Medicine: Neurology and Neuromuscular

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This section contains information to assist providers in billing for medicine procedures related to neurology and neuromuscular services.

Polysomnography

‹‹Polysomnography is a comprehensive diagnostic sleep test that is performed attended in a sleep lab facility.

PSG test includes, but is not limited to, electroencephalogram, electrooculogram, electromyogram, electrocardiogram, nasal/oral airflow, oximetry, body position and respiratory effort (abdominal and chest).

Medi-Cal covers polysomnography when the patient has a history of severe sleep disturbances unexplained by physical evidence.

Polysomnography performed as an outpatient service does not require authorization. Cases justifying hospitalization require authorization.››

Sleep Study and Polysomnography: Physician and Outpatient Services

The following CPT® codes must be used when billing for sleep study and polysomnography for all patients, including those at risk for possible Sudden Infant Death Syndrome (SIDS), regardless of age.

Place of Service Codes

The asterisked (*) codes should be used by physician and physician group providers who have established sleep study capabilities in their offices. On the *CMS-1500* claim form, Place of Service is restricted to office, outpatient hospital, state or local public health clinic and rural health clinic. On the *UB-04* claim form, Place of Service is restricted to clinic – other, hospital – outpatient, hospital – other, clinic – rural health and clinic – free-standing.

Place of Service Codes

CPT Code	Description
95782 *	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist (supplement of code 95808)
95783 *	‹‹Polysomnography;›› younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist (supplement of code 95808)
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95807 *	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist

Place of Service Codes (continued)

CPT Code	Description
95808 *	Polysomnography; any age, sleep staging with 1 thru 3 additional parameters of sleep, attended by a technologist
95810 *	‹‹Polysomnography;›› age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 *	‹‹Polysomnography;›› age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy of bi-level ventilation, attended by a technologist

Note: The physician procedure codes for polysomnography cannot be billed with CPT code 99070 for coverage of supplies because these supplies are already included in the preceding facility codes.

Non-Reimbursable Components

The following codes are not reimbursable when billed with CPT code 94772 (pediatric pneumogram), 95808, 95810 and 95811 by any provider, for the same recipient and date of service.

Non-Reimbursable Codes

CPT Code	Description
82805, 82810	Blood gases with oxygen saturation
94760	Oximetry for oxygen saturation
92265, 95860 thru 95872	Electromyogram
92270	Electro-oculogram
93224 thru 93227	Electrocardiographic monitoring
94010 thru 94618	Pulmonary function tests
95816 thru 95826	Electroencephalogram

For a comprehensive and updated list of non-reimbursable components, providers should refer to the CPT and HCPCS code books, and the National Correct Coding Initiative (NCCI) when billing.

‹‹Home Sleep Apnea test (HSAT)

A home sleep apnea test (HSAT) is an unattended diagnostic study which assesses obstructive sleep apnea (OSA) without the determination of sleep stage.

HSAT must be performed in conjunction with a comprehensive sleep evaluation in patients and is only approved when patients have a high pretest probability of moderate to severe obstructive sleep apnea.

If a single home sleep apnea test is negative, inconclusive, or technically inadequate, polysomnography be performed for the diagnosis of OSA.

HSAT is approved when using Type II, Type III, Type IV sleep testing devices measuring at least three channels one of which is airflow.

HSAT is only approved for the following:

- Diagnosis of suspected OSA in uncomplicated adults at increased risk of moderate to severe OSA.
- To evaluate efficacy of an oral appliance or upper airway surgery for OSA
- To reassess a patient with OSA after weight loss or weight gain.

To guide titration of CPAP/BiPAP therapy in patients with an established diagnosis of OSA.››

‹‹HSAT is not approved for the following:

- For children under 18 years of age.
- Adult patients with the following comorbidities: congestive heart failure, hypo-ventilation syndromes, moderate to severe pulmonary disease, or neuromuscular disease.
- Adult patients for diagnosis of Co-morbid sleep disorders (for example central sleep apnea, hypersomnia disorders, insomnia, parasomnias, circadian rhythm sleep disorders, other sleep apneas, narcolepsy, cataplexy or periodic limb movements etc.).

Home Sleep Apnea Test Codes

CPT/HCPCS Code	Description
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

Frequency

Reimbursement for HSAT is limited to one per year. Reimbursement for HSAT beyond 1 per year requires a TAR for medical necessity››

Evoked Response Testing

Medi-Cal covers visual, auditory and other evoked response testing as indicated in this section.

Billing for Services

When billing for evoked response testing, physicians must use the appropriate CPT codes. These codes, with the exception of 92558, and 92650 thru 92653 require split-billing modifiers. (For audiologist billing, refer to the appropriate Part 2 *Allied Health* provider manual.)

CPT Codes Billable for Evoked Response Testing

Testing Type	CPT Codes
Auditory	92558
Central motor	95928, 95929, 95939
Somatosensory	95925 thru 95927, 95938
Visual	95930
Neuromuscular junction	95937

Reimbursement for CPT code 92558 requires a written report documenting the deficits identified in comparison with the standard tests and describing changes from prior assessments.

Reimbursement for CPT codes 92558, 95925 through 95929 and 95937 through 95939 is restricted to four times per year for the same recipient by any provider. If billed more than four times per year, medical justification must be entered in the *Remarks* field (Box 80)/*Additional Claim Information field* (Box 19) of the claim or on an attachment to the claim.

Note: For information about reimbursement for somatosensory testing during corrective spinal surgery, see “Scoliosis Surgery and Somatosensory Tests” in the *Surgery* section of the appropriate Part 2 provider manual.

Neurological Monitoring

Neurological monitoring services (CPT codes 95955, 95958, 95992 and 95999) require documentation.

Documentation must indicate the procedure performed and the actual time spent monitoring the service. This required information may be entered in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim or on an attachment.

Electromyography (EMG)

Any combination of CPT codes 95860 through 95875 and 95885 through 95887 may be reimbursed a maximum of four times per year for the same recipient by any provider. If billed more than four times per year, medical justification must be entered in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or submitted as an attachment. These services are reimbursable only to providers who have a diploma or certificate of completion of an accredited neurology or physical medicine and rehabilitation residency program.

These procedures are split-billed. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC.

Note: Do not bill modifier 99 on claims for electromyography.

CPT codes 95885 (needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited), 95886 (needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels) and 95887 (needle electromyography, non-extremity [cranial nerve supplied or axial] muscle[s] done with nerve conduction, amplitude and latency/velocity study) are reimbursable only when billed with one of the ICD-10-CM codes listed under “Nerve Conduction” on a following page.

Nerve Conduction

The CPT codes below are reimbursable only when billed with any one of the following ICD-10-CM diagnosis codes:

Reimbursable CPT Codes When Billed With ICD-10-CM Diagnosis Codes (below)

CPT Codes	Description
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
95907	Nerve conduction studies; 1-2 studies
95908	Nerve conduction studies; 3-4 studies
95909	Nerve conduction studies; 5-6 studies
95910	Nerve conduction studies; 7-8 studies
95911	Nerve conduction studies; 9-10 studies
95912	Nerve conduction studies; 11-12 studies
95913	Nerve conduction studies; 13 or more studies

ICD-10-CM Diagnosis Codes

B02.21 G13.0, G13.2,
G51.0 thru G51.9, G52.8,
G54.0 thru G54.1,
G57.00 thru G59,
G60.0 thru G65.2,
M48.062
M50.10 thru M50.13,
M54.11 thru M54.17,
M62.50 thru M62.59,
M62.9,
M63.80 thru M63.89,
R20.0 thru R20.9,
S04.50XA thru S04.52XA [1]
S04.70XA thru S04.72XA [1],
S44.00XA thru S44.92XA [1],
S54.00XA thru S54.92XA [1],
S64.00XA thru S64.92XA [1],
S74.00XA thru S74.92XA [1],
S84.00XA thru S84.92XA [1],
S94.00XA thru S94.92XA [1]

Note: Providers must include the total number of nerves tested on the same claim line.

CPT codes 95905, 95907 through 95913 may be reimbursed a maximum of four times per year for the same recipient by any provider. However, reimbursement for CPT code 95905 continues to be restricted to twice a year, same provider, when billed with ICD-10-CM diagnosis code G56.00 through G56.03 (carpal tunnel syndrome). If billed more than four times per year, medical justification must be entered in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or submitted as an attachment.

CPT codes 95907 through 95913, 95924, 95940 and 95941 can only be billed by Neurologist, Physical Medicine and Rehab Specialists.

Billing for Code 95905

This code is split-billed and may be billed with modifier 26 and TC. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. When billing for both the professional and technical service components, a modifier is neither required nor allowed. Modifier U7 is allowed.

Note: Do not bill modifier 99 with modifiers 26 and TC. The claim will be denied.

Electromyography and Nerve Conduction Test Certification

Electromyography (EMG) and nerve conduction tests are reimbursable only to providers who have a diploma or a certificate of completion of a neurology or physical medicine and rehabilitation residency program accredited by the Accreditation Council of Graduate Medical Education (ACGME). Billing providers who are actually delivering the service or a group or other entity billing for the rendering provider's service are required to include on an attachment to the claim the following exact language:

Billing provider:

"I, (enter name), certify that I performed the nerve conduction test(s) and/or electromyography presently billed and that I possess a valid certificate or diploma of my satisfactory completion of neurology or physical medicine and rehabilitation residency program accredited by the Accreditation Council of Graduate Medical Education (ACGME)."

Group or other entity:

"I, (enter name), am an entity billing for the performance of the indicated nerve conduction test(s) and/or electromyography and certify that, for the professional noted as having completed the test(s), (enter name) possesses a copy of a valid certificate or diploma of satisfactory completion of neurology or physical medicine and rehabilitation residency program accredited by the Accreditation Council of Graduate Medical Education (ACGME)."

The rendering provider must sign the self-certification attachment. The claim will be denied if either the self-certification or the signature is not present.

Central Nervous System Assessments and Tests

For policy, billing instructions and additional information, providers should refer to the *Psychological Services* and *Psychological Services: Billing Codes and Reimbursement Rates* sections in the *Allied Health – Psychological Services* provider manual.

Therapeutic Interventions

CPT codes 97129 (therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct patient contact; initial 15 minutes) and 97130 (each additional 15 minutes) cannot be billed in conjunction with CPT codes 97151 through 97155 (behavior assessment or treatment).

Health Behavior Assessments and Interventions

Health behavior assessments and interventions (CPT codes 96156 through 96159 and 96164 through 96171) cannot be billed in conjunction with codes 90785 through 90899, 99401 through 99412 or 97151 through 97158 for the same provider on the same date of service.

Magnetoencephalography (MEG)

Magnetoencephalography (MEG) is a non-invasive technique that records magnetic fields emitted by neurons. A *Treatment Authorization Request* (TAR) indicating the procedure is for pre-operative brain mapping or epilepsy surgery is required for reimbursement. Allowable modifiers are TC, 26, U7 and/or 99.

Providers may be reimbursed for the following CPT codes:

Table of CPT Codes for MEG

CPT Code	Description
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization)

ICD-10-CM Diagnosis Codes

MEG CPT codes are reimbursable when billed in conjunction with the following ICD-10-CM diagnosis codes:

- G40.0 thru G40.919
- G40.A19
- R90.0 thru R94.7

Magnetic Source Imaging (MSI)

Magnetic Source Imaging (MSI) is a non-invasive technique that combines magnetoencephalography (MEG) and Magnetic Resonance Imaging (MRI) images. A *Treatment Authorization Request* (TAR) indicating the procedure is for pre-operative brain mapping or epilepsy surgery is required for reimbursement. Allowable modifiers are TC, 26, U7 and/or 99.

ICD-10 Diagnosis Codes

MEG CPT codes are reimbursable when billed in conjunction with the following ICD-10-CM diagnosis:

- G40.0 thru G40.919
- G40.A19
- R90.0 thru R94.7

‹‹Phrenic Nerve Stimulator System

The phrenic nerve stimulator is a device that provides electrical stimulation of the recipient's phrenic nerve to contract the diaphragm rhythmically and produce breathing in patients who have hypoventilation (condition of abnormally low amount of air entering the lungs).The device has been used successfully to treat hypoventilation caused by a variety of conditions, including respiratory paralysis resulting from lesions of the brain stem and cervical spinal cord and chronic pulmonary disease with ventilatory insufficiency. The goal of phrenic pacing is to provide adequate ventilatory support, maximum mobility and quality of life. The pacer system consists of an implanted generator, electrodes, leads and an external antenna and transmitter. The recipient must have an intact phrenic nerve and diaphragm for an implanted phrenic nerve stimulator to be effective.

Providers may be reimbursed for the following CPT codes:

Table of CPT Codes for Phrenic Nerve Stimulator System

CPT Code	Description
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography
93153	Interrogation without programming of implanted phrenic nerve stimulator system››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Asterisked codes should be used by physician and physician group providers who have established sleep study capabilities in their offices. On the *CMS-1500* claim form, Place of Service is restricted to office, outpatient hospital, state or local public health clinic and rural health clinic. On the UB-04 claim form, Place of Service is restricted to clinic – other, hospital – outpatient, hospital – other, clinic – rural health and clinic – free-standing
[1]	Only ICD-10-CM diagnosis codes with an extension (seventh character) of “A” (initial encounter) are covered benefits. Diagnosis codes with an extension (seventh character) of “D” (subsequent encounter) or “S” (sequela) are not covered benefits, and claims with these diagnosis codes will be denied.