

Local Coverage Determination (LCD): Nerve Conduction Studies and Electromyography (L36524)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
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LCD Information

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Nerve Conduction Studies and Electromyography

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N/A

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CMS National Coverage Policy

Code of Federal Regulations:

42 CFR Section 410.32 indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) who uses the results in the management of the beneficiary's specific medical problem.

Federal Register:

Federal Register Vol. 62, 59047, Supervision of Diagnostic Tests, describes the degree of physician supervision required for diagnostic tests.

CMS Publications:

CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2:160.23

Sensory Nerve Conduction Threshold Tests (sNCTs)

Program Memorandum Carriers Transmittal B-01-28 Change Request 850, describes tests that may be performed by PTs with ABPTS certification

CMS Publication 100-2. *Medicare Benefit Policy Manual*, Chapter 15, Section 80: Requirements for Diagnostic Tests.

Transmittal 2663 Change Request 8169 April Update to the CY 2013 Medicare Physician Fee Schedule Database (MPFSDB)

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

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 this Contractor, 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.

The electrodiagnostic evaluation is an extension of the neurologic portion of the physical examination. Both require a detailed knowledge of a patient and his/her disease. Training in the performance of electrodiagnostic procedures in isolation of knowledge about clinical diagnostic and management aspects of neuromuscular diseases, may not be adequate for proper performance of an electrodiagnostic evaluation and correct interpretation of electrodiagnostic test results. Without awareness of the patterns of abnormality expected in different diseases and knowledge that the results of nerve conduction studies (NCS) and electromyography (EMG) may be similar in different diseases, diagnosis solely by EMG-NCS findings may be both inadequate and ultimately detrimental to the patient.

Guidelines about proper qualifications for qualified health care professionals performing electrodiagnostic evaluations have been developed and published by American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) 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.

Both EMG and NCS are usually required for a clinical diagnosis of peripheral nervous system disorders. Performance of one type of testing does not eliminate the need for the other. The intensity and extent of testing with EMG and NCS are matters of clinical judgment developed after the initial pre-test evaluation, and later modified during the testing procedure.

Decisions to continue, modify or conclude a testing rely on knowledge of anatomy, physiology and neuromuscular diseases. Ongoing real-time assessment of data is required during the clinical diagnostic evaluation and especially during EMG examination.

Nerve conduction studies (NCS) are used to measure action potentials resulting from peripheral nerve stimulation which are recordable over the nerve or from an innervated muscle. With this technique, responses are measured between two sites of stimulation, or between a stimulus and a recording site.

NCS are of two general types: sensory and motor. Either surface or needle electrodes can be used to stimulate the nerve or record the response. Axonal damage or dysfunction generally results in loss of nerve or muscle potential response amplitude; whereas demyelination leads to prolongation of conduction time and slowing of conduction velocity.

Obtaining and interpreting NCS results requires extensive interaction between the performing qualified health care professional and patient, and is most effective when both obtaining raw data and interpretation are performed concurrently on a real-time basis.

Results of the NCS reflect on the integrity and function of:

- (I) the myelin sheath (Schwann cell derived insulation covering an axon), and
- (II) the axon (an extension of neuronal cell body) of a nerve.

Interruption of axon and dysfunction of myelin will both affect NCS results.

It is often also valuable to test conduction status in proximal segments of peripheral nerves. This assessment can be accomplished by H-reflex, F-wave and blink reflex testing. These proximal segments include the first several centimeters of a compound nerve emerging from the spinal cord or brainstem. H-reflex, F-waves and Blink reflex testing accomplish this task better than distal NCS.

Electromyography (EMG) is the study and recording of intrinsic electrical properties of skeletal muscles. This is carried out with a needle electrode. Generally, the needles are of two types: monopolar or concentric. EMG is undertaken together with NCS. Unlike NCS however, EMG testing relies on both auditory and visual feedback to the electromyographer. This testing is also invasive in that it requires needle electrode insertion and adjustment at multiple sites, and at times anatomically critical sites. As in NCS, during EMG studies the electromyographer depends on ongoing real-time interpretation of clinical diagnoses being evaluated to decide whether to continue, modify, or conclude a test. This process requires knowledge of anatomy, physiology, and neuromuscular diseases.

EMG results reflect not only on the integrity of the functioning connection between a nerve and its innervated muscle but also on the integrity of a muscle itself. The axon innervating a muscle is primarily responsible for the muscle's volitional contraction, survival, and trophic functions. Thus, interruption of the axon will alter the EMG. A few prime examples of conditions in which EMG is potentially helpful are disc disease producing spinal nerve dysfunction, advanced nerve compression in peripheral lesions, Amyotrophic Lateral Sclerosis (ALS), polyneuropathy, etc. After an acute neurogenic lesion, EMG changes may not appear for several days to weeks in the innervated muscles. Primary muscle disease such as polymyositis will also alter a normal EMG pattern. Myotonic disorders may show a pattern of spontaneous repetitive discharges on needle exploration.

In summary, axonal and muscle involvement are most sensitively detected by EMG, and myelin and axonal involvement are best detected by NCS.

A. Nerve Conduction Studies

The dichotomy into axonal and demyelinating neuropathies provides a practical means of correlating electrical abnormalities with major pathophysiologic changes in the nerve. Electrical studies can be of help in localization of an abnormality, and in distinguishing one variety of

neuropathy from another: for example, diffuse vs. multifocal; axonal vs. demyelinating. Such distinction has diagnostic value. Specific classification of nerve injuries into neuropraxia and axonotmesis can be made on the basis of conduction studies and electromyography. Such classification has a bearing on prognosis and treatment.

1. Focal neuropathies or compressive lesions such as carpal tunnel syndrome, ulnar neuropathies or root lesions, for localization.
2. Traumatic nerve lesions, for diagnosis and prognosis.
3. Diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic, metabolic or immune.
4. Repetitive nerve stimulation in diagnosis of neuromuscular junction disorders such as myasthenia gravis, myasthenic syndrome.
5. There may be other instances, not detailed here, where NCS may be of use. Not all possible or potential indications are addressed here.

The broad diagnostic scope of NCS is recognizable by the foregoing description. There may be instances where questions about an indication, or need for a study, will arise. The clinical history and examination, carried out before the study, must always describe and document clearly and comprehensibly the need for the planned test. A "rule-out" diagnosis is typically not acceptable. Noridian is cognizant of the fact that patients are not always referred with a definite diagnosis in mind. Often, pain, paresthesia, or weakness in an extremity is the reason for an NCS or EMG. These common symptoms result not only from axonal and myelin dysfunction but also from systemic, non-neurological illnesses. EMG and NCS may help in making this distinction. Therefore, symptom-based diagnoses such as "pain in limb", "weakness", "disturbance in skin sensation" or "paresthesia" are acceptable, provided the clinical assessment unequivocally supports the need for a study. 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.

Both EMG and NCS are required for a clinical diagnosis of peripheral nervous system disorders. EMG results reflect on the integrity of the functioning connection between a nerve and its innervated muscle and also on the integrity of a muscle itself. Performance of one does not eliminate the need for the other. The intensity and extent of testing with EMG and NCS are matters of clinical judgment developed after the initial pre-test evaluation, and later modified during the testing procedure.

Decisions to continue, modify or conclude a test also rely on a knowledge base of anatomy, physiology and neuromuscular diseases. There is a requirement for ongoing real-time clinical diagnostic evaluation, especially during EMG examination. Also, EMG examination is invasive. Needle placement in the exact muscle of interest is essential. It requires needle exploration near vital structures as the pleura, femoral neurovascular bundle, peritoneum, intraspinal spaces, carotid artery, orbit and brachial plexus. Risk of infection from AIDS, Hepatitis B-E, Creutzfeldt-Jakob encephalopathy, and hemorrhage from anticoagulation can be managed by proper techniques.

The electrodiagnostic evaluation is actually an extension of the neurologic portion of the physical examination. Both require a detailed knowledge of a patient and his/her disease. Training in the performance of electrodiagnostic procedures, in isolation without awareness and ability to diagnose and manage neuromuscular diseases, is not always adequate for electrodiagnostic consultation. Recognition and experience in the management of disparate diseases that produce common electrodiagnostic findings may be necessary. For example, EMG-NCS findings may overlap in the following pairs of disorders: inflammatory myopathies and ALS, ALS and multi-level radiculopathies, myotonia of channelopathies (periodic paralyses) and myotonic dystrophies, focal neuropathies such as Carpal Tunnel Syndrome and proximal plexopathies. Other instances where knowledge of disease behavior is crucial are Chronic Inflammatory Demyelinating Neuropathy (CIDP) and Multifocal Motor Neuropathy. These entities display electrodiagnostic features that resemble generalized polyneuropathies. Neuromuscular transmission disorders require

separation based on clinical presentation and electrical features. Treatment will depend on differentiating among them. Without awareness of the disease spectrum, diagnosis solely by EMG-NCS findings may be wrong, detrimental to the patient or both.

The following definitions are from the American Association of Neuromuscular & Electrodiagnostic Medicine Recommended Policy for Electrodiagnostic Medicine.

"The stimulation of nerves is similar across all NCSs; the characteristics of motor, sensory, and mixed NCSs are different and are discussed separately below. In each case, an appropriate nerve is stimulated and recording is made either from the appropriate nerves or from muscle supplied by the motor nerve.

- a. Motor NCSs are performed by applying electrical stimulation at various points along the course of a motor nerve while recording the electrical response from an appropriate muscle. Response parameters include amplitude, latency, configuration, and motor conduction velocity.
- b. Sensory NCSs are performed by applying electrical stimulation near a nerve and recording the response from a distant site along the nerve. Response parameters include amplitude, latency, and configuration.
- c. Mixed NCSs are performed by applying electrical stimulation near a nerve containing both motor and sensory fibers (a mixed nerve) and recording from a different location along that nerve that also contains both motor and sensory nerve fibers. Response parameters include amplitude, latency, configuration, and motor conduction velocity."

Nerve conduction studies performed independent of needle electromyography (EMG) may only provide a portion of the information needed to diagnose muscle, nerve root, and most nerve disorders. When the nerve conduction study (NCS) is used on its' own without integrating needle EMG findings or when an individual relies solely on a review of NCS data, the results can be misleading, and important diagnoses may be missed.

In most instances, both NCS and usually EMG are necessary to perform diagnostic testing. While a provider may choose to perform just an NCS, when performed alone it is usually considered not medically necessary. The only exception to this is a situation when a provider may consider it appropriate to perform an NCS without doing an EMG for the diagnosis of carpal tunnel syndrome with a high pre-test probability.

B. Electromyography

Neurogenic disorders can be distinguishable from myopathic disorders by a carefully performed EMG. For example, both polymyositis and ALS produce manifest weakness. The former carries a very different prognosis and treatment than the latter. An EMG is valuable in making this distinction. Similarly, classification of nerve trauma into axonal vs. demyelinating categories, with corresponding differences in prognoses, are possible with EMG. Below is a list of common disorders where an EMG, in tandem with properly conducted NCS, will be helpful in diagnosis:

1. Nerve compression syndromes, including carpal tunnel syndrome and other focal compressions.
2. Radiculopathy - cervical, lumbosacral.
3. Mono/polyneuropathy - metabolic, degenerative, hereditary.
4. Myopathy - including poly- and dermatomyositis, myotonic and congenital myopathies.
5. Plexopathy - idiopathic, trauma, infiltration.
6. Neuromuscular junction disorders - myasthenia gravis. Single fiber EMG is of special value here.
7. At times, immediately prior to botulinum toxin injection, for localization.
8. At times, immediately prior to injection of phenol or other substances for nerve blocking or chemodenervation.

There may be other instances, not detailed here, where EMG may be of use.

Use of EMG with Botulinum Toxin Injection

EMG may be used to optimize the anatomic location of botulinum toxin injection. It is expected there will be no more than one study performed per anatomic location of injection, if needed. (Please see the separate LCD "Botulinum Toxin Types A and B.")

Limitations:

Routine testing for polyneuropathy of diabetes or end stage renal disease (ESRD) is not considered medically necessary and is not covered. Testing for the sole purpose of monitoring disease intensity or treatment efficacy in these two conditions is also not covered.

Psychophysical measurements (current, vibration, thermal perceptions), even though they may involve delivery of a stimulus, are considered to be part of the physical exam and may not be billed as a separate service.

Current Perception Threshold/Sensory Nerve Conduction Threshold Test (sNCT) – is not covered by Medicare. *This procedure is different and distinct from assessment of nerve conduction velocity, amplitude and latency. It is also different from short-latency somatosensory evoked potentials.*

Examination using portable hand-held devices, or devices which are incapable of real-time wave-form display and analysis, and incapable of both NCS and EMG testing; will be included in the E/M service. They will not be paid separately. Examples include: The Axon II or delta fiber analysis testing and/or machines with other names.

NCS 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 NCS. Raw measurement data obtained and transmitted trans-telephonically or over the Internet, therefore, do not qualify for the payment of the electrodiagnostic service codes included in this LCD.

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.

Electromyography

The necessity and reasonableness of the following uses of EMG studies have not been established:

- exclusive testing of intrinsic foot muscles in the diagnosis of proximal lesions
- definitive diagnostic conclusions based on paraspinal EMG in regions bearing scar of past surgeries (e.g., previous laminectomies)
- pattern-setting limited limb muscle examinations, without paraspinal muscle testing for a diagnosis of radiculopathy
- EMG testing shortly after trauma, before EMG abnormalities would have reasonably had time to develop
- surface and macro EMGs
- multiple uses of EMG in the same patient at the same location of the same limb for the purpose of optimizing botulinum toxin injections.

For outpatient settings other than a Comprehensive Outpatient Rehabilitation Facility (CORF), references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and

physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.) Each practitioner must provide only those services within the scope of practice for each state.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

Documentation Requirements

The patient's medical records must clearly document the medical necessity for the test. It is not necessary to include documentation with each claim submission. Data gathered during NCS, however, should be available which reflect the actual numbers (latency, amplitude, etc.), preferably in a tabular (not narrative) format. The reason for referral and a clear diagnostic impression are required for each study. In cases where a review becomes necessary, either a hard copy of waveforms or a complete written report with an interpretation of the test must be submitted upon request.

Normal findings and abnormalities uncovered during the study should be documented with the muscles tested, the presence and type of spontaneous activity, as well as the characteristics of the voluntary unit potentials and interpretation.

Sources of Information

1. AANEM. Position Statement, Proper performance and interpretation of electrodiagnostic studies. Approved June 2014. Available at aanem.org
2. AANEM. Position Statement, Risks in electrodiagnostic medicine. Approved July 2014. Available at aanem.org
3. AANEM. Recommended Policy for Electrodiagnostic Medicine. Updated on 08/30/2014. Available at aanem.org
4. ABPTS, 2016 Clinical Electrophysiology Specialist Certification Candidate Guide. Available at: abpts.org.
5. Brown E. An Evidence Based Technology Assessment of the NC-stat® Device; August 21, 2008.

6. Morse, J. Office of the Medical Director, Department of Labor and Industries. Washington State Department of Labor and Industries. Technology Assessment: NC-stat System, NeuroMetrix, Inc. June 8, 2006. Available at: <http://www.lni.wa.gov/claimsins/files/omd/tancstat0506.pdf>

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
12/01/2019	R6	<p>The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD.</p> <p>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> Other (The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD.)
12/01/2019	R5	<p>As required by CR 10901, all billing and coding information has been moved to the companion article, this article is linked to the LCD.</p> <p>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> Revisions Due To Code Removal
10/01/2018	R4	<p>02/22/2019 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Added S345XXD to list of covered codes. It was inadvertently left out of the coding but was included in LCD editing.</p>	<ul style="list-style-type: none"> Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2018	R3	<p>10/16/2018 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>The following ICD-10 codes were added: G51.31, G51.32, G51.33, G71.01, G71.02, G71.09, M79.11, M79.12 and M79.18.</p> <p>The following ICD-10 codes were deleted: G51.3, G71.0, M79.1.</p> <p>The following ICD-10 codes had description changes: M50.01, M50.11, M50.21, M50.31, and M50.81</p> <p>Lists and numbering in the Coverage and Indications section were corrected.</p>	<ul style="list-style-type: none"> • Creation of Uniform LCDs With Other MAC Jurisdiction • Revisions Due To ICD-10-CM Code Changes
10/01/2017	R2	<p>DATE (08/20/2017): At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>Effective 10/1/2017, LCD is revised per the annual ICD-10-CM code update to:</p> <p>Add ICD-10-CM codes: E11.10, E11.11, G12.23, G12.24, G12.25, M33.03, M33.13, M33.93, M48.061 and M48.062</p> <p>Revise ICD-10-CM codes: M33.01, M33.02, M33.09, M33.11, M33.12 and M33.19</p> <p>Delete ICD-10-CM codes: M48.06</p>	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
10/01/2016	R1	<p>The following ICD-10 codes are added/deleted effective 10/1/16:</p> <p>Added codes: G56.03, G56.13, G56.23, G56.33, G56.43, G56.83, G56.93, G57.03, G57.13, G57.23, G57.33,</p>	<ul style="list-style-type: none"> • Creation of Uniform LCDs With Other MAC Jurisdiction • Revisions Due To ICD-

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>G57.43, G57.53, G57.63, G57.73, G57.83, G57.93, G61.82, M50.021, M50.022, M50.023, M50.121, M50.122, M50.123, M50.221, M50.222, M50.223, M50.321, M50.322, M50.323, M50.821, M50.822, M50.823.</p> <p>Deleted codes: M50.02, M50.12, M50.22, M50.32, M50.82. Revised description codes: S54.8X1A, S54.8X2A.</p> <p>Combined the CPT code groups and the ICD-10 code groups for clarification.</p> <p>Removed multiple sources from the Sources of Information and Basis for Decisions section to be consistent with National Workgroup LCD.</p>	10-CM Code Changes

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A54969 - Billing and Coding: Nerve Conduction Studies and Electromyography

A54990 - Response to Comments: Nerve Conduction Studies and Electromyography

Related National Coverage Documents

N/A

Public Version(s)

Updated on 01/29/2020 with effective dates 12/01/2019 - N/A

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