Priority Health	BILLING POLICY No. 115
AUTONOMIC FUNCTION TESTING	
Date of origin: July 11, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Autonomic function tests are a series of non-invasive procedures that access the function of the autonomic nervous system.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

ASC Payment Indicator - IN
Nonsurgical procedure not Medicare allowable in an ASC

Reimbursement specifics and billing details

1. Diagnostic testing may be allowed once to confirm or exclude specific autonomic disease. For patients with diagnosed autonomic disorders, repeat testing is governed by a change in a clinical status or response to a therapeutic intervention. If a repeat test is needed, it is not expected to exceed once per year.
2. Providers who perform these tests on an unusually high proportion of their patients, or at frequencies exceeding once per year may be subject to medical review.
3. Providers who do not have tilt tables and are using code range 95921-95924 may be subject to medical review.

Coding specifics

CPT codes: 95921-95924
Includes:

- Physician interpretation
- Recording
- Report
- Testing for autonomic dysfunction including site and autonomic subsystems

95921: Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio

Includes:

- Data storage for waveform analysis
- Display on monitor
- Minimum two elements performed:
- Cardiovascular function indicated by 30:15 ration (R/R interval at beat 30)/(R-R interval at beat 15)
- Heart rate response to deep breathing obtained by visual quantitative recording analysis with patient taking five to six breaths per minute
- Valsalva ratio (at least two) obtained by dividing highest heart rate by lowest
- Monitoring heart rate by electrocardiography; rate obtained from time between two successive R waves (R-R interval)
- Testing most usually in prone position
- Tilt table testing, when performed

95922: Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt

95923: Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential

95924: Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt

Includes:

- Tilt table testing adrenergic and parasympathetic function

Documentation requirements

- Medical record documentation maintained by the performing provider must clearly support the medical necessity for ANS testing and also the test reports and interpretation. Supportive documentation showing medically reasonable and necessary indications as outlined in this LCD are expected to be documented in the medical record and be available upon request. This documentation includes, but is not limited to, the relevant medical history, physical examination and results of pertinent diagnostic tests or procedures used to rule out more common causes of autonomic signs or symptoms.
- General professional standards with FDA clearance apply for all equipment used in ANS testing.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Get more information about modifier use in our Provider Manual.

Modifier 26: Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Modifier TC: Technical component; Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles

ASC modifiers

- GA: Waiver of liability statement issued as required by payer policy, individual case
- GZ: Item or service expected to be denied as not reasonable and necessary

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

REFERENCES

- Billing and Coding: Autonomic Function Testing (A57551) (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made