Frequently Asked Questions
2013 CPT Coding Changes

Practical Coding Advice on EMG/NCS

In response to numerous member questions on EMG/NCS, the AAN’s Medical Economics & Management Committee provides advice to members facing new codes and reimbursement cuts here: http://www.aan.com/news/?event=read&article_id=11042

Coding Specific Questions – NCS

1. Several questions were asked during the webinar about how to count specific nerves and convert that number into the correct 2013 nerve conduction code. Count each different type of test done on each nerve (according to Appendix J in the CPT book) as “1” study for the purposes of getting to the correct code to use. Here is a link to Appendix J for your reference: http://www.aan.com/globals/axon/assets/10384.pdf

2. Which new code is used for mixed nerve conduction studies?
Each type of study (motor with F-wave, motor without F-wave, sensory, h-reflex) performed on each nerve segment—as listed in “Appendix J” of the CPT code book—counts as one study. Add the number of studies performed to get to the appropriate code (95907-95913).

3. If I perform a sensory study and a motor study for the same nerve, does that count as one study or two studies?
Two.

4. Do we count bilateral H reflex studies separately?
This would count as two studies.

5. If I perform a median motor + sensory and ulnar motor + sensory is that 4 units (95908) or is that 2 units (95907) because I only studied two nerves?
This scenario counts as four studies, and you would report 1 unit of 95908.

6. Is an H-reflex study, motor study, and sensory study of the same nerve regarded as 3 tests?
Yes. The appropriate code would be 95908 (3-4 studies).

7. Is performing NCS on one nerve considered one study?
Not necessarily. If you perform a motor and sensory study on that one nerve, it would be counted as two studies.

8. If we bill 95909, do you report 1 unit or the amount of studies we performed say, 5?
Since the number of studies performed is inherent in the coding structure, the appropriate way to report this service is one unit of 95909 (5-6 NCS studies).
9. If a patient is scheduled for testing with a diagnosis of carpal tunnel syndrome (CTS), but when the physician examines the patient, the patient complains of lower limb pain and is therefore also tested for peripheral neuropathy, is this bundled as one NCS or is the billed separate because different extremities are tested for different diagnoses?
List all of the diagnoses (ICD-9 codes) on the claim form, listing the most complicated first, but lump all of the studies together, as was previously done. Ultimately, one NCS code (95907-95913) will be used.

10. If I perform repetitive stimulation (95937) on two nerves (e.g. ulnar nerve and facial nerve), how would I code for it?
There is no change to code 95937 in 2013.

11. Is it possible to bill for an E/M code as well as EMG and nerve conduction studies on the same date of service?
It is acceptable to bill E/M services with EMG/NCS when medical necessity supports the office or hospital visit, but know that you may need to use modifier -25 (significant, separately identifiable E/M). The practice of always reporting an E/M service on the same day may provoke audits if it is a common occurrence and, as always, it is critical to document the medical necessity. Do not bill an E/M with EMG/NCS unless you are performing a separately justifiable service.

CPT “Appendix J”

12. Where can we get the full “Appendix J” for 2013?
Appendix J is found in the 2013 CPT book and is also available on the AAN Coding and Reimbursement page: http://www.aan.com/go/practice/coding

13. Please give an example of how many nerves should be counted in a typical scenario.
Please refer to the expanded “Appendix J” table found on aan.com under “Coding and Reimbursement” for examples of a reasonable number of studies performed per neurology indication: http://www.aan.com/go/practice/coding

Reimbursement Changes

14. Can you show us the actual new allowed charges for these EMG/NCS codes?
The national 2013 Medicare Fee Schedule RVU and dollar values are available on the AAN Coding and Reimbursement web page. (Please keep in mind this does not take into consideration a number of factors, including the Geographic pricing cost index-GPCI, which varies by region.)
http://www.aan.com/go/practice/coding

15. What is average payment for a study, which includes 8 nerve conductions and one extremity EMG?
Reimbursement will vary by carrier however the 2013 total RVU for code 95910 (7-8 nerve conduction studies) is 5.41 and 95886 (Needle EMG, extremity complete study) is 2.49. Multiply RVUs by the national Medicare conversion factor for 2013 ($34.0230) to get an idea about payments.
16. What is the reimbursement for using an array (non-neurologist performed)?
   The 2013 total Medicare RVU for 95905 is 2.09 (the physician work RVU is 0.05). The reimbursement will vary by carrier/payer and region.

17. Can you give a clear example of a patient who has Medicare what would be the difference of reimbursement in 2012 and 2013 (real numbers)?
   An analysis of the change in reimbursement from 2012 to 2013 is available on the AAN Coding and Reimbursement page under the NCS/EMG Studies section: http://www.aan.com/go/practice/coding

18. Are there proposed changes for reimbursement of single fiber EMG?
   The 2013 total Medicare RVU for 95872 is 5.96 (the physician work RVU is 2.88). The reimbursement will vary by carrier and region.

19. Is there any precedence that advocacy strategies by medical societies have successfully impacted big cuts (as occurred previously with sleep studies and non-invasive cardiology testing)?
   There is precedent for Medicare phasing in big cuts, but not for reversing them entirely.

20. How do you think this will affect the commercial carriers’ reimbursement?
   Private plans often time base their fee schedules off of the Medicare Physician Fee Schedule, but not always. It is important to try to negotiate more favorable rates with the commercial plans with whom you contract. You can articulate reasons why they should not follow suit with such drastic cuts to these services.

Coverage & Modifier Use

21. Is it correct that we are to no longer use 95903, 95904 and 95934 for any payer?
   Correct. Codes 95900, 95903, 95904, 95934, and 95936 have been deleted from the AMA CPT code set. Do not report those codes for any payer for dates of service starting 01/01/2013.
   HIPAA regulations name CPT as the standard:

   In § 142.1010, the requirements sections of part 142, subparts K through R, specified that those who transmit electronic transactions covered by the transaction standards must use the appropriate transaction standard, including the code sets that are required by that standard. These sections would further specify that those who receive electronic transactions covered by the transaction standards must be able to receive and process all standard codes. We proposed code sets for various types of services and diagnoses.


   In contrast, specific state rules govern the effective date of CPT code changes for workers compensation, so your state workers compensation payers may not be using the most current CPT code book to process claims at this time. In those cases, you will continue reporting the codes appropriate for that payer.

22. When can we expect LCD/NCDs to be published for these changes?
   Most payers update their coverage policies on an annual basis. For links to available payer coverage policy pages, visit:
23. Would a follow-up EMG be disallowed and at what time interval?
   Whether a follow-up EMG would be disallowed depends on the clinical circumstances and the policies of the health insurer.

24. What is the number of nerves or studies that will be "medically necessary" or allowed in one visit?
   Unfortunately there is not one answer that applies to all payers. The table in “Appendix J” of the CPT code book includes recommendations for what is reasonable for 90% of cases, but even in those cases it is up to the physician’s discretion to decide how many studies are used. Based upon those recommendations, you can consider the following options:
   1. Perform what you think is the necessary number of tests, submit your claim and see what happens. As you know, it is sometimes hard to see on EOB forms what was accepted and what was rejected by the payer.
   2. Review the coverage policy of the insurer. Even if the insurer doesn't cover what may be submitted, appealing a decision is an option. For example, the table in “Appendix J” outlines 90% of patients, not 100% of patients. There are going to be patients who, because of their symptoms or co-morbidities, will require a more complicated number of studies than what is listed in “Appendix J”. You can then provide a rationale to the payer for why you had to perform additional studies. Check first and be prepared for an appeal.
   3. If it looks like an excessive amount of studies, consider sending an explanatory note right with the claim submission to try and stave off the cost of re-billing or appealing.

25. Are there specific guidelines for how long one has to wait before repeating diagnostic testing for the same indication, particularly if prior testing was performed by another facility/provider?
   No. Policies differ among health insurers. Check with your local payers.

26. Do we still use the KX modifier with NCS codes?
   The KX modifier was required by the Medicare Administrator Contractor (MAC) Trailblazer when billing Electrodiagnostic services. Effective 11-15-2012, Trailblazer is no longer a MAC for the states that were required to use this modifier and the KX is not yet required by the new MAC, Novatis. Continue to check your Medicare Coverage Policy for updates for 2013.

27. Are any modifiers needed on the new codes? For example, is modifier -50 going to apply to a matching pair of extremities on the 2013 codes?
   At this time, we are not aware that any payers are requiring use of a modifier when reporting the new nerve conduction codes.

28. Medicare is requesting a modifier for codes 95885 and 98556 when billed together on the same date. Which modifier is appropriate?
   Carriers vary in their policies, however an appropriate modifier to try would be -59 (distinct procedural service).

29. What is the appropriate use of modifier -26 on physician charges when and EMG is done as well in the hospital?
   Modifier -26 is used on all inpatients wherever they are studied and on outpatients in the hospital.
30. This past year has been difficult with the 95885 & 95886 when more than one limb is being tested. No matter what modifier we used if broken down into multiple lines, modifiers or no modifiers or just one line with the number of units we don’t receive correct payment or line items are denied. Do you have any suggestions on how to bill multiple units? Stress to the payer that, as written in the CPT book, the EMG add-ons may be appropriately billed up to a maximum of 4 units if all limbs are tested.

31. How will this affect workers compensation where the insurance carrier sometimes requires 4 limb studies? It is impossible to even do a generic study of 4 limbs with only 13 nerves? Discuss this issue with the Worker’s Compensation payer. Remember, the highest level code in 2013 is reported for studies of 13 or more.

32. Do you know if commercial insurers will pay for EMG/NCV on the same day? Yes, the EMG codes are add-on codes. By definition, they must be reported with the corresponding appropriate base code (which is one of the NCS codes).

33. Since CMS has decided to look at EMG/NCV codes, can we expect more RAC audits on these procedures? This is unclear. RACs are required to post their issues online. Check your local RAC website at regular time intervals for a complete listing.

Qualifications of the Provider

34. Can chiropractors perform needle EMG?
   The AAN supports the position of the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM): Who Is Qualified to Practice Electrodiagnostic Medicine?

Separating Tests to Two Different Days

35. Can a patient having a test of two limbs be performed on separate days? Would there be more reimbursement if NCV studies were done on one day and had the patient return next day for EMG? Do not perform EMG and NCSs on upper and lower studies on different days to receive increased payments.

Coding Questions – EMG

36. Can I code for a complete EMG of one extremity by performing EMG on 3 limb muscles and 2 paraspinal muscles? No. The descriptor for code 95885 states “Needle EMG, each extremity, with related paraspinal areas, when performed done with nerve conduction” (emphasis added). This means that the related paraspinal is counted with related limb muscle so would not be counted for a total of 5 muscles.

37. In 2013, with the new NCS codes, do we also bill using 2012 EMG codes? Yes, you should continue to report the 2012 EMG add-on codes when performing an EMG and nerve conduction studies on the same patient on the same date of service.
38. Can both EMG codes (95886 and 95887) be billed in one visit?
   Yes, codes 95886 and 95887 can be reported together. Different carriers may require the use of a modifier, so it’s important to check your local carrier policies.

39. What are the scenarios when nerve conduction studies are performed without needle EMG?
   Use codes 95907-95913 without using any of the add-on codes for EMG.

40. Are the 95860/95861 codes still going to be used in 2013 if there is no NCV being performed on the same date of service?
   Yes. Unlike the nerve conduction codes, the previous codes to report EMG still exist. If EMG is performed alone (without NCS), use the previous EMG codes.

41. Are there new rules for doing PNCV/EMG on the same day in order to be reimbursed? Is there a difference in fee as a PCP or neurologist?
   No, however payments and policies vary by carrier. Check with your local payers.

42. Are there any changes to code 95874 in 2013?
   No. Report needle electromyography for guidance in conjunction with chemodenervation the same way as was reported in 2012.

**Timing of the Changes**

43. You stated CMS published 2013 EMG/NCV Fee Schedule in November but yet it is not on their site yet, do you know why?
   The final MPFS is available at: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13AR.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13AR.html)

44. The CPT 2013 Manual seems to have been published before November 1st. Does it contain these new codes?
   Yes, the CPT code book is released each year on or around August 31st and contains all of the new and revised coding language. Medicare’s decisions on reimbursement for any new codes included for the following year does not come out until November 1st each year with the release of the Final Physician Fee Schedule (PFS).