Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Know Which Nerve Conduction Study Code Is Right for You

Take the fear out of modifier 59 using the scenarios our experts reveal

Choosing the appropriate code to describe your nerve conduction test can prove to be a challenging proposition. Listen to what our coding experts have to say to help you make the right choice with no second guessing.

How to Differentiate Between the 3 Possibilities

When you-re looking at nerve conduction study (NCS) coding, you have three options:

- 95900--Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
- 95903--- motor, with F-wave study
- 95904--- sensory.

The first thing you need to remember about these nerve conduction test codes is that you can report only one of the codes when a physician performs the study on the same nerve at multiple sites.

-CPT codes 95900 and 95904 are billed by units--nerves--and can be billed only once per nerve,- says **Marianne Wink-Sturgeon, RHIT, CPC, ACS-EM**, with the **University of Rochester Medical Center** in NY. -Code 95903 includes both F-wave and motor conduction studies. By Correct Coding Initiative exclusion, they cannot be billed at the same time on the same nerve as code 95900.-

Remember: Codes 95900, 95903 and 95904 are -each nerve- codes, according to their descriptors. CPT's parenthetical remark with these codes notes that you should -report 95900, 95903 and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded.- Make sure you follow this guide and aren't reporting multiple sites on the same nerve as -each nerve.-

Know When to Use Modifiers

Modifiers can come in handy when coding for nerve conduction studies, as Wink-Sturgeon describes in the following example.

A patient undergoes a motor nerve conduction study, which the physician performs without F-wave on one nerve. During the same procedure, the physician performs a motor nerve conduction study--this time with F-wave--on a different nerve.

If the physician performed these studies separately, you would code for them using 95900 for the first procedure and 95903 for the second. Because the doctor conducted both tests on the patient at the same time, you should assign modifier 59 (Distinct procedural service) to the second study to indicate that the physician performed a separate procedure on a different nerve.

-We use modifier 59 quite a bit in NCS coding,- says **Meredyth Hurt, CCS-P**, with **Sky Lakes Medical Center** in Klamath Falls, OR.

She describes the following example: A doctor performs motor nerve testing (95900) on the median, ulnar and radial nerves on the patient's left side. The doctor then performs a motor F-wave (95903) on the median and ulnar nerves, again on the left side.

Keep in mind: In this case you would bill 95903 for two units as well as 95900-59 for one unit, according to Hurt. She says that, according to CCI, the 95900 procedure is bundled into 95903 when the doctor performs an F-wave study--as well as a regular motor nerve study (95900)--on the same nerve.

Because 95903 is the primary code describing the more substantial procedure, Hurt says, -You-ll bill for it first. Code 95900-59 is billed second as the additional procedure.-

Even with modifier 59, denials are still a possibility, Hurt says. She notes the example of payers rejecting claims because they say 95900 bundles into 95903. All is not lost, however. In cases like this, she says, -I appeal with the explanation that the nerve tested-for 95900 was tested separately for 95903. I have had about a 90 percent success rate with this appeal.-

Remember: For a successful appeal, you need to include proper documentation to clearly support these coding assignments.

How Medical Necessity Affects NCS Coding

Another key component in your coding process is establishing medical necessity for the NCS.

-The patient's signs and/or symptoms or a diagnosis support medical necessity when ordering a diagnostic procedure,- Wink-Sturgeon says. -This information must be documented in the order and note for the procedure.-

Because these studies test a particular nerve's function, Hurt says that she looks for a condition that would indicate that the function of the nerve has been compromised. -Numbness, tingling, weakness, loss of sensation are symptoms that I look for to determine medical necessity,- she says. -The clinical indications illustrate the necessity.-

You should look for any other conditions the patient has that would contribute to improper nerve function, Hurt says. -If the doctor finds a condition like carpal tunnel or neuropathy, you would code these instead of symptoms,- she says. Other possible conditions include diabetes and rheumatoid arthritis.

Helpful hint: You should reference your local or national reimbursement policies to verify acceptable diagnoses that are covered for these procedures.

For example: Carriers often accept diagnosis codes such as 356.2 (Hereditary sensory neuropathy) or 724.4 (Thoracic or lumbosacral neuritis or radiculitis, unspecified).

Warning: Always assign the appropriate ICD-9 codes, Wink-Sturgeon says. Be careful not to report a diagnosis just because a carrier will pay for it. If it doesn't apply to the case, don't report it. You need to submit the most accurate diagnosis, regardless of the carrier's policy.