

Eli's Rehab Report

Assign Your EMG Code by Number of Muscles And Test Location

Even if the EMG tests more than five muscles in one extremity, use 95860

If your physician performs electromyography (EMG) testing, you must note how many muscles the physician studies and where the physician performs the tests on the body.

Must Have 5 Studies per Limb for 95860-95864

Because an EMG is a site-specific diagnostic test, make sure you know the specifics for each EMG code group before submitting your claims. Denials can stem from problems as basic as assigning the wrong [CPT Codes](#) or your documentation not satisfying Medicare requirements.

The following group of codes (95860-95864) describes EMG testing of the limbs (arms and legs):

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

A physician 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, with a minimum of five muscle studies per limb, according to Medicare guidelines. If the physician does not meet this number, then your reimbursement may be denied or reduced.

"Our physicians have a check-off sheet they use, so if they test five muscles in one extremity, they'll use 95860," says **Mike Snyder**, supervisor of the neurodiagnostic and sleep lab of Mercy Medical Hospital in Cedar Rapids, Iowa. "If it's more than five muscles in an extremity, we still report it as 95860."

Typical scenario: "Routinely, if the diagnosis is carpal tunnel syndrome (unilateral) (354.0), we will check the median and ulnar motor fibers with nerve conduction studies of the symptomatic extremity (two units of 95900, Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study). We'll also check median and ulnar sensory fibers with nerve conduction studies (two units of 95904, ... sensory). Then the physician will examine five muscles in the affected arm (one unit of 95860)," Snyder says.

Watch paraspinals: The "related paraspinal areas" part, mentioned in the code descriptors of 95860-95864, includes all paraspinals except those of the thoracic (T3-T11) region. This means you shouldn't report paraspinal-area testing separately using these codes. In cases in which the physician studies the areas between T3-T11, you would use 95869 (Needle electromyography; thoracic paraspinal muscles [excluding T1 or T2]) instead.

Put Medicare Guidelines Into Practice

A patient presents with numbness in the right leg (782.0, Disturbance of skin sensation), so the physician performs EMG

on five muscles of the affected leg. You should report 95860. The physician goes on to conduct an EMG studying at least five muscles on the symptom-free left leg to provide a comparison. In that case, you can report 95861 instead of 95860.

Keep in mind: The physician must meet the minimum testing requirements (five muscles innervated by three nerves each) for each leg. Your documentation should detail exactly which muscles the physician tested, so that the carrier will see that the physician met the requirement for these codes.

In another example, suppose your physician tests five muscles in the left leg and six in the left arm. In this case, you should report 95861 because he met the five-muscle requirement for each of the two limbs.

However, if the physician tests only three muscles in the left leg and six in the left arm, you should report 95860, the code for a single extremity, and 95870 (Needle electromyography; 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). The reason you should use 95860 for the arm only is that the physician did not meet the five-muscle requirement for each of the two limbs; he only met it for one. "If the number of muscles tested is less than five, our physicians will check off 95870," Snyder says.

Report Minimum Number of Limbs

When assigning 95860-95864, you should only report the minimum number of limbs required to confirm the differential diagnosis (such as, one limb for unilateral CTS symptoms).

Check with the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM [formerly AAEM]) for a table that lists the reasonable "maximum number" of studies necessary for a physician to confirm a diagnosis in 90 percent of patients.

Note: You can find the table either at page 12 of the PDF file <http://www.aanem.org/aaem/pdf/files/recpolicy.pdf> or at the Web site http://www.aanem.org/aaem/practiceissues/RecPolicy/recommended_policy_6.cfm.

[The AANEM's policy states that the judgment of the physician performing the electrodiagnostic evaluation should determine the appropriate number of studies. In a few cases, the patient may require more than the number listed in this table. If so, look to your physician to provide supplementary documentation justifying the additional testing - such as, other differential diagnostic problems the physician needed to rule out.](#)