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Eli's Rehab Report

Maximize Pay Up for Electromyography

Nugget: EMG is a site-specific diagnostic test, and practices must note how many muscles are being studied and where on the body the tests are being performed to optimize reimbursement.

Electromyography (EMG) is a site-specific diagnostic test and many subscribers have written with concerns about how to bill accurately if a new diagnosis is not found during the course of the EMG. Practices can collect for these often costly tests, however, if the patient is presenting with a symptom that falls under Medicares list of covered ICD-9 codes, and physicians are careful to note how many extremities are tested and which muscles are being studied.

CPT Codes for EMG Testing

EMG includes the insertion of a needle electrode into skeletal muscles to measure electrical activity and assess physiologic function, says **Patricia Niccoli**, president of ElectroAge Billing, a medical billing firm in Phoenix that specializes in physical medicine and chiropractic claims. EMG often is used to determine the difference between disorders with similar symptoms, such as polymyositis (**ICD-9 710.4**) and amyotrophic lateral sclerosis (ALS) (335.20), which both produce noticeable weakness. The Health Care Financing Administration (HCFA) recognizes these EMG codes for neurologic and neuromuscular procedures:

95860, 95861, 95863 and 95864 (needle electromyography, one to four extremities with or without related paraspinal areas)
95867 (needle electromyography, cranial nerve supplied muscles, unilateral)
95868 (needle electromyography, cranial nerve supplied muscles, bilateral)
95869 (needle electromyography, thoracic paraspinal muscles) This code refers to studies of muscles between T3 and T11. It cannot be billed with 95860, 95861, 95863 or 95864 if only T1 or T2 paraspinals are studied with an upper extremity.
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)
95872 (needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied)
95875 (ischemic limb exercise with needle electromyography, with lactic acid determination)

Determining Which Code to Use

Most Medicare policies require that a physician evaluate extremity muscles innervated by three nerves (e.g., radial, ulnar, median) or four spinal levels, and study at least five muscles before he or she can bill for codes 95860 to 95864. For example, if a physician performs the test on both legs of a patient suspected of having transient paralysis (781.4), the EMG would have to study at least five muscles on each leg to bill the 95861.

Confusion begins when physicians write notes such as 95860 x 5 on their charts because the biller might not be sure whether five extremities or five muscles were tested. If this occurs, coders should confirm with the physician whether he or she tested only one extremity or whether the x 5 refers to the number of muscles tested per extremity, says **Patricia M. Salmon**, president of Patricia M. Salmon and Associates, a medical consulting firm in Newton Square, Pa.

If the physician tested five muscles on one extremity, the biller should indicate only one unit of 95860 on the claim. Medicare clearly states in its EMG guidelines, For 95860 to 95864, only one unit of service should be billed (this covers all muscles tested including the related paraspinal muscles and recording of motor unit recruitment, amplitude and configuration both at rest and with muscle contraction). Examinations confined to distal muscles only, such as intrinsic

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foot or hand muscles, will be reimbursed as code 95870 and not as 95860 to 95864.

The biller should use 95870, which can be billed at one unit per extremity, if the physician tests fewer than five muscles. According to the American Association of Electrodiagnostic Medicine (AAEM) in Rochester, Minn., 95870 also can be billed per cervical or lumbar paraspinal muscle (unilateral or bilateral) regardless of the number of levels tested. HCFAs national guidelines state that 95870 should not be billed when the paraspinal muscles corresponding to an extremity are tested, or when the extremity codes 95860-95864 also are billed.

When A New Diagnosis Is Not Found

As with many diagnostic tests, only a limited number of ICD-9 codes are covered for the EMG, and this causes concern for many practices. One subscriber reported that Medicare rejected an EMG claim because a new diagnosis was not found during the test, and therefore, it was being considered preventive rather than diagnostic.

But billers should note that many EMG claims are still reimbursable, even if a new diagnosis is not found. If a patient is referred by a primary care physician for limb pain [729.5] and the physiatrist finds evidence of carpal tunnel syndrome [354.0] during the EMG, then you would use the carpal tunnel diagnosis on the claim, says **Mary Ketola**, who bills for five physiatrists at Premiere Provider Services, a medical billing firm in Terre Haute, Ind. But if the doctor finds no new diagnosis following the EMG, you can revert back to the pre-EMG diagnosis, as long as its listed in the insurance companies covered diagnosis codes. Most Medicare carriers will cover limb pain for an EMG.

Salmon agrees that physicians often can justify the EMG by using the patients primary diagnosis code. Practices should look first at their Medicare carriers policy bulletin regarding EMGs [which they can get by phoning their carrier or going to the carriers Web site] to determine coverage limitations and covered diagnoses. Then, if your patients pre-EMG diagnosis is listed as being covered and you still get denied, you should send a paper claim referencing the claim number listed on your denial with backup documentation; the claim number will help speed up the process. The documentation should include a copy of the carriers covered diagnoses with your patients diagnosis highlighted, a written discussion telling why the doctor performed the EMG and copies of the chart notes.

Niccoli notes that billers should not charge separately for the EMG needle, which could be considered as unbundling of comprehensive procedure codes and its component parts. As a rule, practices should always contact their insurance carriers before performing EMGs to ensure that the test is allowable.

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