

SUBJECT: EVOKED POTENTIALS

POLICY NUMBER: 2.01.27

CATEGORY: Technology Assessment

EFFECTIVE DATE: 10/19/00

REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08

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02/20/14**

PAGE: 1 OF: 8

- *If the member's subscriber contract excludes coverage for a specific service it is not covered under that contract. In such cases, medical policy criteria are not applied.*
- *Medical policies apply to commercial and Medicaid products only when a contract benefit for the specific service exists.*
- *Medical policies only apply to Medicare products when a contract benefit exists and where there are no National or Local Medicare coverage decisions for the specific service.*

POLICY STATEMENT:

Based upon our criteria and review of the peer-reviewed literature:

- I. *Auditory-evoked potentials* are **medically appropriate** for the following indications:
 - A. To evaluate brainstem function in acquired metabolic disorders;
 - B. To assess recovery of brainstem function after a lesion compressing the brainstem has been surgically removed;
 - C. To localize the cause of a neurologic deficit seen on exam, not explained by lesions seen on CT or MRI;
 - D. To diagnose and monitor demyelinating and degenerative diseases affecting the brain stem (e.g., multiple sclerosis, central pontine myelinolysis, olivopontocerebellar degeneration, and others);
 - E. To diagnose lesions in the auditory system;
 - F. To evaluate the irreversibility of coma or brain death, along with an EEG; or
 - G. For children under age 5, to determine the type and degree of hearing problems or to determine the developed status of nerves.
- II. *Visual evoked potentials* are **medically appropriate** for the following indications:
 - A. To diagnose and monitor multiple sclerosis;
 - B. To localize the cause of a visual field defect, not explained by lesions seen on CT or MRI, metabolic disorders, or infectious diseases; or
 - C. To diagnose or evaluate deficits or damage to the visual system of infants, or unresponsive/nonverbal patients.
- III. *Somatosensory evoked potentials* are **medically appropriate** for the following indications:
 - A. To assess any decline which may be considered emergent to 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;
 - B. To diagnose and monitor multiple sclerosis;
 - C. To evaluate patients with suspected brain death;
 - D. To diagnose unexplained myelopathy; or
 - E. To localize the cause of a neurologic deficit seen on exam not explained by lesions on CT or MRI.
- IV. *Intra-operative monitoring of sensory evoked potentials or auditory evoked potentials* is **medically appropriate** during spinal, intracranial, or vascular procedures. All other indications for intra-operative monitoring are **not medically necessary**.
- V. *Intra-operative monitoring of visual evoked potentials* is considered **investigational**.
- VI. *Intra-operative monitoring of motor-evoked potentials* using transcranial electrical stimulation is **medically appropriate** during spinal, intracranial or vascular procedures.
- VII. Due to lack of FDA approval, the use of transcranial magnetic stimulation to elicit motor evoked potentials is considered **investigational**.

Refer to Corporate Medical Policy # 10.01.06 regarding Audiology Screening of Newborns.

Refer to Corporate Medical Policy #11.01.03 regarding Experimental and Investigational Services.

SUBJECT: EVOKED POTENTIALS POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14 PAGE: 2 OF: 8
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POLICY GUIDELINES:

The Federal Employee Health Benefit Program (FEHBP/FEF) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

DESCRIPTION:

Evoked Potentials

Evoked potentials (EP) are responses (electrical signals) produced by the nervous system in response to a stimulus. These computerized tests help diagnose nerve disorders, locate the site of nerve damage, and help evaluate the patient's condition after treatment or during surgery. There are several types of evoked potential tests. Each uses mild stimulus to cause the nerves to react and send a message to the brain. Electrodes placed on the skin surface record how the brain and spinal cord respond to stimulus. The responses are analyzed by a computer and printed as a waveform pattern. The wave pattern may reveal certain problems and show where any damage is located along the nerve pathway(s) being tested. Evoked potentials can be further broken down into the following categories according to the type of stimulation used:

I. Somatosensory-Evoked Potentials

Somatosensory-evoked potentials (SSEPs) are electrical waves that are generated by the response of sensory neurons to stimulation. Peripheral nerves, such as the median, ulnar or tibial nerve, are typically stimulated, but in some situations the spinal cord may be stimulated directly. Recording is done either cortically or at the level of the spinal cord above the surgical procedure.

II. Auditory-Evoked Potentials

- A. *Brainstem auditory-evoked potentials (BAEPs)* are generated in response to auditory clicks and can define the functional status of the auditory nerve. Surgical resection of a cerebellopontine angle tumor, such as an acoustic neuroma, places the auditory nerves at risk and BAEPs have been extensively used to monitor auditory function during these procedures.
- B. *Auditory evoked potentials*, also called *auditory brainstem response (ABR)*, are an electrophysiologic measure of auditory function that utilizes responses produced by the auditory nerve and brainstem and helps differentiate sensory from neural hearing loss. The response is the waveform averaged over many auditory clicks.

III. Visual-Evoked Potentials

Visual-evoked potentials (VEPs) are used to track visual signals from the retina to the occipital cortex light flashes. VEP monitoring has been used for surgery on lesions near optic chiasm. However, intraoperatively recorded VEPs are very difficult to interpret due to their sensitivity to anesthesia, temperature, and blood pressure.

IV. Motor-Evoked Potentials

Motor evoked potentials (MEPs) are elicited by either electrical or magnetic stimulation of the motor cortex or the spinal cord. Transcranial electrical stimulation involves stimulation of the motor cortex via electrodes on the scalp, or if the brain is exposed by a craniotomy, the motor cortex is stimulated via electrodes placed directly on the brain surface. Magnetic stimulation delivers a pulsed magnetic field over the scalp in the region of the primary motor cortex. Magnetic stimulation is generally regarded as unsuitable for intraoperative monitoring because it is more sensitive to anesthesia. Electrical stimulation is too painful for clinical use in awake patients. The two modalities are thus complementary, electrical stimulation being the choice for intraoperative monitoring, and magnetic for clinical applications.

Intra-Operative Monitoring of Sensory and Motor Evoked Potentials

Intra-operative monitoring of sensory-evoked potentials is used to assess the functional integrity of the central nervous system (CNS) pathways during operations that put the spinal cord or brain at risk for significant ischemia or traumatic injury. The monitoring of sensory-evoked potentials is commonly used during the following procedures: carotid endarterectomy, brain surgery involving vasculature, surgery with distraction compression or ischemia of the spinal

SUBJECT: EVOKED POTENTIALS POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14 PAGE: 3 OF: 8
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cord, corrective surgery for scoliosis, and brainstem, and acoustic neuroma surgery. Transcranial electrical motor evoked potentials (TceMEPs) have been used more frequently in spinal surgery. MEPs in combination with SSEP has been proposed to improve the accuracy of monitoring spinal cord function.

RATIONALE:

There is sufficient data published in the medical literature to conclude that measurement of evoked potentials and intraoperative monitoring of evoked potentials in appropriate situations improves health outcome. Improved health outcomes have been achieved outside the investigational setting.

Studies have demonstrated a statistically significant association between abnormal visual evoked potentials (VEPs) and an increased risk of developing clinically definite multiple sclerosis (CDMS). In these studies, patients with suspected MS were 2.5 to 9 times as likely to develop CDMS as patients with normal VEPs. VEP sensitivities ranged from 25% to 83%. VEPs improved the ability to predict which MS suspects will develop CDMS by as much as 29%. Measurement of visual evoked responses (VERs) is the primary means of objectively testing vision in infants and young children. VER measurements are useful in infants and young children suspected of having disorders of the visual system, where the child is too young to report differences in color vision or to undergo assessment of visual fields and visual acuity. Lesions affecting the visual pathways can be localized by noting the presence of decreased amplitudes or increased latencies of VERs, and by determining whether VER abnormalities involve one or both eyes.

The clinical utility of BAER over standard auditory testing is due to several of BAER's characteristics: (1) BAER's resistance to alteration by systemic metabolic abnormalities, medications or pronounced changes in the state of consciousness of the patient; and (2) the close association of BAER waveform abnormalities to underlying structural pathology. BAER has been proven effective for differentiating conductive from sensory hearing loss, for detecting tumors and other disease states affecting central auditory pathways (e.g., acoustic neuromas, subclinical lesions in multiple sclerosis), and for noninvasively detecting hearing loss in patients who cannot cooperate with subjective auditory testing (e.g., infants, comatose patients). BAER is the test of choice to assess hearing in infants and young children. It is most useful for following asphyxia, hyperbilirubinemia, intracranial hemorrhage, or meningoencephalitis or for assessing an infant who has trisomy. BAER also is useful in the assessment of multiple sclerosis or other demyelinating conditions, coma, or hysteria. Audiometric analysis using multiple sound frequencies is usually preferred over BAER for testing hearing in cooperative patients who are able to report when sounds are heard.

Intraoperative neurophysiological monitoring has been utilized in attempts to minimize neurological morbidity from operative manipulations. The goal of such monitoring is to identify changes in brain, spinal cord, and peripheral nerve function prior to irreversible damage. Intraoperative monitoring also has been effective in localizing anatomical structures, including peripheral nerves and sensorimotor cortex, which helps guide the surgeon during dissection. SSEP has been the standard of intraoperative monitoring, with excellent ability to assess dorsal column and lateral sensory tract function; it probably also can detect changes in function of anterior motor tracts by stimulating mixed sensorimotor peripheral nerves. However, significant motor deficits have been seen in patients undergoing spinal surgery despite normal SSEPs. MEPs were developed to better monitor the motor neurophysiological pathways.

In patients with pre-operative spinal cord compromise, MEPs may be present when SSEPs are absent or ill-defined. This is because MEPs and SSEPs are conducted in different spinal cord pathways and have different blood supplies. Consequently, being able to perform MEP monitoring makes spinal cord monitoring possible in cases where SSEP signals are unobtainable. In the operating room, transcranial electrical stimulation is preferable to transcranial magnetic stimulation because the electrical stimulus is more reproducible.

SUBJECT: EVOKED POTENTIALS	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14
POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	PAGE: 4 OF: 8

CODES: Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

CPT:	92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
	92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
	95925-95927	Somatosensory-evoked potentials (code range)
	95938	
	95928-95929	Central motor evoked potential study (transcranial motor stimulation) (code range)
	95939	
	95930	Visual-evoked potentials
	95940	Continuous intraoperative neurophysiology monitoring in the operating room, one to one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
	95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)
	0333T (E/I)	Visual evoked potential, screening of visual acuity, automated

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HCPCS:	G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) per patient (attention directed exclusively to one patient) each 15 minutes (List separately in addition to code for primary procedure)
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ICD9:	191.6	Malignant neoplasm of brain, occipital lobe
	198.3	Secondary malignant neoplasm of brain and spinal cord
	225.0	Benign neoplasm of brain
	225.1	Benign neoplasm of cranial nerves (includes acoustic neuroma)
	237.5	Neoplasm of unspecified behavior, brain and spinal cord
	239.6	Neoplasm of unspecified behavior, brain
	368.40-368.47	Visual field defect (code range)
	441.00- 441.03	Aortic aneurysm and dissection
	722.0	Intervertebral disc disorders

SUBJECT: EVOKED POTENTIALS	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14
POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	PAGE: 5 OF: 8

	723.0-723.5, 723.7-723.9	Other disorders of cervical region (code range)
	724.00-724.03, 724.09	Other and unspecified disorders of back (code range)
	737.0-737.39	Curvature of the spine (code range)
	433.1	Occlusion and stenosis of carotid artery
ICD10:	C71.6	Malignant neoplasm of cerebellum
	C79.31	Secondary malignant neoplasm of brain
	D33.0-D33.2	Benign neoplasm of brain (code range)
	D33.3	Benign neoplasm of cranial nerves
	D43.0-D43.42	Neoplasm of uncertain behavior of brain (code range)
	D43.4	Neoplasm of uncertain behavior of spinal cord
	D49.6	Neoplasm of unspecified behavior of brain
	H53.411-H53.419	Scotoma involving central area (code range)
	H53.421-H53.429	Scotoma of blind spot area (code range)
	H53.431-H53.439	Sector or arcuate defects (code range)
	H53.451-H53.459	Other localized visual field defect (code range)
	H53.481-H53.489	Generalized contraction of visual field (code range)
	H53.461-H53.469	Homonymous bilateral field defects (code range)
	H53.47	Heteronymous bilateral field defects (code range)
	I63.031-I63.039	Cerebral infarction due to thrombosis of carotid artery (code range)
	I63.131-I63.139	Cerebral infarction due to embolism of carotid artery (code range)
	I63.231-I63.239	Cerebral infarction due to unspecified occlusion or stenosis of carotid arteries (code range)
	I65.21-I65.29	Occlusion and stenosis of carotid artery (code range)
	I71.00-I71.03	Dissection of aorta (code range)
	M40.00-M40.05	Postural kyphosis (code range)
	M40.202- M40.209	Unspecified kyphosis (code range)
	M40.292-M40.299	Other kyphosis (code range)
	M40.30-M40.37	Flatback syndrome (code range)
	M40.40-M40.57	Lordosis (code range)
	M41.00-M41.27	Idiopathic scoliosis (code range)
	M41.30-M41.35	Thoracogenic scoliosis (code range)
	M41.80-M41.9	Other forms of scoliosis(code range)

SUBJECT: EVOKED POTENTIALS	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14
POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	PAGE: 6 OF: 8

M41.9	Scoliosis, unspecified
M43.6	Torticollis
M48.00-M48.08	Spinal stenosis (code range)
M50.10-M50.13	Cervical disc disorder with radiculopathy (code range)
M50.20-M50.23	Other cervical displacement (code range)
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.81-M53.83	Other specified dorsopathies (code range)
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.13	Radiculopathy, cervicothoracic region
M54.81	Occipital neuralgia
M96.3	Postlaminectomy kyphosis
M96.4	Postsurgical lordosis
M99.20-M99.29	Subluxation stenosis of neural canal (code range)
M99.30-M99.39	Osseous stenosis of neural canal (code range)
M99.40-M99.49	Connective tissue stenosis of neural canal (code range)
M99.50-M99.59	Intervertebral disc stenosis of neural canal (code range)
M99.60-M99.69	Osseous and subluxation stenosis of intervertebral foramina (code range)
M99.70-M99.79	Connective tissue and disc stenosis of intervertebral foramina (code range)

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SUBJECT: EVOKED POTENTIALS POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14 PAGE: 7 OF: 8
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SUBJECT: EVOKED POTENTIALS	EFFECTIVE DATE: 10/19/00 REVISED DATE: 12/20/01, 04/20/06, 03/15/07, 03/20/08 ARCHIVED: 12/19/02-04/20/06, 02/19/09 EDITED DATE: 02/18/10, 02/17/11, 02/16/12, 02/21/13 02/20/14
POLICY NUMBER: 2.01.27 CATEGORY: Technology Assessment	PAGE: 8 OF: 8

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*key article

KEY WORDS:

ABR, BAEPs, Evoked potentials, MEPS, SEEPs, VEPS.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for Evoked Response Tests. Please refer to the following NCD website for Medicare Members: <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDID=200&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s>New+York++Upstate&CptHcpcsCode=36514&bc=gAAAAABAAAAAA&>

There is currently a Local Coverage Determination (LCD) for Somatosensory Testing. Please refer to the following LCD website for Medicare Members: http://apps.ngsmedicare.com/lcd/LCD_L28204.htm