Priority Health	BILLING POLICY No. 135
NERVE CONDUCTION STUDIES / ELECTROMYOGRAPHY	
Date of origin: Aug. 2025	**Review dates: 8/2026**

POLICY OVERVIEW

This policy outlines billing and payment requirements associated with nerve conduction studies. This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards.

DEFINITION

Electromyography (EMG) and **nerve conduction studies (NCS)** are diagnostic tests used to assess the electrical activity of muscles and the function of peripheral nerves.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Billing details

Priority Health does not expect to receive claims for nerve conduction testing accomplished with discriminatory devices that use fixed anatomic templates and computer-generated reports used as an adjunct to physical examination routinely on all patients.

Evaluation/Management (E/M)

1. Usually, an E&M service is included in the exam performed just prior to and during nerve conduction studies and/or electromyography. If the E&M service is a separate and identifiable service, the medical record must document medical necessity, and the CPT code must be billed with modifier 25.
2. A clinical history from the referral source must indicate the need for testing. Such data containing pertinent clinical information must be attainable for review in instances where the need for a test may come under scrutiny. Absolute inclusive or exclusive criteria for performance of a diagnostic test are difficult to enumerate.

Coding specifics

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply:

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

59, XE, XS, XU - Used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances. A health care provider may need to use modifier 59 to indicate that a procedure or service was distinct or independent from other services performed on the same day.

25 - Significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

95860	Needle electromyography; 1 extremity with or without related paraspinal areas
95861	Needle electromyography; 2 extremities with or without related paraspinal areas
95863	Needle electromyography; 3 extremities with or without related paraspinal areas
95864	Needle electromyography; 4 extremities with or without related paraspinal areas
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868	Needle electromyography; cranial nerve supplied muscle(s), bilateral
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolites(s)
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited
95886	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels
95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study
95907	Nerve conduction studies; 1-2 studies
95908	Nerve conduction studies; 3-4 studies
95909	Nerve conduction studies; 5-6 studies
95910	Nerve conduction studies; 7-8 studies
95911	Nerve conduction studies; 9-10 studies
95912	Nerve conduction studies; 11-12 studies
95913	Nerve conduction studies; 13 or more studies
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli); each nerve, any 1 method

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Code	Description
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient

021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
071x	Clinic - Rural Health
085x	Critical Access Hospital

Code	Description
0920	Other Diagnostic Services - General Classification
0922	Other Diagnostic Services - Electromyogram
0929	Other Diagnostic Services - Other Diagnostic Service

A nerve conduction study (NCS) can be performed in various settings, including:

- Outpatient settings: Many NCSs are conducted in outpatient clinics, allowing for quick and convenient testing.
- Hospital settings: In some cases, NCS may be performed as part of a patient's hospital stay, depending on the specific circumstances

Nerve Conduction Studies

Nerve conduction studies must provide a number of response parameters in a real-time fashion to facilitate provider interpretation. Those parameters include amplitude, latency, configuration, and conduction velocity. Priority Health aligns with Medicare and does not accept diagnostic studies that do not provide this information or those that provide delayed interpretation as substitutes for NCS. Raw measurement data obtained and transmitted trans-telephonically or over the Internet, therefore, does not qualify for the payment of the electrodiagnostic service codes included.

Electromyography

It is expected that providers will use the correct procedural code for sampling muscles other than the paraspinals associated with the extremities, which have been tested. It is not expected to see this code billed when the paraspinal muscles corresponding to an extremity are tested and when the extremity EMG code is also billed. The following uses of EMG studies have not been established:

- exclusive testing of intrinsic foot muscles in the diagnosis of proximal lesions
- definitive diagnostic conclusions based on paraspinal EMG in regions bearing scar of past surgeries (e.g., previous laminectomies)
- pattern-setting limited limb muscle examinations, without paraspinal muscle testing for a diagnosis of radiculopathy
- EMG testing shortly after trauma, before EMG abnormalities would have reasonably had time to develop
- surface and macro EMG’s
- multiple uses of EMG in the same patient at the same location of the same limb for the purpose of optimizing botulinum toxin injections.

In most cases, repeat testing shouldn’t be needed more than once a year. Acceptable limits per diagnosis per year are:

- Up to 2 tests: For carpal tunnel, radiculopathy, mononeuropathy, polyneuropathy, myopathy, and NMJ disorders.
- Up to 3 tests: For motor neuron disease, plexopathy, and acute inflammatory demyelinating conditions. More tests may be allowed if:
    - A second opinion is needed.

- A second diagnosis is being evaluated. In these cases, the doctor should explain why the extra test is needed and compare it to previous results.

Sometimes, patients need repeat EMG or nerve tests for good medical care. Documentation should support the rationale for why repeat testing is done. Here are common reasons:

- New symptoms
- Unclear results
- Fast-changing diseases
- Monitoring disease
- Unexpected changes
- Recovery tracking

The Professional Practice Committee of the AANEM developed the following recommendations as part of the ABIM Choosing Wisely Initiative:

- Don’t do EMG for just neck or back pain after a car accident.
- Don’t test all four limbs for neck/back pain after trauma.
- Don’t do nerve tests without also doing EMG when checking for pinched nerves

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

The patient's medical records must clearly document the medical necessity for the test. Data gathered during NCS, however, should be available which reflect the actual numbers (latency, amplitude, etc.), preferably in a tabular (not narrative) format. The reason for referral and a clear diagnostic impression are required for each study. In cases where a review becomes necessary, either a hard copy of waveforms or a complete written report with an interpretation of the test must be submitted upon request.
Normal findings and abnormalities uncovered during the study should be documented with the muscles tested, the presence and type of spontaneous activity, as well as the characteristics of the voluntary unit potentials and interpretation.

Documentation required justifying electrodiagnostic testing:

- Reason for the study, clinical history and examination findings are required
- Numerical values are required – latency, amplitude and nerve conduction
- Type of needle – monopolar or concentric
- When documentation is required submit hard copy of waveforms and complete written report, including test interpretation
- Name, signature, professional designation of all individuals performing, interpreting or supervising the test must be included

Inadequate Documentation:

- Narrative reports alluding to ‘normal’ or ‘abnormal’ results without numerical data
- Description of F-wave without reference to corresponding motor conduction data
- Pattern-setting unilateral H-reflex measurements
- Absence of clinical history, preferably written by the referral source, indicating the need for the test

- Absence of documentation to support repeat testing on the same beneficiary or testing every beneficiary referred for pain

Reimbursement specifics

Nerve conduction studies can be reimbursed only once per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve. For instance, testing the ulnar nerve at wrist, forearm, below elbow, above elbow, axilla, and supraclavicular regions will all be considered as a single nerve. Motor and sensory nerve testing are considered separate tests. Nerve conduction tests when performed with preconfigured electrodes customized to a specific anatomic site are payable only once per limb studied and cannot be used in conjunction with any other nerve conduction codes.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

- LCD - Nerve Conduction Studies and Electromyography (L34594)
- Electrodiagnostic Testing (EMG/NCV)
- Nerve Conduction Studies - Medical Clinical Policy Bulletins | Aetna
- Neurophysiologic Testing and Monitoring – Commercial and Individual Exchange Medical Policy

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these

requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Aug. 20, 2026	"Overview" section added