Eli's Rehab Report

Solutions to Nerve Conduction Study and EMG Coding Challenges

Many physiatrists face big coding problems when billing for nerve conduction studies (NCSs) and electromyography (EMG). Practices that erroneously apply bilateral modifiers to nerve conduction study codes or fail to document medical necessity for these tests can avoid lengthy appeals by following our experts advice. Further, billing the two tests on the same day or with an evaluation and management service can be made easier if the physiatrist is aware of the CCI edits and HCFA laws that affect coding.

How to Use Modifiers With Studies

A coder opens a file belonging to a patient suffering from hand tingling and numbness. The physiatrist has performed two types of nerve conduction studies, but the coder cannot determine from the notes how many nerves were tested. The doctor has attempted to code the procedure, and has written, 95900, 95904, modifier -50. Mirror image x2.

The coder cannot determine whether the modifier -50 (bilateral procedure) refers to bilateral tests of 95900 or 95904, and whether the mirror image x2 was performed in addition to the previous bilateral modifier indication.

Based on Part B billing guidelines, 95900 (nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study) and 95904 (nerve conduction, amplitude and latency/velocity study, each nerve; sensory or mixed) are bilateral-exempt, says **Sylvia Albert, CPC,** customer support manager at AcSel Billing Corporation, a medical billing and reim-bursement firm in Virginia Beach, Va. Therefore, modifier -50 is not valid and should not be added to the claim.

The coder should ask the physiatrist whether multiple sites of the same nerve were tested. If the answer is yes, then two units of 95900 and/or 95904 cannot be billed. Per CPT 2001, 95900 and 95904 should be reported only once when multiple sites on the same nerve are stimulated or recorded, says Albert.

Assuming that two sites along the same nerve on the left hand were tested using motor (95900) and sensory (95904) studies, and then the same procedure was performed on the right hand, the coding would be:

95900 x1 unit -LT (left side)
95904 x1 unit -LT
95900 x1 unit -RT (right side)
95904 x1 unit -RT
782.0 (disturbance of skin sensation)

Alternatively, if the coder approaches the physiatrist with this chart and the physiatrist says that 95900 and 95904 were performed on two nerves on each hand, the coding would change. For example, if the physiatrist indicated that both motor and sensory studies on two nerves of the patients left hand/wrist were performed, and then repeated the studies on two nerves of the patients right hand/wrist, coding would be as follows:

95900 x2 units, -LT
95904 x2 units, -RT
95900 x2 units, -LT
95904 x2 units, -RT
782.0

Documenting Medical Necessity

Albert reminds coders who are billing for different nerve conduction studies (95900 as well as 95904) to record clearly the medical necessity for performing sensory and motor tests on the same day. Documentation should explain the performance of both 95900 and 95904 on the same day, says Albert, because each nerve test can be billed separately. Therefore, the coder in the first scenario must ask the physiatrist to indicate accurately in the chart notes why separate tests were performed, and that separate nerves were tested. The physiatrist should include with the claim any exam notes discussing why it was necessary to perform both motor and sensory tests on the same day.

According to **Tiffany Eggers, JD, MPA,** policy director and legislative counsel for the American Association of Electrodiagnostic Medicine, contrary to how some payers view the codes, 95900 should not be bundled into 95904. She states that HCFA is deleting a recently invoked CCI edit (6.3) that bundled all motor and sensory nerve conduction studies into 95904, but physiatrists who are face denials from payers who bundle 95900 and 95904 should use modifier -59 (distinct procedural service) to ensure that the codes are paid separately.

Reporting EMG and NCSs Performed Together

A coder receives a chart for a patient with numbness, tingling and pain on the left side of his back. The chart reads, Level 3 exam; 95900 x 3 nerves; 95904 x 2 nerves; 95861 x 5 muscles per extremity. Diagnosis: lumbosacral radiculitis.

In this scenario, the coder has the information that he or she needs regarding the number of nerves tested in the nerve conduction study, and we have already confirmed that 95900 and 95904 can be billed together. In addition, 95861 (needle EMG, two extremities with or without related paraspinal areas) refers to a needle EMG with five muscles on each of two extremities tested. However, the coder is still unsure of how to bill the service. His or her primary questions are:

Can the EMG and the two nerve conduction studies be billed together?

If yes to the above question, can the E/M code be billed in addition to the EMG and nerve conduction studies?

Does the coder bill only one unit of 95861? Or, since five muscles on two extremities were tested, would it be appropriate to bill 10 units?

EMG and nerve conduction studies are complementary studies and are in no way mutually exclusive tests, so the appropriate nerve conduction study code should be used to identify the nerves tested, and the appropriate EMG code should be used to identify the muscles or limbs tested with the needle EMG, says **Gregory Mulford, MD, FAAPMR, FAAEM,** chairman of the department of rehabilitation medicine at Morristown Memorial Hospital in New Jersey, and advisor to the AMA CPT Advisory Committee for the American Academy of Physical Medicine and Rehabilitation. This topic is fraught with confusion by many physicians and payers, says Mulford, but physical medicine and rehabilitation (PM&R) practices have to be aware that they can and should bill EMG and nerve conduction studies together.

Dianna Hofbeck, RN, CCM, AFCE, president of North Shore Medical Inc., a medical billing and case management company in Absecon, N.J., recommends billing combined EMG and nerve conduction study claims in hard-copy form (versus electronic) with all documentation sent to the insurer at the outset of the process. It is more effective to send out the bills with hard-copy documentation right at the beginning of the claim. Let the payer know why you should be paid. If you do this on your first claim submission, you wont have to appeal. This method has worked for us for over 30 years of billing these claims.

The hard-copy claim should include the physiatrists chart notes, any diagrams of where the tests occurred, and any dictation associated with the claim.

Billing for an E/M With a Study

As for the E/M service, if the physiatrist determined during his or her evaluation that EMG and nerve conduction studies were required for further diagnosis determination, then all three services could be billed together, provided that modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) was added to the E/M code, and that the chart notes demonstrate medical necessity for

all services provided. In addition, confirm with the physiatrist that a full level-three evaluation was performed, rather than the short history, assessment and muscle examination that most physicians perform prior to EMG and nerve conduction studies, during which they isolate the problem area.

Regarding the number of units for billing EMG tests, most Medicare carriers 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 billing 95860-95864. No matter how many muscles are tested during the EMG, only one unit of service should be billed per extremity. Therefore, the physiatrist performing the EMG on five muscles per each of two extremities would bill one unit of 95861.

The claim for this scenario is coded:

95900 x 3 units
95904 x 2 units
95861 x 1 unit
99213-25
724.4 (thoracic or lumbosacral neuritis or radiculitis, unspecified)

Limitations on EMG and NCS Codes

Remember that these codes may have utilization parameters, says Albert, meaning that certain EMG and nerve conduction study codes can be performed only every six or 12 months, depending on carriers different policies. In addition, Medicare carriers are very specific about covered diagnosis codes for these tests, so PM&R practices must ensure that the patients symptoms fit in with a covered ICD-9 code to ensure timely payment.