Eli's Rehab Report

Reader Questions: EMG Can Be Billed Bilaterally

Question: The September 2002 issue stated that we could append modifier -59 (Distinct procedural service) to **CPT 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) if the physiatrist tests bilateral limbs. Medicare, however, is the only insurer that pays us for both limbs when we perform the EMG on both upper extremities. Private insurers tell us that because the code states "unilateral or bilateral," we can bill it only once. Is there a solution for this?

Idaho Subscriber

Answer: According to the April 2002 CPT Assistant, "This code may be reported once per extremity." Therefore, you should list 95870 on two separate line items with modifier -59 appended to the second line.

Some insurers prefer the site modifiers instead, in which case you would report 95870-LT on one line to reflect the left arm and 95870-RT on the second line to reflect the right arm.

If your private insurers still deny the service, send a copy of the CPT Assistant article with your appeal letter, showing that you performed the EMG on separate limbs.

Some insurers deny the second line item assuming that your claim refers to bilateral spine EMGs. CPT Assistant states that 95870 "may be reported only one time for studying cervical or lumbar paraspinal muscles (unilateral or bilateral), regardless of the number of levels tested." But the insurer should not balk at paying for EMGs when the physiatrist studies separate limbs.