NEUROMetrix®

Nerve Conduction Studies (NCS) Performed with Preconfigured Electrodes

Reimbursement and Coding Information

NeuroMetrix provides customers with general reimbursement guidance for procedures performed with our products. This information is not intended to increase or maximize reimbursement by any third party payer but to assist providers in accurately obtaining coverage and reimbursement for healthcare goods and services. It is always the responsibility of the provider to determine appropriate coding, charges and reimbursement. Please contact your local carrier/payer for their specific coverage, coding and payment policies. NeuroMetrix makes no guarantee that the use of this information will result in coverage/payment for the services provided.

Nerve Conduction Studies

Coding

For nerve conduction studies performed with preconfigured (nerve specific) electrodes:

CPT Code

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

- Do not report 95905 in conjunction with 95907-95913.

Units

For 95905, report 1 unit for **each lim**b studied.

Modifiers

- Modifier 50 (Bilateral Procedure) is not appropriate, even if NCS are performed on contralateral nerves.
- CPT code 95905 is considered "Modifier 51 exempt"; this modifier (Multiple procedures) should not be reported with this code.
- If a physician only performs the diagnostic interpretation of a NCS, append modifier 26 (Professional component) to the corresponding CPT code.

ICD-9-CM Diagnosis Codes

Diagnosis codes are used by physicians and hospitals to report the documented clinical indication for diagnostic studies. Use of the following ICD-9-CM Official Guidelines for Coding and Reporting when assigning ICD-9-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA):

- List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider.
- For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.
- Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Medicare and third-party payers often use ICD-9-CM codes to verify medical necessity for the procedures / services being billed. Some payer's coverage policies include a list of diagnosis codes to indicate what clinical circumstances justify medical necessity of an individual diagnostic test. Payers can create their own rules when it comes to allowing certain diagnostic studies with certain diagnoses so it is best to check with your local Medicare contractor/third-party payer regarding potential medical necessity diagnosis limitations.

Proper ICD-9-CM code assignment must be based solely on documentation, not on the arbitrary assignment of a diagnosis code that will be reimbursed by the insurance company. Code the ICD-9-CM code to the highest degree of accuracy and completeness based on the results of the test, or use the documented patient signs/symptoms that prompted the physician to perform the diagnostic study.

Frequently Asked Questions

Q. What is the appropriate CPT code to bill when performing NCS with preconfigured electrodes?

A. CPT 95905 should be used for billing when utilizing preconfigured electrodes. Please check with your payers for specific coverage and coding guidelines.

Q. If multiple nerves are tested with preconfigured electrode arrays on a single limb, e.g. the right median nerve and right ulnar nerve, how many units of 95905 should be billed?

A. Coding for NCS performed with preconfigured electrode arrays is based on each limb studied rather than the quantity of nerves. CPT 95905 should be billed once per limb.

Q. How many limbs can be billed with 95905?

A. For most indications, no more than 2 limbs are medically necessary. If testing more than 2 limbs, contact the payer for any utilization limitations and coverage polices.

Q. How many units of each 95905 should be billed?

A. One (1) unit of 95905 should be billed for **each limb** tested.

Q. Should multiple units of 95905 be billed together or split?

A. For most payers, multiple units of 95905 should be billed as a single line item rather than splitting the units across multiple lines. It is best to check with payer for any coding guidelines.

Q. Can the provider bill for an office visit the same day as the NCS study is performed?

A. An office visit should only be billed when the patient's condition requires a separately identifiable and significant Evaluation and Management (E/M) service above and beyond the brief history and physical exam associated with the nerve conduction studies. The medical necessity for the office visit should be substantiated by the physician's documentation. The E/M service may be prompted by the symptom or condition for which the diagnostic study was performed and as such, different diagnosis (ICD-9-CM codes) are not required for reporting of the E/M services on the same date. Some payers may require use of modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service) reported with the appropriate level of E/M service to clearly indicate the additional physician work.

Q. Why would Medicare deny a claim for Medical Necessity?

A. Many Medicare contractors have Local Coverage Determination (LCD) policies that include medical necessity limitations based on the patient's diagnosis. Check to ensure that the ICD-9-CM code indicating the patient's diagnosis and/or sign/symptoms is included on your specific Medicare contractor's LCD. Additionally, confirm that the ICD-9-CM code representing the primary reason for the diagnostic study was correctly linked to the corresponding CPT code.

Q. Why would a third-party payer deny a claim submitted for an NCS?

A. Payer policies and procedures vary by provider agreement and patient health plans and often contain exceptions and exemptions. As with any procedure or service, NeuroMetrix encourages providers to validate their reimbursement with their payers.

Q. What are the requirements/restrictions regarding frequency of testing for NCS?

A. Medicare contractor and third-party payer coverage policy restrictions on testing frequency vary. Please contact your local contractor/payer for their specific rules.

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