# MEDICAL POLICY

**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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- If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.
- If a commercial product, including an Essential Plan product, covers a specific service, medical policy criteria apply to the benefit.
- If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

**POLICY STATEMENT:**

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

I. **Auditory-evoked potentials** are **medically appropriate** for the following indications:
   - To evaluate brainstem function in acquired metabolic disorders;
   - To assess recovery of brainstem function after a lesion compressing the brainstem has been surgically removed;
   - To localize the cause of a neurologic deficit seen on exam, not explained by lesions seen on CT or MRI;
   - To diagnose and monitor demyelinating and degenerative diseases affecting the brain stem (e.g., multiple sclerosis, central pontine myelinolysis, olivopontocerebellar degeneration, and others);
   - To diagnose lesions in the auditory system;
   - To evaluate the irreversibility of coma or brain death, along with an EEG; or
   - 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:
   - To diagnose and monitor multiple sclerosis;
   - To localize the cause of a visual field defect, not explained by lesions seen on CT or MRI, metabolic disorders, or infectious diseases; or
   - 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:
   - 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;
   - To diagnose and monitor multiple sclerosis;
   - To evaluate patients with suspected brain death;
   - To diagnose unexplained myelopathy; or
   - To localize the cause of a neurologic deficit seen on exam not explained by lesions on CT or MRI.

IV. **Intra-operative neurophysiologic monitoring** is **medically appropriate** during high risk thyroid or parathyroid surgery, 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. 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.
POLICY GUIDELINES:
The Federal Employee Health Benefit Program (FEHBP/FEP) 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.

V. Intra-Operative Neurophysiologic Monitoring

Intraoperative neurophysiologic monitoring (IONM) describes a variety of procedures used to monitor the integrity of neural pathways during high-risk neurosurgical, orthopedic, and vascular surgeries. It involves the detection of electrical signals produced by the nervous system in response to sensory or electrical stimuli to provide information about the functional integrity of neuronal structures. Different methodologies include, but may not be limited to:
somatosensory-evoked potentials, motor-evoked potentials using transcranial electrical stimulation, brainstem auditory-evoked potentials, electromyography (EMG) of cranial nerves, electroencephalography, and electrocorticography.

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. 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.

For individuals who are undergoing thyroid or parathyroid surgery and are at high risk of injury to the recurrent laryngeal nerve (RLN) who receive IONM, the evidence includes a large randomized controlled trial (RCT) and systematic reviews. Relevant outcomes are morbidity events, functional outcomes, and quality of life. The strongest evidence on neurophysiologic monitoring derives from an RCT of 1000 patients undergoing thyroid surgery. This RCT found a significant reduction in RLN injury in patients at high risk for injury. High risk in this trial was defined as
surgery for cancer, thyrotoxicosis, retrosternal or giant goiter, or thyroiditis. The high-risk category may also include patients with prior thyroid or parathyroid surgery or total thyroidectomy. A low volume of surgeries might also contribute to a higher risk for RLN injury. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**CODES:**

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<th>Number</th>
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<td>Eligibility for reimbursement is based upon the benefits set forth in the member’s subscriber contract.</td>
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**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, 95938 Somatosensory-evoked potentials (code range)
- 95928-95929, 95939 Central motor evoked potential study (transcranial motor stimulation) (code range)
- 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

**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)

**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

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<tr>
<th>Code Range</th>
<th>Description</th>
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<td>H53.411-H53.419</td>
<td>Scotoma involving central area (code range)</td>
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<td>Scotoma of blind spot area (code range)</td>
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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)

REFERENCES:


*key article

**KEY WORDS:** ABR, BAEPs, Evoked potentials, MEPS, SEEPs, VEPS.
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=gAAAABAAAAA&