Coding & Billing for the Electrodiagnostic Practice

An AANEM Teleconference
December 16, 2009
The Announcement

• 2010 will bring some important coding changes for reporting nerve conduction studies
• Providers who utilize preconfigured electrode arrays need to make sure they are ready for these changes
• A more complete definition for traditional nerve conduction studies will also be implemented in 2010; this clarification will affect some providers more than others
• Finally, make sure you are correctly coding other EDX studies, from H reflexes to F waves
2010 Changes in Coding and Policy

• NCS coding
  – New section header
  – New nerve conduction code

• Consult coding
  – CMS eliminates consult codes
Rationale for Code 95905

• Code 95905 has been established to report the performance of motor and sensory nerve conduction using pre-configured arrays.

• New introductory language to assist in differentiating nerve conduction studies performed with individually placed stimulating electrodes from tests performed with preconfigured electrodes has also been added.
New Code 95905

- Code 95905 describes nerve conduction tests when performed with preconfigured electrodes customized to a specific anatomic site.

- **95905**: Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report.
Parentheticals With Code 95905

- Report 95905 only once per limb studied
- Do not report 95905 in conjunction with 95900-95904, 95934-95936
Modifier 51 Exemption

• Similar to codes 95900, 95903 and 95904, a modifier 51 exemption designation has been added to code 95905, as this procedure is usually performed with other services, and thus the pre- and post-service activities in this service are minimal and already reflect a reduced relative value unit (RVU)
Clinical Example (95905)

• A 42-year-old female data entry clerk reported that, although she had had no injuries and during the day she felt okay, she woke in the middle of each night for the past 2 weeks with a numb, aching, burning feeling in her right hand that was relieved by holding her hand down and shaking it, rubbing it and running cold water over it.

• Physical examination reveals weakness of right thumb abduction; wasting of the right thenar eminence; numbness of the palmar aspects of the right thumb, index finger and middle finger; and a Tinel’s sign over the right median nerve at the carpal tunnel.

• History and exam are reported separately with evaluation and management [E/M] codes.

• Nerve conduction testing using preconfigured arrays for the right arm is performed.
Description of Procedure (95905)

• The physician reviews a summary of electrodiagnostic data from each nerve tested and assesses it in the context of comparison to normal values and the patient’s history and physical examination.
According to the 2010 Medicare Physician Fee Schedule, the new code has 0.05 physician work relative value units (RVUs). The higher technical component for the new code reflects the higher cost of the disposable supplies for the automated test.
CODING MEMORANDUM

DATE: October 20, 2009

FROM: American Association of Neuromuscular & Electrodiagnostic Medicine


The 2010 CPT® codebook includes a new code to report nerve conduction tests performed using preconfigured electrode arrays. Starting January 1, 2010, physicians who perform nerve conduction testing with preconfigured electrode arrays should report report code 95905: Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report. Parenthetical instructions further direct that, by definition, 95905 should be reported once per limb, and that 95905 should not be reported in conjunction with 95900-95904 or 95934-95936.

Additionally, some payors may require this service to be reported with HCPCS code S3905 that was created in 2008 to describe these services. HCPCS S codes are used by some payors to report services for which there are no national codes, but for which codes are needed by the private sector to manage policies and claims processing.

Please direct questions to James Vavricek, AANEM Medical Economics Manager, at jvavricek@aanem.org or 507-288-0100.
Traditional EMG and Nerve Conduction Studies

New Header, Old Codes…
The following applies to nerve conduction tests (95900-95904): Codes 95900-95904 describe nerve conduction tests when performed with individually placed stimulating, recording, and ground electrodes.

The stimulating, recording, and ground electrode placement and the test design must be individualized to the patient’s unique anatomy.

Nerves tested must be limited to the specific nerves and conduction studies needed for the particular clinical question being investigated.
• The stimulating electrode must be placed directly over the nerve to be tested, and stimulation parameters properly adjusted to avoid stimulating other nerves or nerve branches

• In most motor nerve conduction studies, and in some sensory nerve conduction studies, both proximal and distal stimulation will be used

• Motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested
• Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested
• Waveforms must be reviewed on site in real time, and the technique (stimulus site, recording site, ground site, filter settings) must be adjusted, as appropriate, as the test proceeds in order to minimize artifact, and to minimize the chances of unintended stimulation of adjacent nerves and the unintended recording from adjacent muscles or nerves
• Reports must be prepared on site by the examiner, and consist of the work product of the interpretation of numerous test results, using well-established techniques to assess the amplitude, latency, and configuration of waveforms elicited by stimulation at each site of each nerve tested.

• This includes the calculation of nerve conduction velocities, sometimes including specialized F-wave indices, along with comparison to normal values, summarization of clinical and electrodiagnostic data, and physician or other qualified health care professional interpretation.
New Header Clarifies Coding

1. Testing should be limited to those nerves necessary to address the clinical question being investigated
2. Standardized screening tests are not the same as carefully designed NCSs and do not entail the same physician work
3. Waveforms must be reviewed on site
4. Reports must be prepared on site
Nerve Conduction Studies

Recording Site: APB

<table>
<thead>
<tr>
<th>Stimulus Site</th>
<th>Lat1 ms</th>
<th>Dur ms</th>
<th>Amp mV</th>
<th>Area mVms</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1: wrist</td>
<td>4.3</td>
<td>6.0</td>
<td>6.9</td>
<td>20.8</td>
</tr>
<tr>
<td>A2: antecubital</td>
<td>10.7</td>
<td>9.0</td>
<td>2.4</td>
<td>13.8</td>
</tr>
<tr>
<td>A3: axilla</td>
<td>12.8</td>
<td>14.6</td>
<td>2.0</td>
<td>13.4</td>
</tr>
<tr>
<td>A4: Erb's pt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A5: root</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Nerve Conduction Studies and F-Wave Testing

• **95900**: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

• **95903**: … motor, with F-wave study

• **95904**: … sensory

• (For listing of nerves considered for separate study, see Appendix J)

• (Report 95900, 95903, and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded)
H-Reflex Testing

• **95934:** H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle

• **95936:** … record muscle other than gastrocnemius/soleus muscle

• (To report a bilateral study, use modifier 50)
Using 95900 and 95903 Together

• Some payers reject code 95900 and/or code 95903 whenever they are reported together, indicating 95900 is a component code of 95903

• This is true only if 95900 and 95903 are reported for the same motor nerve conduction study, but not true if reported for studies of different motor nerves
What is the Mixed Nerve Code?

• Mixed nerves contain motor and sensory nerve fibers
  – Stimulate and record from a mixed nerve
• How to code for these studies?
  – Use 95904, the sensory nerve conduction code
How to Count Units of NCS

A. Lateral antebrachial cutaneous sensory nerve
B. Medial antebrachial cutaneous sensory nerve
C. Medial brachial cutaneous sensory nerve
D. Median nerve
   1. Median sensory nerve to the first digit
   2. Median sensory nerve to the second digit
   3. Median sensory nerve to the third digit
   4. Median sensory nerve to the fourth digit
   5. Median palmar cutaneous sensory nerve
   6. Median palmar mixed nerve
E. Posterior antebrachial cutaneous sensory nerve
   ...

...
Multiple Sites Rule

- One nerve, many segments = one unit
- Many nerves, one or more segments each = many units
## Number of Studies/Diagnosis

<table>
<thead>
<tr>
<th>Indication</th>
<th>Needle EMG</th>
<th>NCS</th>
<th>Other EMG Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness, fatigue, cramps, or twitching (focal)</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Weakness, fatigue, cramps, or twitching (general)</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Pain, numbness, or tingling (unilateral)</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pain, numbness, or tingling (bilateral)</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

“The appropriate number of studies to be performed is based upon the physician’s discretion.”
Electromyography

A

200 μV

10 ms.

B

C
The Basic Limb EMG Codes

- **95860**: Needle electromyography; one extremity with or without related paraspinal areas
- **95861**: … two extremities with or without related paraspinal areas
- **95863**: … three extremities with or without related paraspinal areas
- **95864**: … four extremities with or without related paraspinal areas
Some “Limited” EMG Studies

• Needle electromyography;
• 95869: … thoracic paraspinal muscles (excluding T1 or T12)
• 95870: … 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
Proper Use of Needle EMG
CPT Codes 95860-95864

• Extremity muscles innervated by three nerves or four spinal levels must be evaluated, with a minimum of five muscles studied per limb

• One cannot bill paraspinals separately with these codes
  – Thoracic paraspinals - use 95869
  – Cervical and lumbar paraspinals - use 95870
Proper Use of Needle EMG
CPT Code 95869

• CPT code 95869 should be used when exclusively studying thoracic paraspinal muscles, excluding T1 or T12

• One unit can be billed, regardless of the number of levels studied or whether unilateral or bilateral
  – Cannot be billed with codes 95860-95864 if only T1 and/or T2 paraspinals are studied with an upper extremity
Proper Use of Needle EMG
CPT Code 95870

• CPT code 95870 can be billed at one unit per extremity or for muscles on the thorax or abdomen (unilateral or bilateral)

• One unit per cervical or lumbar paraspinals (unilateral or bilateral), regardless of the number of levels tested
  – Should not be billed when paraspinals corresponding to an extremity are tested and codes 95860-95864 are also billed
About CPT Modifiers
Can I code for an E/M service and a procedure provided for the same patient on the same date?
Billing for Same Day Evaluation and Management and Electrodiagnostic Testing

Position Statement

The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM [formerly AAEM]) 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., 95860, 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 consultation and electrodiagnostic medicine (EDX) testing. EDX testing includes such procedures as needle electromyography (EMG) and nerve conduction studies (NCS).

Patients are referred for both a consultation 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 consult will be able to arrive at the correct diagnosis only after the completion of a medical consultation. 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 consultation progresses.

After conducting a history and physical examination, the consultant develops a working diagnosis that may modify the referral diagnosis. The consultant’s working diagnosis may also be modified as the study proceeds. A number of tests may 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 consultant, the patient’s correct diagnosis would not have been discovered.

The Health Care Financing Administration 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 consultation 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 consultation and EDX testing can be grouped into four main categories, discussed below.

1. A patient is referred for a neurologic or physiatric consultation. During the E/M consultation the physician determines that EDX testing is necessary.

A diabetic patient with walking problems is referred by her primary care physician for a consultation. 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 is diabetic, but has not checked blood sugar levels for many months. Physical examination by the physician reveals good strength throughout the upper extremities, but proximal weakness in the
Modifier 25

• Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
• Add modifier 25 to the E/M code
• Different diagnoses are not required
  – Classic example: performance of a lumbar puncture and E/M service on the same date
  – Some carriers: use with any E/M services performed on the same date as neurodiagnostic procedures
How do I code for a procedure I do in the hospital?
Modifier 26

• Professional Component
• Certain procedures are a combination of a physician component and a technical component
• When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure code
  – Used with neurodiagnostic tests performed on inpatients anywhere or on outpatients in the hospital
If I do a bilateral procedure, do I always bill for two units?
Modifier 50

- Bilateral Procedure
- Used when a unilateral procedure is done on both sides
- H-reflex codes are defined as unilateral studies
  - Add modifier 50 to the H-reflex codes 95934, 95936 for bilateral studies
  - Never use two units of the H-reflex codes for bilateral studies!
I couldn’t complete the procedure.
What can I do now?
Modifier 52

• Reduced Services
• Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion
• Use modifier 52 for:
  – Unilateral SEPs
  – Long-term EEG monitoring between 6 and 12 hours
Modifier 53

• Discontinued Procedure
• Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued
  – An unsuccessful lumbar puncture could be coded using this modifier
They rejected some motor nerve conduction studies. Help!
Modifier 59

• Distinct Procedural Service
• Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances
  – Flag studies mixing motor nerve conduction without and with F-waves (95900 and 95903) using this modifier
    • Add modifier 59 to the lesser code (95900)
CMS Eliminates Payment for Consultations in 2010

Thanks to
Mary McDermott and Marc Nuwer
(AAN Webinar 12/08/09)
No More Consult Codes For Medicare

- Medicare disallows use of the Consult codes 99241-99255 in 2010
- Medicare will not pay as a secondary carrier for these codes even when the primary requires use of these codes
- Exception: use consult “G” codes for Medicare teleconsultation
- No announcement yet about Medicaid or Tricare
- Most commercial carriers continue to use Consult codes
In Place of Outpatient Medicare Consult Codes

- Use New Outpatient Visit Codes 99201-99205 for a consultation on a patient not seen previously by you or anyone in your group within the last 3 calendar years.

- Use Established Patient Visit Codes 99211-99215 if the patient has been seen face-to-face by you or a member of your group within the last 3 calendar years.
  - Even if being seen for a new problem.
  - Reading an EEG is not face-to-face.
New vs. Established Patient?

• When is an outpatient “new”?
  – When not seen face to face within 3 years by you or any neurologist in your group with same tax ID or Group NPI
    – Subspecialties of neurology not recognized
• What if the patient now is seen in office within 3 years for new problem?
  – It is still is an established patient
In Place of Medicare Inpatient Consults

• Use Initial Hospital Care codes 99221-99223 for the initial consultation provided to a hospital inpatient

• For follow-up days for inpatient consults, continue to use the Subsequent Day Hospital Care codes 99231-99233
Inpatient Consult FAQs

• I thought only the admitting physician of record could bill for the Initial Hospital Care (Admission) codes 99221-99223?
  – CMS has developed a new modifier - AI for use by the admitting physician of record

• What if the admitting physician forgets to use the AI modifier?
  – “The payment for both the admission and the consult may delayed if the required modifier is not used”
Considerations to Mull Over…

• Pesky consult requirements go away for CMS patients
• You will still want to document the requests (e.g. for concurrent care)
• What if Medicare is secondary?
  – Primary may pay more - take the money and write off
• Re-tool your front end - mistakes will be costly
• Develop a strategy for inpatients
  – Obtain and verify demographic information
  – New modifier for CMS Admits: - AI
• Monitor other contracted payers
  – Currently this only affects CMS patents
The 2010 Reimbursement Picture

1. Elimination of consult codes with recommended cross walks
2. Increase in reimbursement for follow-up codes
   – If you consider a patient encounter (especially in the hospital) as the total of all visits, this increase may mitigate the decrease in reimbursement for the initial visit
3. Increase in practice expense reimbursement for certain procedures
   – Will help procedures in the office, but not the hospital
4. Possible inclusion in the 10% E/M bonus pool, which could also mitigate loss of consult codes
   • Each practice has a different mix of services and procedures, so the impact of the new rules will differ considerably
   • Financial impact calculator on AAN.com:
     <http://www.aan.com/news/?event=read&article_id=8527>
Keep Up To Date With AANEM.org
AANEM Unveils Action Potential, a Health Policy Blog

Visit the AANEM’s Official Health Policy Blog, Action Potential, for information and discussion of coding issues, payer coverage policies, the State Liaison Program, news headlines, and draft documents.

Teleconference Helps You Prepare for Correct EDX Coding in 2010

2010 will bring some important coding changes for reporting nerve conduction studies. Make sure you are ready for the changes. Get the details and more when you register for the December 16, 2009 AANEM Coding and Billing Teleconference. Registration deadline is December 10.

Toxic and Drug Induced Myopathies Discussed in New Podcast

Hear the discussion with Dr. Marinos Dalakas discuss toxic and drug induced myopathies, in the newest Nerve & Muscle Junction podcast. This is one of 49 free podcasts now available on topics of interest to physicians who treat muscle and nerve disorders.

ATTENTION: 2009 AANEM Annual Meeting Attendees

Claim your meeting CME! Log in with your member number and password to access:

- AANEM Annual Meeting CME Form
- Course and Plenary Self-Assessment Quizzes
- Annual Meeting Forum

Already logged in? Click on the “welcome” link on the left under the login area.

Electrodiagnostic Laboratory Accreditation Program to Launch Soon

Will you be ready for Electrodiagnostic Laboratory Accreditation? Read the brief overview of the information and documents required for the application process, and start preparing now. Watch this website, AANEM News, and AANEM E-News for more information as it is released.

AANEM – The best resource for EMG Education, Nerve Conduction Education, and Neuromuscular Education
Friday, December 11, 2009

**AMA Morning Rounds: Early data for ALS drug candidate shows improved muscle function**

The AP (12/10) reports, "Sangamo Biosciences Inc. said Wednesday that early data from a clinical trial shows its Lou Gehrig's disease drug candidate, "SB-509, "improved patients' muscle function." Patients injected with the drug "were about twice as likely to have improved muscular function," according to Sangamo. Specifically, "32 percent of patients who received SB-509 had improved muscle function, compared to 17 percent of patients who took standard treatments." The company "is also testing SB-509 as a treatment for diabetic neuropathy."

Posted by AANEM Policy Department at 7:37 AM 0 comments Links to this post

Labels: ALS, news, research

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Thursday, December 10, 2009

**HIPAA 5010 Resources for January 2012**

Are you preparing for the compliance deadlines for the Health Insurance Portability and Accountability Act (HIPAA) 5010 standard transactions, the next version of HIPAA? Beginning Jan. 1, 2012, physicians will be required to use only the 5010 standard transactions when conducting them electronically. The AMA has prepared several educational resources to assist physicians with implementing the 5010 standard transactions.

Posted by James Vavricek at 8:33 AM 0 comments Links to this post

Labels: AMA, HIPAA, regulations
AANEM.org Practice Issues Area

- Legislation
- Coding
- Recommended Policy
- List of Nerves
- Practice Guidelines
- Position Statements
- Standard Response Letters
- Technology Literature Reviews
- AANEM News
Practice Issues

Welcome to the Practice Issues/Legislative Advocacy section of the website. This section of the website provides information on coding and coding and reimbursement, federal and state advocacy, position statements, technology literature reviews, and practice guidelines.

AANEM State Liaison Program
The State Liaison Program is the premiere training program in payer relations. Selected participants learn how to effectively educate payors about quality electrodiagnostic medicine. Learn more about the AANEM State Liaison Program and the 2008 State Liaisons.

Visit AANEM’s Health Policy Blog, Action Potential
Visit the AANEM’s Official Health Policy Blog, Action Potential, for information and discussion of coding issues, payer coverage policies, the State Liaison Program, news headlines, and draft documents.

New Webpage Tracks Electrodiagnostic Policies
Track electrodiagnostic reimbursement policies that comply with any aspect of the AANEM Recommended Policy for Electrodiagnostic Medicine and Proper Performance and Interpretation of Electrodiagnostic Studies. Information is updated online as policies change and as staff identifies more policies that meet AANEM standards.

AANEM Advocacy Fund
The AANEM has been battling to ensure that only qualified physicians are allowed to perform needle electromyography and interpret nerve conduction studies. Contribute to the AANEM Advocacy Fund to assure quality care for patients and protect your practice into the future.

AANEM Advocacy Award
The AANEM Advocacy Award recognizes extraordinary contributions by a member or non-member toward increasing public awareness or advocating to government entities or insurance companies about the role of electrodiagnostic medicine in the diagnosis and treatment of muscle and nerve disorders. To nominate someone for this award, please fill out and submit an Award Nomination Form.

Patient Advocacy
The AANEM is helping electrodiagnostic medicine (EDX) physicians fight for patient’s rights in areas including patient access to quality specialty care, such as EDX procedures. The AANEM actively advocates for patient’s rights and protections in its communications with Congress and state legislatures, as well as federal and state health agencies. One of the most useful tools for patient advocacy and reimbursement is the AANEM Recommended Policy for Electrodiagnostic Medicine. This policy was recently sent to over 550 insurance companies to assist them in drafting policies consistent with AANEM’s.

Coding & Reimbursement
The AANEM works hard to keep its members up-to-date with the latest in coding and Medicare policy, and offers a number of valuable resources. We also devote significant time to ensuring that our members get the codes they need — and the reimbursement to which they are entitled.

Through the AANEM Policy Department and representatives to the AMA’s Current Procedural Terminology (CPT) and Relative Value Scale Update (RVS) Committees
Recommended Policy for Electrodiagnostic Medicine - Page 1

American Association of Neuromuscular & Electrodiagnostic Medicine
American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation

Key words: nerve conduction • electromyography • H reflex •
F wave • neuromuscular junction • somatosensory

Executive Summary

The electrodiagnostic medicine (EDX) consultation is an important and useful extension of the clinical evaluation of patients with disorders of the peripheral and/or central nervous system. EDX tests are often crucial to evaluating symptoms, arriving at a proper diagnosis, and in following a disease process and its response to treatment in patients with neuromuscular disorders. Unfortunately, EDX studies are poorly understood by many in the medical and lay communities. Even more unfortunate, these studies have occasionally been abused by some providers, resulting in overutilization and inappropriate consumption of scarce health resources. The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) (formerly AEM) has developed this model policy to improve the quality of patient care, to encourage appropriate utilization of the procedures involved, and to assist Medicare Carrier Advisory Committees and other insurance carriers in developing policy regarding EDX testing. This document contains recommendations which can be used in developing and revising current reimbursement guidelines.

This document is based on the AANEM’s publication, The Electrodiagnostic Medicine Consultation, and was further refined by consensus at a conference of 43 experts in the field of electrodiagnostic medicine held on April 8, 1994, in Chicago, Illinois. This consensus conference was held to produce guidelines that could be used to identify overutilization. Participants in the conference represented a diversity of practice types and were either neurologists or physician specialists and included the AANEM Board of Directors, committee chairs, Professional Practice Committee members, and other members of the association. Physicians from both academic medical centers and private practice were represented. With the help of the AANEM Professional Practice Committee, the guidelines have continuously been expanded to produce this comprehensive policy regarding the optimal use of EDX procedures.

This document provides:

1. An introduction to the mission of the AANEM.
2. An overview of the scope of electrodiagnostic medicine.
3. Indications for the performance of EDX testing.
5. A recommended source for a list of ICD-9-CM diagnosis codes that are acceptable indications for needle electromyography (EMG) and nerve conduction procedures.
6. An overview of nerve conduction studies (NCSs).
7. An overview of needle EMG.
8. An overview of single responses, including H-reflex and F-wave studies.
10. An overview of neuromuscular junction (NMJ) studies.
11. An overview of somatosensory evoked potentials (SEPs).
12. An overview of autonomic nervous system function testing.
13. A recommended maximum number of EDX studies necessary for certain
List of Nerves with Added Specificity

Appendix A

Determining the proper number of units for nerve conduction has always been a challenge. The AANEM worked with the American Medical Association (AMA) and the American Academy of Neurology (AAN) to create a list of nerves to assist physicians and billing departments to clarify the specific nerves that can be billed for nerve conduction studies. Each study on the list qualifies as one unit for nerve conduction studies (95900, 95903 and 95904).

Codes 95900 and 95903 involve the following nerves:

I. Upper Extremity/Cervical Plexus/Brachial Plexus Motor Nerves
   A. Axillary motor nerve to the deltoid
   B. Long thoracic motor nerve to the serratus anterior
   C. Median nerve
      1. Median motor nerve to the abductor pollicis brevis
      2. Median motor nerve, anterior interosseous branch, to the flexor pollicis longus
      3. Median motor nerve, anterior interosseous branch, to the pronator quadratus
      4. Median motor nerve to the first lumbrical
      5. Median motor nerve to the second lumbrical
   D. Musculocutaneous motor nerve to the biceps brachii
   E. Radial nerve
      1. Radial motor nerve to the extensor carpi ulnaris
      2. Radial motor nerve to the extensor digitorum communis
      3. Radial motor nerve to the extensor indicis proprius
      4. Radial motor nerve to the brachioradialis
   F. Suprascapular nerve
      1. Suprascapular motor nerve to the supraspinatus
      2. Suprascapular motor nerve to the infraspinatus
   G. Thoracodorsal motor nerve to the latissimus dorsi
   H. Ulnar nerve
      1. Ulnar motor nerve to the abductor digiti minimi
      2. Ulnar motor nerve to the palmar interosseous
      3. Ulnar motor nerve to the first dorsal interosseous
      4. Ulnar motor nerve to the flexor carpi ulnaris
   I. Other

II. Lower Extremity Motor Nerves
   A. Femoral motor nerve to the quadriceps
      1. Femoral motor nerve to vastus medialis
      2. Femoral motor nerve to vastus lateralis
      3. Femoral motor nerve to vastus intermedius
      4. Femoral motor nerve to rectus femoris
   B. Obturator motor nerve
   C. Peroneal nerve
      1. Peroneal motor nerve to the extensor digitorum brevis
      2. Peroneal motor nerve to the peroneus brevis
      3. Peroneal motor nerve to the peroneus longus
      4. Peroneal motor nerve to the tibialis anterior
   D. Planatar motor nerve
   E. Sciatic nerve
   F. Tibial nerve
      1. Tibial motor nerve, inferior calcaneal branch, to the abductor digiti minimi
      2. Tibial motor nerve, medial planatar branch, to the adductor hallucis
      3. Tibial motor nerve, lateral planatar branch, to the flexor digitorum brevis