Codify
BY AAPC

Eli's Rehab Report

Reader Question: Modifier for EMG Services?

Question: When 95867 is used in combination with **CPT 95860** or **CPT 95861** , should a modifier be added to indicate that it is a distinctly separate procedure?

Alabama Subscriber

Answer: According to the latest version of the Correct Coding Initiative (CCI), 95860 (needle electromyography, one extremity with or without related paraspinal areas) and 95861 (needle electromyography, two extremities with or without related paraspinal areas) are not listed as component codes of 95867 (needle electromyography, cranial nerve supplied muscles, unilateral). Therefore, you can bill either of these codes with 95867, and you are not required to add modifier -59 (distinct procedural service) to the claim. If your carrier denies these combined codes, mention in your appeal that these are separate procedures and send a copy of the CCI edits that correspond to the codes in question.

In addition, remember that most Medicare policies require that a physician evaluate extremity muscles innervated by three nerves (e.g., radial, ulnar, median) or four spinal levels, and study at least five muscles before he or she can bill needle electromyography codes 95860 to 95864. For example, if a physician performs the test on both legs of a patient suspected of having transient paralysis (781.4), the electromyogram would have to study at least five muscles on each leg to bill 95861.