Rate / Code Changes

1. Where can I find more information on the financial impact of the 2013 coding changes to my practice?
   Answer: Members should review materials included in the AANEM’s Coding Toolkit, including the RVU impact calculator and the Medicare fee schedule for EDX codes.

2. Can we expect all payers – including private and workers compensation payers -- to use the 2013 code changes?
   Answer: The code set provided in the 2013 CPT code book is the code set you will use for services provided in 2013. 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. Review the Workers Compensation Code Rules document in the AANEM Toolkit to verify the code set your state’s work comp payer is using.

3. Do you have any idea on the dollar amount for reimbursement by Medicare and by private insurers for the new codes 95907-13?
   Answer: Medicare payments are based on multiplying the total RVUs by a “conversion factor” that will remain at the 2012 amount in 2013. Most private payers follow a similar fee-setting process. See the AANEM Toolkit for more specifics on 2013 reimbursement amounts.

4. How does the professional/technical billing change in this new model of billing nerve conduction codes?
   Answer: The values assigned for billing of the professional or technical portion of the nerve conduction codes can be found in the AANEM Toolkit in the Medicare Fee Schedule document.

5. Our doctors are certified in EMG. Does that in any way allow them to get reimbursed at a higher rate by Medicare?
   Answer: No. CMS doesn’t determine who is qualified to perform these tests. However, we will work with CMS in 2013 to gather data indicating that certified professionals are better able to achieve high quality patient outcomes by conducting appropriate diagnostic testing. We also are working with private payers to recognize Lab Accreditation to indicate that our physicians are highly trained in EMG testing.
Electromyography 95860-95887

6. What changes have been made in 2013 to the CPT codes for EMG?
Answer: No new CPT codes have been introduced for EMG. You will continue to report codes 95885-95887 when performing EMG the same day as nerve conduction testing.

7. Why did CMS reduce the work RVUs for needle EMG codes that were just created 1 year ago?
Answer: Unfortunately, the EMG and NCS codes have been under CMS review for two years. During that time, CMS considered the 2012 EMG code values interim. CMS reviewed EMG codes 95886 and 95887 as part of their final review before publishing 2013 values. We pointed out to CMS, that their values did not take into account work intensity or physician effort that is included in these codes. As we move forward with CMS on these codes, we hope they will consider returning those values to their initial amounts.

8. Does AANEM have a suggested price guide for Medicare and commercial payers for the new 2013 EMG codes?
Answer: Due to anti-trust guidelines, we do not comment on fee schedules or payment guidelines other than to provide the information in the Federal Register. Our understanding is that some physicians review the Medicare fee schedule (MFS) and set their private payer fees based on a percentage of the MFS. Other physicians, with contracts, have their fees set by the private payers. We expect most Medicare Administrative Contractors will have a final MFS available on-line soon.

9. Is EMG reimbursement better when performed on a different day than nerve conduction studies?
Answer: It depends on which studies you perform. Most of the EMG codes you would use if you were going to perform it on a different day than NCSs should get the same reimbursement as they have previously. It is AANEM policy that you perform both procedures on the same day to correctly diagnose a patient and splitting them out over two days will likely result in denials by payers.

10. For EMG performed in the hospital as outpatient, is the reimbursement higher than if performed in the physician office? Are the new codes and cuts going to affect hospitals also?
Answer: The 2013 code set will be used by all providers and can be reported on both HCFA and UB claim forms. Typically, the reimbursement will not change for EMG or NCS based on location of service. Because the practice expense and work values of these codes were impacted, both the professional and technical portions of reimbursement will decrease in 2013.

11. Why do some payers not recognize the 3 new EMG codes?
Answer: Some of the confusion with the new EMG codes is the number of units you can bill on the same day and not that payers do not recognize the new codes. A total of 4 units of 95885 and 95886 can be billed on the same day. So, if you do a limited exam on 2 extremities and a complete exam on 2 other extremities, you would bill 2 units of each 95885 and 95886.

We have a crosswalk between the 2011 and the 2012 (and current) EMG codes in our AANEM Toolkit to help people understand which code they would report when. Basically, if you were reporting a full EMG of the extremity 95860 through 95864 before, you will now report 95886. If you were reporting 95870 limited limb EMG, you will report 95885, limited limb EMG reported same day as NCS. If you are not doing EMG and NCS on the same day and it is appropriate not to do them on the same day, you would report the codes from the code list that everyone is more familiar with, 95860-95870.
12. Is there any issue with billing 1 extremity and a limited extremity EMG on the same day?
Answer: Some payers may need to see the -59 modifier (distinct procedural service) attached to the limited EMG code. But, in the strictest sense of CPT coding, you may bill up to a total of 4 units for EMG codes 95885 and 95886 for any one day.

13. Do we still have the EMG without NCS codes available, i.e., 95860-95864?
Answer: Yes. For those times when you perform EMG of the extremity without NCS, you should continue to report codes 95860-95864.

14. What changes will occur for the billing of EMG guidance during botulinum toxin injections for diseases like cervical dystonia?
Answer: Code 95874, Needle EMG for Guidance in Conjunction with Chemodenervation, was not reviewed by the AMA CPT and RUC panels. You should continue reporting this code when botulinum toxin injections are performed with EMG guidance.

15. Code 95886 means 5 or more muscles to constitute a complete EMG. However, to do 2 complete EMGs on the same patient, upper and lower, would that be 5 muscles in the upper and 5 muscles in the lower?
Answer: Yes, in order to bill 2 units of 95886, you would need to test 5 or more muscles in both extremities.

16. Why are many payers requiring modifier -59 with 95885 when also performing 95886?
Answer: Many payers have purchased software to “scrub” claims during the payment process. The edits are based on the national Correct Coding Initiative (CCI), which indicates the -59 modifier should be reported when performing a limited EMG the same day as a complete EMG.

17. First, if a bilateral H reflex is done, will that now count as two of these units? Secondly, when NCS are done, do I still use last year’s code 95886 (with 1, or 2, or 3, or 4 units)? Third, is the larynx code still used like before? Fourth, is the 95887 code still used in lieu of the cranial nerve CPT code, the thoracic, the non-limb CPT codes?
Answer: In 2013, bilateral H Reflex will equal 2 nerves. 95886 is a complete EMG done the same day as NCS. You may bill up to four units, depending on the total number of extremities tested. Larynx EMG code is still 95865. 95887 is used INSTEAD of 95867 (cranial) 95868 (cranial) or 95869 (thoracic).

18. Your EDX coding cuts chart appears inaccurate. For example, you would bill 2 units of 95886 for a plexopathy, but I would not do a complete exam on two limbs for a problem in one limb.
Answer: We recognize not every physician performs the same number of tests for each patient and/or diagnosis. Included in our AANEM Toolkit is an RVU calculator to help each member determine the impact of the 2013 RVU cuts to their practice.

19. What is the appropriate code to use for thoracic paraspinals when done in conjunction with an upper and lower limb along with NCS, such as when doing an ALS study?
Answer: The codes 95886 (complete EMG performed same day as NCS) and 95885 (limited EMG performed the same day as NCS) include testing of related paraspinal regions.

20. What about needle EMG of face, diaphragm, and thoracic paraspinals? Are each of these to be billed as a separate non-extremity 95887? If you perform needle EMG of the face and thoracic paraspinals, is that two units of non-extremity?
Answer: EMG of cranial nerves or thoracic paraspinals performed the same day as NCS is billed as 95887. Unfortunately, there is a correct coding edit set on this code to only allow 1 unit per day. We continue to discuss this issue with the staff who set the CCI edits. Hopefully, we will reach an understanding to allow 2 or more units of 95887 in one day. Diaphragm EMG is still billed as 95866.
21. I am getting rejections from some insurance companies on NCS studies 95900, 95903, and 95904, saying they are bundled with the EMG code so they refuse to pay for the NCS. Is this true and how do I code to get them to pay?

Answer: Please double check the EMG CPT codes you are billing. This link should help you resolve any denials.

**Nerve Conduction Studies (95900-95905)**

22. Will private payers still recognize old NCS codes or will we have to use new NCS codes?

Answer: It is our understanding that the code set provided in the 2013 CPT code book is what you will use for most payers this year. Please keep in mind that some payers, mostly workers compensation payers, may not be ready to accept the 2013 CPT codes early in the year. In those cases, you will continue reporting the codes that are most appropriate for that payer.

23. What changes in practice expense have suddenly become 50% less expensive?

Answer: In 2012, each NCS you performed received the same level of practice expense. That is to say, if you performed 3 NCSs on a patient, you multiplied the practice expense rate times 3. We believe CMS felt practice expense for multiple procedures should instead be pro-rated to match the actual expenses consumed. The 2013 NCS codes have practice expense values that are more typical of the actual costs incurred for the specific number of tests provided.

24. How do the new NCS codes affect the old tool/table that lists the maximum number of tests necessary in 90% of cases? Is there an update for this table?

Answer: Appendix J of the 2013 CPT Code Book will have a copy of the maximum number table, but it will no longer differentiate between motor, sensory, F-wave, or H-reflex. However, AAN and AANEM will continue to provide a maximum number table that differentiates between the different types of NCS studies. Here is a link to that table.

25. Under the new codes, how would you bill for 2 diagnoses? For instance, someone has CTS and lumbar radiculopathy. Can you use 2 different NCS codes? Does RVU vary with diagnostic codes?

Answer: When testing for multiple diagnoses, you will add up all the NCS tests performed to arrive at the total number of studies performed. Review the NCS codes to find the code descriptor that matches your total. You will bill just one NCS code per day per patient regardless of the diagnosis. RVUs are tied to the CPT codes you bill, not the diagnosis codes.

26. Will there be any change in how a single nerve conduction study is defined, e.g., median sensory orthodromic and antidromic are now considered to be 2 nerves?

Answer: If two or more methods of testing are used (such as orthodromic and antidromic testing) to obtain results from a single nerve, only one unit will be paid unless clear reasons exist for performing both studies and those reasons are documented.

For coding these new codes, a single conduction study is defined as:
1. a sensory (antidromic and/or orthodromic) conduction test … OR
2. a motor conduction test with an F-wave … OR
3. a motor conduction test without an F wave … OR
4. an H-reflex test

27. What is the difference between F-wave code 95903 and code 95905?

Answer: CPT code 95905 was established in 2010 to report the performance of motor, F-wave, and sensory nerve conductions using highly automated devices. This code appropriately distinguishes the use of these devices from traditional NCSs devices, which were reported using 95900-95904 in 2012.

28. If I perform 2 motors with F wave and 2 sensory conductions, do I code for 95909 or 95908?

Answer: Four (4) nerve conduction studies would be reported under CPT code 95908.
29. If I perform bilateral H-reflexes, is that 2 nerve conduction?
   Answer: Per the 2013 CPT book, bilateral H-reflexes should be counted as 2 nerve conduction and added
   together with any motor, sensory, or F-wave testing to arrive at a total number of NCS studies per day. If you are
   treating a workers compensation patient, remember that billing rules will vary by state. If your state is not using
   the 2013 CPT Code book to set reimbursement fees, continue to report the previously established CPT codes for
   H-reflex studies and nerve conduction studies.

30. Is facial nerve conduction study counted separately or with limb NCS?
   Answer: An EMG of the face should be billed as 95887. An EMG of the limb is billed as 95886. For a list of the
   nerve conduction segments that you may bill, please review Appendix J in the Toolkit.

31. Will performing an F wave add to the total count in billing?
   Answer: You may bill for an F-wave if it is a separate nerve “segment” than those tested via motor studies. Please
   refer to Appendix J for a list of the nerve segments.

32. When performing lower extremity NCS testing on the peroneal nerve, how will I charge a superficial
    peroneal nerve and the tibialis anterior motor without F wave?
   Answer: For motor testing, there are up to 4 nerve “segments” that can be counted when testing the peroneal
   (fibular) nerve, as documented in Appendix J:
   • Peroneal motor nerve to the extensor digitorum brevis
   • Peroneal motor nerve to the peroneus brevis
   • Peroneal motor nerve to the peroneus longus
   • Peroneal motor nerve to the tibialis anterior

   For sensory testing, there are up to 3 nerve “segments” that can be counted when testing the peroneal nerve:
   • Deep peroneal sensory nerve
   • Superficial peroneal sensory nerve, medial dorsal cutaneous branch
   • Superficial peroneal sensory nerve, intermediate dorsal cutaneous branch

   Each nerve “segment” constitutes one unit of service. To ensure appropriate reimbursement, the medical record
   documentation for the nerves tested should match the descriptions listed above.

33. How many median motor and sensory nerve studies are documented in Appendix J?
   Answer: There are up to 5 median motor nerve studies that may be billed and up to 6 median sensory nerve
   studies that may be billed.

34. One online resource states that you will only be able to bill one nerve per side (e.g. medial) even if you test
    both motor and sensory. Is this the case?
   Answer: The list of nerves in Appendix J will continue to be used in 2013 to identify the number of tests you can
   count when billing. Because motor and sensory nerve segments continue to be listed separately, you may
   continue to bill for both. Just be sure to verify that the nerve segment you are billing is listed in Appendix J.

35. Can I bill for both a motor NCS and a sensory NCS on the same nerve?
   Answer: In a February 2008 article, the CPT Assistant newsletter addressed this issue. The article makes it clear
   that you may bill for any nerve “segment” that is listed in Appendix J. Since motor and sensory testing each have
   their own list of nerves, it is our opinion, supported by the AMA article in CPT Assistant, that you may continue to
   bill for both.
36. Can you clarify how we would bill for a tibial motor nerve study without F waves?

**Answer:** You may bill for any of the nerve “segments” that appear in Appendix J. For the tibial nerve, there are three segments that can be counted as unique nerves.

- Tibial motor nerve, inferior calcaneal branch, to the abductor digiti minimi
- Tibial motor nerve, medial plantar branch, to the abductor hallucis
- Tibial motor nerve, lateral plantar branch, to the flexor digiti minimi brevis

37. For the new NCS codes, are we permitted to bill more than one unit or RT and LT modifiers?

**Answer:** The new NCS codes were created to represent the sum total of tests performed. In the strictest sense of CPT coding, no modifiers should be necessary. However, we recognize some payers may create their own claim edits that will force you to report modifiers.

38. How are nerves defined in the new coding?

**Answer:** The list of nerves included in Appendix J has not changed. The new codes are billed by nerve and type of test (motor or sensory). Antidromic and orthodromic studies regardless of if it is motor (i.e., F-waves) or sensory are billed as 1.

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you perform a median motor and a median antidromic sensory study</td>
<td>2</td>
</tr>
<tr>
<td>If you perform a median motor and a median antidromic AND orthodromic sensory studies</td>
<td>4</td>
</tr>
<tr>
<td>If you perform a median &amp; ulnar motor and a median and ulnar antidromic sensory studies</td>
<td>4</td>
</tr>
<tr>
<td>If you perform a median &amp; ulnar motor and a median and ulnar antidromic AND</td>
<td></td>
</tr>
<tr>
<td>orthodromic sensory studies</td>
<td>4</td>
</tr>
</tbody>
</table>

39. If a motor with F wave, motor without F wave, and sensory were all performed on the radial nerve, would the correct 2013 code be 95908? The definition says to add the numbers of separate tests to get the correct code.

**Answer:** In order to bill separately for the two F wave tests, the nerve segments tested must be different. Review Appendix J for a complete list of the nerve segments that may be billed.

40. Is there a maximum number of NCS units Medicare will pay for in 1 year for 1 patient?

**Answer:** We are not aware of any national coverage policy that would limit the number of nerve conduction studies performed in a 12-month period.

**Evoked Potentials (95925-95939)**

41. Will repetitive stimulation and blink reflex be used in 2013?

**Answer:** Repetitive stimulation (95937) and blink reflex (95933) can still be billed. These codes will continue to be recognized as separately reimbursable services in 2013.

42. What is the correct code and billing for a patient undergoing a bilateral blink reflex assessment, with bilateral NCS of three branches of the facial nerve and EMG of one or two sides of the face?

**Answer:** Beginning in 2013, you will bill:

- 95933 - 1 unit, 50 modifier
- 95957 - EMG of face (cannot bill for more than one unit a day)

Depending on the specific facial nerves you test, you may be able to bill up to 4 nerves per side of the face (total of 8 for bilateral testing). The nerves include:

- Facial nerve to frontalis
- Facial nerve to the nasalis
- Facial nerve to the orbicularis oculis
- Facial nerve to the orbicular oris

Please refer to Appendix J in the Toolkit for further definition of the nerves that can be reported in 2013.
Chemodenervation 64612 – 64615, 95874

43. What changes have been made to Chemodenervation codes in 2103?
Answer: The introductory guidelines for codes 64600-64681 have been revised to instruct the use of a separate supply code for reporting the Chemodenervation agent. Also, instructions have been added to not use a destruction code when utilizing therapies that do not destroy a nerve. Finally, a new code was created to report Chemodenervation for migraines.

44. What is the new Chemodenervation code for chronic migraine and what is the RVU assigned to it?
Answer: CPT code 64615 has a work RVU of 1.85, a practice expense RVU of 1.78, and a malpractice RVU of .60 for a total RVU of 4.23. The RVUs for EDX codes may be viewed on the RVU Impact Calculator included in the AANEM Coding Toolkit.

45. Does the code for chemodenervation for migraines apply to private payers as well as Medicare?
Answer: Yes. Private payers should recognize this code effective January 1, 2013.

46. Code 64615 means bilateral, right?
Answer: This code includes the word “bilateral” in the code descriptor. As such, you can only bill one unit per day.

47. Does chemodenervation for migraines include botulinum toxin?
Answer: This code is to be reported for the physician work to inject the medication. Previously, there was not a separate code to recognize the work of injecting botulinum toxin for migraines. As with all Chemodenervation codes, you may bill a separate supply code for the medications.

48. Can you bill bilateral chemodenervation of limbs in 2013?
Answer: CPT code 64614 (Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia cerebral palsy, multiple sclerosis) can be billed twice.

49. Will we have to use the 64615 instead of 64613+64612 when injecting for blephorspasm and cervical dystonia on the same day?
Answer: CPT 64615 is for the treatment of migraines only, so you should not report 64615 with 64612 or 64613. When injecting for blepharospasms, use CPT code 64612. When injecting for cervical dystonia, use CPT code 64613.

50. Is the code for EMG guidance for chemodenervation (95874) still valid?
Answer: Yes. EMG guidance for chemodenervation may be reported in 2013.

Autonomic Function Tests (95921-95923)

51. Has there been a change to 95923 sympathetic skin response/QSART for 2013?
Answer: There are no coding/reporting changes for CPT code 95923. However, the RVUs for this code will increase in 2013. Please review the Medicare Fee Schedule for EDX Codes in the AANEM Toolkit for those values.

Intraoperative Monitoring 95940-95941

52. What will be the impact on intraoperative monitoring CPT codes in 2013?
Answer: CMS has indicated that code 95940 is appropriate for one-on-one monitoring from within the operating room. However, CMS will not consider 95941 a valid code in 2013. To report monitoring of Medicare patients from outside the operating room, you now will report G0453. This code is to be reported for each 15 minutes of undivided attention to one patient. We understand that Medicare must include reimbursement for “G” codes. When/if we learn of private payers policies for CPT code 95941, we will update our Coding FAQs. At this time, private payers expect CPT code 95941 to be reported per hour for remote monitoring. Do not report the code if less than 31 total minutes of monitoring has occurred.
53. So how will we use CPT codes 95940 & 95941? Am I correct that as of January 1, 2013, I must only bill for one Medicare IOM case at a time? In other words, if I have two screens running simultaneously on the same laptop from 8 am to 11 am for patient A and B, I would only bill 95941 x 3 (instead of 95941 x6)?

Answer: Yes. Medicare claims for this type of monitoring will use G0453, which can only be used for one patient at a time. The code is set up to bill in increments of 15 minutes, so, if you spend 45 minutes with one patient, you would bill 3 units of G0453. For most private payers at this time, 95941 is in the CPT code book and should be considered valid for reporting IOM from outside the operating room. This code does not set a limit on the number of cases you can monitor and allows you to bill per hour of monitoring.

54. Can I report 95940 inside the OR, with 95941 outside the OR for the same case?

Answer: If you have a case for 45 minutes within the OR then you also monitor that case outside the OR after that, you would bill 3 units of 15 minutes within the OR, then bill the remaining time outside the OR with the other code (05041 for private payers; G0453, for Medicare). You can't, however, bill these codes for simultaneous work. In other words, you can't be inside and outside the OR at the same time. So you have to break down when you were in the OR and when you were out, then combine the codes.

55. Does 95940 and 95941 limit MDs to one case at a time?

Answer: 95940 is one patient at a time. 95941 does not have a limit on the number of patients you may monitor simultaneously and is the code you will use for commercial/private payers. However, Medicare wants you to report G0453 and only bill for 1 patient at a time for monitoring done outside the operating room.

56. With no RVU for IOM codes 95941 and G0453, will reimbursement be zero?

Answer: Although Medicare does not recognize code 95941 and lists the RVUs for this code as zero, CMS has assigned RVU values to code G0453. It is our understanding that private payers will create a payment value for 95941 based on the values set for G0453.

**Evaluation and Management (E&M)**

57. Do the new codes include a component of evaluation and management (E&M) or is it separate?

Answer: The relative value of every CPT code includes an accounting for 3 distinct periods of physician work (pre, intra, and post), and many payers are now including a brief history and physical as part of the “pre” work in EDX testing, disallowing a separate E&M code.

However, you are able to bill an E&M code separately in 2013 if you provide documentation to support it. The documentation should include a separate consultation note where you list the reason for the encounter and relevant history, physical exam findings, any prior diagnostic investigations you have reviewed, your assessment, and your impressions, including your EMG diagnosis as well as a plan of care. In order to receive payment, the service must be considered reasonable and necessary. Therefore, the service must be furnished for the direct care and treatment for the patient’s medical condition and compliant with the standards of good medical practice.

For additional information, we have linked AANEM’s position statement on billing an E&M service on the same day as an EMG. Also linked is a MedLearn document that may be of benefit as you review the array of E&M codes that are available.