

Clinical Policy: Evoked Potential Testing

Reference Number: WNC.CP.229

Last Review Date: 05/24

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description

Types of evoked potentials include somatosensory, brainstem auditory, visual and motor. Sensory evoked potentials evaluate electrical activity in the nervous system in response to stimulation of specific nerve pathways. Monitoring of neurophysiologic evoked potentials intraoperatively helps prevent neurologic injury during neurological, orthopedic, and other types of surgeries. This policy describes the medically necessary indications for neurophysiologic evoked potentials.

Policy/Criteria

- I. It is the policy of WellCare of North Carolina® that evoked potential testing is **medically necessary** for the following indications:
 - A. **Somatosensory Evoked Potentials Testing**
 1. Aid in the evaluation of prognosis of acute anoxic encephalopathy, within the initial 72 hours of onset (e.g., after cardiac arrest);
 2. Assessment of a decline in status which may warrant emergent surgery in unconscious spinal cord injury patients who show specific structural damage to the somatosensory system, and who are candidates for emergency spinal cord surgery;
 3. Aid in the diagnosis of multiple sclerosis;
 4. Aid in the assessment of coma following traumatic, hypoxic-ischemic, and other diffuse brain injuries;
 5. Assessment of central nervous system deficiency identified on clinical exam when not explained by appropriate imaging studies;
 6. Management of conditions causing spinocerebral degeneration, such as Friedreich's ataxia or peripheral nerve degeneration (e.g., diabetic neuropathy);
 7. Intraoperative monitoring during surgeries that may affect neural structures.
 - B. **Brainstem Auditory Evoked Potential Testing**
 1. Assessment of brainstem function such as during tumor infiltration of the brainstem and after a lesion has been surgically removed;
 2. Diagnosis and monitoring of demyelinating and degenerative diseases affecting the brain stem such as multiple sclerosis, central pontine myelinolysis, and olivopontocerebellar degeneration;
 3. Diagnosis of lesions in the auditory system (e.g., acoustic neuroma);
 4. Aid in the evaluation of prognosis in coma within the initial 72 hours of onset, excluding evaluation of brain death;

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5. Screening for hearing loss of infants and preverbal children or children with developmental delay or intellectual disability;
6. Intraoperative monitoring during surgeries that may affect neural structures.

C. Visual Evoked Potential Testing

1. Diagnosis and monitoring of optic nerve function and/or during demyelinating disorders of the optic nerve (e.g., multiple sclerosis, optic neuritis);
2. To localize the cause of a visual field defect not explained by lesions seen on Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI) metabolic disorders, or infectious diseases;
3. Assessment of suspected disorder of the optic nerve, optic chiasm or pre-optic chiasmatic radiations (visual evoked potentials are not useful for post-chiasmatic disease);
OR;
4. Evaluation of visual loss in those unable to communicate.

II. It is the policy of WellCare of North Carolina® that somatosensory evoked potentials, motor evoked potentials using transcranial electrical stimulation, and brainstem auditory evoked potentials are **medically necessary** during intracranial, orthopedic, spinal, and vascular surgeries.

III. It is the policy of WellCare of North Carolina® that there is insufficient evidence in the published peer-reviewed literature to support evoked potential testing for the following indications:

- A. Intraoperative monitoring of visual evoked potentials;
- B. Motor evoked potentials from transcranial magnetic stimulation.

IV. It is the policy of WellCare of North Carolina that evoked potential testing is **not medically necessary** for the following indications:

- A. Motor evoked potentials for non-operative monitoring;
- B. Visual evoked potentials, **any** of the following:
 1. Glaucoma or glaucoma suspect
 2. Amblyopia
 3. Diabetes
- C. For the evaluation/assessment of all other conditions than those specified above.

Background

Sensory evoked potentials provide electrical recordings of afferent and efferent networks within the central and peripheral nervous systems in response to specific stimulation. These sophisticated tests facilitate the diagnosis nerve damage, or locate the specific site of nerve damage. There are several types of evoked potentials including sensory evoked potentials and motor evoked potentials. Examples of sensory evoked potentials include somatosensory,

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brainstem auditory, and visual evoked potentials. Somatosensory evoked potentials generate sensory information from peripheral nerve stimulation.¹ Brainstem auditory evoked potentials are created in response to aural cues and are evaluated at the brainstem and posterior fossa.²

Visual evoked potentials provide information regarding conduction within the visual pathway, including the retino-striate conduction time.¹ Motor evoked potentials are elicited by electrical or magnetic stimulation of the motor cortex or spinal cord.

Intraoperative monitoring of neurophysiologic responses involves the electrophysiologic measurement of myogenic and neural responses during the course of surgeries. These measurements and testing are in response to controlled and modality specific stimulation. According to the American Speech Language Hearing Association’s Position Statement on Intraoperative Monitoring, the primary objectives of intraoperative monitoring include: (1) to avoid intraoperative injury to neural structures; (2) to facilitate specific stages of the surgical procedure; (3) to reduce the risk of permanent postoperative neurological injury; and (4) to assist the surgeon in identifying specific neural structures.¹

The American Academy of Neurology published an assessment of intraoperative neurophysiologic monitoring with an evidence based guideline update in 2012.³ This guideline specifically addressed whether spinal cord intraoperative monitoring with somatosensory and motor evoked potentials predict adverse surgical outcomes. All studies that met inclusion criteria were consistent in showing all of the occurrences of paraparesis, paraplegia, and quadriplegia in the intraoperative monitoring of patients with evoked potential changes, and showed no occurrences of paraparesis, paraplegia, and quadriplegia in patients without evoked potential changes.³ Thus, intraoperative neurophysiologic monitoring provides operating teams with information regarding increased risk of severe adverse neurologic outcomes. Furthermore, the American Society Clinical Neurophysiology has published specific guidelines on an array of specifications, including the amplifier, safety, filtering, calibration, replication, and interpretation of results.⁴

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT®* Codes | Description |
|----------------|--|
| 92652 | Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report |
| 92653 | Auditory evoked potentials; neurodiagnostic, with interpretation and report |

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| CPT®* Codes | Description |
|------------------------|--|
| 95925 | Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs |
| 95926 | Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs |
| 95927 | Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head |
| 95928 | Central motor evoked potential study (transcranial motor stimulation); upper limbs |
| 95929 | Central motor evoked potential study (transcranial motor stimulation); lower limbs |
| 95930 | Visual evoked potential (VEP) testing central nervous system, checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report. (BILLABLE AS 1 UNIT PER TEST) |
| 95938 | Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs |
| 95939 | Central motor evoked potential study (transcranial motor stimulation), in upper and lower limbs |
| 0333T | Visual evoked potential, screening of visual acuity, automated |

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

| ICD-10-CM Code | Description |
|-----------------------|---|
| A17.0-A17.89 | Tuberculosis of nervous system |
| A39.82 | Meningococcal retrobulbar neuritis |
| C30.1 | Malignant neoplasm of middle ear |
| C41.0 | Malignant neoplasm of bones of skull and face |
| C41.2 | Malignant neoplasm of vertebral column |
| C70.0-C70.9 | Malignant neoplasm of meninges |
| C71.0-C71.9 | Malignant neoplasm of brain |
| C72.0-C72.9 | Malignant neoplasm of spinal cord, cranial nerves and other parts of the central nervous system |
| C79.31-C79.32 | Secondary malignant neoplasm of brain and cerebral meninges |
| C79.49 | Secondary malignant neoplasm of other parts of nervous system |
| D02.3 | Carcinoma in situ of other parts of respiratory system |
| D14.0 | Benign neoplasm of middle ear, nasal cavity and accessory sinus |
| D16.6 | Benign neoplasm of vertebral column |

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| ICD-10-CM Code | Description |
|-----------------------|---|
| D18.02 | Hemangioma of intracranial structures |
| D32.0-D32.9 | Benign neoplasm of meninges |
| D33.0-D33.9 | Benign neoplasm of brain and other parts of central nervous system |
| D38.5 | Neoplasm of uncertain behavior of other respiratory organs |
| D42.0-D42.9 | Neoplasm of uncertain behavior of meninges |
| D43.0-D43.9 | Neoplasm of uncertain behavior of brain and central nervous system |
| D44.3 | Neoplasm of uncertain behavior of pituitary gland |
| D44.4 | Neoplasm of uncertain behavior of craniopharyngeal duct |
| D44.5 | Neoplasm of uncertain behavior of pineal gland |
| D49.1 | Neoplasm of unspecified behavior of respiratory system |
| D49.6 | Neoplasm of unspecified behavior of brain |
| E08.40 | Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified |
| E08.41 | Diabetes mellitus due to underlying condition with diabetic mononeuropathy |
| E08.42 | Diabetes mellitus due to underlying condition with diabetic polyneuropathy |
| E08.43 | Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy |
| E08.44 | Diabetes mellitus due to underlying condition with diabetic amyotrophy |
| E08.49 | Diabetes mellitus due to underlying condition with other diabetic neurological complication |
| E71.520 | Childhood cerebral X-linked adrenoleukodystrophy |
| E71.521 | Adolescent X-linked adrenoleukodystrophy |
| E71.522 | Adrenomyeloneuropathy |
| E71.528 | Other X-linked adrenoleukodystrophy |
| E71.529 | X-linked adrenoleukodystrophy, unspecified type |
| G06.0-G06.2 | Intracranial and intraspinal abscess and granuloma |
| G11.10 | Early-onset cerebellar ataxia, unspecified |
| G11.11 | Friedreich ataxia |
| G11.19 | Other early-onset cerebellar ataxia |
| G23.0 | Hallervorden-Spatz disease |
| G23.1 | Progressive supranuclear ophthalmoplegia (Steele-RichardsonOlszewski) |
| G23.2 | Striatonigral degeneration |
| G23.8 | Other specified degenerative diseases of basal ganglia |
| G31.89 | Other specified degenerative diseases of nervous system |
| G31.9 | Degenerative disease of nervous system, unspecified |

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| ICD-10-CM Code | Description |
|-----------------------|--|
| G35 | Multiple sclerosis |
| G36.0-G36.9 | Other acute disseminated demyelination |
| G37.0-G37.9 | Other demyelinating diseases of central nervous system |
| G50.0-G50.9 | Disorders of trigeminal nerve |
| G52.0-G52.9 | Disorders of other cranial nerves |
| G54.0 | Brachial plexus disorders |
| G54.1 | Lumbosacral plexus disorders |
| G54.2 | Cervical root disorders, not elsewhere classified |
| G54.3 | Thoracic root disorders, not elsewhere classified |
| G54.4 | Lumbosacral root disorders, not elsewhere classified |
| G90.3 | Multi-system degeneration of the autonomic nervous system |
| G90.8 | Other disorders of autonomic nervous system |
| G90.9 | Disorder of the autonomic nervous system, unspecified |
| G93.0 | Cerebral cysts |
| G93.1 | Anoxic brain damage, not elsewhere classified |
| G93.5 | Compression of the brain |
| G95.9 | Disease of spinal cord, unspecified |
| G96.89 | Other specified disorders of central nervous system |
| H35.54 | Dystrophies primarily involving the retinal pigment epithelium |
| H46.0-H46.9 | Optic neuritis |
| H47.011-H47.649 | Other disorders of optic (2nd) nerve and visual pathways |
| H53.001 – H53.9 | Visual disturbances |
| H54.3 | Unqualified visual loss, both eyes |
| H54.60-H54.62 | Unqualified visual loss, one eye |
| H81.01 – H81.09 | Meniere’s disease |
| H81.391 – H81.399 | Other peripheral vertigo |
| H81.4 | Vertigo of central origin |
| H90.0-H90.72 | Conductive and sensorineural hearing loss |
| H91.01-H91.93 | Other and unspecified hearing loss |
| H93.3X1 – H93.3X9 | Disorders of acoustic nerve |
| I60.00-I60.8 | Nontraumatic subarachnoid hemorrhage |
| I61.0-I61.8 | Nontraumatic intracerebral hemorrhage |
| I62.00-I62.1 | Other and unspecified nontraumatic intracranial hemorrhage |
| I63.00-I63.9 | Cerebral infarction |
| I65.01-I65.9 | Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction |
| I66.01-I66.9 | Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction |
| I67.0-I67.7 | Other cerebral vascular diseases |

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| ICD-10-CM Code | Description |
|---|--|
| I71.00-I71.9 | Aortic aneurysm and dissection |
| I72.0 | Aneurysm of carotid artery |
| I77.71 | Dissection of carotid artery |
| I77.74 | Dissection of vertebral artery |
| M40.00-M40.57 | Kyphosis and lordosis |
| M41.00- M41.9 | Scoliosis |
| M43.00-M43.09 | Spondylolysis |
| M43.10-M43.19 | Spondylolisthesis |
| M47.011-M47.9 | Spondylosis |
| M48.00-M48.08 | Spinal stenosis |
| M50.00-M50.93 | Cervical disc disorders |
| M51.04-M51.9 | Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders |
| P10.0-P10.9 | Intracranial laceration and hemorrhage due to birth injury |
| P11.0-P11.9 | Other birth injuries to central nervous system |
| P14.0-P14.9 | Birth injury to peripheral nervous system |
| Q01.0-Q01.9 | Encephalocele |
| Q04.0-Q04.9 | Other congenital malformations of brain |
| Q05.0-Q05.9 | Spina bifida |
| Q07.00-Q07.03 | Arnold –Chiari syndrome |
| Q28.0-Q28.9 | Other congenital malformations of circulatory systems |
| Q76.2 | Congenital spondylolisthesis |
| Q85.00-Q85.09 | Phakomatoses, not elsewhere classified |
| R40.20-R40.2444 | Coma |
| R44.1 | Visual hallucinations |
| R48.3 | Visual agnosia |
| R94.110 – R94.138 | Abnormal results of function studies of peripheral nervous system and special senses |
| S02.0XX- S02.42X (add 7 th digit A-S) | Fracture of skull and facial bones |
| S04.011-S04.9XX (add 7 th digit A-S) | Injury of optic nerve and pathways |
| S06.0X0-S06.899 (add 7 th digit A-S) | Intracranial injury |
| S07.0XX -S07.9XX (add 7 th digit A-S) | Crushing injury of head |
| S12.000 -S12.9XX (add 7 th digit A-S) | Fracture of cervical vertebrae and other parts of the neck |
| S14.0XX- S14.9XX (add 7 th digit A-S) | Injury of nerves and spinal cord at neck level |

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| ICD-10-CM Code | Description |
|---|--|
| S22.000 -S22.089 (add 7th digit A-S) | Fracture of thoracic vertebrae |
| S24.101-S24.9XX (add 7th digit A-S) | Other and unspecified injuries of thoracic spinal cord |
| S34.01X -S34.9XX (add 7th digit A-S) | Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level |
| Z01.110 | Encounter for hearing examination following failed hearing screening |
| Z08 | Encounter for follow-up examination after completed treatment for malignant neoplasm |
| Z82.0 | Family history of epilepsy and other diseases of the nervous system |
| Z87.710 - Z87.798 | Personal history of (corrected) congenital malformations |

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|--|----------------------|----------------------|
| Original approval date | 04/21 | 05/21 |
| Reviewed CPT and ICD-10-CM codes. Added CPTs 92652 and 92653. Added diagnosis code Z82.0. Updated references. | 08/21 | 11/21 |
| Annual review. “Experimental/investigational” verbiage replaced with descriptive language in policy statement III. References reviewed, updated, and reformatted. Coding reviewed and updated. Removed intraoperative CPT codes 95940, 95941. Removed HCPCS code G0453. Added ICD-10 codes H53.40 H53.421-H53.429 H53.431-H53.439 H53.451-H53.459 H53.47 | 08/22 | 08/22 |
| NCHC verbiage removed from NC Guidance Verbiage. | 04/23 | 04/23 |
| Annual Review. Deleted Criteria I.C.4. and deleted ICD-10-CODES H53.40, H53.421-H53.429, H53.431-H53.439, H53.451-H53.459, H53.47 codes regarding visual field defect | 05/23 | 05/23 |
| Criteria I.C.1. changed “To diagnose and monitor multiple sclerosis (acute or chronic phases) or other disease states by identifying conditions of the optic nerve, i.e., optic neuritis,” to “Diagnosis and monitoring of optic nerve function and/or during demyelinating disorders of the optic nerve (e.g., multiple sclerosis, optic neuritis)” Criteria I.C.2. added “Assessment of suspected disorder of the optic nerve, optic chiasm or pre-optic chiasmatic radiations (visual evoked potentials are not useful for post-chiasmatic disease); Criteria I.C.3. changed “To evaluate signs and symptoms of visual loss in beneficiaries who are unable to communicate clearly,” to “Evaluation of visual loss in those unable to communicate.” | 11/23 | 11/23 |
| Annual Review | 05/24 | 05/24 |

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1A-28 Visual Evoked Potential. [Program Specific Clinical Coverage Policies | NC Medicaid \(ncdhhs.gov\)](#). Published October 15, 2023. Accessed March 11, 2024.
2. Walsh P, Kane N, Butler S. The clinical role of evoked potentials. *J Neurol Neurosurg Psychiatry*. 2005;76 Suppl 2(Suppl 2):ii16 to ii22. doi:10.1136/jnnp.2005.068130
3. American Speech-Language-Hearing Association. Neurophysiologic intraoperative monitoring [Position Statement]. <https://www.asha.org/policy/ps1992-00036/>. Published 1992. Accessed August 16, 2023.
4. Nuwer MR, Emerson RG, Galloway G, et al. Evidence-based guideline update: intraoperative spinal monitoring with somatosensory and transcranial electrical motor evoked potentials: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the American Clinical Neurophysiology Society. *Neurology*. 2012;78(8):585 to 589. doi:10.1212/WNL.0b013e318247fa0e
5. American Clinical Neurophysiology Society. Guideline 9A: Guidelines on evoked potentials. *J Clin Neurophysiol*. 2006;23(2):125 to 137. doi:10.1097/00004691-200604000-00010
6. Legatt AD, Emerson RG, Epstein CM, et al. ACNS Guideline: Transcranial Electrical Stimulation Motor Evoked Potential Monitoring. *J Clin Neurophysiol*. 2016;33(1):42 to 50. doi:10.1097/WNP.0000000000000253
7. Holdefer RN, MacDonald DB, Skinner SA. Somatosensory and motor evoked potentials as biomarkers for post-operative neurological status. *Clin Neurophysiol*. 2015;126(5):857 to 865. doi:10.1016/j.clinph.2014.11.009
8. Local coverage determination: Neurophysiology Evoked Potentials (NEPs) (L34975). Centers for Medicare and Medicaid Services Web site. <http://www.cms.hhs.gov/mcd/search.asp>. Published October 1, 2015 (revised October 17, 2019.) Accessed August 21, 2023.

North Carolina Guidance

Eligibility Requirements

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
- b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or

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procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;

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- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- a. Claim Type - as applicable to the service provided:
 - Professional (CMS-1500/837P transaction)
 - Institutional (UB-04/837I transaction)Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

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- d. Modifiers - Providers shall follow applicable modifier guidelines.
- e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- f. Co-payments -
For Medicaid refer to Medicaid State Plan:
<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>
- g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to

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recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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