

# Medicare Medical Policy

## Nerve Conduction Studies

MEDICARE MEDICAL POLICY NUMBER: 131

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**INSTRUCTIONS FOR USE:** Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

**SCOPE:** Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

## PRODUCT AND BENEFIT APPLICATION

Medicare Only

### MEDICARE COVERAGE CRITERIA

**IMPORTANT NOTE:** More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
<ul style="list-style-type: none"> <li>• <i>Non-Automated Nerve Conductions Studies (CPT 95907-95913)</i></li> <li>• <i>Automated Nerve Conduction Studies (CPT 95905)</i></li> </ul>	Local Coverage Determination (LCD): Nerve Conduction Studies and Electromyography ( <a href="#">L36526</a> )
<i>Sensory Nerve Conduction Threshold Testing (sNCT) (HCPCS G0255)</i>	National Coverage Determination (NCD): Sensory Nerve Conduction Threshold Tests (sNCTs) ( <a href="#">160.23</a> )
<i>Quantitative sensory testing (CPT 0106T-0110T)</i>	Company medical policy for <a href="#">Nerve Conduction Studies</a>  I. These services are considered <b>not medically necessary</b> for Medicare based on the Company medical policy. <u>Services deemed “investigational” are considered not medically necessary for Medicare Plan members. See Policy Guidelines below</u>

**IMPORTANT NOTICE:** While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member’s benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

## POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

## POLICY GUIDELINES

### MEDICARE AND MEDICAL NECESSITY

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given medical service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*)

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. (*Medicare Claims Processing Manual, Ch. 23, §30 A*)

## REGULATORY STATUS

### U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

## BILLING GUIDELINES AND CODING

### GENERAL

Please refer to the following local coverage article (LCA) for coding and billing guidelines:

- Billing and Coding: Nerve Conduction Studies and Electromyography ([A54992](#))

The Medicare Administrative Contractor (MAC) - Noridian Healthcare Solutions, LLC. - 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 Providence Health Assurance (PHA), 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 & Rehabilitation physicians.

### **AUTOMATED NERVE CONDUCTION STUDIES**

CPT codes 95907 - 95913 should **not** be used to bill *automated* nerve conduction testing. CPT code 95905 should be used when billing automated nerve conduction studies, such as NC-stat.

Note that CPT code 95905 is payable only once per limb studied **and only** when paired with diagnosis codes G56.00-G56.03. It cannot be used in conjunction with any other nerve conduction codes and it is not allowed to be billed by Physical Therapists. Please see LCA [A54992](#) for more details regarding Medicare Physician Fee Schedule levels of supervision designation for these diagnostic procedures.

### **NON-AUTOMATED NERVE CONDUCTION STUDIES**

Each of the following 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.

CPT codes 95907-95913, 95937, 95860-95872, and 95885-95887 may be billed, if authorized by state law, by Physical Therapists. Please see LCA [A54992](#) for more details regarding Medicare Physician Fee Schedule levels of supervision designation for these diagnostic procedures.

### **SENSORY NERVE CONDUCTION THRESHOLD TESTING (sNCT) (HCPCS G0255)**

The *National Physician Fee Schedule Relative Value File (NPF SRVF)*, which is published by the Centers for Medicare and Medicaid Services (CMS)<sup>1</sup>, indicates HCPCS code G0255 has been assigned a Status Indicator of "N," which is defined as "Non-covered Services." This is a statutorily excluded service based on NCD 160.23.

<b>CODES*</b>		
<b>CPT</b>	0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation
	0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation
	0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia
	0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia
	0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation

	95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report
	95907	Nerve conduction studies; 1-2 studies
	95908	Nerve conduction studies; 3-4 studies
	95909	Nerve conduction studies; 5-6 studies
	95910	Nerve conduction studies; 7-8 studies
	95911	Nerve conduction studies; 9-10 studies
	95912	Nerve conduction studies; 11-12 studies
	95913	Nerve conduction studies; 13 or more studies
	95999	Unlisted neurological or neuromuscular diagnostic procedure
<b>HCPCS</b>	G0255	Current perception threshold/sensory nerve conduction test, (sNCT) per limb, any nerve (CMS-assigned Status "N" code – See "Billing Guidelines")

**\*Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services*)
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

## REFERENCES

1. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

## POLICY REVISION HISTORY

DATE	REVISION SUMMARY
7/2022	Annual review (converted to new format 2/2023)
6/2023	Annual review, no changes