MEDICAL POLICY	Nerve Conduction Studies (Medicare Only)
Effective Date: 12/1/2021  12/1/2021 Medical Officer Date	Medical Policy Number: 131 Medical Policy Committee Approved Date: 7/18; 8/19; 4/2020; 8/2020; 05/2021; 10/2021

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

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").

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

This policy is based on the following Centers for Medicare & Medicaid Services (CMS) guidance:

Service	Medicare Guidelines
• *Non-Automated Nerve Conductions Studies* • *Automated Nerve Conduction Studies*	Local Coverage Determination (LCD): Nerve Conduction Studies and Electromyography (L36526)
Sensory Nerve Conduction Threshold Testing (sNCT)	National Coverage Determination (NCD): Sensory Nerve Conduction Threshold Tests (sNCTs) (160.23)

In the absence of a Medicare coverage policy or guidance (e.g., manual, national coverage determination [NCD], local coverage determination [LCD] article [LCA], etc.), Medicare guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an objective, evidence-based process, based on authoritative evidence. (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5) Therefore, the commercial medical policy, Nerve Conduction Studies (All Lines of Business Except Medicare**,** *applies to the following services:*

- Quantitative sensory testing

Under Medicare, only medically reasonable and necessary services are covered (Title XVIII of the Social Security Act, §1862(a)(1)(A)). Procedures, devices, or other medical technologies which lack scientific evidence regarding safety and efficacy because they are investigational or experimental are considered ***"not medically reasonable or necessary"*** *to treat illness or injury under Medicare. (Medicare IOM Pub. No. 100-04, Ch. 23, §30 A)*

BILLING GUIDELINES

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

- Billing and Coding: Nerve Conduction Studies and Electromyography (A54992)
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The Medicare Administrative Contractor (MAC), Noridian, 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.

CPT code 95905 is not allowed to be billed by Physical Therapists. Please see LCD (L34594) 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 LCD (L34594) for more details regarding Medicare Physician Fee Schedule levels of supervision designation for these diagnostic procedures.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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
G0255	Current perception threshold/sensory nerve conduction test, (snct) per limb, any nerve
No Prior Authorization Required	
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
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
95999	Unlisted neurological or neuromuscular diagnostic procedure

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical

practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

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.

REFERENCES

None