either wrong or detrimental to the patient.

In summary, axonal and muscle involvement are most sensitively detected by EMGs, and myelin and axonal involvement are best detected by NCSs.

Electromyography (EMG)

EMG results reflect not only on the integrity of the functioning connection between a nerve and its innervated muscle but also on the integrity of a muscle itself. The axon innervating a muscle is primarily responsible for the muscle's volitional contraction, survival, and trophic functions. Thus, interruption of the axon will alter the EMG. A few prime examples of neurologic conditions in which EMG is potentially helpful, although not an all inclusive listing, are disc disease producing spinal nerve dysfunction, advanced nerve compression in peripheral lesions, Amyotrophic Lateral Sclerosis (ALS), and polyneuropathy, etc. After an acute neurogenic lesion, it is important to note that EMG changes may not appear for several days to weeks in the innervated muscles.

Primary muscle diseases such as polymyositis will also alter a normal EMG pattern. Myotonic disorders may show a pattern of spontaneous repetitive discharges on needle exploration.

Neurogenic disorders can be distinguishable from myopathic disorders by a carefully performed EMG. For example, both polymyositis and ALS (Amyotrophic Lateral Sclerosis) produce manifest weakness. The former carries a very different prognosis and treatment than the latter. An EMG is very valuable in making this distinction. Similarly, classification of nerve trauma into axonal vs. demyelinating categories, with corresponding differences in prognoses, are possible with EMG. Below is a list of common disorders where an EMG, in tandem with properly conducted NCS, will be helpful in diagnosis:

Nerve compression syndromes, including carpal tunnel syndrome and other focal compressions.

Radiculopathy - cervical, lumbosacral.

Mono/polyneuropathy - metabolic, degenerative, hereditary.

Myopathy - including poly-and dermatomyositis, myotonic and congenital myopathies.

Plexopathy - idiopathic, trauma, infiltration.

Neuromuscular junction disorders - myasthenia gravis. Single fiber EMG is of especial value here.

At times, immediately prior to Botulinum A toxin injection, for localization.

At times, immediately prior to injection of phenol or other substances for nerve blocking or chemodenervation.

There may be other instances, not detailed here, where EMG may be of use.

Use of EMG with Botulinum Toxin Injection

EMG may be used to optimize the anatomic location of botulinum toxin injection. It is expected there will be one study performed per anatomic location of injection, if needed.

It is expected that providers will use CPT code 95870 for sampling muscles other than the paraspinals associated with the extremities, which have been tested. Medicare would not expect to see this code billed when the paraspinal muscles corresponding to an extremity are tested and when the extremity EMG code 95860, 95861, 95863 or 95864 is also billed. The necessity and reasonableness of the following uses of EMG studies have not been established:

exclusive testing of intrinsic foot muscles in the diagnosis of proximal lesions

definitive diagnostic conclusions based on paraspinal EMG in regions bearing scar of past surgeries (e.g., previous laminectomies)

pattern-setting limited limb muscle examinations, without paraspinal muscle testing for a diagnosis of radiculopathy

EMG testing shortly after trauma, before EMG abnormalities would have reasonably had time to develop

surface and macro EMG (95999) This is not the same as a conventional EMG and involves the use of a probe that is passed over the surface of the skin in order to measure electrical muscle activity. This method of EMG testing is considered investigational and is not a covered service. Surface and macro EMGs will be denied as not medically necessary.

multiple uses of EMG in the same patient at the same location of the same limb for the purpose of optimizing botulinum toxin injections.

Nerve Conduction Studies (NCS)

The dichotomy into axonal and demyelinating neuropathies provides a practical means of correlating electrical abnormalities with major pathophysiologic changes in the nerve. Electrical studies can be of help in localization of an abnormality, and in distinguishing one variety of neuropathy from another: for example, diffuse vs. multifocal; axonal vs. demyelinating. Such distinction has diagnostic value. Specific classification of nerve injuries into neuropraxia and axonotmesis can be made on the basis of conduction studies and electromyography. Such classification has a bearing on prognosis and treatment.

Focal neuropathies or compressive lesions such as carpal tunnel syndrome, ulnar neuropathies or root lesions, for localization.

Traumatic nerve lesions, for diagnosis and prognosis.

Diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic, metabolic or immune.

Repetitive nerve stimulation in diagnosis of neuromuscular junction disorders such as myasthenia gravis, myasthenic syndrome.

There may be other instances, not detailed here, where NCS may be of use. Not all possible or potential indications are addressed here.

The following definitions are from the American Association of Neuromuscular Electrodiagnostic Medicine Recommended Policy for Electrodiagnostic Medicine

http://www.aan.com/globals/axon/assets/4061.pdf

"The stimulation of nerves is similar across all NCSs; the characteristics of motor, sensory, and mixed NCSs are different and are discussed separately below. In each case, an appropriate nerve is stimulated and recording is made either from the appropriate nerves or from muscle supplied by the motor nerve.

a. Motor. Motor NCSs are performed by applying electrical stimulation at various points along the course of a motor nerve while recording the electrical response from an appropriate muscle. Response parameters include amplitude, latency, configuration, and motor conduction velocity.

b. Sensory. Sensory NCSs are performed by applying electrical stimulation near a nerve and recording the response from a distant site along the nerve. Response parameters include amplitude, latency and configuration.

c. Mixed NCSs are performed by applying electrical stimulation near a nerve containing both motor and sensory fibers (a mixed nerve) and recording from a different location along that nerve that also contains both motor and sensory nerve fibers. Response parameters include amplitude, latency, configuration, and motor conduction velocity."

d. CPT code 95905 -Nerve conduction studies performed using automated devices (for example devices such as NC-stat® System) cannot support testing of other locations and other nerves as needed

depending on the concurrent results of testing and they should not be billed to Medicare with the current CPT codes other than 95905.

When the beneficiary has a high (more than 80%) pre-test or a prior probability for having the diagnosis of Carpal Tunnel Syndrome, the NC-stat® System (alone) will be allowed, one service per arm, per patient, per lifetime using CPT code 95905. The diagnosis ICD-9 354.0 should be used. All other ICD-9 codes will be denied as not medically necessary.

Nerve conduction studies performed independent of needle electromyography (EMG) may only provide a portion of the information needed to diagnose muscle, nerve root, and most nerve disorders. When the nerve conduction study (NCS) is used on its own without integrating needle EMG findings or when an individual relies solely on a review of NCS data, the results can be misleading, and important diagnoses may be missed.

In most instances, both NCS and EMG are necessary to perform diagnostic testing. While a provider may choose to perform just a NCS, when performed alone it will be considered to be a screening exam. The only exception to this is a situation when a provider may consider it appropriate to perform a NCS without doing an EMG for the diagnosis of carpal tunnel syndrome with a high pre-test probability, that has yet to be confirmed.

It is often also valuable to test conduction status in proximal segments of peripheral nerves. This assessment can be accomplished by H-reflex, F-wave and blink reflex testing. These proximal segments include the first several centimeters of a compound nerve emerging from the spinal cord or brainstem. H-reflex, F-waves and Blink reflex testing accomplish this task better than distal NCS. Current evidence in standard peer-reviewed medical journals does not support the use of F waves, in isolation, to diagnose radiculopathy. This is to be contrasted with the investigation of distal peripheral nerves, which is accomplished by nerve conduction studies generally accompanied by EMG.

Each descriptor (code) from codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 can be reimbursed only once per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve. For instance, testing the ulnar nerve at wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a single nerve. Motor and sensory nerve testing are considered separate tests. CPT code 95905 is payable only once per upper extremity imb studied, per patient, per lifetime when there is a high probability of a carpal tunnel syndrome diagnosis (80% or greater) and cannot be used in conjunction with any other nerve conduction codes.

Screening testing for polyneuropathy of diabetes or endstage renal disease (ESRD) is NOT covered. Testing for the sole purpose of monitoring disease intensity or treatment efficacy in these two conditions is also not covered.

Psychophysical measurements (current, vibration, thermal perceptions), even though they may involve delivery of a stimulus, are considered to be part of the physical exam and may not be billed as a separate service.

Current Perception Threshold/Sensory Nerve Conduction Threshold Test (sNCT) is not covered by Medicare. This procedure is different and distinct from assessment of nerve conduction velocity, amplitude and latency. It is also different from short-latency somatosensory evoked potentials. Codes designated for eliciting nerve conduction velocity, latency or amplitude, and those designed for short latency evoked potentials are not to be used for sNCT. The sNCT has a unique code G0255: Effective October 1, 2002, CMS initially concluded that there was insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test reasonable and necessary within the meaning of section 1862(a)(1)(A) of the law. Therefore, sNCT was noncovered. Based on a reconsideration [in March, 2004] of current Medicare policy for sNCT, CMS concludes that there continues to be insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test as reasonable and necessary within the meaning of section 1862(a)(1)(A) of the law. CMS Publication 100-3, Medicare National Coverage Issues Manual, Chapter 1, Section 160.23

Examination using portable hand-held devices, or devices which are incapable of real-time wave-form display and analysis, and incapable of both NCS and EMG testing; will be included in the E/M service. They will not be paid separately. Examples include; The Axon II or delta fiber analysis testing and/or machines with other names.

Nerve conduction studies must provide a number of response parameters in a real-time fashion to facilitate provider interpretation. Those parameters include amplitude, latency, configuration and conduction velocity. Medicare does not accept diagnostic studies that do not provide this information or those that provide delayed interpretation as substitutes for Nerve conduction studies. Raw measurement data obtained and transmitted trans-telephonically or over the Internet, therefore, does not qualify for the payment of the electrodiagnostic service codes included in this LCD.

Medicare does not expect to receive claims for nerve conduction testing accomplished with discriminatory devices that use fixed anatomic templates and computer-generated reports used as an adjunct to physical examination routinely on all patients.

EMG/NCS studies will not be covered when provided in the home of the beneficiary.

Guidelines about proper qualifications for qualified health care professionals performing electrodiagnostic evaluations have been developed and published by AANEM (American Association of Neuromuscular and Electrodiagnostic Medicine) and other medical organizations, including the AMA, the American Academy of Neurology, the American Academy of Physical Medicine and Rehabilitation, American Neurological Association, the American Board of Physical Therapy Specialties (ABPTS) in Clinical Electrophysiology, and the Department of Veterans Affairs.

Novitas Solutions, Inc expects healthcare professionals who perform electrodiagnostic (ED) testing will be appropriately trained and/or credentialed, either by a formal residency/fellowship program, certification by a nationally recognized organization, or by an accredited post-graduate training course covering anatomy, neurophysiology and forms of electrodiagnostics (including both NCS and EMG) acceptable to this Contractor, in order to provide the proper testing and assessment of the patient's condition, and appropriate safety measures. It would be highly unlikely that this training and/or

credentialing is possessed by providers other than Neurologists, or Physical Medicine and Rehabilitation physicians.

Physical Therapists Performing EMGs

Program Memorandum Transmittal B-01-28/Change Request 850 sets forth revised levels of physician supervision required for diagnostic tests payable under the Medicare Physician Fee Schedule.; Effective July 1, 2001, certain codes in the range of CPT 95860-95937 were assigned new supervision levels (21, 22, 6a, 66, 77 or 77a).; This implementation date would make it possible for physical therapists to acquire the certification required to perform these services without supervision. A physical therapist who is presently certified by the American Board of Physical Therapy Specialties can perform procedures assigned level of 21, 22, 66, 6a, 77, or 77a without supervision. These numeric levels assigned to the CPT codes are listed in the Medicare Physician Fee Schedule Database (MFSDB). Physical therapists who do not possess the ABPTS (American Board of Physical Therapy Specialties) certification by July 1, 2001, may continue to furnish those tests that require the certification if they have been furnishing such diagnostic tests prior to May 1, 2001.

Payment will be based on the Medicare Physician Fee Schedule level of supervision designation.

The nerve conduction test codes (95905-95913) do not have one of the above designations and are therefore not allowed by Physical Therapists.

Neuromuscular junction testing code 95937 does not have one of the above designations and is therefore not allowed by Physical Therapists.

Needle electromyographic (EMG) codes 95860-95872 and 95885-95887 have the designation of 6A for the technical portion of the test. Therefore if authorized by state law Physical Therapists are allowed the technical portion of the test. Physical Therapists are not permitted to perform a needle EMG in New Jersey.

For outpatient settings other than Comprehensive Outpatient Rehabilitation Facility (CORF)s, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.) Each practitioner must provide only those services within the scope of practice for each state.

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Coding Information

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

012x

Hospital Inpatient (Medicare Part B only)

013x

Hospital Outpatient

021x

Skilled Nursing - Inpatient (Including Medicare Part A)

022x

Skilled Nursing - Inpatient (Medicare Part B only)

023x

Skilled Nursing - Outpatient

071x

Clinic - Rural Health

075x

Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)

083x

Ambulatory Surgery Center

085x

Critical Access Hospital

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0920

Other Diagnostic Services - General Classification

0922

Other Diagnostic Services - Electromyelgram

0929

Other Diagnostic Services - Other Diagnostic Service

CPT/HCPCS Codes

Italicized and/or quoted material is excerpted from the American Medical Association, Current Procedural Terminology (CPT) codes.

Electromyography (EMG)

92265

Eye muscle evaluation

95860

Muscle test one limb

95861

Muscle test 2 limbs

95863

Muscle test 3 limbs

95864

Muscle test 4 limbs

95865

Muscle test larynx

95866

Muscle test hemidiaphragm

95867

Muscle test cran nerv unilat

95868

Muscle test cran nerve bilat

95869

Muscle test thor paraspinal

95870

Muscle test nonparaspinal

95872

Muscle test one fiber

95874

Guide nerv destr needle emg

95885

Musc tst done w/nerv tst lim

95886

Musc test done w/n test comp

95887

Musc tst done w/n tst nonext

Nerve Conduction Studies (NCS)

95873

Guide nerv destr elec stim

95905

Motor &/ sens nrve cndj test

95907

Motor&/sens 1-2 nrv cndj tst

95908

Motor&/sens 3-4 nrv cndj tst

95909

Motor&/sens 5-6 nrv cndj tst

95910

Motor&sens 7-8 nrv cndj test

95911

Motor&sen 9-10 nrv cndj test

95912

Motor&sen 11-12 nrv cnd test

95913

Motor&sens 13/> nrv cnd test

95933

Blink reflex test

95937

Neuromuscular junction test

95999

Neurological procedure

G0255

Current percep threshold tst

ICD-9 Codes that Support Medical Necessity

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

ICD-9-CM codes that support medical necessity of procedure codes 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95874, 95885, 95886, 95887, 95873, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95933, 95999, G0255:

005.1

BOTULISM FOOD POISONING

037

TETANUS

138

LATE EFFECTS OF ACUTE POLIOMYELITIS

192.0 - 192.8

MALIGNANT NEOPLASM OF CRANIAL NERVES - MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF NERVOUS SYSTEM

198.3

SECONDARY MALIGNANT NEOPLASM OF BRAIN AND SPINAL CORD

198.4

SECONDARY MALIGNANT NEOPLASM OF OTHER PARTS OF NERVOUS SYSTEM

225.1

BENIGN NEOPLASM OF CRANIAL NERVES

225.3

BENIGN NEOPLASM OF SPINAL CORD

225.4

BENIGN NEOPLASM OF SPINAL MENINGES

225.8

BENIGN NEOPLASM OF OTHER SPECIFIED SITES OF NERVOUS SYSTEM

237.70

NEUROFIBROMATOSIS UNSPECIFIED

237.71

NEUROFIBROMATOSIS TYPE 1 VON RECKLINGHAUSEN'S DISEASE

237.72

NEUROFIBROMATOSIS TYPE 2 ACOUSTIC NEUROFIBROMATOSIS

237.73

SCHWANNOMATOSIS

237.79

OTHER NEUROFIBROMATOSIS

249.60 - 249.61

SECONDARY DIABETES MELLITUS WITH NEUROLOGICAL MANIFESTATIONS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED - SECONDARY DIABETES MELLITUS WITH NEUROLOGICAL MANIFESTATIONS, UNCONTROLLED

250.60 - 250.63

DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

265.1

OTHER AND UNSPECIFIED MANIFESTATIONS OF THIAMINE DEFICIENCY

269.1

DEFICIENCY OF OTHER VITAMINS

272.5

LIPOPROTEIN DEFICIENCIES

332.0

PARALYSIS AGITANS

333.2

MYOCLONUS

333.3

TICS OF ORGANIC ORIGIN

333.6

GENETIC TORSION DYSTONIA

333.71

ATHETOID CEREBRAL PALSY

333.72

ACUTE DYSTONIA DUE TO DRUGS

333.79

OTHER ACQUIRED TORSION DYSTONIA

333.81 - 333.89

BLEPHAROSPASM - OTHER FRAGMENTS OF TORSION DYSTONIA

333.90

UNSPECIFIED EXTRAPYRAMIDAL DISEASE AND ABNORMAL MOVEMENT DISORDER

334.1

HEREDITARY SPASTIC PARAPLEGIA

334.2

PRIMARY CEREBELLAR DEGENERATION

334.3

OTHER CEREBELLAR ATAXIA

334.4

CEREBELLAR ATAXIA IN DISEASES CLASSIFIED ELSEWHERE

334.8

OTHER SPINOCEREBELLAR DISEASES

334.9

SPINOCEREBELLAR DISEASE UNSPECIFIED

335.0 - 335.9

WERDNIG-HOFFMANN DISEASE - ANTERIOR HORN CELL DISEASE UNSPECIFIED

336.0 - 336.9

SYRINGOMYELIA AND SYRINGOBULBIA - UNSPECIFIED DISEASE OF SPINAL CORD

337.00 - 337.9

IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY, UNSPECIFIED - UNSPECIFIED DISORDER OF AUTONOMIC NERVOUS SYSTEM

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NEUROMYELITIS OPTICA - DEMYELINATING DISEASE OF CENTRAL NERVOUS SYSTEM UNSPECIFIED

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FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE

343.0 - 343.9

CONGENITAL DIPLEGIA - INFANTILE CEREBRAL PALSY UNSPECIFIED

350.1 - 350.9

TRIGEMINAL NEURALGIA - TRIGEMINAL NERVE DISORDER UNSPECIFIED

351.0

BELL'S PALSY

351.8

OTHER FACIAL NERVE DISORDERS

351.9

FACIAL NERVE DISORDER UNSPECIFIED

352.1

GLOSSOPHARYNGEAL NEURALGIA

352.2

OTHER DISORDERS OF GLOSSOPHARYNGEAL (9TH) NERVE

352.3

DISORDERS OF PNEUMOGASTRIC (10TH) NERVE

352.4

DISORDERS OF ACCESSORY (11TH) NERVE

352.5

DISORDERS OF HYPOGLOSSAL (12TH) NERVE

352.6

MULTIPLE CRANIAL NERVE PALSIES

352.9

UNSPECIFIED DISORDER OF CRANIAL NERVES

353.0 - 353.9

BRACHIAL PLEXUS LESIONS - UNSPECIFIED NERVE ROOT AND PLEXUS DISORDER

354.0 - 354.9

CARPAL TUNNEL SYNDROME - MONONEURITIS OF UPPER LIMB UNSPECIFIED

355.0 - 355.9

LESION OF SCIATIC NERVE - MONONEURITIS OF UNSPECIFIED SITE

356.0 - 356.9

HEREDITARY PERIPHERAL NEUROPATHY - UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY

357.0 - 357.89

ACUTE INFECTIVE POLYNEURITIS - OTHER INFLAMMATORY AND TOXIC NEUROPATHY

358.00 - 358.9

MYASTHENIA GRAVIS WITHOUT (ACUTE) EXACERBATION - MYONEURAL DISORDERS UNSPECIFIED

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CONGENITAL HEREDITARY MUSCULAR DYSTROPHY - MYOPATHY UNSPECIFIED

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SPASTIC ECTROPION

378.00 - 378.9

ESOTROPIA UNSPECIFIED - UNSPECIFIED DISORDER OF EYE MOVEMENTS

458.0

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478.30 - 478.34

UNSPECIFIED PARALYSIS OF VOCAL CORDS - COMPLETE BILATERAL PARALYSIS OF VOCAL CORDS

478.75

LARYNGEAL SPASM

478.79

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530.0

ACHALASIA AND CARDIOSPASM

710.3

DERMATOMYOSITIS

710.4

POLYMYOSITIS

710.5

EOSINOPHILIA MYALGIA SYNDROME

721.0

CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY

721.1

CERVICAL SPONDYLOSIS WITH MYELOPATHY

721.2

THORACIC SPONDYLOSIS WITHOUT MYELOPATHY

721.3

LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY

721.41

SPONDYLOSIS WITH MYELOPATHY THORACIC REGION

721.42

SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION

721.5

KISSING SPINE

721.6

ANKYLOSING VERTEBRAL HYPEROSTOSIS

721.7

TRAUMATIC SPONDYLOPATHY

721.8

OTHER ALLIED DISORDERS OF SPINE

721.90

SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY

721.91

SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY

722.0 - 722.11

DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY - DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY

722.2

DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY

722.30

SCHMORL'S NODES OF UNSPECIFIED REGION

722.31

SCHMORL'S NODES OF THORACIC REGION

722.32

SCHMORL'S NODES OF LUMBAR REGION

722.39

SCHMORL'S NODES OF OTHER SPINAL REGION

722.4

DEGENERATION OF CERVICAL INTERVERTEBRAL DISC

722.51

DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC

722.52

DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC

722.6

DEGENERATION OF INTERVERTEBRAL DISC SITE UNSPECIFIED

722.70 - 722.73

INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY UNSPECIFIED REGION - INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION

722.80 - 722.83

POSTLAMINECTOMY SYNDROME OF UNSPECIFIED REGION - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION

722.91 - 722.93

OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION - OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION

723.0

SPINAL STENOSIS IN CERVICAL REGION

723.1

CERVICALGIA

723.4

BRACHIAL NEURITIS OR RADICULITIS NOS

723.5

TORTICOLLIS UNSPECIFIED

723.9

UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK

724.00 - 724.09

SPINAL STENOSIS OF UNSPECIFIED REGION - SPINAL STENOSIS OF OTHER REGION

724.1

PAIN IN THORACIC SPINE

724.2

LUMBAGO

724.3

SCIATICA

724.4

THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED

724.5

BACKACHE UNSPECIFIED

725

POLYMYALGIA RHEUMATICA

728.0

INFECTIVE MYOSITIS

728.2

MUSCULAR WASTING AND DISUSE ATROPHY NOT ELSEWHERE CLASSIFIED

728.85

SPASM OF MUSCLE

728.87

MUSCLE WEAKNESS (GENERALIZED)

728.88

RHABDOMYOLYSIS

728.89

OTHER DISORDERS OF MUSCLE LIGAMENT AND FASCIA

728.9

UNSPECIFIED DISORDER OF MUSCLE LIGAMENT AND FASCIA

729.1

MYALGIA AND MYOSITIS UNSPECIFIED

729.2

NEURALGIA NEURITIS AND RADICULITIS UNSPECIFIED

729.5

PAIN IN LIMB

729.82

CRAMP OF LIMB

729.89

OTHER MUSCULOSKELETAL SYMPTOMS REFERABLE TO LIMBS

736.05

WRIST DROP (ACQUIRED)

736.06

CLAW HAND (ACQUIRED)

736.09

OTHER ACQUIRED DEFORMITIES OF FOREARM EXCLUDING FINGERS

736.70

UNSPECIFIED DEFORMITY OF ANKLE AND FOOT ACQUIRED

736.71

ACQUIRED EQUINOVARUS DEFORMITY

736.72

EQUINUS DEFORMITY OF FOOT ACQUIRED

736.73

CAVUS DEFORMITY OF FOOT ACQUIRED

736.74

CLAW FOOT ACQUIRED

736.75

CAVOVARUS DEFORMITY OF FOOT ACQUIRED

736.76

OTHER ACQUIRED CALCANEUS DEFORMITY

736.79

OTHER ACQUIRED DEFORMITIES OF ANKLE AND FOOT

738.4

ACQUIRED SPONDYLOLISTHESIS

741.90

SPINA BIFIDA UNSPECIFIED REGION WITHOUT HYDROCEPHALUS

741.91

SPINA BIFIDA CERVICAL REGION WITHOUT HYDROCEPHALUS

741.92

SPINA BIFIDA DORSAL (THORACIC) REGION WITHOUT HYDROCEPHALUS

741.93

SPINA BIFIDA LUMBAR REGION WITHOUT HYDROCEPHALUS

742.51

DIASTEMATOMYELIA

754.1

CONGENITAL MUSCULOSKELETAL DEFORMITIES OF STERNOCLEIDOMASTOID MUSCLE

780.79

OTHER MALAISE AND FATIGUE

780.93

MEMORY LOSS

780.94

EARLY SATIETY

780.95

EXCESSIVE CRYING OF CHILD, ADOLESCENT, OR ADULT

780.99

OTHER GENERAL SYMPTOMS

781.0

ABNORMAL INVOLUNTARY MOVEMENTS

781.2

ABNORMALITY OF GAIT

781.3

LACK OF COORDINATION

781.4

TRANSIENT PARALYSIS OF LIMB

781.7

TETANY

782.0

DISTURBANCE OF SKIN SENSATION

784.40 - 784.49

VOICE AND RESONANCE DISORDER, UNSPECIFIED - OTHER VOICE AND RESONANCE DISORDERS

784.51

DYSARTHRIA

784.52

FLUENCY DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE

784.59

OTHER SPEECH DISTURBANCE

794.17

NONSPECIFIC ABNORMAL ELECTROMYOGRAM (EMG)

806.00 - 806.9

CLOSED FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY - OPEN FRACTURE OF UNSPECIFIED VERTEBRA WITH SPINAL CORD INJURY

951.4

INJURY TO FACIAL NERVE

951.8

INJURY TO OTHER SPECIFIED CRANIAL NERVES

952.00 - 952.09

C1-C4 LEVEL SPINAL CORD INJURY UNSPECIFIED - C5-C7 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY

952.10 - 952.19

T1-T6 LEVEL SPINAL CORD INJURY UNSPECIFIED - T7-T12 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY

952.2

LUMBAR SPINAL CORD INJURY WITHOUT SPINAL BONE INJURY

952.3

SACRAL SPINAL CORD INJURY WITHOUT SPINAL BONE INJURY

952.4

CAUDA EQUINA SPINAL CORD INJURY WITHOUT SPINAL BONE INJURY

952.8

MULTIPLE SITES OF SPINAL CORD INJURY WITHOUT SPINAL BONE INJURY

952.9

UNSPECIFIED SITE OF SPINAL CORD INJURY WITHOUT SPINAL BONE INJURY

953.0 - 953.9

INJURY TO CERVICAL NERVE ROOT - INJURY TO UNSPECIFIED SITE OF NERVE ROOTS AND SPINAL PLEXUS

954.0 - 954.9

INJURY TO CERVICAL SYMPATHETIC NERVE EXCLUDING SHOULDER AND PELVIC GIRDLES - INJURY TO UNSPECIFIED NERVE OF TRUNK EXCLUDING SHOULDER AND PELVIC GIRDLES

955.0 - 955.9

INJURY TO AXILLARY NERVE - INJURY TO UNSPECIFIED NERVE OF SHOULDER GIRDLE AND UPPER LIMB

956.0 - 956.9

INJURY TO SCIATIC NERVE - INJURY TO UNSPECIFIED NERVE OF PELVIC GIRDLE AND LOWER LIMB

957.0 - 957.9

INJURY TO SUPERFICIAL NERVES OF HEAD AND NECK - INJURY TO NERVES UNSPECIFIED SITE

ICD-9-CM codes that support medical necessity of procedure code 95905:

354.0

CARPAL TUNNEL SYNDROME

ICD-9-CM codes that support medical necessity of procedure code 95937:

005.1

BOTULISM FOOD POISONING

040.42

WOUND BOTULISM

335.20

AMYOTROPHIC LATERAL SCLEROSIS

335.21

PROGRESSIVE MUSCULAR ATROPHY

335.22

PROGRESSIVE BULBAR PALSY

335.23

PSEUDOBULBAR PALSY

335.24

PRIMARY LATERAL SCLEROSIS

335.29

OTHER MOTOR NEURON DISEASES

335.8

OTHER ANTERIOR HORN CELL DISEASES

335.9

ANTERIOR HORN CELL DISEASE UNSPECIFIED

357.0

ACUTE INFECTIVE POLYNEURITIS

357.82

CRITICAL ILLNESS POLYNEUROPATHY

358.00

MYASTHENIA GRAVIS WITHOUT (ACUTE) EXACERBATION

358.01

MYASTHENIA GRAVIS WITH (ACUTE) EXACERBATION

358.1

MYASTHENIC SYNDROMES IN DISEASES CLASSIFIED ELSEWHERE

358.2

TOXIC MYONEURAL DISORDERS

358.30

LAMBERT-EATON SYNDROME, UNSPECIFIED

358.31

LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE

358.39

LAMBERT-EATON SYNDROME IN OTHER DISEASES CLASSIFIED ELSEWHERE

358.9

MYONEURAL DISORDERS UNSPECIFIED

359.21

MYOTONIC MUSCULAR DYSTROPHY

359.22

MYOTONIA CONGENITAL

359.3

PERIODIC PARALYSIS

359.81

CRITICAL ILLNESS MYOPATHY

368.2

DIPLOPIA

374.30

PTOSIS OF EYELID UNSPECIFIED

784.51

DYSARTHRIA

784.59

OTHER SPEECH DISTURBANCE

787.21

DYSPHAGIA, ORAL PHASE

787.23

DYSPHAGIA, PHARYNGEAL PHASE

787.24

DYSPHAGIA, PHARYNGOESOPHAGEAL PHASE

787.29

OTHER DYSPHAGIA

Diagnoses that Support Medical Necessity

Conditions that are listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity

All those not listed under the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Conditions that are not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Other Information

Refer to LCD L32943 for information on Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters.

Refer to LCD L32239 for more detailed guidelines on Neuromuscular Junction Testing.

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Other Information

Documentation Requirements

All documentation must be maintained in the patient's medical record and available to the contractor upon request.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.

The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.

The medical record documentation must support the medical necessity of the services as directed in this policy

Data gathered during NCS, however, should be available which reflect the actual numbers (latency, amplitude, etc.), preferably in a tabular (not narrative) format. The reason for referral and a clear diagnostic impression are required for each study. In cases where a review becomes necessary, either a hard copy of waveforms or a complete written report with an interpretation of the test must be submitted upon request.

Normal findings and abnormalities uncovered during the study should be documented with the muscles tested, the presence and type of spontaneous activity, as well as the characteristics of the voluntary unit potentials and interpretation.

Appendices

N/A

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

95905 is covered only once per upper extremity limb per patient per year for a diagnosis of carpal tunnel syndrome (354.0).

Excessive use of units of testing (see table immediately below, based on a White Paper prepared by the American Association of Electrodiagnostic Medicine will be considered not medically necessary. Consistent repeated testing on the same patient, or testing every patient referred for pain, weakness or paresthesia may become evident on review. In such cases, the claim will be considered not medically necessary. The NCS-EMG performing provider, in consultation with the referring provider, is responsible for determination of the appropriateness of a study.

Conditions

Limb

Studies

by

Needle

EMG

(95860-95864,

95867-95870)

Nerve

Conduction

Studies

Total

Nerves

Studied

(95907, 95913)

Neuromuscular

Junction

Testing

Repetitive

Stimulation

(95937)

Carpal Tunnel (Unilateral)

1

7

Not Applicable

Carpal Tunnel (Bilateral)

2

10

Not Applicable

Radiculopathy

2

7

Not Applicable

Mononeuropathy

1

8

Not Applicable

Polyneuropathy/Mononeuropathy Mulitplex

3

10

Not Applicable

Myopathy

2

4

2

Motor Neuronopathy (eg, ALS)

4

6

2

Plexopathy

2

12

Not Applicable

Neuromuscular Junction

2

4

3

Tarsal Tunnel Syndrome (Unilateral)

1

8

Not Applicable

Tarsal Tunnel Syndrome (Bilateral)

2

11

Not Applicable

Weakness, Fatigue, Cramps, or Twitching (Focal)

2

7

2

Weakness, Fatigue, Cramps, or Twitching (General)

4

8

2

Pain, Numbness, or Tingling (Unilateral)

1

9

Not Applicable

Pain, Numbness, or Tingling (Bilateral)

2

12

Not Applicable

Testing of the contralateral limb must be supported by medical necessity.

Sources of Information and Basis for Decision

Contractor is not responsible for the continued viability of websites listed.

AANEM Recommended Policy for Electrodiagnostic Medicine. Available at: http://www.aan.com/globals/axon/assets/4061.pdf

AANEM Position Statement, Muscle Nerve 33: 436-439, 2006

AANEM Practice Topics, September, 2006

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ABPTS. 2011 Physical Therapy Specialist Clinical Electrophysiology Certification Examination Application & Information Booklet. 2010. Available at: http//www.apta.org.

American Association of Electrodiagnostic Medicine Position Statement - Recommended Policy for Electrodiagnostic Medicine

American Association of Electrodiagnostic Medicine Position Statement - Technologists Conducting Nerve Conduction Studies and Somatosensory Evoked Potential Studies Independently to be reviewed by a Physician at a Later Time

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CMD Neurophysiology Workgroup Review Model Policy for Electromyography

Consultants in Various Specialties

Department of Health and Human Services Office of the Inspector General Work Plan Fiscal Year 2004. Available at http://oig.hhs.gov/reading/workplan/2004/Work%20Plan% 202004.pdf Accessed September 13, 2005.

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Other Contractor(s)' Policies

Novitas Solutions Contractor Medical Directors

Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Directors. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups that include representatives from Physiatry.

CAC Distribution: 01-22-2009, 01/29/2013

Start Date of Comment Period

01/29/2013

End Date of Comment Period:

03/20/2013

Start Date of Notice Period

N/A

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Revision History

Revision History Number

DL29547

Revision History Explanation

Date Policy # Description

01/29/2013

DL29547

Draft LCD posted for comment.

04/02/2012

L29547

LCD revised to reflect contractor name change from Highmark Medicare Services to Novitas Solutions, Inc.

01/01/2012

L29547

LCD revised to reflect the annual CPT/HCPCS update effective 01/01/2012. The following codes have been added to the Electromyography (EMG) list: 95885, 95886 and 95887.

02/21/2011

L29547

Per Change Request 7135, this LCD is effective for dates of service on and after 02/21/2011 for those providers in the states of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia serviced by Wisconsin Physicians Service (WPS), contractor number 52280, that are being transitioned to Highmark Medicare Services, contractor number 12901, effective 02/21/2011.

11/10/2010

L29547

LCD revised to include limited coverage for 95905 when reported for carpal tunnel syndrome effective for dates of service on and after 06/18/2010.

10/27/2010

L29547

LCD revised effective 10/27/2010. The following changes are per the annual ICD-9-CM code update: ICD-9-CM code 787.6 removed for dates of service on and after 10/01/2010. ICD-9-CM codes 724.03 and 787.60 added for coverage effective for dates of service on and after 10/01/2010. The descriptor for ICD-9-CM code 724.02 was revised for dates of service on and after 10/01/2010. Some of these changes may be in code ranges.

09/08/2010

L29547

LCD revised effective 09/09/2010. The descriptions have changed for the following bill type codes: 11, 12, 13, 83, and 85 with an effective date of 07/01/2010. The descriptions have changed for the following revenue codes: 0920, 0922, and 0929 with an effective date of 07/01/2010. Some or all of these changes may be in code ranges.

01/13/2010

L29547

LCD effective 01/14/2010. The following CPT/HCPCS code changes are effective retroactive to 01/01/2010. Code description changes: 95860 and 95870. New code added: 95905 as non-covered.

10/08/2009

L29547

LCD revised effective 10/09/2009. LCD revised due to ICD-9-CM annual updates. The following ICD-9-CM code change is effective 10/01/2009. Revised code descriptor for 784.49. Also, table in utilization guidelines section revised for clarification.

04/03/2009

L29547

Original LCD posted for notice. LCD to become effective 05/28/2009.

01/22/2009

DL29547

Original LCD posted for comment.

Reason for Change

Creation of uniform LCDs with other MAC Jurisdiction

Related Documents

This LCD has no Related documents.

LCD Attachments

There are no attachments for this LCD.