Priority Health	BILLING POLICY No. 154
Somatosensory Testing	
Date of origin: Sept 2025	**Review dates: 07/2026**

DEFINITION
Somatosensory testing is a diagnostic procedure that evaluates the function of the somatosensory system, which processes sensory information from the body, including touch, temperature, pain, vibration, and proprioception (sense of body position and movement).

Medical Policy
Intraoperative Neurophysiological Monitoring # 91646

For Medicare
For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click **here** for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Performing provider documentation must show:
- Why the test was needed
- That results influenced treatment
- That the test was performed

Required documentation includes:
- Hard copy of test results
- Provider's interpretation
- Details on nerves tested, latencies, and whether results are normal/abnormal

If the testing provider differs from the ordering provider, they must retain:
- Test results and interpretation
- A copy of the order from the referring provider

Billing details

Somatosensory evoked potential (SEP) studies should only be performed when a thorough clinical history, neurological examination, and appropriate diagnostic tests—such as imaging, electromyography (EMG), and nerve conduction studies—suggest that a lesion in the central somatosensory pathways is a likely and reasonable part of the differential diagnosis.

- Quantitative Sensory Testing (QST) using portable devices is not equivalent to Somatosensory Evoked Potential (SEP) testing.
- QST should not be billed using CPT codes 95925–95938.
- QST is considered part of the Evaluation and Management (E/M) service and is not separately billable.
- For intraoperative somatosensory monitoring during spinal surgeries:
  Use the codes 95940 or G0453.
- These codes may be used in addition to appropriate study codes.
- Monitoring must be performed by a qualified provider, not the neurosurgeon or a technician.
- Routine lumbar or cervical decompression surgeries typically do not require intraoperative monitoring.
- Bilateral or multiple procedure modifiers are not applicable to SEP codes.
  The codes already include stimulation of all relevant sites.

Coding specifics

Short-Latency Somatosensory Evoked Potential (SSEP) Studies
Tests that measure sensory nerve pathway responses from peripheral stimulation to the central nervous system.

- **95925** – Upper limbs
- **95926** – Lower limbs
- **95927** – Trunk or head
- **95938** – Both upper and lower limbs

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. Please see our provider manual page for modifier use **here**.

- **Modifier 59** – Distinct Procedural Service
- **Modifier 52** - reduced services.
- **Modifier 26** - professional component only
- **Modifier TC** - technical component only

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. Click **here** for additional information.

Reimbursement rates

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

REFERENCES

CG-MED-50 Visual, Somatosensory and Motor Evoked Potentials

Evoked Potential Studies - Medical Clinical Policy Bulletins | Aetna

Article - Billing and Coding: Somatosensory Testing (A57597)

Article - Billing and Coding: Somatosensory Testing (A57540)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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
Sept 2025	New Policy – effective date Oct 16, 2025
July 2026	Reviewed, no changes