Position Statement
American Association of Neuromuscular & Electrodiagnostic Medicine

AANEM POSITION STATEMENT: BILLING FOR SAME DAY EVALUATION AND MANAGEMENT AND ELECTRODIAGNOSTIC TESTING

The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) is concerned about an emerging pattern among some payors to deny reimbursement of evaluation and management (E/M) codes to physicians who also bill an electrodiagnostic medicine code (e.g., 95886, 95900) on the same day. This practice is not appropriate. There are many patient-physician interactions that clearly require both a neurologic, physiatric, or electrodiagnostic evaluation and electrodiagnostic medicine (EDX) 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 general internists, primary care physicians, and other healthcare providers. Some patients are referred for electrodiagnostic testing with a provisional diagnosis; others are not. Many patients are referred with merely symptoms and/or previous clinical findings with the expectation that the EDX physician will be able to arrive at the correct diagnosis only after the completion of a medical evaluation. 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.

After conducting a history and physical examination, the EDX physician develops a working diagnosis that could modify the referral diagnosis. The working diagnosis can also be modified as the study proceeds. A number of tests could be needed to address the referral and working diagnosis, and to arrive at the correct diagnosis. Frequently, without additional history and physical examination by the EDX physician, the patient's correct diagnosis would not have been discovered.

The Centers For Medicare and Medicaid Services (CMS) has outlined the requirements for billing an evaluation and management code. A policy that categorically denies reimbursement for correctly documented E/M codes when billed with EDX codes is inappropriate. Allowing billing for both an E/M code and EDX codes in the proper circumstances increases the quality of patient care and reduces the costs associated with unnecessary treatment or surgery due to incorrect diagnoses. It is also more convenient for the patients to have evaluation and testing performed on the same day, rather than requiring them to return for a later visit.

Physician-patient interactions that clearly require both an EDX evaluation and EDX testing can be grouped into four main categories, discussed below.

1. A PATIENT IS REFERRED FOR A NEUROLOGIC OR PHYSIATRIC EVALUATION. DURING THE E/M PROCESS THE PHYSICIAN DETERMINES THAT EDX TESTING IS NECESSARY.

A patient with diabetes and walking problems is referred by her primary care physician for an evaluation. While taking the patient's history, the physician finds that the patient has some leg pain, difficulty rising from a seated position, and has fallen several times in the past week. The patient usually walks without a cane and denies a history of falls. The patient has diabetes, but has not checked blood sugar levels for many months. Physical examination by the physician reveals good strength throughout the upper limbs, but proximal weakness in the lower limbs. The physician recognizes that EDX testing will help distinguish between possible diagnoses, including lumbar stenosis, lumbar radiculopathy, and diabetic amyotrophy. Depending on the diagnosis, medical intervention could vary. For example, if the EDX study discloses the diagnosis of diabetic amyotrophy, a more specialized therapy program to help maintain existing strength and muscle bulk, or an assistive device for ambulation could be necessary. Conversely, if no significant nerve injury is detected on EDX testing, a simpler treatment plan could be used. To convey the most meaningful, expeditious, and cost effective information to the patient and referring physician, the physician recommends that the EDX study be performed on the same day as the evaluation. EDX testing is performed and reveals a diffuse peripheral neuropathy, and a co-existing lumbosacral polyradiculopathy.

COMMENT: If the EDX physician had confined the evaluation to E/M only, the patient might have received unnecessary treatment or could have been forced to return again to the physician for the EDX testing on another day.

Instead, the patient is treated in an effective and efficient manner by including both E/M services and EDX testing on the same day.

2. A PATIENT IS REFERRED FOR EDX TESTING OF ONE MEDICAL PROBLEM; HOWEVER, THE PATIENT HAS ADDITIONAL PROBLEMS REQUIRING E/M.

The patient is referred having symptoms of low back pain and right leg weakness, with the possible diagnosis of lumbar radiculopathy. When the EDX physician records the patient's history, the patient states that he has had chronic low back pain for 10 years with some recent increase in pain. However, history taking also uncovers the fact that the patient has had some generalized weakness and swallowing problems and regurgitation over the past few months. Due to these additional symptoms, the EDX physician expands the possible diagnoses to include disorders of the neuromuscular junction, more widespread neuropathy, motor neuron disease, or myopathy. Because of the various possibilities, the EDX physician conducts an expanded physical examination, whereupon the physician detects mild generalized weakness and occasional fasciculations in the tongue. This leads 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 a diagnosis of motor neuron disease is likely. This leads the physician to counsel the patient and the family and arrange for a swallowing evaluation and further testing. Ultimately the patient is diagnosed with amyotrophic lateral sclerosis (ALS).

COMMENT: If the physician had confined the EDX examination only to the leg, the presence of generalized weakness and a diagnosis of ALS would have been missed. Instead, focal abnormalities would have led to a misdiagnosis such as radiculopathy, spinal stenosis, or focal neuropathy. It is the E/M that avoided a misdiagnosis.

3. A PATIENT IS REFERRED TO THE EDX FACILITY FOR ONE MEDICAL PROBLEM, BUT ACTUALLY HAS A DIFFERENT PROBLEM THAT DEMANDS ADDITIONAL E/M.

The patient is referred for an electrodiagnostic 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, i.e., 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 ruled that out. 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.

4. A PATIENT IS REFERRED FOR EDX EVALUATION WITH NO DIAGNOSIS OTHER THAN COMPLAINTS OF SYMPTOMS, REQUIRING FURTHER E/M OF THE PATIENT.

A patient is referred to the electrodiagnostic laboratory because he has had increasing weakness in the lower limbs. The referring physician made no tentative diagnosis. The evaluation and EDX study is requested to help make the diagnosis. Upon a comprehensive history taken by the EDX physician, 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. Billing an E/M code and an EDX code is appropriate under the four 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.

Approved by the American Association of Neuromuscular & Electrodiagnostic Medicine: May 1999.

Reapproved: May 2012