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Eli's Rehab Report

Learn 4 Tactics for EMGs With No New Diagnosis

Submitting raw data that proves medical necessity may be key

If your physician didn't find a new diagnosis during an electromyography (EMG) test, Medicare may view the EMG (95860-95872) as "preventive" rather than "diagnostic." But there's still hope - and most of it comes in the form of more documentation.

Let's say a primary-care physician refers a patient with extremity numbness (**782.0**) to your practice and your physician finds evidence of carpal tunnel syndrome (354.0) during an EMG. In this case, you should use 354.0 on your claim. However, if the physician is not able to make a diagnosis following the EMG, you can revert back to the pre-EMG documented signs and/or symptoms. You should always check to see if the patient's carrier lists his pretesting signs and/or symptoms as covered diagnoses.

Tactic 1: One overriding tactic is making sure you submit sufficient documentation. Interpreting EMG results can be complex because physicians interpret sounds and waveforms produced by EMG needles real- time. Therefore, you may earn your reimbursement by providing raw data for (1) the exact location of the EMG needle electrode insertion sites in the patient's body, (2) the auditory output of the EMG during the exam, and (3) the correlation between the recorded waveforms and the patient's effort during voluntary muscular contraction.

Tactic 2: Check your Medicare carrier's policy bulletin regarding EMGs before your physician performs the test in order to determine coverage limitations and covered diagnoses. Get a letter of medical necessity or office notes from the referring physician prior to the test, and have the patient sign an advance beneficiary notice (ABN) prior to the test if you see that the pretesting sign/symptom(s) aren't covered.

Tactic 3: If the payer denies your patient's pre-EMG diagnosis, you can send a paper claim with a copy of the carrier's covered diagnoses with your patient's diagnosis highlighted, a cover letter explaining why the physician performed the EMG, and copies of the chart notes.

Tactic 4: Your physician may perform an EMG on a patient more than once for reasons such as (1) second diagnosis, (2) inconclusive diagnosis, (3) rapidly evolving disease, (4) course of the disease, (5) unexpected course or change in the course of the disease, and (6) recovery from injury. Take special care in determining how many occurrences per calendar year your carrier will reimburse.
"Reasonable limits can be set for the frequency of repeat EMG testing per year for a given patient by the same physician," says **Tiffany Schmidt, JD,** director of policy at AANEM.

For instance, carriers may reimburse two tests for carpal tunnel and radiculopathy, among others, and three tests for motor neuronopathy and plexopathy. "These limits do not apply if the patient requires evaluation by more than one physician in a given year or if the patient requires evaluation for a second diagnosis in a given year," Schmidt adds.

Make sure that you submit a letter of medical necessity or office notes that provide a clear explanation for the need to perform the EMG test again.

"We don't always perform EMGs on the same individual for the same problem," says **Mike Snyder**, supervisor of the neurodiagnostic and sleep lab of Mercy Medical Hospital in Cedar Rapids, Iowa. "The patient may have been here for carpal tunnel, but another time he or she might have come here for diabetic polyneuropathy. Sometimes we'll perform a base line for a patient and then perform another down the road" for a change in patient signs and/or symptoms or a progression of a diagnosed disease.

"You should include the reason for the repeat study in the body of the patient's chart," Schmidt says, "but remember, repeat EMG should not be necessary in a 12-month period in 80 percent of all cases."