



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Subject Nerve Conduction Velocity Studies Including Late Response (H-reflex and F-wave)

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INSTRUCTIONS FOR USE

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Coverage Policy

CIGNA covers nerve conduction velocity (NCV) testing as medically necessary when they are conducted and interpreted at the same time as needle electromyography (NEMG) studies, to confirm the diagnosis of ANY of the following conditions:

- myopathy, including but not limited to ANY of the following:
 - polymyositis
 - dermatomyositis
 - myotonic myopathy
 - congenital myopathy
- disorder of brachial or lumbosacral plexus
- plexopathy (e.g., idiopathic, trauma, infiltration)
- focal neuropathy, entrapment neuropathy, compressive lesion/syndrome, including but not limited to ANY of the following:
 - carpal tunnel
 - cubital tunnel syndrome
 - tarsal tunnel syndrome
 - peroneal nerve compression
 - thoracic outlet syndrome
- diagnosis or confirmation of a generalized neuropathy, including but not limited to ANY of the following:

- metabolic and nutritional [diabetic, uremic, amyloidosis, hypothyroidism, immune, vitamin B₁₂ or thiamine deficiency])
- toxic neuropathy (e.g., vincristine, amiodarone)
- hereditary polyneuropathy (e.g., Charcot-Marie Tooth disease)
- infectious neuropathy (e.g., HIV, Lyme disease, Leprosy)
- demyelinating neuropathy (e.g., Guillain-Barre syndrome)
- idiopathic peripheral neuropathy
- repetitive stimulation in the diagnosis of a neuromuscular junction disorder (e.g., myasthenia gravis, myasthenic syndrome, botulism)
- neurotrauma (e.g., traumatic nerve lesion)
- symptom-based presentation suggesting nerve root, peripheral nerve, muscle, or neuromuscular junction involvement, when pre-test evaluations are inconclusive and clinical assessment supports the need for the study, such as for ANY of the following:
 - muscle weakness
 - muscle atrophy
 - muscle fasciculation
 - myokymia
 - myotonia
 - loss of dexterity
 - spasticity
 - hyperreflexia
 - sensory deficits
 - diplopia
 - ptosis
 - swallowing dysfunction
 - dysarthria
 - impaired bowel motility
- motor neuron disease (e.g., amyotrophic lateral sclerosis)
- spine disorder and BOTH of the following:
 - appropriate imaging studies (e.g., CT scan, MRI, myelogram) confirm nerve root impingement
 - any one of the following:
 - to differentiate radiculopathy from other neuropathies or non-neuropathic processes
 - to establish whether imaging findings are responsible for reported pain
 - to reconcile when pattern of pain, sensory impairment, or weakness does not match imaging findings
 - to document degree of axonal nerve damage in an individual with weakness

CIGNA covers nerve conduction velocity (NCV) testing when performed alone for ANY of the above indications, as medically necessary in ANY of the following situations:

- as a follow-up study of a neuromuscular structure that has undergone previous electrodiagnostic evaluation
- current use of an anticoagulant
- presence of lymphedema
- carpal tunnel syndrome

CIGNA does not cover nerve conduction velocity testing when performed with NEMG testing for ANY of the following because it is considered not medically necessary:

- screening of the general population, in the absence of related symptoms
- screening, monitoring of disease intensity or monitoring of treatment efficacy for polyneuropathy of diabetes
- screening, monitoring of disease intensity or monitoring of treatment efficacy for end stage renal disease

CIGNA does not cover any of the following electrodiagnostic tests because each is considered experimental, investigational or unproven:

- nerve conduction velocity (NCV) testing performed without needle electromyography, other than when performed for follow-up testing, with current use of anticoagulants, the presence of lymphedema, or for carpal tunnel syndrome
 - nerve conduction testing where the interpretation is delayed and not completed at the time of testing
 - nerve conduction velocity testing performed without the direct supervision of a trained electrodiagnostic physician
 - automated noninvasive nerve conduction testing (e.g., NC-stat System, Brevio[®] nerve conduction monitoring system)
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General Background

Electrodiagnostic studies are frequently used to evaluate a subset of patients with suspected neuromuscular disorders and include needle electromyography and other nerve stimulation tests such as nerve conduction studies. Electrodiagnostic testing may provide an important means of diagnosing conditions attributable to nerve, muscle or neuromuscular junction weakness such as myopathies (muscle weakness), radiculopathies (nerve root disease), plexopathies (peripheral neuropathy), neuropathies (nerve disease), neuromuscular junction disorders, and nerve compression syndromes. In addition, electrodiagnostic testing may be indicated for symptom-based presentations, (e.g., pain in limb, muscle weakness) when appropriate pre-test evaluations are inconclusive and the clinical assessment unequivocally supports the need for the study (American Association of Neuromuscular and Electrodiagnostic Medicine [AANEM], 2010).

Sensitivity and specificity reports for electrodiagnostic testing methods (in general) vary. A clearly established measure of comparison is lacking in the medical literature, making comparisons across studies difficult. Some studies have compared results with clinical examination findings, imaging studies such as magnetic resonance imaging, computed tomography, myelography, or the observation of nerve root compression during surgery. Interobserver differences, the variety of tests employed, the presence of symptoms that may influence patient outcomes (e.g., pain), the presence of abnormal imaging studies in asymptomatic patients, and the subjectivity of the surgeon's interpretations may all lead to variances in sensitivity and specificity results. Despite these variances however, electrodiagnostic testing is commonly used to assist in diagnosing disorders involving the nerves, muscles and neuromuscular junction. Sensitivity and specificity data for automated/portable devices, used instead of or as an adjunct to standard nerve conduction testing, is insufficient to draw conclusions regarding predictive value.

Nerve Conduction Studies

Nerve conduction studies (NCS), also referred to as nerve conduction velocity studies, and are performed to diagnose disorders of the peripheral nervous system. The nerve is stimulated with surface electrodes placed on the skin over the nerve in various locations, although in some situations needle electrodes may be used. A mild electrical stimulus is applied to the nerve in two or more points. Recording of the electrical response to stimulation of the nerve between these points along its route is conducted and compared to normal responses. The study measures speed (conduction velocity and/or latency), amplitude (size) and the shape of neurologic response for detecting demyelination and axon loss.

NCS are generally performed with needle electromyogram (NEMG), enabling the presence and extent of peripheral nerve pathology to be determined (Katirji, 2002; North American Spine Society [NASS], 2003; Aminoff, 2003; Asbury, 2004; AANEM] 2004). EMG studies measure the electrical activity of muscles. When performed together, they can be extremely helpful in detecting whether the pathology originates in the proximal or distal root ganglia and whether the neuromuscular dysfunction relates to peripheral nerve disease.

Both EMG and NCS are required for a clinical diagnosis of peripheral nervous system disorders (AANEM, 2004). For example, radiculopathies cannot be definitively diagnosed by NCS alone; EMG is performed to confirm the radiculopathy. 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.

Abnormal nerve conduction results are caused by nerve damage or destruction and include conduction slowing, conduction blockage, lack of responses and/or low amplitude responses. In general, a physician assesses the results of the degree of myelination or axonal loss; however, it may be performed by a trained technologist under the direct supervision of a physician. Direct supervision implies that a physician is in close proximity to the patient undergoing testing, is immediately available to provide the trained technician with assistance and direction if necessary, and is responsible for determining the nerve conduction studies that are appropriate.

Another type of NCS is referred to as late response (H-reflex and F-wave testing) and is usually performed on nerves more proximal to the spine. The H-reflex involves conduction from the periphery to and from the spinal cord. The H-reflex study involves the assessment of the gastrocnemius/soleus muscle complex in the calf, and is usually performed bilaterally due to the need to assess symmetrical results in determining abnormalities. The F-wave study is a late response similar to the H-reflex. F-wave studies are used to assess the proximal segments of the motor nerve function, and are performed in combination with the examination of motor nerves. Both studies are helpful in diagnosing conditions of radiculopathies, plexopathies, polyneuropathies, and proximal mononeuropathies (AANEM, 2004). Late response studies are additional studies complementary to NCV and are performed during the same patient evaluation.

Professional Societies/Organizations: The AANEM has published guidance for the performance of nerve conduction studies. According to the AANEM a typical nerve conduction examination includes: development of a differential diagnosis based upon appropriate history and physical exam, the NCV study (recording and studying of electrical responses from peripheral nerves or muscles) and the completion of indicated needle EMG studies to evaluate the differential diagnosis and to complement the nerve conduction study.

The minimum standards recommended by the AANEM for NCV testing include the following:

- The testing is medically indicated.
- It is performed using equipment that provides assessment of all parameters of the recorded signals (equipment designed for screening purposes is not acceptable).
- The test is performed by a physician, or by a trained technician under the direct supervision of a trained electrodiagnostic physician
- The EMG must be performed by a trained physician.
- One physician supervises and performs all components of the exam.

The AANEM provides specific recommendations for reporting needle EMG and NCV results. According to the AANEM, the recommendation for documentation of nerve conduction and EMG testing should include (but are not limited to) a description of the patient's clinical problem (demographics, reason for referral), the electrodiagnostic tests performed (techniques, distances, lab reference values, and temperature monitoring), all relevant data derived from these tests (nerves/muscles tested, numerical values for latencies and action potential), and the diagnostic interpretation of the data, including limitations. Complete NCV test measurements should also include amplitude measurements, normal reference values and criteria for abnormalities (AANEM, 2005).

In a position statement published by the AANEM regarding the performance and interpretation of electrodiagnostic studies (AANEM, 2006), the AANEM states, "The performance of or interpretation of NCS separately from the needle EMG component of the testing should clearly be the exception. Nerve conduction studies performed independent of needle EMG may only provide a portion of the information needed to diagnose muscle, nerve root, and most nerve disorders. When the 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. Moreover, individuals who interpret NCV data without patient interaction or who rely on studies that have delayed interpretation, who have interpretation made off-site, and who interpret results without complementary information obtained from EMG studies are not meeting the standards outlined in the AANEM policy recommendations. "

Except in limited clinical situations, performing nerve conduction studies (NCS) together with needle electromyography (NEMG) is required to diagnose peripheral nervous system disorders. According to the AANEM circumstances under which NCS and EMG should not be performed together include, but are not limited to, limited follow-up studies of neuromuscular structures that have undergone previous electrodiagnostic

evaluation, the current use of anticoagulants, or the presence of lymphedema. In addition, the AANEM indicates that for suspected carpal tunnel syndrome, the extent of the needle EMG examination depends on the results of the NCSs and the differential diagnosis considered for the individual patient (AANEM, 2004).

Automated Nerve Conduction Testing

Proponents of automated nerve conduction tests suggest that they can be used in a variety of clinical settings, including a physician's office, without the need for specialized training or equipment, theoretically obtaining results within minutes. Portable, automated devices have been developed to provide nerve conduction studies at the point of care (e.g., primary care setting), particularly for carpal tunnel evaluation and evaluation of diabetic peripheral neuropathy, as an alternative to or as an adjunct to other conventional testing methods. Manufacturers state these devices have computational algorithms, provide delivery of stimulus, measure and analyze the patient's response, and provide a detailed report of study results.

One device, the NC-stat System (NEUROMetrix[®] Inc., Waltham, MA) is a hand-held, noninvasive, automated nerve conduction testing system that has been proposed as an alternative to conventional nerve conduction testing. The device has been marketed for use in an office or clinic setting, to assess nerves of the upper and lower extremities assisting in the diagnosis of peripheral nerve disorders such as carpal tunnel syndrome, diabetic peripheral neuropathy, and sciatica. The manufacturer suggests that data can be analyzed and readily available within minutes and then transmitted to the physician via email, internet or as a faxed document. A computerized system interprets the data. The proposed benefits of the device are ease of use and rapid results.

Another device proposed for automated testing of peripheral nerves is the Brevio nerve conduction monitoring system (Neurotron Medical, Inc., West Trenton, NJ). According to the manufacturer, the device calculates latency and amplitude for sensory, motor, and f-wave responses using a single noninvasive neuro-sensor for testing performed on the patient. Similar to the NC-stat device, when testing is performed, the results can be immediately sent to a printer in the office or through a Web service for an electronic report.

U.S Food and Drug Administration (FDA): Several nerve conduction measurement devices have received approval through the FDA 510(k) process for marketing in the U.S as point of care devices. These devices are regulated as Class II devices and are subject to controls. Examples of FDA approved devices include, but are not limited to, the NC-stat System (NEUROMetrix, Inc., Waltham, MA); the Brevio (Neurotron Medical, Inc., West Trenton, NJ); and the Virtual Medical Systems VT 3000 (Scientific Imaging, Inc., Larkspur, CO).

Literature Review: Evidence evaluating the diagnostic utility of the Brevio and Virtual Medical Systems VT 3000 nerve conduction monitor systems is lacking.

Evidence evaluating the diagnostic utility of the NC-stat System consists mainly of case series, case control studies and retrospective reviews. Some of these studies compare results obtained using automated devices with results obtained from standard diagnostic testing (NCV testing and EMG), other studies did not have a comparison to conventional testing. Most of the published clinical studies have evaluated use of the NC-stat device for assessment of median and ulnar nerves (Megerian, et al., 2007; Kong, et al., 2006; Vinik, et al., 2004); other published studies evaluated use of the device for disorders such as lumbosacral radiculopathies (Fisher, et al., 2008) and sensorimotor polyneuropathy in diabetic patients (Perkins et al., 2008). In some of these studies a strong correlation has been demonstrated when comparing NC-stat with reference standards (Perkins, et al., 2006; Kong, et al., 2006). The diagnostic accuracy for other conditions, such as those involving the lower extremities, has not been sufficiently demonstrated in the literature.

Data regarding diagnostic performance, sensitivity and specificity of the automated NCV testing devices compared to standard testing is inconsistent and does not lead to strong conclusions; the studies are not well-designed, involve small populations and the results cannot be generalized. In some studies authors have reported high sensitivity and specificity when examining NC-stat accuracy for carpal tunnel syndrome compared to controls (Leffler, et al., 2000; Rotman, et al., 2004), other authors however have reported NC-stat is no more sensitive or specific than a traditionally performed distal motor latency for the diagnosis of carpal tunnel syndrome (Katz, 2006). In 2008 Armstrong and colleagues published the outcomes of a cohort study comparing the results obtained with the NC-stat device to traditional nerve conduction studies for carpal tunnel screening (n=33). All correlations were significant. The authors reported sensitivity, with respect to the traditional results, ranged from 93.8% to 100% and specificity ranged from 84.6% to 94.1%. Nonetheless, the authors did not

address limitations such as lack of needle EMG testing and did not evaluate the clinical relevance to the results (Armstrong, et al., 2008).

Despite some reports of high sensitivity and specificity, the clinical utility of automated NCV testing for diagnosing peripheral nerve disorders has not been clearly demonstrated. There is insufficient evidence to support improvement in health outcomes such as accurate diagnosis and successful treatment, as a result of point of service testing. Diagnostic value has not been clearly established and few studies evaluate the effect of automated testing on clinical management (i.e., treatment). A technology assessment conducted by the Washington State Department of Labor and Industries (2006) concluded that the scientific evidence does not show NC-stat to be equivalent to conventional methods for nerve conduction testing. Authors generally agree that further studies are needed to determine the role automated testing has as a component of clinical care. Furthermore, some concerns remain among specialists regarding lack of standard EMG testing and incomplete assessment when using automated NCV testing devices. The AANEM recommends electrodiagnostic studies be performed by properly trained physicians and that interpretation of nerve conduction study data alone, absent face-to-face patient interaction and control over the process, provides substandard care (AANEM, 2006). The AANEM (2010) does not support the following:

- electrodiagnostic testing with automated, noninvasive nerve conduction testing devices
- screening testing, monitoring disease intensity, or monitoring treatment efficacy for polyneuropathy of diabetes or polyneuropathy of end stage renal disease (ESRD).

Number of Services Recommended

Table 1 summarizes the recommendations of the AANEM regarding the reasonable maximum number of studies per diagnostic category necessary for a physician to arrive at a diagnosis for 90% of patients with that final diagnosis (AANEM, 2004).

Table 1 Number of Services Recommended:

Indication	Needle Electromyography (EMG) CPT™ Codes 95860-95864 and 95867-95870	Nerve Conduction Studies (NCS) CPT™ Codes 95900,95903, 95904		Other Electromyographic Studies CPT Codes 95934, 95936, 95937	
		Motor NCS with and/or without F Waves	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (Repetitive Stimulation)
Carpal Tunnel (unilateral)	1	3	4	n/a	n/a
Carpal Tunnel (bilateral)	2	4	6	n/a	n/a
Radiculopathy	2	3	2	2	n/a
Mononeuropathy	1	3	3	2	n/a
Polyneuropathy/Mononeuropathy Multiplex	3	4	4	2	n/a
Myopathy	2	2	2	n/a	2
Motor Neuropathy (e.g., ALS)	4	4	2	n/a	2
Plexopathy	2	4	6	2	n/a
Neuromuscular Junction	2	2	2	n/a	3
Tarsal Tunnel Syndrome (unilateral)	1	4	4	n/a	n/a

Tarsal Tunnel Syndrome (bilateral)	2	5	6	n/a	n/a
Weakness, fatigue, cramps, or twitching (local)	2	3	4	n/a	2
Weakness, fatigue, cramps, or twitching (general)	4	4	4	n/a	2
Pain, numbness, or tingling (unilateral)	1	3	4	2	n/a
Pain, numbness, or tingling (bilateral)	2	4	6	2	n/a

Summary

Evidence in the peer-reviewed, scientific literature indicates that nerve conduction velocity studies and needle electromyography are performed to aid in the diagnosis of neuromuscular disorders when the results of the testing will impact patient management. The diagnostic accuracy of these tests and improvement in health outcomes as a result of treatment have been demonstrated in the medical literature for a select subset of individuals. Some published evidence has shown a correlation of automated portable nerve conduction test results with standard testing. However, the diagnostic utility of portable automated nerve conduction testing and subsequent improvement in health outcomes has not been clearly demonstrated in the medical literature. Concerns remain regarding misdiagnosis, lack of specialist interpretation and absence of needle EMG studies. The role of automated/portable hand-held devices for nerve conduction testing when used in clinical practice has not been established.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT®* Codes	Description
95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
95904	Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936	H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method

ICD-9-CM Diagnosis Codes	Description
053.13	Postherpetic polyneuropathy
072.72	Mumps polyneuropathy
138	Late effects of acute poliomyelitis
249.60-249.61	Secondary diabetes mellitus with neurological manifestations
250.60-250.63	Diabetes with neurological manifestations
330.2	Cerebral degeneration in generalized lipidoses
333.0	Other degenerative diseases of the basal ganglia

333.2	Myoclonus
333.6	Genetic torsion dystonia
333.71	Athetoid cerebral palsy
333.72	Acute dystonia due to drugs
333.79	Other acquired torsion dystonia
333.81	Blepharospasm
333.82	Orofacial dyskinesia
333.83	Spasmodic torticollis
333.84	Organic writers' cramp
333.89	Other fragments of torsion dystonia
333.90	Unspecified extrapyramidal disease and abnormal movement disorder
333.99	Other extrapyramidal disease and abnormal movement disorder
334.1	Hereditary spastic paraplegia
334.2	Primary cerebellar degeneration
335.0	Werdnig-Hoffmann disease
335.10	Spinal muscular atrophy, unspecified
335.11	Kugelberg-Welander disease
335.19	Other spinal muscular atrophy
335.20-335.9	Motor neuron disease
336.0-336.9	Other diseases of spinal cord
337.00-337.9	Disorders of the autonomic nervous system
340	Multiple sclerosis
341.0-341.9	Other demyelinating diseases of central nervous system
342.00-342.92	Hemiplegia and hemiparesis
343.0-343.9	Infantile cerebral palsy
344.00-344.9	Other paralytic syndromes
345.90-345.91	Epilepsy, unspecified
348.1	Anoxic brain damage
348.4	Compression of brain
349.82	Toxic encephalopathy
350.1-350.9	Trigeminal neuralgia
351.0-351.9	Facial nerve disorders
352.0-352.9	Disorders of other cranial nerves
353.0-353.9	Nerve root and plexus disorders
354.0-354.9	Mononeuritis of upper limb and mononeuritis multiplex
355.0-355.9	Mononeuritis of upper limb and unspecified site
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0-357.9	Inflammatory and toxic neuropathy
358.00-358.9	Myoneural disorders
359.0	Congenital hereditary muscular dystrophy
359.1	Hereditary progressive muscular dystrophy
359.21-359.29	Myotonic disorders
359.3	Periodic paralysis
359.4	Toxic myopathy
359.5	Myopathy in endocrine diseases classified elsewhere
359.6	Symptomatic inflammatory myopathy in diseases classified elsewhere
359.81-359.89	Other myopathies
359.9	Unspecified myopathy
368.2	Diplopia
374.30-374.34	Ptosis of eyelid

378.00-378.9	Strabismus and other disorders of binocular eye movements
384.20	Perforated tympanic membrane, NOS
384.21	Central perforation of tympanic membrane
385.30-385.35	Cholesteatoma of middle ear and mastoid
434.00-434.91	Occlusion of cerebral arteries
438.20-438.32	Monoplegia of upper limb
438.40-438.42	Monoplegia of lower limb
478.30-478.34	Paralysis of vocal cords or larynx
478.75	Laryngeal spasm
478.79	Other diseases of larynx
596.51	Hypertonicity of bladder
596.54	Neurogenic bladder, NOS
625.6	Stress incontinence, Female
646.40-646.44	Peripheral neuritis in pregnancy
710.3	Dermatomyositis
710.4	Polymyositis
715.90-715.98	Osteoarthritis, unspecified
717.9	Internal derangement of knee
719.40-719.49	Pain in joint
721.1	Cervical spondylosis with myelopathy
721.2	Thoracic spondylosis without myelopathy
721.41-721.42	Thoracic or lumbar spondylosis with myelopathy
721.7	Traumatic spondylopathy
721.91	Spondylosis of unspecified site with myelopathy
722.0	Displacement of cervical intervertebral disc without myelopathy
722.10-722.11	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.4	Degeneration of cervical intervertebral disc
722.51-722.52	Degeneration of thoracic lumbar 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
722.90-722.93	Other and unspecified 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	Spinal stenosis, unspecified region
724.01	Spinal stenosis of thoracic region
724.03	Spinal stenosis of lumbar region, with neurogenic claudication
724.09	Spinal stenosis , other region 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	Unspecified backache
724.6	Disorders of sacrum
725	Polymyalgia rheumatica
726.2	Other affections of shoulder region, not elsewhere classified

728.0	Infective myositis
728.2	Muscular wasting and disuse atrophy, not elsewhere classified
728.85	Spasm of muscle
728.87	Muscle weakness (generalized)
728.9	Unspecified disorder of muscle, ligament, and fascia
729.0	Rheumatism, unspecified and fibrositis
729.1	Myalgia and myositis, unspecified
729.2	Neuralgia, neuritis, and radiculitis, unspecified
729.4	Fasciitis, unspecified
729.5	Pain in soft tissues of limb
729.82	Cramp of 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 deformity of ankle and foot
737.30	Scoliosis (and kyphoscoliosis), idiopathic
738.4	Acquired spondylolisthesis
747.81-747.82	Anomalies of cerebrovascular system
756.11	Congenital spondylolysis, lumbosacral region
756.12	Congenital spondylolisthesis
767.4-767.7	Injury to spine and spinal cord
781.2	Abnormality of gait
781.3	Lack of coordination
781.4	Transient paralysis of limb
781.6	Meningismus
781.7	Tetany
781.93	Ocular torticollis
781.99	Other symptoms involving nervous and musculoskeletal systems
782.0	Disturbance of skin sensation
784.40	Voice disturbance, nonspecific
784.42	Dysphonia
784.49	Other voice and resonance disorders
784.51	Dysarthria
784.59	Other speech disturbance
787.20-787.29	Dysphagia
787.6	Incontinence of feces
788.21	Incomplete bladder emptying
788.30-788.39	Urinary incontinence
796.1	Abnormal reflex
951.0-951.9	Injury cranial nerves
952.00-952.9	Spinal cord injury without evidence of spinal bone injury
953.0-953.9	Injury to nerve root and spinal plexus
954.0-954.9	Injury to other nerve(s), 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

Not Medically Necessary and Not Covered:

ICD-9-CM Diagnosis Codes	Description
	All other codes

Experimental, investigational or unproven and not covered when used to report automated or portable hand-held noninvasive nerve conduction testing/devices:

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

HCPCS Codes	Description
S3905	Non-invasive electrodiagnostic testing with automatic computerized hand-held device to stimulate and measure neuromuscular signals in diagnosing and evaluating systemic and entrapment neuropathies

ICD-9-CM Diagnosis Codes	Description
	All codes

***Current Procedural Terminology (CPT®) © 2010 American Medical Association: Chicago, IL.**

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Policy History

<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
CIGNA HealthCare	7/15/2008	0117	Nerve Conduction Velocity Studies Including Late Response (H-reflex and F-wave)

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