Topic Area	Question	Answer
Chemodenervation	CPT Code 64616 1. Bilateral – do you use 50 modifier and one unit, or two units? 2. EMG guidance (95874) – ok to use in combination? a. Can you use with US guidance (76942)? b. Use 59 modifier if you do? c. 50 modifier if bilateral or only one bill/patient/day? 3. US guidance (76942) – ok to use in combination? a. Can you use with EMG guidance (95874)? b.Use 59 modifier if you do?	1. Medicare: Append 50 modifier with 1 unit. Check with other third-party payors for how they perfer bilateral procedures identified on claim forms. 2. Yes, CPT code 64616 has a parenthetical note inidcating to use 95873-95874 to report EMG guidance, but report only once. 2a. There are no NCCI Edits that prohibit these codes from being billed together. However, some payor may have coverage determinations in place, check with your specific payor. 2b. No modifier should be needed.
Chemodenervation	Can CPT code 64640 be combined with 1. 76942 (and would you use a 59 modifier) 2. 95874 (and would you use a 59 modifier)	Yes, CPT codes 64640 can be billed with both 76942 or 95874, no modifier should be needed.
EMG	EMG./NCS 4 limbs with combination of limited and extended and separate thoracic paraspinal study.	For chemodenervation guided by needle electromyography or muscle electrical stimulation, report one guidance code for each corresponding chemodenervation of extremity or trunk code)
Evaluation & Management	Do we need 2/3 or all of the elements of the historical components to count? For example, to have a detailed history, do we need 4+ elements from the HPI AND at least 2 ROS and 3/3 past medical, familyy, social history? Or do only two of those elements need to be met for the whole thing to be considered a detailed history? Same question for all levels of history (except problem focused) and medical decision making (except straightforward)	In the CPT Professional book, the CPT Editorial Panel has created "Evaluation and Management (E/M) Services Guidelines." This section of the book gives you a detailed description of how to select the appropriate level of E/M codes. The Academy highly recommends that you get a new CPT Professional book each year as the guidelines may change annually.

Evaluation & Management	Coding subsequent visits, how do we determine the code, examples include consults on hip fractures, rotator cuff injuries . Differences when have surgery versus conservative care.	For Medicare and third-party payors who follow Medicare guidelines, initial hospital care codes (99221-99223) are used to report the first hospital inpatient encounter with the patient by the admitting or consulting physician. All levels of subsequent hospital care by the consulting physician are reported with the subsequent horpital care codes (99231-99233).
Injections	Diagnostic Ultrasound with office visit performed by MD- Max of 2 units on 76881	This is correct.
Injections	Injection large joint/bursa (20611), office visit, EMG, NCV- Add Modifier 59 to 95909, mod 25 to 99202	This is correct.
Injections	Ultrasound guidance, peripheral nerve block (64640), office visit- Mod 25 to 99202	Correct. You can also bill 76942 for the US guidance.
Miscellaneous	What procedures or exams should be split into multiple visits instead of billing in all one visit and getting denied payment.	If there is not a medical neccesity that requires the patient to return for follow-up or continued care on a different day, having a patient come back to your office on a different day, solely because payment is denied is not recommended by the Academy.
Modifiers	In what Situations Should we be using modifier 25?	It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

Modifiers	In what scenarios should we be using Modifier 59. What would be considering overuse?	Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. It should not be used to unbundle services that are not typically billable together. On January 1, CMS created new modifiers collectively referred to as X{EPSU} modifiers, which define specific subsets of the 59 modifier. These modifiers may also be appropriate. For more information on how to use these modifiers, see the Dec/Jan 2015 Physiatrist article "2015 Medicare Physician Fee Schedule and CPT code changes that will impact PM&R practice."
Ultrasound	Code 76881, 1. Can you bill for a portion of a joint (anterior wrist) 2. Does it need to include an artery, nerve, and tendon? Chemodenervation	Yes, however, this service is coded using CPT code 76882, not 76881. Code 76882 is used for limited ultrasound of a joint. All portions of the anterior portion of the joint should be addressed including arteries, nerves, tendon. If the entire joint is evaluated, then 76881. Image documentation must be saved.
EMG	In the past we have tried billing 95860-95864 with 95900 and 95904. The insurance then only pays for the 95860-95864 and denies the rest. I also notice that we are unable to bill for an office visit on the same day of the EMG. Should we instead be using 95907-95913? If so, how do we code this correctly for Work Comp, Private Insurance and Medicare/Medicaid?	CPT codes 95900 and 95904 were deleted in 2012. The Academy suggests that you get a new AMA CPT Professional book each year as codes and guidelines are revised, deleted, and new information is added annually. For more coding information on billing same day E/M with EMGs, please see the July 2015 article in the Physiatrist, "Electrodiagnostic Testing with Same Day Evaluation Management."

EMG	For 4 limb emg (for ALS evaluation), do we get reimbursed when we enter 4 units or is there a modifier?	Yes, you should be reimbursed. The parenthetical in the CPT book states, "Report either 95885 or 95886 once per extremity. Codes 95885 and 95886 can be reported together up to a combined total of four units of service per patient when all four extremities are tested."
Evaluation & Management	Seeing a patient you have seen before for a different problem within 3 years – can that be billed as a new patient?	A **new patient** is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. An **established patient** is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
Injections	Diagnostic Ultrasound with office visit (99202) performed by PA- Max of 2 units on 76881	This is correct.
Injections	Ultrasound guidance, injection, EMG, NCV and office visit- Mod RT/LT on Injection, Mod 25 on 99202, Mod 59 on 95886 or 95909	This is correct.
Injections	Ultrasound guidance, sacroiliac joint injection (27096), office visit- Add Modifier 59 to 27096, Mod 25 to 99202	CPT code 27096 is for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT). If CT or fluoroscopy imaging is not performed, use 20552. This should be billed as 20552 and 76942 with modifier 25 on the E/M.

Injections	Greater occipital nerve block, can US guidance be billed?	Yes, you can bill the injection code 64405 plus the 76942 for US guidance. This is one of the injection codes that has not been bundled with image guidance.
Injections	Can you bill Trigger fingers – 2 units	This service is billed with CPT code 20550, tendon sheath injection.
Modifiers	Are the following use of modifiers and units correct for the below codes. Diagnostic Ultrasound with EMG, NCV, office visit and ultrasound guidance (76942) and carpal tunnel injection (20526)-Modifier 59 to 76881, RT/LT on 20526 and Mod 25 on 99202	Do not put modifier 59 on CPT 76881. RT/LT on 20526 is appropriate; as well as 25 on 99202.
Modifiers	Can we attach modifier 59 to: 1. NCS, NEE and dx US (95907, 95886, 76881) 2. NCS, NEE and US guidance and injection (99507, 95886, 76942, 20551) 3. NCS, NEE and combined US guidance/injection code (99507, 95886 and 20611) 4. NCS, NEE, dx US, US guidance and injection (95907, 95886, 76881, 76942, 20551) 5. NCS, NEE, dx US, US guidance/injection code (95907, 95886, 76881, 20611)	There are no NCCI Edits that prevent these services from being billed together, thus, modifier 59 is not necessary.
Modifiers	Do Injections use 50 modifier	Some of the injection codes use the 50 modifier, for example, to report 64612 (Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm) bilaterally you would append modifier 50.

Chemodenervation	Can we use CPT code 64640 for" 1. Ulnar nerve injections at the elbow (most important) 2. Ulnar nerve injections at the wrist 3. Radial nerve injections in the elbow 4. Radial nerve injections in the wrist 5.Tarsal tunnel injections (most important) 6.Fibular nerve injections at the knee 7. Superficial fibular sensory nerve injections in the calf 8. Deep fibular nerve injections in the ankle	Destruction with neurolytic agent for all these nerves? 64450 is injection of other peripheral nerve, which is I think what they mean.
EMG	If we are billing for EMG guidance on Botox injections into an upper and lower limb can we bill for two units of EMG guidance.	CPT code 95874 is used to bill needle electromyography for guidance in conjunction with chemodenervation. The guidance code may be reported with each corresponding chemodenervation code.
Injections	Diagnostic Ultrasound with EMG (95886) and NCV (95909)- Add Mod 59 to 95909 or 95886, Max 2 Units on 76881 Mod LT/RT	Modifer 59 is not needed
Chemodenervation	If you do 4 extremities, 1-4 muscles, would you use 64642 one unit and 64643 three units?	Yes, this is correct.
EMG	In electrodiagnostics, we have traditionally coded for one unit of 95904 (or one study in the newer 95907-95913 codes) but have been recently advised otherwise in the following circumstance: when doing a “numb thumb” median to radial sensory comparison (or as part of a combined sensory index calculation), we are now being told that each of the median sensory to thumb and radial sensory to thumb (using the same recording ring electrodes) should be coded, thus counting as 2 units of 95904 (or 2 studies in the newer codes). Which is correct?	CPT code 95904 have been deleted. For nerve conduction studies, see 95907-95913. The Academy suggests that you get a new AMA CPT Professional book each year as codes and guidelines are revised, deleted, and new information is added annually. Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use.

ICD-10	Help with ICD-9 codes transition to ICD-10 for approved Trigger point (20552, etc.) also with EMG codes. For example: 20552, ICD-9 720.1 and EMG codes: 356.9	With the change to ICD-10 there will be codes in ICD-9 that do not Crosswalk to a single code, but to several codes, based on laterality and increased specificity. The Academy has created Top 100 ICD-10 Crosswalk sheets to help you begin to crosswalk the codes most utilized in PM&R practices. Please visit me.aapmr.org for more information.
Injections	Injection large joint/bursa bilateral, diagnostic ultrasound, office visit-Add Modifier 50 to 20611 and Mod 25 to 99202	This is correct.
Injections	We are under the understanding that we cannot bill Carpal Tunnel injections and guidance. I want to make sure that is correct.	You can bill carpal tunnel injection code 20526 with US guidance code 76942.
Inpatient Rehab	How do the E/M coding guidelines apply to the CMS required 3 Physician Supervision notes for IRH per week?	The documentation required for compliance with the 3 “Face to Face” rehab physician visits in an Inpatient Rehabilitation Facility are to meet compliance for a patient’s hospitalization. They do not specifically add to medical complexity but could be considered as part of data reviewed and medical decision making when determining an appropriate E/M code for a particular physician encounter.
Modifiers	What is the harm if we never use modifier 25?	The harm in never using modifier 25 is that you are under coding, if you have performed a medically necessary E/M on the same day as a minor procedure.

Modifiers	Does H-reflex use 50 modifier	For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. The CPT codes are based on the number of studies performed, not the side.
Ultrasound	US guidance – can only be billed once per day per patient no matter how many limbs or areas are used	Yes. Ultrasound guidance can only be billed once per day per patient, regarless of the number of limbs or areas.
Evaluation & Management	Does saying someone is breathing normally count as a vital sign, etc	No. In order to count vitals there needs to be 3 types of vitals listed. Height, weight, temperature, BMI, BP, pulse etc.
EMG	In the course of an electrodiagnostic study, we performed 4 sensory nerve conduction studies, 4 motor conduction studies with F-waves, 2 (lower) limb electromyography with lumbar paraspinal muscles and bilateral thoracic paraspinal muscle (based on the clinical presenting complaint of mid thoracic and low back pain and limb symptoms). The carrier (Blue Shield) is denying the 95910 code based on bundling with 95869 (which was paid in addition to 95886 and 99204). It doesn't seem to make sense that thoracic paraspinal EMG is bundled with nerve conductions, according to the carrier who is referencing CPT Manual and CMS Coding Manual Instructions.	CPT codes 95869 is only used when no nerve conduction studies (95907-95913) are performed on that day. Use 95885, 95886, and 95887 for EMG services when nerve conduction studies (95907- 95913) are performed in conjunction with EMG on the same day. In this case you would bill CPT code 95887 with the appropriate NCS codes, based on the total number of studies performed.
Evaluation & Management	What are the components of the history (HPI, ROS, PFSH) and medical decision making and which part are mandatory	The CPT Professional Manual provides detailed instructions for selecting a Level of E/M Service.
Injections	Billing bilateral diagnostic ultrasound (76881) –Max of 2 units, No Mod 50	How payors want these codes reported on claims may vary, check with your specific payor. Some payors may require the use of the LT/RT modifiers and others 2 units.

Injections	Ultrasound guidance with injection, EMG, NCV- Add Modifier 59 to 20526	Modifer 59 is not needed
Injections	BOTOX inj, can US and/or EMG guidance be billed, any modifiers needed?	Yes. No modifier is necessary.
Miscellaneous	Case 2 is Orthovisc coding. I have included two separate office visit notes with slightly different wording. We are not getting paid for the Orthovisc. We are doing bilateral knees. Originally the coder was submitting the claims with: 20610-RT 20610-LT J7324-RT 1 unit J7324-LT 1unit	J7324 should be billed as two units rather than RT/LT. CPT code 20610 can be billed either with LT/RT or 50. Payment may be denied if prior authorization is required, or if medical necessity was not documented properly in the E/M visit note leading up to the injection. Some private payors will reimburse for one brand of hyaluronic acid derivate vs. another, so it is important to know the policy for each insurer before ordering these medication and injecting.
Pain Management	We have many patients that are on pain medications that require monitoring. We perform the visual testing of urine with various multi-panel cups for an instant reading and then send the cup in to a lab for detailed toxicology testing. Most insurance is paying for this, but some are not. We even have trouble getting Medicare and Medicaid to cover this in some instances. What is the best way to code this for Work Comp? For Private Insurance? For Medicaid and Medicare?	The appropriate CPT code for the in-house testing is G0434. ICD-9 codes for diagnoses may be V58.83 - long term use of other medications and V58.69. Or the code for the specific pain diagnosis requiring chronic opioids and monitoring.