Eli's Rehab Report

NCCI 10.1 Edits Could Cost You More Than $120 Per Test

16 testing codes are now bundled into scores of spinal injection codes

If your physiatrist performs electromyography, nerve conduction studies or other neurological tests before administering Botox or spinal injections, you may find yourself jumping through hoops to collect payment.

The National Correct Coding Initiative's (NCCI) latest version (10.1), which took effect April 1, bundles 16 testing codes into more than 520 procedure codes. Because services like two-extremity electromyographic studies (95861) can reimburse more than $120, this news could severely affect PM&R practices.

The comprehensive codes include spine surgery procedures (22100-22855), laminectomies and other spinal procedures (63001-63746), spinal injections (64400-64530), destruction by neurolytic agent (64600-64681), and neuroplasty (64702-64727).

NCCI now bundles the following procedures into the above codes:

1. **CPT 92585** (Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive)
2. **CPT 95822** (Electroencephalogram [EEG]; recording in coma or sleep only)
3. Needle electromyography (EMG) codes 95860-95861 and 95867-95868
4. Nerve conduction, amplitude and latency/velocity study codes 95900 and 95904
5. Evoked potentials and reflex tests codes 95925-95937.

Separate Services May Warrant -59

"Some of these bundle combinations will be a big surprise to medical practices," says **Heather Corcoran**, coding manager at CGH Billing Services, a medical reimbursement consulting firm in Louisville, Ky. "The new edit bundling EMGs and nerve conduction studies into the chemodenervation codes seems to go against what some Medicare policies currently state."

What you'll face: National Heritage Insurance Company, a Part B carrier for five states, publishes a policy that says, "There may be patients who require electromyography in order to determine the proper injection site(s) for the use of medications such as botulinum toxin or other agents. The ICD-9-CM code 781.99 (Other symptoms involving nervous and musculoskeletal systems) should be used in these situations."

This policy was published before these NCCI edits took effect, however, so you should ask your carrier where it stands on reporting both services together.

Tip: You can use a modifier to separate the new bundled services if your documentation demonstrates that the services were distinct from one another, says **Marvel J. Hammer, RN, CPC, CHCO**, owner of MJH Consulting, a healthcare reimbursement consulting firm in Denver. "I am not sure if the standard EMG service provided for location of the dystonic or spastic muscle would support the use of the -59 modifier (Distinct procedural service)," she says. "Certainly a diagnostic EMG performed separately at the same visit of the botulinum injection for medical reasons beyond injection site location would clearly support the use of the distinct-procedure modifier."

The catch: "The caveat," Hammer says, "is that the limited EMG code 95870 is **not** bundled with any of the

chemodenervation codes. The vast majority of chemodenervation services do not require the complete requirements of a "full" extremity EMG testing. In my audits of the documentation of the botulinum injections, the more typical service provided and documented is the limited study."

Because the NCCI does not bundle the limited EMG study code 95870 into the Botox injection codes, you can still report these services together without appending a modifier.

Note: Visit www.cms.hhs.gov/physicians/cciedits/default.asp for links to documents that explain the edits, including the NCCI Policy Manual for Part B Medicare Carriers, the Medicare Carriers Manual, and an NCCI Question-and-Answer page.