Benefit Criteria to Change for Evoked Response Tests and Neuromuscular Procedures for the CSHCN Services Program

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Effective for dates of service on or after April 1, 2013, benefit criteria for evoked response tests and neuromuscular procedures will change for the Children with Special Health Care Needs (CSHCN) Services Program.

Note: *For the purposes of this article, "advanced practice registered nurse (APRN)" includes nurse practitioner (NP) and clinical nurse specialist (CNS) providers only.*

Benefit Changes for Evoked Response Tests and Neuromuscular Procedures

The medical component (type of service [TOS] 1) of electromyography (EMG) procedure codes 95873 and 95874 will no longer be a benefit of the CSHCN Services Program.

Procedure codes 95873 and 95874 will no longer be a benefit when rendered in the office, home, or inpatient hospital setting by psychologist providers.

EMG (procedure code 95870) may be reimbursed in multiple quantities of up to four services per day, if specific muscles are documented.

Nerve conduction study (procedure code 95905) may be reimbursed one limb per day, per procedure, by the same provider without prior authorization.

Evoked potential test (procedure code 95930) will no longer be diagnosis restricted.

The following procedure codes may be reimbursed to the specific providers and place of service indicated:

Procedure Codes	TOS	Place of Service	Provider Types
51784, 51785	2, T	Office	Radiological and physiological laboratory
51784, 51785	2	Outpatient Hospital	Hospital
95930, 95933	5	Office	Radiological and physiological laboratory
95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95875, 95937	I, T	Office	Physician
95921, 95922, 95923, 95925, 95926, 95927, 95928, 95929	I	Office	Physician

Procedure Codes	TOS	Place of Service	Provider Types
95921, 95922, 95923, 95925, 95926, 95927, 95929, 95937	T	Office	APRN
95928	T	Office	APRN, radiological and physiological laboratory
95928, 95929, 95930, 95933	5	Outpatient Hospital	Hospital
95930, 95933, 95999	T	Office	APRN, physician, optometrist
95905	T	Office	APRN, physician
95999	I	Office	Physician, optometrist
95928	5	Office	Physician, radiological and physiological laboratory
95929	5, T	Office	Physician, radiological and physiological laboratory
95999	I	Inpatient hospital, Outpatient hospital	Optometrist
95999	5	Office	Optometrist, radiological and physiological laboratory
51784, 51785, 92585, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95875, 95905, 95921, 95922, 95923, 95925, 95926, 95927, 95928, 95929, 95930, 95933, 95937, 95999	T	Office, Outpatient Hospital	Radiation treatment center
2= Surgical component, 5= Total component, I= Professional component, T= Technical component			

The following procedure codes *will no longer be reimbursed* to the provider types in the place of service indicated:

Procedure Codes	Type of Service	Place of Service	Provider Types No Longer Reimbursed
51784, 51785	2	Inpatient hospital	Hospital
51784, 51785	T	Outpatient hospital	Hospital
95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, 95875, 95937	5	Office	Independent laboratory, hospital, nephrologist, renal dialysis facility

Procedure Codes	Type of Service	Place of Service	Provider Types No Longer Reimbursed
95860, 95861, 95863, 95864, 95866, 95867, 95868, 95869, 95872, 95875, 95937	5	Outpatient Hospital	Physician, independent laboratory, nephrologist, renal dialysis facility, radiological and physiological laboratory
95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95875, 95937, 95928, 95929	I	Inpatient hospital, outpatient hospital	Radiological and physiological laboratory
95870	5	Office	Independent laboratory, podiatrist, radiation treatment center, hospital, nephrologist, renal dialysis facility
95870	5	Outpatient hospital	Physician, independent laboratory, podiatrist, radiation treatment center, nephrologist, renal dialysis facility, radiological and physiological laboratory
95865, 95866	5	Office	Independent laboratory, radiation treatment center, nephrologist, renal dialysis facility
95865	5	Outpatient hospital	Physician, independent laboratory, radiological and physiological laboratory
95922, 95923, 95925, 95926, 95927	5	Outpatient hospital	Radiological and physiological laboratory
95933	5	Outpatient hospital	Physician, optometrist
95930	T	Office	Federally qualified health center (FQHC)
95905	5	Office	APRN
92585	5	Office	APRN, rehabilitation center
95930	T	Outpatient hospital	Physician, optometrist
95928, 95929	5	Outpatient hospital	Physician
51784, 51785	2	Outpatient hospital	Physician
95999	5	Outpatient hospital	Rehabilitation center
2= Surgical component, 5= Total component, I= Professional component, T= Technical component			

The following procedure codes *will no longer be reimbursed* when rendered in the place of service indicated by any provider:

Procedure Codes	Type of Service	Place of Service
95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95875, 95937	5	Inpatient hospital, independent laboratory
95860, 95861, 95863, 95864, 95867, 95868, 95869, 95870, 95872, 95875, 95933, 95937	T	Independent laboratory
95865, 95866	T	Inpatient hospital, independent laboratory
92586,95922, 95923, 95925, 95926, 95927, 95928, 95930, 95933, 95999	5	Inpatient hospital
95929	5	Inpatient hospital
51784, 51785	2	Inpatient hospital
2= Surgical component, 5= Total component , T= Technical component		

Electromyography

EMG (procedure codes 95873 and 95874) will be a benefit of the CSHCN Services Program and will be limited to four occurrences per calendar year, by the same provider, any procedure.

Procedure codes 95873 and 95874 may be reimbursed in the following place of service by the following provider types:

Component	Places of Service	Provider Types
Total	Office	Physician, radiological and physiological laboratory providers
	Outpatient hospital	Hospital providers
Professional	Office, inpatient hospital, and outpatient hospital	Physician providers
Technical	Office	Physician, radiation treatment center, and radiological and physiological laboratory providers
	Outpatient hospital	Radiological and physiological laboratory providers

Procedure codes 95873 and 95874 must be billed in conjunction with one of the following procedure codes or the service will be denied:

Procedure codes			
95860	95863	95864	95865
95866	95867	95868	95869
95870	95872	95875	95900
95903	95904	95905	

Motion Analysis Studies

Motion analysis (procedure codes 96000, 96001, 96002, and 96003) will be a benefit of the CSHCN Services Program for clients who are 3 through 20 years of age.

Procedure codes 96000, 96001, 96002, and 96003 may be reimbursed to physician, radiological laboratory, and physiological laboratory providers in the office setting and hospital providers in the outpatient setting.

Procedure codes 96000, 96001, 96002, and 96003 will be limited to one per date of service by the same provider and two per year, any provider.

Motion analysis studies will be considered for reimbursement through the CSHCN Services Program with prior authorization for clients who are 3 through 20 years of age and have a diagnosis of, but not limited to, cerebral palsy.

Prior Authorization

Prior authorization is not required for autonomic function tests (AFTs), EMG services, or evoked potential tests. Prior authorization is required for motion analysis and unlisted neurological services.

Prior Authorization for Motion Analysis Studies

Prior authorization requests for motion analysis studies must include documentation with the following information that indicates the client meets all the requirements for motion analysis studies:

- Diagnosis of cerebral palsy
- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices
- Minimum client age of 3 years
- Physically able to tolerate up to three hours of testing
- Clear documentation that indicates the study is performed as part of a preoperative or postoperative assessment based on the surgical plan of the client

Prior authorization requests for a diagnosis other than cerebral palsy or for more than two motion analysis studies per year must be referred for medical review by the CSHCN Services Program Assistant Medical Director or designee for consideration.

Prior Authorization for Unlisted Procedure Code 95999

Prior authorization is required for unlisted neurological procedure code 95999; the following information is required to determine coverage:

- The client’s diagnosis
- A clear description of the neurological procedure that will be performed
- Documentation that indicates medical necessity of the neurological procedure
- Place of service where the neurological procedure is to be performed

- The physician’s intended fee for the neurological procedure being requested or a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code that is comparable to the procedure.

Providers must complete the form "CSHCN Services Program Authorization and Prior Authorization Request Form and Instructions" for prior authorization requests.

Autonomic Function Tests

AFTs are a benefit of the CSHCN Services Program when submitted with procedure codes 95921, 95922, 95923, 95924, and 95943.

Procedure codes 95921, 95922, 95923, 95924, and 95943 are limited to once per date of service, by the same provider.

AFTs analyze changes in response to parasympathetic and sympathetic system stimulation to check for imbalances in the part of the body that controls many autonomic processes. Autonomic disorders may be congenital or acquired (primary or secondary).

Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Irregular heart rate
- Orthostatic symptoms
- Gastrointestinal dysfunction
- Excessive sweating
- Diabetic autonomic neuropathy
- Amyloid neuropathy
- Sjogren’s syndrome
- Idiopathic neuropathy
- Pure autonomic failure
- Multiple system atrophy
- Distal small fiber neuropathy
- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)

Evoked Potential Procedures

Evoked potential (EP) procedures are a benefit of the CSHCN Services Program. The most common EP procedures are:

- Brainstem auditory evoked potentials (BAEPs)
- Somatosensory evoked potentials (SEPs)
- Motor evoked responses (MEPs)
- Visual evoked potentials (VEPs)

Each EP test (procedure codes 92585, 92586, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and will be limited to once

per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

Brainstem Auditory Evoked Potentials

Providers must use procedure code 92585 or 92586 when submitting claims for BAEPs.

Motor Evoked Potentials

Providers must use procedure code 95928 or 95929 when submitting claims for MEPs.

Somatosensory Evoked Potentials

Providers must use procedure code 95925, 95926, 95927, or 95938 when submitting claims for SEPs.

Intraoperative Neurophysiology Testing

Intraoperative neurophysiology testing (procedure codes 95940 and 95941) are a benefit when performed in addition to each evoked potential test on the same day.

The documentation for the intraoperative neurophysiology testing must include the time for which each test is performed.

Procedure code 95940 and 95941 are limited to a maximum of two hours per date of service, per client.

Procedure code 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

Procedure codes			
92585	95822	95860	95861
95867	95868	95870	95907
95908	95909	95910	95911
95912	95913	95925	95926
95927	95928	95929	95930
95933	95934	95936	95937

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

Nerve Conduction Studies (NCS)

Providers may use the following procedure codes when submitting claims for NCS:

Procedure codes			
95885	95886	95887	95905

95907	95908	95909	95910
95911	95912	95913	95933
95937			

Each NCS procedure may be reimbursed up to four services per calendar year, same provider.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.

Procedure codes 95885, 95886, and 95887 must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.

For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.