Eli's Rehab Report

Clarification: Ask Your Payer About E/M With EMG

The November 2003 article "Reporting E/M and EMG? Avoid These Pitfalls" stated that in most cases you cannot report an E/M service in addition to electromyo-graphy (EMG, 95860-95864; 95870) if the patient arrives only for testing at the request of another physician. Physicians who provide these electrodiagnostic services are encouraged to determine their payers' policies.

Just because an insurer's policy may state, "An E/M service may not be charged in addition to EMG codes, unless the referring source has clearly and expressly requested an E/M service," your practice may still be able to recoup reimbursement for these E/M services.

Many insurers' policies will allow payment of an E/M service if the documentation supports it. If you appeal a decision to deny payment of an E/M service, says **Gregory Mulford, MD**, medical director at Atlantic Rehabilitation Services and chairman of Rehabilitation Medicine at Morristown Memorial Hospital in New Jersey, there is a good chance your appeal will succeed if you can explain why the E/M was reasonable and necessary and you are confident that your documentation supports the service that you performed.

"The work RVUs (relative value units) for the EMG don't include doing a thorough history, exam or any decision-making, and cover only the actual testing itself," Mulford says. "I usually suggest that a physician who performs and documents an appropriate history and exam and makes suggestions and recommendations for further management should bill for the appropriate E/M service. In my opinion, only when the electromyographer doesn't perform or document a history and physical, or just reports the results without doing an interpretation and making recommendations, should they not bill for a level of E/M service."

Mulford says that a physiatrist or neurologist should routinely perform an appropriate history and examination before determining exactly what combination of electrodi-agnostic tests he or she should use in each case. "If the physician doesn't do a history and physical, then they're acting as technicians, and they can't accurately perform or interpret the test or make any reasonable recommendations," he says. "In the vast majority of EMG referral cases, it is reasonable to bill a level-one or -two consult (99241-99242) and sometimes even **CPT 99243** if the case is more complicated."

Of the policies posted on CMS' local medical review policy clearinghouse (www.cms.hhs.gov/mcd), 14 states publish a restrictive policy not allowing E/M codes reported with EMGs. Only Empire Medicare, HealthNow and Group Health Inc., all New York and New Jersey carriers, say that practices can report EMGs with the consult codes, as long as the physician meets the requirements for a consultation.

Even if your carrier's policy restricts you from reporting EMGs with consult codes, however, Mulford advises physiatrists to fight for reimbursement. "I've had this discussion with many insurance carriers over the years and I've usually been successful in getting support for my position on this issue," he says.

If it is medically necessary for the physiatrist or neurologist to perform an E/M service before determining which EMG studies are appropriate for your patient, you should write to your insurer's medical director and appeal its policy against paying for E/M services with EMGs.

Codify
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