

Comments:

Nerve Conduction Studies and Electromyography (NEURO-005) (L31346)

Comment:

A request was made that the last paragraph in the billing and coding guidelines about physical therapy be moved to the very beginning of the LCD so that people are more likely to see it.

Response

CMS has directed contractors to have only policy guidelines in the body of the LCD and the billing coding guidelines following the LCD to avoid the issue of Administrative Law Judges (ALJ) s changing national language. However, under "Indications and Limitations of Coverage and/or Medical Necessity" the following information has been added:

Physical therapists who are authorized by State law and possess board certification in Clinical Electrophysiologic Physical Therapy from the ABPTS or who do not possess ABPTS certification, but furnished ED testing prior to May 1, 2001 are qualified healthcare professionals who may perform ED testing without physician supervision."

Comment:

The Billing and Coding Guidelines for draft policy L31346, under Reasons for Denial, section B, number 10, states:

Since the NC-stat® System and similar automated devices cannot support testing of other locations and other nerves as needed depending on the concurrent results of testing until a specific code for this service is established that describes automated testing, this procedure must be billed with procedure code 95999 and "Automated NCS Device".

CPT 2010 has a specific code for this service--95905. Moreover, AANEM recommends using this code for NC-stat. See this link:

<http://www.aanem.org/Practice/Coding-Resources/FAQs/Nerve-Conduction-Studies.aspx>

Should I be using the new 95905 code?

Response:

WPS is aware that the AANEM published the following

"The 2010 CPT® book includes a new code to report nerve conduction testing performed with preconfigured arrays, i.e., NC-stat®. Physicians who provide this service should begin reporting the new code in 2010. Use 95905 to report, "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."

Parenthetical instructions further direct that, by definition, 95905 should be reported once per limb, and that 95905 should not be reported in conjunction with 95900-95904 or 95934-95936. It is AANEM's opinion that CPT code 95905 should be used for the NC-stat® and other similar devices when used with preconfigured electrode arrays."

The LCD now reads:

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 (95900, 95903, or 95904).

Comment:

We do not believe that CPT codes 95873 and 95874 should be included in this LCD.

CPT codes 95873 and 95874 report electrical stimulation and needle electromyography for guidance with chemodenervation. In the 2010 CPT Manual, these are "add-on" codes to be used

in conjunction with CPT codes 64612 – 64614. These codes are not included in the “Electromyography” or “Nerve Conduction Tests” sections of the CPT manual. Because these codes do not represent diagnostic services, but instead are used to report guidance during chemodenervation procedures, we do not believe that the documentation requirements included in the LCD apply to these services.

Therefore, we ask that CPT codes not be included in this LCD.

Response:

95873, “Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)”, and 95874, “Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)”, are no longer included in this LCD.

The following has been added to the LCD: Coverage for CPT/HCPCS add-on codes 95873 and 95874, when EMG is used for directed treatment of botulinum toxin injections, is found in LCD L28555.

Comment:

The first paragraph describes the appropriate training for healthcare professionals who perform electrodiagnostic testing: *“Wisconsin Physicians Service (WPS) expects healthcare professionals who perform electrodiagnostic (ED) testing will be appropriately trained and/or credentialed, either by a formal residency/ fellowship program and certification by a nationally recognized organization, or by an accredited post-graduate training course covering anatomy, neurophysiology and forms of electrodiagnostics (including both NCT and EMG) acceptable to this Carrier, in order to provide the proper testing and assessment of the patient's condition, and appropriate safety measures.”*

In order to ensure that all Primary and Secondary Geographic Jurisdictions understand and apply this LCD correctly, please accept the following edits:

p. 2 *“Wisconsin Physicians Service (WPS) expects healthcare professionals who perform electrodiagnostic (ED) testing will be appropriately trained and/or credentialed, either by a formal residency/fellowship program, ~~and~~ certification by a nationally recognized organization, or by an accredited post-graduate training course covering anatomy, neurophysiology and forms of electrodiagnostics (including both ~~NCT~~ and EMG) acceptable to this Carrier, in order to provide the proper testing and assessment of the patient's condition, and appropriate safety measures.”*

Response:

This has been updated. Thank you.

Comment:

p. 3 *“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.*

Physical therapists who are authorized by State law and possess board certification in Clinical Electrophysiologic Physical Therapy from the ABPTS or who do not possess ABPTS certification, but furnished ED testing prior to May 1, 2001 are qualified healthcare professionals who may perform ED testing without physician supervision.”

Response:

This has been updated. Thank you.

Comment:

Sources of Information and Basis for Decision” on page 18 lacks references regarding physical therapists. Please include the following references:

1. APTA. Electrophysiologic Examination and Evaluation Position Statement. June 1985. HOD P06-96-20-04. Available at: <http://www.apta.org>.
2. ABPTS. *Clinical Electrophysiologic Physical Therapy: Description of Specialty Practice*. Alexandria, VA. 2005.
3. ABPTS. 2011 Physical Therapy Specialist Clinical Electrophysiology Certification Examination Application & Information Booklet. 2010. Available at: <http://www.apta.org>.
4. CMS. IOM 100-2. Medicare Benefit Policy Manual Chapter 15 Section 80 Requirements for Diagnostic Tests. p. 88-91. 2009.

Response:

This has been added to the LCD. Thank you.

Comment:

The document as written supports the use of automated devices for confirmatory testing in cases with a high pre-test probability of CTS. I would refer you to an article published in 2006 by an occupational physician RT Katz. Dr. Katz is one of the few authors on these devices with no financial relationships to these companies and I believe offers the best analysis of these devices. The full article can be found at:

Katz, RT. NC-stat as a screening tool for carpal tunnel syndrome in industrial workers. Journal of Occupational and Environmental Medicine, 2006, April, volume 48(4), pp. 414-418.

This article nicely demonstrates the lack of specificity of these devices and the problems with the proprietary diagnostic algorithms.

Response:

Thank you for your comment and the information.

Comment:

I absolutely agree that NCS and needle EMG should be performed by appropriately trained and qualified healthcare individuals, but at some point this may need to be better defined. I have enclosed the AANEMs position statement on who is qualified to perform and interpret NCS and needle EMG, which we adhere to in our department and our neurophysiology laboratories.

Response:

Thank you this has been added to the LCD under “**I. Coding Guidelines**”

Comment:

The draft LCD reads:

Indications and Limitations of Coverage and/or Medical Necessity”, section A., “In most instances, both NCS and usually EMG are necessary to perform diagnostic testing. While a provider may choose to perform just a NCS, when performed alone it is usually considered 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.”

We would like the policy to also include medical anticoagulation, bleeding disorders, and infection, or risk of infection in certain patient populations, as valid medical contraindications to performing needle EMG. In these patients when neuromuscular disorders are suspected it may be

necessary to perform nerve conduction study alone in order to obtain diagnostic data. Please see the attached file titled "Risks in Electrodiagnostic Medicine" published by the American Association of Neuromuscular and Electrodiagnostic Medicine for further support of our position. At times the patient refuses needle EMG and/or the ordering physician does not want needle EMG. We would like these reasons to be considered valid as well.

Response:

WPS is cognizant of the fact that medical anticoagulation, bleeding disorders, and infection, or risk of infection in certain patient populations can cause problems during needle EMGs. However, it is up to the provider of services, not the Medicare contractor, to evaluate the risk/benefit ratios and decide whether or not to perform this, or other services.

Comment:

"Indications and Limitations of Coverage and/or Medical Necessity", section A., the draft policy states "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." Additionally in section B. under Indications and Limitations of Coverage and or Medical Necessity the policy states that necessity and reasonableness has not been established to support "EMG testing shortly after trauma, before EMG abnormalities would have reasonably had time to develop surface and macro EMG's".

Both NCS and EMG have proven to be useful in acute injury as acknowledged by the AANEM in their Model Policy for Needle Electromyography and Nerve Conduction Studies.

In this document they state, "In combination, NCSs and a needle EMG examination may be most helpful when performed several weeks after the injury has occurred. However, NCSs are often useful acutely after nerve injury, for example, if there is concern that a nerve has been severed. In fact, if studies are delayed, the opportunity to precisely identify the region of injury or to intervene may be lost. In some cases, even needle EMG testing performed immediately after a nerve injury may demonstrate abnormal motor unit action potential (MUAP) recruitment and/or provide baseline information that can be helpful to document preexisting conditions, date the injury, or serve as a baseline for comparison with later studies." We are asking that you change the language of the policy to accommodate these situations.

Response:

It is up to the provider of services, not the Medicare contractor, to evaluate the risk/benefit ratios and decide whether or not to perform this, or other services.

Comment:

Please consider the addition of the following diagnoses to the policy. I have attached articles that show evidence that these conditions are valid indicators of possible neuromuscular disease and should support medical necessity of needle EMG and/or Nerve Conduction Studies.

We are also requesting the addition of the diagnosis Stiff Man Syndrome which is a disorder that is often diagnosed by neurodiagnostic testing.

Stiff-man syndrome

368.2 Diplopia

368.8 Other specified visual disturbance

374.30 Ptosis of Eyelid (PTOSIS EYELID UNSP)

787.20 Dysphagia (DYSPHAGIA UNSP)

781.94 Facial Weakness

<http://www.aanem.org/getmedia/ec7b8fd9-b6ad-4c78-ad2f-ae4bae7b3880/referral-gl.PDF.aspx>

786.05 Shortness of Breath

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1736576/pdf/v067p00539.pdf>

790.5 Abnormal Aldolase (OTH NONSPEC ABNORM SERUM ENZYME LEVEL)

- o <http://jnnp.bmj.com/content/80/8/904.long>

Response:

After a review with the Medical Director, a decision was made not to add the codes. If a provider knows the diagnosis the test would not be necessary and if they do not know the diagnosis the reason the test is necessary rather than a “possible” diagnosis should be used. The provider can always submit a denied claim, with the appropriate documentation, for a redetermination. A request for a redetermination can always be requested with published documentation showing that these are standard reasons to perform the test.