Codify by AAPC

Eli's Rehab Report

Reader Question: Report 95869 Once per Session

Question: Our physiatrist used electromyography (EMG) to test levels T3 and T4 of a patient's thoracic paraspinal muscles bilaterally. I reported 95869-50 x 2 with the thoracic radiculopathy diagnosis (724.4), but Medicare rejected the claim. How should I have coded?

Michigan Subscriber

Answer: The EMG code 95869 (Needle electromyo-graphy; thoracic paraspinal muscles [excluding T1 or T12]) properly describes EMG testing of the thoracic paraspinal muscles, and your diagnosis is sufficient to establish medical necessity. But because the descriptor specifies "muscles" (plural), you may report this code only once per session, regardless of the number of levels that the physician tests.

In addition, the CMS Physician Fee Schedule assigns a bilateral-procedure indicator of "0" to 95869, meaning that modifier -50 (Bilateral procedure) does not apply. Medicare carriers will not reimburse you additionally for bilateral testing.

In this case, therefore, you should report a single unit of 95869 with no modifiers appended.

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