



A CMS Contracted Agent

National Government Services, Inc.
www.NGSMedicare.com

Medicare

Comments and Responses Regarding Draft Local Coverage Determination: Nerve Conduction Studies (NCS)/Electromyography (EMG)

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Nerve Conduction Studies/Electromyography LCD. The official notice period for the final LCD begins on May 15, 2008, and the final determination will become effective on July 1, 2008.

Comment: An orthopaedic surgeon noted that 3 provisions listed in the draft should not restrict his use of products such as NC-stat for appropriate patients. The 3 provisions are:

1. "Examination using portable hand-held devices, which are incapable of real-time wave-form display and analysis, will be included in the E/M service. They will not be paid separately."
2. "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."
3. "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."

He explained that NC-stat is used by physicians to test and diagnose neuropathies in patients by using four components – disposable biosensors consisting of an array of electrodes including nerve stimulation electrode, active recording electrode, indifferent electrode and skin surface temperature measurement chip; an instrument that displays nerve conduction in real-time on the LCD readout; a docking station to receive and transmit data; and the onCall Information System which can generate the test report. Studies have demonstrated that the results from NC-stat are comparable to those using older devices. He feels that this system meets Medicare requirements because it performs real-time

wave-form analysis and immediately displays amplitude, latency, configuration and conduction velocity.

The commenter agrees that nerve conduction testing should not be used as an adjunct to physical examination routinely on all patients, as this would constitute screening.

He feels that Medicare should not favor one product over another if literature shows that both tests produce similar results. NC-stat is equivalent to other FDA approved equipment.

Response: The LCD does not favor one product over another. This LCD defines what is expected to be documented if the listed CPT codes are submitted for reimbursement. As long as a procedure meets all of the requirements for the listed CPT codes than it is valid to utilize that code.

Comment: A representative from a manufacturer of electrodiagnostic equipment applauds the efforts in the LCD to ensure that nerve conduction studies are done in a medically appropriate manner and that studies are performed only with appropriate nerve conduction equipment. This Draft will ensure that technologies not meeting accepted standards for NCS equipment as well as unqualified mobile service providers or telemedicine service are not covered.

The commenter listed items for which the LCD defines standards for NCS equipment and procedures: NCS equipment must have FDA clearance; must record amplitude, duration and response configuration (motor NCV) and latency and sensory nerve action potential amplitudes (sensory NCV); must be capable of real-time wave form analysis and provide response parameters; must be interpreted by the physician performing or supervising the procedure; and NCS may not be used for screening purposes.

Response: Agreed

Comment: The APTA had several comments on the draft:

The use of the term "physician" to describe the type of practitioner who can perform NCS and EMG should be amended to include qualified certified physical therapists. Electrophysiologic examinations and evaluations as practiced by physical therapists encompass both the professional and technical components of the observation, recording, analysis, and interpretation of bioelectric muscle and nerve potentials, detected by means of surface or needle electrodes, for the purpose of evaluating the integrity of the neuromuscular system.

The commenter included references from the Federal Register and CMS transmittals to demonstrate Medicare's agreement that that physical therapists can perform and bill these services. They recommend that language from Transmittal B-01-28 be added to the LCD.

The term "physician" should be replaced in the LCD to "health care professional" in several sections which they defined in the comments.

Under Limitations, the commenter asked that the sentence, "Sensory nerve testing should be reported using CPT code 95903." be changed and that CPT code 95903 be replaced with CPT code 95904. CPT

code "95903" is for motor studies with F-wave. The correct code for sensory nerve testing should be "95904."

Under "Other Comments", in reference to the paragraph on Advance Beneficiary Notice (ABN), the commenter recommends that the LCD inform the provider/supplier that the ABN should be provided to the beneficiary in instances when the provider/supplier anticipates that the service will be denied based on medical necessity and that the beneficiary may be financially responsible. In addition, resource information should be provided on where to access additional information regarding the ABN and NEMB.

Response: The Contractor agrees with replacing the term "physician" with "qualified health care professional" who is allowed by the scope of practice in his/her state to both perform and interpret the test.

The Contractor agrees that CPT code 95903 will be replaced by 95904 in the Limitations section of the LCD.

Concerning the ABN paragraph in Other Comments, this is standard language in all of National Government Services' LCD's. No change will be made at this time to this LCD but these suggestions will be considered for possible later implementation.

Comment: A physiatrist commented that he is concerned with the number of providers performing substandard electrodiagnostic studies in their offices. Physiatrists, and some neurologists are trained in the design, performance and interpretation of the tests, and become proficient in them. Many tests are performed by other providers and result in incomplete findings. The commenter would like to see standards set on the credentialing of physicians performing the studies.

The commenter submitted a position statement from the American Association of Neuromuscular and Electrodiagnostic Medicine on credentialing for physicians performing these studies. The association takes the position that physicians performing EMG examinations must be specially trained in electrodiagnostic medicine. The tests require detailed knowledge of anatomy and carry a small risk of injury to anatomic structures and of transmitting possibly lethal diseases. Improper interpretation of electrodiagnostic data may be dangerous to the patient.

Full competency in these studies can only be achieved by a year of experience following training.

The commenter also submitted a draft recommendation for electrodiagnostic testing guidelines from the Washington State Department of Labor and Industries. They recommend that EMG be performed only by a formally trained neurologist, physiatrist or physical therapist who are board certified as Clinical Electrophysiologic Certified Specialists from the ABPTS. The guidelines also define the supervision levels required for testing.

Response: At the present time, the Contractor is not able to require specific certification as a prerequisite for performing procedures. The LCD attempts to make it clear that providers must be trained and experienced in this mode of testing for consideration of reimbursement for these procedures.

In accordance with these comments, the second paragraph of the Abstract will be modified to read:

Guidelines about proper qualifications for physicians performing electrodiagnostic evaluations have been developed and published by AAEM (American Association of 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 Specialists in Neurophysiology, and the Department of Veterans Affairs. These guidelines will be considered by NGS when evaluating a health care professional as qualified to perform nerve conduction studies and electromyography.

Comment: A neurophysiologist submitted several comments on the draft:

- Since EMGs are often done for patients with complaints of numbness and tingling, code 782.0 is the only code for these symptoms. The code is included in the draft.
- Under the Utilization Guidelines section of the draft, the commenter feels that the number of nerves allowed for nerve conduction is unreasonable. Typical EMGs for ALS would include motor and sensory studies in at least two extremities and needle exam in at least three motor and three sensory. Most plexopathy recommendations use 5 sensory nerves. The guidelines did not mention requirements for testing the opposite side. For carpal tunnel syndrome, radiculopathy and myopathy, the numbers seem reasonable.
- If two or more methods of testing are used, such as orthodromic and antidromic, only one unit would be paid. The commenter states that this is not what was previously stated. The different methods of testing were listed as separate studies.
- Coding for needle EMG, 95860-95864, requires an evaluation of muscles innervated by three nerves or four spinal levels and a minimum of five muscles must have been studied. CPT code 95870 can be billed once per extremity when fewer than 5 muscles are examined.

Journal references from the American Academy of Neurology were submitted on these subjects:

- Ulnar Neuropathy – general principals for ulnar sensory and motor NCSs
- Recommendations regarding electrodiagnostic studies to confirm a clinical diagnosis of carpal tunnel syndrome
- Recommended protocol for nerve conduction studies.

Response: The utilization guidelines are the recommendation of the American Association of Electrodiagnostic Medicine). The Contractor will consider revising the Utilization Guidelines after review of submitted literature to support the requested change.

The following comments were made at the New Jersey CAC meeting:

Comment:

A CAC member questioned if an E/M service could be billed separately from the testing.

Response: The pre and post work is included in the RVUs for the testing. A history and brief examination would still be necessary. The distinction is made between a referral for the testing and a referral for evaluation of the patient's symptoms. For example, if a patient is referred for testing as a result of a thorough evaluation and the documented need for the test, there would be no E&M required or paid to the provider performing the test. If the patient is referred for evaluation and as a result of the evaluation, testing is required, then the original evaluation is a covered E&M.

A CAC member questioned a limitation that each code can be reimbursed once per nerve regardless of the numbers of sites tested or the number of methods used on that nerve. He believes different branches of the same nerve should each be payable.

Response: Contractor Agrees and named branches of the same nerve will be individually paid.

An observer from the Physical Therapy Association indicated physical therapists could perform the technical component of these tests within the scope within their licensure.

Response: Contractor Agrees

A CAC member stated that multiple uses of an EMG at the same location for the purpose of optimizing botulinum toxin injections should not apply to different limbs.

Response: Contractor agrees

A CAC member indicated that hard copies of wave forms may not always be available.

Response: This is acceptable as long as a detailed report was available in the medical record.

A CAC member suggested that the allowable units of service for polyneuropathy should be changed from 4 to 6 for CPT codes 95900 and 95904.

Response: Contractor is awaiting supporting literature to consider this change.

A CAC member expressed concern that a patient with a normal study who therefore would not then undergo any treatment, would not have the tests covered.

Response: As long as the indication for the test was clearly documented in the chart, including potential therapy planned if the diagnoses were confirmed, this would be sufficient for coverage.

The following comments were made at the New York CAC meeting:

Comments:

The CAC co-chair commented that the code for sphincter EMG is not included in the policy and also commented that the requirements for credentialing were not defined in various states.

Response: Because NGS LCD's pertain to multiple states, it is impractical to list each states requirements in any LCD. The LCD refers to training and experience required and will evaluate each provider according to the restrictions imposed by local legislation.

A physical therapist representative stated that PT association will be submitting comments. Credentialing requirements should be tightened up in the policy, and services should not be done by a technician.

Response: Agreed, LCD changes may be considered after receipt of submitted comments

Regarding the statement from Utilization Guidelines that testing of the contralateral limb must be medically necessary, NY CAC co chair noted that the testing is usually okay, but there are some instances where it is not medically necessary, like laceration, or absence of the contralateral limb.

Response: The LCD does not limit testing of the contralateral limb, it does require documentation of the medical necessity.

Question was asked about services done in nursing homes, where providers may bring their own equipment to the NH, but are only reimbursed for the professional component. This is an issue of consolidated billing. The NH should reimburse the physician for technical services if they bring the equipment.

Response: Providers should not perform services in the NH unless they have an agreement with the NH to be paid for the services.

The following comments were made at the Indiana CAC meeting:

Comments:

A CAC member stated that he thinks that this is a good policy, but would like to add some additional ICD-9-CM codes to the policy. He will submit codes to Dr. Cunningham in writing.

Response: ICD-9-CM codes 215.9 and 225.8 were suggested as additions and have been added to the LCD.

A CAC member stated that physical therapists are doing nerve conduction studies/EMGs in orthopedic practices and asked if they can be paid. Dr. Kincaid stated that this was a grey area. The health

professions bureau requires specific training for nerve conduction studies/EMGs. Kentucky state law allows physical therapists to do testing if they are certified. In Indiana physical therapists can bill for the technical components of some of these tests as specified by the Medicare Physicians Fee Schedule Database. The Medicare Physician Fee Schedule Database has no requirement for "supervision" for the global fee.

Response: This is an example of local legislation which may limit performance of these studies by certain providers.