Medicare Medical Policy

Nerve Conduction Studies

MEDICARE MEDICAL POLICY NUMBER: 131

Effective Date: 6/1/2024

Last Review Date: 5/2024

Next Annual Review: 5/2025

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, and Providence Plan Partners 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
• *Non-Automated Nerve Conductions Studies (CPT 95907-95913)* • *Automated Nerve Conduction Studies (CPT 95905)*	Local Coverage Determination (LCD): Nerve Conduction Studies and Electromyography (L36526)
Sensory Nerve Conduction Threshold Testing (sNCT) (HCPCS G0255)	National Coverage Determination (NCD): Sensory Nerve Conduction Threshold Tests (sNCTs) (160.23)
Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below)* • **Medicare Coverage Manuals:** Medicare does not have criteria for quantitative sensory testing (QST) in a coverage manual. • **National Coverage Determination (NCD):** Medicare has a national noncoverage policy on sensory nerve conduction threshold testing (see above). Medicare has **not** addressed coverage for **other** types of QST. • **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, two MACs have active LCDs which address quantitative sensory testing. However, neither of these are the MAC for the J-F service area. • Therefore, in the absence of established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making.	
Quantitative sensory testing (CPT 0106T-0110T)	Company medical policy for Nerve Conduction Studies I. These services are considered **not medically necessary** for Medicare based on the Company medical policy. *See Policy Guidelines below*

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

Quantitative Sensory Testing (QST) (0106T-0110T)

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)*.

National Coverage Policy

In 2002, Medicare announced a national noncoverage policy on sensory nerve conduction threshold (sNCT) testing, concluding that any use of sensory nerve conduction threshold testing to diagnose sensory neuropathies or radiculopathies is not reasonable and necessary. This decision was reaffirmed in 2004 when they received a reconsideration request. Medicare does not address other types of QST in a **national** coverage policy (NCD).

Local Coverage Policy

Two MACs have a local coverage determination (LCD) and article (LCA) which addresses quantitative sensory testing (First Coast Service Options LCD L34859/LCA A57123 and Novitas LCD L35081/LCA A54095), but neither of these MACs are the assigned MAC with jurisdiction over the health plan service area. It is worth noting that the plan's non-coverage position is consistent with the non-coverage position detailed in the above LCDs and LCAs.

The MAC for the health plan service area – Noridian – does not have an *active* LCD or LCA which addresses these services. Historically, the now-retired Noridian LCD for *Non-Covered Services* (L35008) considered all Category III codes to be noncovered, "**unless** specifically approved for payment by CMS or the Noridian Medical Directors and listed as "approved" in the separate local coverage article (LCA) for *Additional Information Required for Coverage and Pricing for Category III CPT® Codes* (A55681).

Category III codes 0106T-0110T used to report quantitative sensory testing have been included in LCD L35008 since at least 2015. They have also been included in the LCA A55681 as "Group 1" non-covered codes since July 2017, as well as the LCA for *Billing and Coding: Non-Covered Services* (A57642) since

2019. This indicates this was a service which Noridian considered non-covered for several years. This is also consistent with the health plan's current non-coverage position.

While the LCD L35008 and LCAs A57642 and A55681 were retired June 2020 to "align with Chapter 13 of the Program Integrity Manual (PIM)," this retirement does not mean these services became medically necessary, it only means the Medicare contractor does not choose to maintain a new LCD/LCA for this service.

Absence of Medicare Coverage Policy

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

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. The Company medical policy criteria for quantitative sensory testing will apply to Medicare Advantage plan members, and is consistent with the Medicare findings detailed above.

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 (NPFSRVF)*, which is published by the Centers for Medicare and Medicaid Services (CMS)[1], 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.

CODES*		
CPT	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
HCPCS	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
6/2024	Annual review, no changes