An Introductory Guide to Electrodiagnostic Billing Part 3: Frequently-Asked-Questions

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For this month's coding installment, we take you through several questions that commonly arise when billing for electromyography and nerve conduction studies.

Can I use CPT code 95887 (NON-EXTREMITY EMG, done same day as nerve conduction studies) when I perform needle EMG on the cervical paraspinal muscles on the same day as nerve conduction studies (NCS)?

Yes, this is possible in the right situation.

Code 95887 (NON-EXTREMITY EMG, done same day as NCS) can be used when testing paraspinal muscles only if muscles in the corresponding limb are NOT tested. For example, if you needle the RIGHT cervical paraspinal muscles along with muscles from the LEFT upper limb or EITHER lower limb, you could bill both 95887 and 95885 (LIMITED needle EMG of extremity, done same day as NCS) or 95886 (COMPLETE needle EMG of extremity, done same day as NCS).

A common question comes up when someone performs a limited needle EMG extremity study (fewer than 5 muscles) on a given limb along with the corresponding paraspinal musculature. This might occur if you have to stop the test early due to pain. For instance, if you were to test the biceps, triceps and deltoid in the LEFT arm along with the LEFT cervical paraspinal muscles, you would use code 95885 because this would qualify as a LIMITED needle EMG extremity study. It would be incorrect to also bill 95887 in this scenario.

Keep in mind that 95887 is considered an "add-on" code (similar to 95885 and 95886), which is why it is listed with a "+" sign if you are reviewing the code in the CPT codebook, because it is only used when NCS is done on the same day. In this case, the primary code it is being added on to is the code for the NCS (95907-95913). You would not report 95887 in conjunction with EMG codes 95867-70, since the latter group of codes are not add-on codes and you would only use them if no nerve conduction studies were performed on that day.

Definitions:

- Complete needle EMG: five or more muscles studied, innervated by three or more nerves or four or more spinal levels
- Limited needle EMG: four or fewer muscles studied
- Non-extremity EMG: Includes the cranial nerves and all axial muscles (e.g., paraspinal muscles)

We submitted a claim for a nerve conduction study on the right hand including the right median sensory nerve to the second digit, right median nerve to the fourth digit, right ulnar sensory nerve to the fourth digit, and right ulnar sensory nerve to the fifth digit. We billed for four nerves according to Appendix J, but our claim was denied. The insurance company said it was because each nerve constitutes one unit of service per CPT, therefore the median sensory and ulnar sensory could only be billed once each. What should we do?

A complete list of motor, sensory and mixed nerves and nerve segments can be found in Appendix J in the back of the CPT codebook. Each nerve and nerve segment listed on this table can be counted separately towards the total. The sum of the separate nerves tested should be added to determine which NCS code to report.

Misinterpretation of Appendix J by insurance companies is a fairly common reason for denials. An appeal to the denied claim should be initiated. From a CPT perspective, as long as the testing is performed on different nerves or nerve branches included in Appendix J, each nerve or nerve segment may be reported as one unit. For example, the median sensory nerve has six different nerve segments that can each be counted (and billed) separately.

Can I bill 95885 (LIMITED needle EMG of extremity, done same day as NCS) and 95886 (COMPLETE needle EMG of extremity, done same day as NCS) together if the testing was done on separate limbs? I am having difficulty getting reimbursed.

Yes. CPT codes 95885 and 95886 can be billed concurrently for the same patient on the same day. Any combination of these code can be used for a total of four separate limbs billed on the same day. However, there is a National Correct Coding Initiative (NCCI) Edit in place to prevent these codes from being billed at the same time on the same limb. If you use modifier 59 on code 95885 to indicate that testing was performed on a different anatomic location, this can help ensure that the claim goes through. If it is denied despite using a modifier 59, an appeal should be initiated.

Your Academy is a great resource for questions on billing and coding. Contact Academy staff at **codingquestions@aapmr.org.** ❖