



Billing for Same Day Evaluation & Management and Electrodiagnostic Testing

The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) is concerned about some payers denying reimbursement of evaluation and management (E/M) codes to physicians who also bill an electrodiagnostic medicine code (e.g., 95907, 95886) on the same day. This practice is not appropriate. There are many patient-physician interactions that clearly require both a neurologic or physiatric evaluation, and electrodiagnostic (EDX) medicine testing. EDX testing includes such procedures as needle electromyography (EMG) and nerve conduction studies (NCSs).

Patients are referred for both an evaluation and/or an EDX examination from a variety of sources, including neurologists and physiatrists, who are trained in neuromuscular diagnosis, as well as by primary care physicians, general internists, pediatricians, orthopedic surgeons, neurosurgeons, rheumatologists and also other healthcare providers. Some patients are referred for EDX testing with a provisional diagnosis but others are referred with symptoms and/or clinical findings only with the expectation that the EDX physician will be able to arrive at the correct diagnosis based on the testing alone. In some instances the brief pre-test history and focused physical exam, which is part of a standard EDX evaluation, may not be sufficient to further refine the diagnostic process. In that situation, expanding the evaluation to include a more complete and separate E&M service, along with the EDX testing, is appropriate and efficient from both the patient and physician perspective. The decision to expand the medical history and physical examination is directly related to the individual patient's medical situation and the physician's clinical judgment as the evaluation progresses.

Examples of physician-patient interactions that clearly require both an EDX testing and a full E&M evaluation can be grouped into five main categories, discussed below.

1. The referring physician requests both an E/M and EDX testing be performed by the EDX physician.

A referring provider recognizes that the patient he is referring to the EDX physician may have several potential diagnoses to explain the symptoms or signs which are prompting the referral for the testing and that both a clinical and EDX evaluation will most likely be needed. The referral requests that both an E/M and a separate EDX evaluation be done at the same visit.

Comment: If the EDX physician had confined the evaluation to E/M only, the patient would have needed to return for the EDX testing on another day, incurring preventable travel expenses, and management would have been delayed.

2. A patient is referred for clinical evaluation and during the E/M process the evaluating physician determines that EDX testing is necessary.

A diabetic patient with walking problems is referred by her primary care physician for a clinical evaluation. The physician learns that the patient has leg pain, difficulty rising from a seated position, and has fallen several times in the past 2 weeks. Physical examination reveals good upper extremity strength, but significant proximal weakness is present in the lower limbs. The physician recognizes that EDX testing will help distinguish between possible diagnoses, including lumbar radiculopathy, diabetic amyotrophy or a myopathy. The refined diagnosis, after reviewing the data from the EDX testing, should help direct management of the patient. The physician has the capability to perform the EDX testing the same day as the evaluation. EDX testing and reveals lumbosacral polyradiculopathy and an underlying polyneuropathy

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3. A patient is referred for EDX testing but the pretest history suggests an alternate diagnosis is present and that a more comprehensive history and physical examination is needed to better define the potential diagnoses.

The patient is referred for symptoms of low back pain and right leg weakness, with lumbar radiculopathy as the pretest diagnosis. During the pre-test history, the EDX physician learns that the patient has chronic low back pain for 10 years with some recent increase in pain. The physician also learns that the patient has also experienced generalized weakness and swallowing problems over the past few months. Based on this additional information, the EDX physician expands the differential diagnoses to include disorders of the neuromuscular junction, more widespread neuropathy, motor neuron disease, or myopathy. The EDX physician conducts an expanded physical examination and detects mild generalized weakness and fasciculation. These findings lead the EDX physician to perform more complex neuro-diagnostic testing, including NCSs and needle EMG of the upper and lower extremities and a needle EMG of the tongue. Based on examination results, the EDX physician concludes that the diagnosis is motor neuron disease.

Comment: If the physician had confined the EDX examination only to the leg, the presence of generalized weakness and a diagnosis of motor neuron disease would have been missed and unnecessary surgery for lumbar radiculopathy could have been occurred.

4. A patient is referred to the EDX facility for one medical problem, but is suspected to have a different problem that demands an additional E/M.

The patient is referred for an EDX evaluation to determine the presence of carpal tunnel syndrome

(CTS). While recording the patient's history, the EDX physician finds that the patient's hand has been painful to the touch and has had some temperature changes that are different from the other hand. Through an extensive physical examination, the EDX physician discovers that the patient has symptoms of pain greater than numbness in the hand, and that the patient has limited usage of the hand because of pain. The patient reports that there is pain all the time, including at night. The EDX physician also uncovers some physical examination findings, e.g., positive Tinel's which could be consistent with CTS. The electrodiagnostic study does not find any evidence of CTS, but the patient's history, findings on physical examination, and overall picture is most consistent with the diagnosis of complex regional pain syndrome, Type I. Recommendations concerning the diagnosis, further testing (i.e. autonomic studies), and appropriate treatment are made to the referring physician.

Comment: The patient had been referred to test for CTS, but the EDX findings had were not consistent with the diagnosis. If an E/M had not been performed, the alternative possibility of complex regional pain syndrome would have been overlooked. The E/M abbreviated further diagnostic work-up that would have been undertaken in search of an explanation of the patient's pain. An E/M code is clearly appropriate in this situation because it was necessary for the EDX physician to perform an extensive history and physical examination, in addition to the EDX testing, in order to arrive at the true diagnosis.

5. A patient is referred for EDX evaluation based only on symptoms.

A patient is referred to the EDX laboratory because he has had increasing weakness in the lower limbs. The referring physician made no tentative diagnosis. The EDX study is requested to help make the diagnosis. During the pre-test history, the physician learns that this weakness occurred first on the left, over the last month, and now on the right, for approximately 1 week. The EDX physician further discovers that over the last week the patient has developed some slowness of urinary stream, but still has fairly intact sensation. On physical examination by the EDX physician, the patient has decreased strength in both lower limbs, and bilateral clonus in the lower limbs and upgoing toes. The patient's gait is slightly wide based, but there is no significant loss of balance. Based on this history and physical examination, the EDX physician has concerns about central nervous system diseases and determines that additional evaluation (including tests that are not electrodiagnostic) are needed.

Comment: The E/M carried out by the EDX physician was instrumental in directing the patient to the most effective diagnostic tests. An E/M code is clearly appropriate in this situation.

CONCLUSION

Billing an E/M code and an EDX code is appropriate under the five categories described above when properly documented by the physician. These examples are not intended to be the exclusive descriptors



of all situations in which billing both an E/M code and an EDX code are appropriate; they are provided as illustrative examples. We strongly discourage adopting a blanket policy of denying payment for E/M and EDX on the same date-of service. Before reimbursement decisions are made, the physician should be consulted if questions remain regarding the appropriateness of the EDX physician's reasons for performing an evaluation that merits additional E/M billing.

In each of these scenarios, a full history and physical examination must be performed and documented along with the EDX testing and accompanying report. The charges should include the -25 modifier for “significant separately identifiable evaluation and management services by the same physician on the same day of procedure or other procedure”.

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