

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954

**Contractor Type**

Carrier

**LCD Database ID Number**

Wisconsin	L20812
Illinois	L20814
Michigan	L20816
Minnesota	L20818

**LCD Version Number**

**LCD Title**

Nerve Conduction Studies and Electromyography

**Contractor's Determination Number**

NEURO-005

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**CMS National Coverage Policy**

CMS Transmittal B-01-28 REV 850  
100-03 §160.23

**Primary Geographic Jurisdiction**

Wisconsin, Illinois, Michigan, Minnesota

**Oversight Region**

Region V

**CMS Consortium**

Midwest

**Original Policy Effective Date**

Wisconsin:	09/01/2003
Illinois:	09/01/2003
Michigan:	09/01/2003
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**Revision Effective Date**

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### **Indications and Limitations of Coverage and/or Medical Necessity**

Electrodiagnostic (EDX) testing is used to evaluate the integrity and function of the peripheral nervous system (most cranial nerves, spinal roots, plexi, and nerves), Neuromuscular Junction (NMJ) Disorders, muscles, and the central nervous system (brain and spinal cord).

- A. Nerve conduction studies (NCS) are used to measure action potentials resulting from peripheral nerve stimulation recordable over the nerve or from an innervated muscle. With this technique, nerve conduction velocities are measured between two sites of stimulation, or between a stimulus and a recording site. Nerve conduction studies are typically performed together with electromyography (EMG). Since EMG and NCS go hand-in-hand, the term EMG is often used to encompass NCS. Nerve conduction velocity measurement (NCV) is one aspect of a nerve conduction study.

Results of NCS reflect on the integrity and function of the (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. Nerve conduction studies are of two broad 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 amplitude; whereas, demyelination leads to prolongation of conduction time. The following are a few prime examples where NCS are helpful in diagnosis: carpal tunnel syndrome, ulnar neuropathy at the elbow, metabolic and immune peripheral neuropathies or traumatic nerve damage.

It is often valuable to test conduction status in proximal segments of peripheral nerves. These 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 (CPT 95934, 95936, 95903, 95933) accomplish this task better than distal NCS (CPT 95900, 95904).

Repetitive NCS may be of value in rare, selected situations e.g. defects of neuromuscular transmission where testing is done before and after isometric exercise.

- B. Electromyography (EMG) is the study and recording of intrinsic electrical properties of skeletal muscles. This is carried out with a needle electrode, often - but not always - a disposable one. Generally, the electrodes 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 insertion and adjustment at multiple sites, and at anatomically critical areas. In common with NCV, the electromyographer depends on ongoing real-time clinical diagnostic evaluation for deciding whether to continue, modify or conclude a test. This requires a knowledge base 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 are disc disease, advanced nerve compression, ALS, neuropathy and so on. 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. After an acute neurogenic lesion, EMG changes may not appear for several days to weeks in the innervated muscles. Single fiber testing in defects of neuromuscular transmission may be useful. In summary, axonal and muscle

involvement are most sensitively detected by EMGs and myelin and axonal involvement are best detected by NCSs.

## **Indications and Limitations of Coverage and/or Medical Necessity**

### **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 not always acceptable. The Carrier 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 NCV 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 EMGs and NCSs 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 (Amyotrophic Lateral Sclerosis), ALS and multi-level radiculopathies, myotonia of channelopathies (periodic paralyses) and myotonic dystrophies, focal neuropathies 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 either wrong or detrimental to the patient.

Healthcare professionals who carry out EMG-NCS should be appropriately trained and qualified and when appropriate, supervised

The following definitions are from the American Association of Neuromuscular & Electrodiagnostic Medicine Recommended Policy for Electrodiagnostic Medicine (page 2)  
[http://www.aanem.org/practiceissues/recPolicy/recommended\\_policy\\_3.cfm](http://www.aanem.org/practiceissues/recPolicy/recommended_policy_3.cfm)

"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. Motor NCSs (CPT™ codes 95900 and 95903) 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. Sensory NCSs (CPT™ code 95904) 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, configuration, and sensory conduction velocity.
- c. Mixed NCSs (CPT™ code 95904) 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 both sensory and motor conduction velocity."

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). 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" indicated in Item 19 of the CMS-1500 form. If filing electronically, the description should be included in the comment field.

When the beneficiary has a high pre-test or a priori probability for having the diagnosis of Carpal Tunnel Syndrome, the NC-stat® System (alone) will be allowed, one service per arm, using CPT code 95999. The diagnosis ICD-9 354.0 should be used and the type of nerve conduction machine should be placed in Item 19 of the CMS-1500 form. If filing electronically, the description should be included in the comment field.

When the beneficiary has a high pre-test or a priori probability for having the diagnosis of Carpal Tunnel Syndrome, the NC-stat® System **or similar automated nerve conduction device** (alone, **without any additional nerve conduction studies**) will be allowed, one service per arm, using CPT code 95999. The diagnosis ICD-9 354.0 should be used and the type of nerve conduction machine should be placed in Item 19 of the CMS-1500 form. If filing electronically, the description should be included in the comment field.

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.

Individuals without medical education in neuromuscular disorders and without special training in electrodiagnostic procedures typically are not qualified to interpret the waveforms generated by NCS and needle EMG or to correlate the findings with other clinical information to reach a diagnosis.

**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 to 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.

Healthcare professionals who carry out EMG-NCS should be appropriately trained and qualified and when appropriate, supervised

## **B. Electromyography**

Neurogenic disorders are distinguishable from myopathic disorders by a carefully performed EMG. For example, both polymyositis and ALS (Amyotrophic Lateral Sclerosis) produce manifest weakness. The former carries a very different prognosis and treatment than the latter. An EMG is very 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 especial value here.
7. At times, before Botulinum A toxin injection, for localization.
8. At times, 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. See item 5 under NCS "Indications."

### Coverage Topic

Diagnostic Tests (Other)

### CPT/HCPCS Codes

#### A. Nerve Conduction Studies (NCS)

- |       |  |
|-------|--|
| 95873 | Electrical stimulation for guidance in conjunction with chemodenervation (list separately in addition to code for primary procedure) |
| 95900 | Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study                                      |
| 95903 | Motor, with F-wave study   |
| 95904 | Sensory  |
| 95933 | Orbicularis oculi (blink) reflex, by electrodiagnostic testing   |
| 95934 | H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle  |
| 95936 | Record muscle other than gastrocnemius/soleus muscle   |
| 95937 | Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method                                  |
| 95999 | Unlisted neurological or neurophysiological or neuromuscular diagnostic procedure  |

#### B. Electromyography (EMG)

- |       |   |
|-------|---|
| 95860 | Needle electromyography, one extremity with or without related paraspinal areas   |
| 95861 | Needle electromyography, two extremities with or without related paraspinal areas   |
| 95863 | Needle electromyography, three extremities with or without related paraspinal areas   |
| 95864 | Needle electromyography, four extremities with or without related paraspinal areas  |
| 95865 | Needle Electromyography; larynx   |
| 95866 | Needle electromyography: hemidiaphragm  |
| 95867 | Needle electromyography, cranial nerve supplied muscles, unilateral   |
| 95868 | Needle electromyography, cranial nerve supplied muscles, bilateral  |
| 95869 | Needle electromyography; thoracic paraspinal muscles  |
| 95870 | Limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles or sphincters |
| 95872 | Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied            |
| 95874 | Needle electromyography for guidance in conjunction with chemodenervation (list separately in addition to code for primary procedure)   |
| 51785 | Needle electromyography studies (EMG) of anal or urethral sphincter, any technique  |

92265 Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report

**Does the CPT 30% Rule Apply**

No

**ICD-9 Codes that Support Medical Necessity**

Note: ICD-9 CM codes must be coded to the highest level of specificity.

005.1	Botulism
037	Tetanus
138	Late effects of poliomyelitis
192.2	Malignant neoplasm of spinal cord
192.3	Malignant neoplasm of spinal meninges
*249.60 - 249.61	Secondary diabetes mellitus with neurological manifestations;
250.60	Diabetes with neurological manifestations; type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
250.61	Type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
250.62	Type II [non-insulin dependent type] [NIDDM] [adult-onset type] or unspecified type, uncontrolled
250.63	Type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled
265.1	Other and unspecified manifestations of thiamine deficiency
269.1	Deficiency of other vitamins
272.5	Lipoprotein deficiencies
332.0	Paralysis agitans (Parkinson's Disease)
333.3	Tics of organic origin
333.6	Idiopathic torsion dystonia
333.71	Symptomatic torsion dystonia
333.72	Acute dystonia
333.79	Symptomatic torsion dystonia
333.81	Blepharospasm
333.82	Orofacial dyskinesia
333.83	Spasmodic torticollis
333.84	Organic writers' cramp
333.89	Other torsion dystonia
333.90	Unspecified extrapyramidal disease and abnormal movement disorders
334.1	Hereditary spastic paraplegia
335.0	Werdnig-Hoffmann disease
335.10	Spinal muscular atrophy, unspecified
335.11	Kugelberg-Welander disease
335.19	Other spinal muscular atrophy
335.20 - 335.29	Motor neuron disease
335.8	Other anterior horn cell diseases
335.9	Anterior horn cell disease, unspecified
336.0 - 336.9.	Other diseases of spinal cord
*337.00 - 337.9	Disorders of the autonomic nervous system Includes: disorders of peripheral autonomic, sympathetic, parasympathetic, or vegetative system
340	Multiple sclerosis
341.0 - 341.9	Other demyelinating diseases of central nervous system
342.11 - 342.12	Spastic hemiplegia
343.0 - 343.9	Infantile cerebral palsy
344.00 - 344.9	Other paralytic syndromes

350.2	Atypical face pain
350.9	Trigeminal nerve disorder, unspecified
351.0	Bell's palsy
351.8	Other facial nerve disorders
351.9	Facial nerve disorder, unspecified
352.1	Glossopharyngeal neuralgia
352.2	Other disorders of glossopharyngeal (9 <sup>th</sup> ) nerve
352.3	Disorders of pneumogastric [10th] nerve
352.4	Disorders of accessory [11 <sup>th</sup> ] nerve
352.5	Disorders of hypoglossal [12th] nerve
352.6	Multiple cranial nerve palsies
353.0	Brachial plexus lesions
353.1	Lumbosacral plexus lesions
353.2	Cervical root lesions, not elsewhere classified
353.3	Thoracic root lesions, not elsewhere classified
353.4	Lumbosacral root lesions, not elsewhere classified
353.5	Neuralgic amyotrophy
353.8	Other nerve root and plexus disorders
353.9	Unspecified nerve root and plexus disorder
354.0	Carpal tunnel syndrome
354.1	Other lesion of medial nerve
354.2	Lesion of ulnar nerve
354.3	Lesion of radial nerve
354.5	Causalgia of upper limb
354.5	Mononeuritis multiplex of upper limb
354.8	Other mononeuritis multiplex of upper limb
354.9	Mononeuritis of upper limb, unspecified site
355.0 - 355.9	Mononeuritis of lower limb and unspecified site
356.0 - 356.9	Hereditary and idiopathic peripheral neuropathy
357.0 - 357.89	Inflammatory and toxic neuropathy
358.00 - 358.9	Myoneural disorders
359.0 - 359.9	Muscular dystrophies and other myopathies
374.13	Spastic ectropion
378.00 - 378.9	Esotropia
458.0	Orthostatic hypotension
478.30 - 478.34	Paralysis of vocal cords or larynx
478.75	Laryngeal spasm
478.79	Other diseases of larynx
530.0	Achalasia and cardiospasm
625.6	Stress incontinence, female
710.3	Dermatomyositis
710.4	Polymyositis
710.5	Eosinophilia myalgia syndrome
721.0	Cervical spondylosis without myelopathy
721.1	Cervical spondylosis with myelopathy
721.2	Thoracic spondylosis without myelopathy
721.3	Lumbosacral spondylosis without myelopathy
721.41	Spondylosis with myelopathy, thoracic region
721.42	Spondylosis with myelopathy, lumbar region
722.0 - 722.11	Displacement of cervical, thoracic, or lumbar intervertebral disc without myelopathy

722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.4	Degeneration of cervical intervertebral disc
722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.6	Degeneration of intervertebral disc, site unspecified
722.70 - 722.73	Intervertebral disc disorder with myelopathy
722.80 - 722.83	Postlaminectomy syndrome
722.91 - 722.93	Other specified disc disorder
723.0	Spinal stenosis in cervical region
723.1	Cervicalgia
723.4	Brachial neuritis or radiculitis NOS
723.5	Torticollis, unspecified
723.9	Unspecified musculoskeletal disorders and symptoms referable to neck
724.00 - 724.09	Spinal stenosis, other than cervical
724.1	Pain in thoracic spine
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Backache, unspecified
728.0	Infective myositis
728.85	Spasm of muscle
728.87	Muscle weakness
728.88	Rhabdomyolysis
728.89	Other disorders of muscle, ligament, and fascia
728.9	Unspecified disorder of muscle, ligament, and fascia
729.1	Myalgia and myositis, unspecified
729.2	Neuralgia, neuritis, and radiculitis, unspecified
729.5	Pain in limb
729.89	Other musculoskeletal symptoms referable to limbs
736.05	Wrist drop (acquired)
736.06	Claw hand (acquired)
736.09	Other acquired deformities of forearm, excluding fingers
736.79	Other acquired deformities of ankle and foot
738.4	Acquired spondylolisthesis
754.1	Congenital musculoskeletal deformities of sternocleidomastoid muscle
780.79	Other malaise and fatigue
780.93	Memory loss
780.94	Early satiety
780.95	Other excessive crying
780.99	Other general symptoms
781.0	Abnormal involuntary movements
781.2	Abnormality of gait
781.3	Lack of coordination
781.4	Transient paralysis of limb
781.7	Tetany
782.0	Disturbance of skin sensation
784.40	Voice disturbance, unspecified
784.41	Aphonia
784.49	Other voice disturbance
784.5	Other speech disturbance
787.6	Incontinence of feces

788.21	Incomplete bladder emptying
788.30 - 788.39	Incontinence of urine
952.00 - 952.09	Spinal cord injury without evidence of spinal bone injury-cervical
952.10 - 952.19	Spinal cord injury without evidence of spinal bone injury-dorsal [thoracic]
952.2	Spinal cord injury without spinal bone injury-lumbar
952.3	Spinal cord injury without spinal bone injury-sacral
952.4	Spinal cord injury without spinal bone injury-cauda equina
952.8	Multiple sites of spinal cord injury without spinal bone injury
952.9	Unspecified site of spinal cord injury without spinal bone injury
953.0 - 953.9	Injury to nerve roots and spinal plexus
954.0 - 954.9	Injury to other nerve(s) of trunk, excluding shoulder and pelvic girdles
955.0 - 955.9	Injury to peripheral nerve(s) of shoulder girdle and upper limb
956.0 - 956.9	Injury to peripheral nerve(s) of pelvic girdle and lower limb
957.0 - 957.9	Injury to other and unspecified nerves

### **Diagnoses that Support Medical Necessity**

NA

### **ICD-9 Codes that DO NOT Support Medical Necessity**

All diagnoses not listed in the "ICD-9 Codes that Support Medical Necessity."

### **Diagnoses that DO NOT Support Medical Necessity**

NA

### **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.

If conditions are outside of listed guidelines, paper claims can be submitted accompanied by supportive medical data for review. If processing results in denial, it is appropriate to ask for a review.

### **Utilization Guidelines**

NA

### **Sources of Information and Basis for Decision**

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21. *Practical Electromyography*, second edition, Rehabilitation Medicine Library, Williams & Wilkins, 1982
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40. Electromyography and Nerve Conduction Studies (EMG/NCS)[http://medpolicy.bluecrossca.com/policies/guidelines/MED/EMG\\_NCS.html](http://medpolicy.bluecrossca.com/policies/guidelines/MED/EMG_NCS.html) AND [http://medpolicy.bluecrossca.com/policies/MED/auto\\_nerve\\_conduction.html](http://medpolicy.bluecrossca.com/policies/MED/auto_nerve_conduction.html)
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### Advisory Committee Notes

#### Meeting Date:

Wisconsin: 09/28/2007, 01/14/2005, 05/17/2002  
 Illinois: 09/26/2007, 01/26,2005, 05/22/2002  
 Michigan: 09/05/2007, 01/26/2005, 05/15/2002  
 Minnesota: 09/20/2007, 01/06/2005, 11/20/1997; 05/16/2002

#### Start Date of Comment Period

Wisconsin: 10/01/2007, 01/26/2005, 05/22/2002  
 Illinois: 10/01/2007, 01/26/2005, 05/22/2002  
 Michigan: 10/01/2007, 01/26/2005, 05/22/2002  
 Minnesota: 10/01/2007, 01/26/2005, 05/22/2002

#### End Date of Comment Period

#### Start Date of Notice Period

##### (Published)(Website)

Wisconsin: \*10/01/2008 article; 04/01/0008 article; 09/01/2007, article; 09/01/2006, Article;

- 01/01/2006, article; 9/01/2005; 10/01/2003; 08/01/2003; 06/01/2003; 07/01/2003, Article, 09/01/2002;
- Illinois: \*10/01/2008 article; 04/01/0008 article; 09/01/2007, article; 09/01/2006, Article; 01/01/2006, article; 9/01/2005; 10/01/2003; 08/01/2003; 06/01/2003; 07/01/2003, Article, 09/01/2002;
- Michigan: \*10/01/2008 article; 04/01/0008 article; 09/01/2007, article; 09/01/2006, Article; 01/01/2006, article; 9/01/2005; 10/01/2003; 08/01/2003; 06/01/2003; 07/01/2003, Article, 09/01/2002;
- Minnesota: \*10/01/2008 article; 04/01/0008 article; 09/01/2007, article; 09/01/2006, Article; 01/01/2006, article; 9/01/2005; 10/01/2003; 08/01/2003; 06/01/2003; 07/01/2003, Article, 09/01/2002;

### Revision History

- Wisconsin: \*10/01/2008, seventeen, ICD-9 update added 249.60-249.61 removed 337.0, added 337.00, 337.01, 337.09; 06/01/2008, sixteen, removed words NeuroMetrix, Neuropath and replaced with NC-stat® System; 05/01/2008; fifteen, updated with NC-stat guidelines and AANEM information; 10/01/2007, fourteen, added ICD-9 359-20-359.29 per 2008 update; 10/01/2006, thirteen, ICD-9 CM update 333.71, 333.72, 333.79, 341.20-341.22; 01/01/2006, twelve, HCPCS update; 09/01/2005, eleven, converted to LCD with multiple changes; 10/01/2003, ten, 2004 ICD-9 update (added ICD-9 358.00, 358.01, 728.87, 782.88); 08/01/2003, nine, added IDTF as a valid POS; 07/01/2003, eight, added ICD 780.79; 06/01/2003, seven (Corrected a typographical error); 10/15/2002, six, Replaced NEURO 001; 11/01/2000, five); 12/31/1997, four; 12/01/1996, three, database, code changes; 10/15/1995, two, code correction; 06/15/1995, one, reformat, code corrections.
- Illinois: \*10/01/2008, seventeen, ICD-9 update added 249.60-249.61 removed 337.0, added 337.00, 337.01, 337.09; 06/01/2008, sixteen, removed words NeuroMetrix, Neuropath and replaced with NC-stat® System; 05/01/2008; 04/01/2008; fifteen, updated with NC-stat guidelines and AANEM information; 10/01/2007, eight, added ICD-9 359-20-359.29 per 2008 update; 10/01/2006, seven, ICD-9 CM update 333.71, 333.72, 333.79, 341.20-341.22; 01/01/2006, six, HCPCS update; 09/01/2005, five, converted to LCD with multiple changes; 10/01/2003, four, 2004 ICD-9 update (added ICD-9 358.00, 358.01, 728.87, 782.88); 08/01/2003, three, added IDTF as a valid POS;); 07/01/2003, two, added ICD 9 780.79; 06/01/2003, one, corrected typographical error.
- Michigan: \*10/01/2008 ICD-9 seventeen, update added 249.60-249.61 removed 337.0 added 337.00, 337.01, 337.09; 06/01/2008, sixteen, removed words NeuroMetrix, Neuropath and replaced with NC-stat® System; 05/01/2008; 04/01/2008; fifteen, updated with NC-stat guidelines and AANEM information; 10/01/2007, eight, added ICD-9 359-20-359.29 per 2008 update; 10/01/2006, seven, ICD-9 CM update 333.71, 333.72, 333.79, 341.20-341.22; 01/01/2006, six, HCPCS update; 09/01/2005, five, converted to LCD with multiple changes; 10/01/2003, four, 2004 ICD-9 update (added ICD-9 358.00, 358.01, 728.87, 782.88); 08/01/2003, three, added IDTF as a valid POS;); 07/01/2003, two, added ICD 9 780.79; 06/01/2003, one, corrected typographical error.
- Minnesota: \*10/01/2008, seventeen ICD-9 update added 249.60-249.61 removed 337.0 added 337.00, 337.01, 337.09; 06/01/2008, sixteen, removed words NeuroMetrix, Neuropath and replaced with NC-stat® System; 05/01/2008; 04/01/2008; fifteen, updated with NC-stat guidelines and AANEM information; 10/01/2007, ten, added ICD-9 359-20-359.29 per 2008 update; 10/01/2006, nine, ICD-9 CM update 333.71, 333.72, 333.79, 341.20-341.22; 01/01/2006, eight, HCPCS update; 09/01/2005,

seven, converted to LCD with multiple changes; 10/01/03, six, 2004 ICD-9 update (added ICD-9 358.00, 358.01, 728.87, 782.88); 08/01/2003, five, added IDTF as a valid POS); 07/01/2003, four, added ICD 9 780.79; 10/15/2002, two, replaced 98-03A; 06/01/2003, three, Corrected a typographical error; 11/01/1998, one (PN 162);

**Last Reviewed On**

\*10/01/2008

**Notes**

**[See companion article Coding and Billing Guidelines for NEURO-005 Nerve Conduction Studies and Electromyography](#)**

\*This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from Neurological Medicine and Rehabilitation, Carrier Advisory Committee members, and other Medicare medical directors, and outside consultants.

\* - An asterisk indicates a revision to that section of the policy.

This policy replaces the following:

Minnesota - 98-03A

Wisconsin - NEURO 001

**Does this LCD contain a "Least Costly Alternative" Provision?**

No