American Association of Clinical Endocrinologists

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November 26, 2001

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Dear Dr. Whyte:

We are writing in support of the clinical use of the Sensory Nerve Conduction Threshold (sNCT) exam as being considered "reasonable and necessary" for the Medicare population. Our decision is based on a careful review of quantitative sensory testing, reviewing official statements from AAEDM, discussions with neurologists, and the clinical experience of members of the American Association of Clinical Endocrinology. Some of the reasons most commonly cited by our members in support of their use of the sNCT/CPT procedure to evaluate their patients are presented below.

The sNCT/CPT evaluation is conducted from the most distal sensory nerve fibers in the body located at the tip of the great toe. The most common type of diabetic and endocrine related polyneuropathy is a distal axonal neuropathy which begins at the tips of the toes and impairs sensory nerve function long before impairing motor nerve function. The alternative electrodiagnostic procedure, the sensory Nerve Conduction Velocity (sNCV) evaluation, can not be conducted from the tips of the toes and is limited to being conducted over major sensory nerve branches. The sNCV test is most commonly conducted on the back of the leg over the sural nerve. It may take years for the sensory neuropathy to progress to this location. Consequently the sNCT/CPT test from the big toe superficial and deep peroneal nerve testing site provides earlier detection of the most common type of endocrine or metabolic polyneuropathy, thereby permitting earlier therapeutic intervention which can arrest the development of more advanced and more costly to manage neuropathological conditions.

The sNCT/CPT test can be conducted at any cutaneous site on the body permitting the endocrinologist to map the distribution of a polyneuropathy and measure its advance. This is particularly important for patients with advanced diabetic neuropathy or lower extremity edema whose nerves cannot be evaluated by sNCV testing. More proximal testing with the sNCT/CPT procedure, allows the efficacy of therapeutic interventions to be determined.

The sNCT/CPT procedure is automated and employs a double blinded testing methodology that assures accurate measures under a wide variety of operating conditions and environments. It also offers more convenience for the patietns, avoiding a second or third visit for the procedure.

Endocrinologists can perform in-office sNCT/CPT evaluations of symptomatic patients to determine whether they should be advised to optimize diabetic control or whether other forms of therapy might be advisable, including, but not limited to splinting, physical therapy, or medication. The sNCV test is not sensitive to radiculopathies and paraspinal demyelinating lesions.

The ability of the sNCT/CPT examination to specifically evaluate the smaller fibers not measured by

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sNCV testing provides significant additional advantages in the medical management of the patient with polyneuropathy. For instance, the evaluation of smaller fiber function permits the assessment of protective sensation which, when lost in the presence of intact large fiber sensation, can result in a painless neuropathy that is often difficult to detect clinically and can lead to ulceration or amputation in advanced cases. Also, small fiber neuropathy is an extremely sensitive predictor of mortality in diabetic uremics and a sensitive indirect marker of autonomic cardiovascular dysfunction. Left undetected and untreated, this
condition is a major cause of mortality in this patient population.

The sNCT/CPT procedure is the only neurodiagnostic test which can detect both the hyperesthetic and hypoesthetic conditions. Hyperesthesia has been demonstrated to occur before hypoesthesia in the development of diabetic peripheral polyneuropathy and can not be
quantified by other neurodiagnostic tests. Therapeutic intervention in the earliest and most reversible stage of diabetic polyneuropathy can avert the development of advanced neuropathy and other complications of diabetes.

The sNCT/CPT test is perceived by the vast majority of patients as painless, thus permitting repeated testing over time and the monitoring of improvement or worsening of their polyneuropathy. Most patients, however, describe EMG and sNCV testing as painful and are
very reluctant to repeat these tests undermining the viability longitudinal evaluations.

In summary, AACE believes that it is reasonable to perform quanititative sensory testing, such as sNCT in some of our patients on Medicare who have diabetes mellitus. The results of the test would behoove the health care provider and the patient to more aggressively manage one's diabetes to minimize their suffering and improve their quality of life.

Sincerely,

Rhoda H. Cobin, MD, FACE
AACE President

Sethu K. Reddy, MD, FACE
Coding Committee Chairman

cc: AACE Coding Committee
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