Eli's Rehab Report

5 Easy Ways to Improve EMG Reimbursement

If choosing from the numerous electromyography (EMG) codes feels like a tough workout, it's time to take a breather with this expert coding advice: As long as you identify the specific muscles the physician tested, you will choose the correct EMG code. Follow these five tips and recoup hard-earned reimbursement for EMGs.

1. Count limbs for 95860-95864. If your physiatrist performs a needle EMG of the arms and legs, CPT offers four codes, depending on the number of extremities the physician studies:

1. 95860 - Needle electromyography; one extremity with or without related paraspinal areas
2. 95861 - ... two extremities ...
3. 95863 - ... three extremities ...
4. 95864 - ... four extremities ...

For instance, if the physiatrist evaluates both the left and right arms at the wrist to test for bilateral carpal tunnel syndrome, you should report 95861. For testing of both legs and one arm, such as during diabetes-related neuropathy evaluations, report 95863.

In all cases, however, the physiatrist must evaluate extremity muscles innervated by three nerves, such as radial, ulnar, median, tibial, peroneal or femoral (but not sub-branches), or four spinal levels, while studying a minimum of five muscles per limb, says **Neil Busis, MD**, director of the neurodiagnostic laboratory at the University of Pittsburgh Medical Center at Shadyside.

"Medicare guidelines are very specific about the number of muscles required per limb," Busis says. "Coders should ensure that the physician has clearly listed the number and names of the muscles tested in the medical record to sustain the claim."

A single unit of 95860, 95861, 95863 or 95864 includes all muscles of five or more tested in a particular extremity. In other words, you may report only a single unit of 95860-95864 per session, and you cannot bill additional units for more than five muscles per extremity. If the physician studies or documents fewer than five muscles per limb, you must report a limited study (95870) rather than 95860-95864, says **Tiffany Schmidt, JD**, policy director for the American Association of Electrodiagnostic Medicine (AAEM).

Because 95860-95864 include testing of related paraspinal muscles, you should not report paraspinal testing separately unless the physiatrist studies those levels from T2 to T11 (inclusive). In this case you may report 95869, according to AAEM recommendations. Likewise, if the physician fails to test related paraspinal muscles, this does not constitute a reduced or discontinued service. You should not, therefore, append any modifiers when reporting such services.

2. Supplied by cranial nerve? Choose 95867-95868. When coding for electromyographic testing of one or more muscles supplied by the cranial nerves, you should report either 95867 (Needle electromyography; cranial nerve supplied muscle[s], unilateral) for one side of the body or 95868 (... bilateral) for both sides of the body.
You may not report 95867 and 95868 during the same session, Busis says, and you should not append modifier -50 (Bilateral procedure) to either code. And, once again, the physician should clearly document the muscles he or she tested.

You may assign 95867, for instance, when the physiatrist diagnoses possible motor neuron disease (335.2x). The physiatrist studies the motor neurons on a single side of the brain, which, if degenerated, can lead to muscle weakness and wasting. The physiatrist may perform the same procedure bilaterally (95868) to diagnose Bell's palsy (351.0). Bilateral testing provides a "control" for comparison of the affected and unaffected sides of the body.

3. Look to 95869 for paraspinals T2-T11. You may report a separate study using 95869 (Needle electromyography; thoracic paraspinal muscles) when the physician tests thoracic paraspinal muscles other than those at levels T1 and T12. And, you should code examinations confined to distal muscles only, such as intrinsic foot or hand muscles, using 95869 rather than 95860-95864.

Report only a single unit of 95869 regardless of the number of spinal levels the physician tests, Schmidt says. These codes are either unilateral or bilateral and, therefore, you should not append modifier -50 for bilateral studies. You may report 95869 in addition to 95860-95864, but only when testing levels T2-T11.

4. Four or fewer muscles, use 95870. For limited studies - studies that involve fewer than five muscles per extremity and therefore do not qualify for 95860-95864 - you should report 95870 (... limited study of muscles in one extremity or non-limb [axial] muscles [unilateral or bilateral], other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters). This code also corresponds to nonlimb muscle testing.

Report 95870 when testing muscles on the thorax or abdomen (unilateral or bilateral), as well as for studies of the cervical or lumbar paraspinal muscles (unilateral or bilateral), Busis says. Although you may report one unit of 95870 per extremity, as with 95869, you should report only a single unit when the physiatrist studies multiple cervical or lumbar paraspinals.

For example, if the physician tests four muscles on each arm, report 95870 x 2. If the physiatrist studies paraspinals at four cervical levels, however, you should claim only a single unit of 95870, even if he or she studies the muscles bilaterally.

5. Reserve 95872 for a single fiber electrode. If the physiatrist studies action potentials from individual muscle fibers, you should select 95872 (Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied), says **Carol Pohlig, BSN, RN, CPC**, reimbursement analyst and senior coding and education specialist in the department of medicine at the Hospital of the University of Pennsylvania in Philadelphia. Report 95872 for such tests as neuro-muscular transmission test, which physicians use to diagnose diseases such as myasthenia gravis (358.0).

You should report one unit of 95872 for each muscle the physician tests, according to CPT guidelines. The physician will generally test at least two muscles (one test serves as a "control"), so you will report a minimum of two units of service. As with all other EMG codes, you should make sure that when you report 95872 the physician's documentation identifies the muscle(s) tested and the test results.