An Introductory Guide to Electrodiagnostic Billing – Part 1

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Introduction

Electrodiagnostic (EDx) testing can be an important and helpful extension of the clinical evaluation for patients with peripheral and/or central nervous system disorders. EDx testing can be used to evaluate symptoms, achieve diagnostic clarity, and follow the clinical course of a disease process and response to treatment. Billing for EDx procedures can seem more complex than billing for other physician services; however, in this article, we offer a guide for appropriate EDx coding. This article is the first of a three-article EDx series. Future issues will include case studies to demonstrate how to put this coding into practice as well as frequently-asked-questions.

EDx testing typically includes both a nerve conduction study (NCS) and needle electromyography (EMG). However, in select cases one may be performed without the other. The EMG codes are chosen based on whether or not NCS is also performed on the same day, so this will be discussed first.

Nerve Conduction Study Coding

Physicians are encouraged to test the fewest number of nerves needed to assess or diagnose a medical issue when performing an NCS. The AANEM has developed a position statement[1] to aid electrodiagnosticians in designing an NCS that tests a reasonable number of nerves to achieve a diagnosis in >90% of cases. The "Maximum Number of Studies" table in the position statement is designed to identify outlier trends and prevent abuse and overutilization. The guideline does not provide a "hard maximum"; however, physicians who differ more than 10% from established norms might be asked to provide information about the characteristics of their patient population or practice style to justify their billing.

There are 7 main codes used to bill for NCS. The correct code is selected based on the number of nerves tested as identified in Appendix J of the American Medical Association Current Procedural Terminology (CPT) codebook[2].

NERVE CONDUCTION STUDIES (BILL ONE CODE PER PATIENT PER DAY.)*	
95907	1-2 nerves
95908	3-4 nerves
95909	5-6 nerves
95910	7-8 nerves
95911	9-10 nerves
95912	11-12 nerves
95913	13 or more nerves

* See Appendix J in the AMA CPT codebook for the list of nerves that may be counted.

Appendix J is described in further detail below and has a list of distinct nerves that can be counted for NCS. Each nerve qualifies as a distinct nerve in your sum for billing NCS for a given patient on a single day. For the purposes of coding, a single nerve is defined as a sensory nerve, motor (with or without F waves) nerve, mixed nerve, or an H-reflex test. Each nerve is counted only once when multiple sites on the same nerve are tested, such as with "inching" studies.

It should be noted that most nerves have a contralateral counterpart, and bilateral testing is often necessary for comparison purposes; the nerve on each side should be counted separately toward the total. Multiple NCS CPT codes cannot be billed for a given patient on a single day.

Appendix J

Appendix J found in the AMA CPT® codebook is a list of individual nerves created for the purposes of billing NCS. The list identifies each individual sensory, motor, or mixed nerve, or nerve segment that can be counted separately toward the NCS total. Each line of Appendix J's list of nerves refers to a different nerve and should be counted as an individual unit. For example, the ulnar motor nerve has 4 different nerve segments that can each be counted separately toward the total (i.e., ulnar motor nerve to the abductor digiti minimi, ulnar motor nerve to the palmar interosseous, ulnar motor nerve to the first dorsal interosseous, ulnar motor nerve to the flexor carpi ulnaris).

Electromyography Coding

EMG coding is generally based on the number of limbs examined (or, in certain cases, specific paraspinal muscle levels), but the choice of which group of CPT codes to use for billing depends on whether an NCS is also performed on the same day.

For EMG studies performed with an NCS on the same day, one should bill using CPT codes 95885 (limited study), 95886 (complete study), or 95887 (non-extremity study). These are considered "add-on" codes, and may not be billed independent of an NCS code. These are billed in units based on the number of extremities tested. One unit includes all muscles tested in a particular extremity, with or without the relevant paraspinal muscles. A complete study of a limb should include at least 5 muscles that are innervated by 3 or more peripheral nerves (e.g., radial, ulnar, median, tibial, peroneal, femoral) or 4 or more spinal levels. In some instances, a complete study may be billed without the relevant paraspinals muscles when this testing is contraindicated or not feasible and the reasons are appropriately documented. A non-extremity code can be billed when evaluating muscles innervated by the cranial nerves (e.g., genioglossus, laryngeal muscles), the phrenic nerve (i.e., diaphragm), paraspinal muscles tested independent of limb testing, abdominal muscles, or other muscles not associated with an extremity. Codes 95885 (limited study) and 95887 (non-extremity study) can be billed in multiple units, although some carriers may deny such claims unless you list multiple units as separate line items.

When there is no NCS performed on the same day, one should bill using CPT codes 95860-95864 (complete studies, based on number of limbs evaluated), 95870 (limited study), 95865 (larynx), 95866 (hemidiaphragm), 95867 (unilateral muscles supplied by cranial nerves), 95868 (bilateral muscles supplied by cranial nerves), or 95869 (thoracic paraspinals). Only 1 unit of service of codes 95860-95864 may be reported per patient for a given examination. See chart on the next page for additional information on how/when to use EMG codes with NCS. ❖

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NEEDLE EMG			
NCS performed on same day		No NCS performed, may only bill each code once	
95885	Limited study • Bill one unit per limb • Less than 5 muscles • Includes related paraspinals	95870	Limited study
95886	Complete study • Five or more muscles innervated by 3+ nerves, with or without relevant paraspinals muscles • Or 4+ spinal levels Bill 1 unit for each limb	95860 95861 95863 95864	Complete study • Five or more muscles innervated by 3+ nerves, with or without relevant paraspinals muscles • Or 4+ spinal levels 1 limb 2 limbs 3 limbs 4 limbs
95887	Non-extremity (e.g., cranial nerve or axial) muscle(s)	95865 95866 95867 95868 95869	Non-extremities Larynx Hemidiaphragm Cranial nerve muscle (unilateral) Cranial nerve muscle (bilateral) Thoracic paraspinals (not T1-2)

1 AANEM Recommended Policy for Electrodiagnostic Medicine: https://www.aanem.org/getmedia/ede0fe55-c120-4e90-9c4d-ba7c9e40b2c7/Recommended-Policy-for-Electrodiagnostic-Medicine_1.pdf.
2 CPT® 2019 Professional Edition. American Medical Association 2018.

CMS finalized the IRF Prospective Payment System Rule for 2020

On July 31, CMS finalized the IRF Prospective Payment System Rule for 2020. In the final rule, CMS has deferred to the inpatient rehabilitation facility to define and assess the definition of "rehabilitation physician."

While this is a disappointing outcome, our work is far from over. AAPM&R is taking action.

Your Academy will be convening key stakeholders across rehabilitation to establish consensus guidelines to better define the qualifications of a rehabilitation physician and set clear and necessary expectations and standards for rehabilitation. We believe physiatrists are a necessary and integral leader of the rehabilitation team within the IRF setting.

Collaboration, open dialogue, and a united voice among physiatrists will be essential to our success. In the weeks and months ahead, please be on the lookout for requests from AAPM&R to get involved and to support our efforts. AAPM&R will continue to advocate for the long-term interests of physiatrists, IRFs, Medicare beneficiaries in need of intensive, coordinated, interdisciplinary inpatient hospital rehabilitation, and the Medicare program itself.

Despite this outcome, we are immensely proud of the work more than 1,100 of our members put into advocating against this proposal being finalized. In their preamble to the final rule, CMS acknowledged the comments received from AAPM&R and other collaborators. Our members demonstrated that physiatrists are advocates for their patients, in and out of the treatment setting. ❖

ACADEMY IN ACTION

- On June 18, your Academy submitted comments to the proposed Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for FY 2020, continuing our efforts to advocate for fair reimbursement.
- On June 19 and 21, your Academy supported letters from the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition. The first letter advocated to the Centers for Medicare and Medicaid Services (CMS) for patient access to non-invasive ventilators and the second letter advocated for Congress to pass legislation restoring access to Complex Rehabilitation Technology (CRT) manual wheelchair accessories.
- On July 12, your Academy submitted comments to the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) draft strategic plan for FY 2020-2024. The comments were drafted by members of the Health Policy & Legislation Committee (HP&L) and the wider Academy membership.
- On July 17, your Academy supported the American Medical Association's (AMA) letter advocating for an independent dispute resolution process to be an essential piece of any surprise billing legislative solution.
- On July 30-31, your Academy attended the 2019 AMA State Advocacy Roundtable, to discuss physiatry-relevant topics including: surprise billing, state scope of practice review committees, ending the opioid epidemic, and prior authorization. A dedicated state and specialty roundtable provided a forum for 2019 developments and emerging issues.