# Eli's Rehab Report

## Follow AAEM Guidelines for EDX Testing

By following guidelines from the American Association of Electrodiagnostic Medicine (AAEM) for electrodiagnostic (EDX) tests, PM&R practices can minimize claim denials and speed reimbursement.

The April 2002 CPT Assistant notes that EDX claims (diagnostic studies such as electromyography [95860-95872], nerve conduction studies [95900-95904], and H-reflex tests [95934-95936]) have been scrutinized recently due to many factors, "including overutilization by some providers, lack of understanding of the tests by third-party payers, and inappropriate use of codes."

To aid physicians, the AAEM developed a chart listing the "maximum number of tests necessary in 90 percent of cases" (see chart, at right). The number of tests varies according to the suspected condition(s) or confirmed diagnosis(es).

Medicare and other payers frequently state in their medical review policies for EDX testing that claims exceeding the AAEM recommendations "should be reviewed for medical necessity." The implication is that payers will apply additional scrutiny to such claims, and that physiatrists must be ready to justify the need for additional testing.

For instance, the AAEM Recommended Policy for Electrodiagnostic Testing states that a minimal evaluation for radiculopathy (729.2) "Includes one motor [95900] and one sensory [**CPT 95904** ] NCS [nerve conduction study] and a needle [electromyography] EMG examination of the involved limb [95860]" but also states that testing can include "up to three motor NCSs (in cases of an abnormal motor NCS, the same nerve in the contralateral limb and another motor nerve in the ipsilateral limb can be studied) and two sensory NCSs."

The AAEM policy further notes that H-reflexes and F-waves [95903] may provide complementary data to evaluate suspected radiculopathy.

**Note:** The complete text of the AAEM Recommended Policy for Electrodiagnostic Testing, along with the associated chart, is available online at www.aaem.net/ aaem/position_statements/recommended_policy_1.cfm.

Sometimes More Is Better

In a minority of cases (about 10 percent or fewer), the AAEM's recommended maximum number of tests for a given diagnosis may not provide sufficient information to properly evaluate the patient's condition.

"In very complex cases, the maximum numbers in the table will be insufficient for the physician to arrive at a complete diagnosis," says **Tiffany Schmidt, JD,** policy director for the AAEM. "Also, in cases where there are borderline findings, additional tests may be required to determine if the findings are significant."

"One common circumstance is where the diagnosis found does not fully explain the patient's condition," says **Neil Busis, MD,** director of the neurodiagnostic laboratory at the University of Pittsburgh Medical Center at Shadyside.

"For example," Busis says, "a patient has a numb arm, and the only thing found after several tests is carpal tunnel syndrome (354.0), which doesn't explain all the patient's signs and symptoms. The number of tests allowed for CTS is far smaller than the number needed to diagnose that patient."

Report Two Diagnoses If Necessary

"Another situation where the table falls down is when there are two diagnoses found," Busis says. "The text explaining

the AAEM recommendations explicitly states that the table does not apply in these cases."

To justify medical necessity in the first example above, for instance, Busis explains that the examiner must submit two ICD-9 codes: One to describe the unexplained symptoms (e.g., numbness, 782.0) and one for the CTS. "This signifies that CTS was not the whole story," Busis says.

Busis further notes that unlike CPT, ICD-9 has no modifier to describe a bilateral condition, which may require additional testing. "The numbers for unilateral and bilateral CTS in the [AAEM] table are different, for example, but there is no way to flag the bilateral patients automatically. You will need to submit supplemental information."

The physiatrist should include this supplemental information in the patient note and the physician EMG report. "If you want to dictate a separate rationale for the study, that is OK, too," Busis says.

If payers balk at reimbursing for necessary procedures that nevertheless exceed the AAEM recommendations, remind them that the AAEM's Recommended Policy stresses that "underutilization of needed diagnostic testing may cost payers money. If the physician does not get the full information needed for proper diagnosis from an initial consultation because the evaluation is inadequate, the consultation may need to be repeated in a more thorough manner with additional expense." If you have to submit an appeal letter, include a copy of the AAEM policy with it, indicating this information.

Follow Payer Frequency Guidelines

Physiatrists must also be cautious not to bill EDX tests too frequently for the same patient. Aetna U.S. Healthcare's coverage policy bulletin for NCS, for instance, states, "Utilization of nerve conduction studies & at a frequency of two sessions per year would be considered appropriate for most conditions (e.g., unilateral or bilateral carpal tunnel syndrome, radiculopathy, mononeuropathy [355.9], polyneuropathy [356.9], myopathy [359.9] and neuromuscular junction disorders). Nerve conduction velocity studies performed more frequently than twice a year should be reviewed for medical necessity."

As noted by the AAEM Recommended Policy, however, some patients may require repeat testing, perhaps in as much as 20 percent of cases.

Examples of when repeated testing might be in order include new conditions, inconclusive diagnoses, when the patient has a rapidly developing disease (e.g., Guillain-Barr syndrome), or if a patient is recovering from an injury (e.g., traumatic nerve injury) and requires repeat evaluations to monitor recovery, to help establish prognosis and/or to determine the need for and timing of surgical intervention.

If the physician determines that a patient's condition requires EDX testing in excess of a payer's frequency guidelines - and he or she can document medical necessity - the payer should recognize the claim and reimburse accordingly.

In such situations, the AAEM recommends that the reason for the repeat study be included in the body of the report or in the patient's chart, and that the treating physician document a comparison with the previous test results.