To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Visual Evoked Potential (VEP) test is a diagnostic tool for the neurological assessment of the visual system. VEP measures the time it takes for nerves to respond to stimulation. The size of the response is also measured. During the VEP test, the eyes are stimulated by looking at a test pattern. Each type of response is recorded from brain waves by using electrodes taped to the head. The VEP test is the most commonly used evoked potential test in the diagnosis of multiple sclerosis (MS). Interpretation is provided by neurologists, physiatrists, ophthalmologists or optometrists specially trained or skilled in VEP testing.

The VEP test involves a flashing stroboscope or viewing a black and white checkered pattern on a television (TV) monitor in a darkened room. The black and white squares alternate on a regular cycle which generates electrical potentials along the optic nerve and into the brain producing wave patterns that are recorded. These are detected with electroencephalographical (EEG) sensors placed at specific sites on the back of the head (the occipital scalp). Each eye is tested independently while an eye patch is worn on the other eye.

VEPs are very sensitive at measuring slowed responses to visual events and can often detect dysfunction which is undetectable through clinical evaluation and the person is unaware of any visual defects.

Because of their ability to detect silent lesions and historic demyelinating episodes, they are very useful diagnostic tools. A definite diagnosis of multiple sclerosis requires at least two distinct demyelinating episodes, in two different central nervous system sites which are separated by at least one month (the Schumacher criteria). VEPs can often provide evidence of such episodes when other tests, even MRI, cannot.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
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.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

None Apply.

2.2 Special Provisions

2.2.1 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 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.

b. **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/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Visual Evoked Potential (VEP) is considered medically necessary for any of the following indications:

a. 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;
b. 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; or
c. to evaluate signs and symptoms of visual loss in beneficiaries who are unable to communicate clearly.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid do not cover VEP for a beneficiary who does not meet any of the indications listed in **Subsection 3.2.1**. VEP is considered experimental and investigational for all other indications.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid does not cover VEP as a routine screening tool to meet the requirements of vision screening during an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam. However, if during an EPSDT exam the physician documents a medical need for additional vision services, (i.e. an abnormality is suspected) the physician is expected to make the appropriate referral for a more formal vision assessment. Physicians providing children's vision assessments shall follow the American Academy of Pediatrics policy for "Eye Examination in Infants, Children, and Young Adults by Pediatricians." (Refer to http://pediatrics.aappublications.org/content/111/4/902)

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for Visual Evoked Potential (VEP).

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

None Apply.

6.0 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;
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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Qualifications

For interpretation of VEP test results, the provider shall have a current active license to practice medicine as a neurologist, a physiatrist, an ophthalmologist or an optometrist.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 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).

7.2 Documentation of VEP Interpretation Results

VEP abnormalities are not specific and can occur in a wide variety of ophthalmological and neurological problems. The interpretation shall include statements about the normality and abnormality of the result in relation to normative data as well as comparison between the eyes or with previous records. The type of abnormality in the response shall be described and this should be related to the clinical picture and other visual electrodiagnostic results.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1996

Revision Information:

Date	Section Revised	Change
1/15/2012	Throughout	Initial promulgation of current coverage
1/15/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1A-28 under Session Law 2011-145
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
05/08/2013	Section 1.0	Fixed hyperlink to "the Schumacher criteria" so it functions properly in PDF.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/01/2017	Subsection 4.2.2	Revised website to http://pediatrics.aappublications.org/content/111/4/902
10/01/2017	Subsection 4.2.3	Revised website to http://pediatrics.aappublications.org/content/111/4/902
10/01/2017	Subsection 6.2	Add or an optometrist.
10/01/2017	Attachment A, C.	Delete CPT code +95920
10/01/2017	Subsection 1.0	Add or optometrists to the definition
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/04/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/04/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
09/15/2020	Attachment A (F)	Revised Place of Service to include Independent Diagnostic Testing Facilities (IDTF)
08/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023.

Date	Section Revised	Change
10/15/2023	Attachment A (B)	Annual update to ICD-10 codes

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks 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

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

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.

ICD-10-CM Code(s)		
G35	H46.8	H53.432
G36.8	H46.9	H53.433
G36.9	H53.40	H53.439
G37.1	H53.421	H53.451
G37.2	H53.422	H53.452
G37.4	H53.423	H53.453
G37.8	H53.429	H53.459
G37.81	H53.431	H53.47
G37.89		Z82.0
G37.9		

ICD-10-PCS Code(s)		
4A00X2Z	4A10X2Z	4B01XVZ
4A01329	4A11329	4B0FXVZ
4A0132B	4A1132B	F01Z77Z
4A01X29	4A11X29	F01Z9JZ
4A01X2B	4A11X2B	
4A07X0Z	4B00XVZ	

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.

CPT Code(s)
95930

Revenue Code(s)
920
929

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.

D. Modifiers

Use modifier 26 when billing the professional component.
Use modifier TC when billing the technical component.

E. Billing Units

95930 is billable at one unit per test.

F. Place of Service

Inpatient, Outpatient, Office and Independent Diagnostic Testing Facilities (IDTF).

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/