

Medical Policy



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Title: Electromyography (EMG), Nerve Conduction Studies (NCS), and Other Electrodiagnostic (EDX) Related Services

See also: Automated Point-of-Care Nerve Conduction Tests policy

Professional

Original Effective Date: January 1, 2005
Revision Date(s): February 17, 2006;
March 7, 2006; August 9, 2006;
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Institutional

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DESCRIPTION

Electrodiagnostic medicine (EDX) includes a variety of electrodiagnostic studies, which are an important means of diagnosing motor neuron diseases, myopathies, radiculopathies, plexopathies, neuropathies, and neuromuscular joint disorders. EDX studies are also useful when evaluating tumors involving and extremity, the spinal cord, and/or the peripheral nervous systems, and in neurotrauma, low-back pain, and spondylosis and cervical and lumbosacral disc diseases.

Electrodiagnostic (EDX) medicine and related services may include:

- Nerve conduction studies (NCS) - Nerve conduction studies (NCS) are performed to assess the integrity of, and diagnose diseases of, the peripheral nervous system. Specifically, they assess the speed (conduction velocity, and/or latency), size (amplitude), and shape of the response. Pathological findings include conduction slowing, conduction block, no response, and/or low amplitude response. NCS results can assess the degree of demyelination and axon loss in the segments of the nerve studied.
- Needle electromyography (EMG) - Needle EMG is performed to exclude, diagnose, describe and follow diseases of the peripheral nervous system and muscle. Needle EMG refers to the recording and study of electrical activity of muscle using a needle electrode.
- Late responses including H-Reflex and F-Wave studies - Late responses are performed to evaluate nerve conduction in portions of the nerve more proximal (near the spine) and, therefore, inaccessible to direct assessment using conventional techniques. Electrical stimulation is applied on the skin surface near a nerve site in a manner that sends impulses both proximally and distally. Characteristics of the response are assessed, including latency.

- Blink reflexes - The blink reflex is an electrophysiologic analog of the corneal reflex. The latency of the responses, including side-to-side differences, can help localize pathology in the region of the fifth or seventh cranial nerves, or in the brainstem. The latencies and amplitudes of directly elicited facial motor responses should be determined to exclude a peripheral abnormality if the blink reflexes are abnormal.
- Neuromuscular junction (NMJ) studies - Repetitive stimulation studies are used to identify and to differentiate disorders of the NMJ. This test consists of recording muscle responses to a series of nerve stimuli (at variable rates), both before, and at various intervals after, exercise or transmission of high frequency stimuli.
- Somatosensory evoked potentials (SEP) - SEPs are an extension of the electrodiagnostic evaluation and can be used to test condition in various sensory fibers of the peripheral and central nervous systems. SEPs may be used to assess the functional integrity of the central and peripheral sensory pathways.
- Autonomic nervous system function testing - The purpose of autonomic nervous system function testing is to determine the presence of autonomic dysfunction, the site of autonomic dysfunction, and the various autonomic systems that may be disordered.
- Diagnostic ultrasound
- Other related services

POLICY

1. Electromyography and Nerve Conduction Studies are **medically necessary** as referenced in the AANEM (American Association of Neuromuscular and Electrodiagnostic Medicine) Maximum Number of Studies and Maximum Number of Studies for Additional Codes charts.

| AANEM Recommended Maximum Number of Studies | | | | | |
|--|--|---|--------------------|--|--|
| | Needle Electromyography CPT 95860-95864 and 95867-95870 | Nerve Conduction Studies CPT 95900, 95903, 95904 | | Other Electromyographic Studies CPT 95934, 95936, 95937 | |
| Indication | Number of Services (Tests) | Motor NCS with and/or without F wave | Sensory NCS | H-Reflex | Neuromuscular Junction Testing (Repetitive Stimulation) |
| Carpal Tunnel (unilateral) | 1 | 3 | 4 | | |
| Carpal Tunnel (bilateral) | 2 | 4 | 6 | | |
| Radiculopathy | 2 | 3 | 2 | 2 | |
| Mononeuropathy | 1 | 3 | 3 | 2 | |
| Polyneuropathy/ Mononeuropathy Multiplex | 3 | 4 | 4 | 2 | |
| Myopathy | 2 | 2 | 2 | | 2 |
| Motor Neuronopathy (e.g., ALS) | 4 | 4 | 2 | | 2 |
| Plexopathy | 2 | 4 | 6 | 2 | |
| Neuromuscular Junction | 2 | 2 | 2 | | 3 |
| Tarsal Tunnel Syndrome (unilateral) | 1 | 4 | 4 | | |

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|---|---|---|---|---|---|
| Tarsal Tunnel Syndrome (bilateral) | 2 | 5 | 6 | | |
| Weakness, Fatigue, Cramps, or Twitching (focal) | 2 | 3 | 4 | | 2 |
| Weakness, Fatigue, Cramps, or Twitching (general) | 4 | 4 | 4 | | 2 |
| Pain, Numbness, or Tingling (unilateral) | 1 | 3 | 4 | 2 | |
| Pain, Numbness, or Tingling (bilateral) | 2 | 4 | 6 | 2 | |

| Maximum Number of Studies for Additional Codes | |
|--|-----------|
| Codes | Units |
| 95865 | 1 |
| 95866 | 1 |
| 95872 | By Report |
| 95921 | 1 |
| 95922 | 1 |
| 95923 | 1 |
| 95925 | 1 |
| 95926 | 1 |
| 95927 | 2 |
| 95933 | 2 |

- Surface EMG (SEMG) (S3900) is **experimental / investigational**. This refers to a recording of electrophysiologic signals from skeletal muscles. The recording is made using electrodes placed on the surface of the skin overlying the muscle, and consists of motor unit action potential (MUAP) discharges. The electrical activity is only observed when the muscle is activated. It does not include any monitoring of externally stimulated muscle activity as occurs in nerve conduction studies, H reflexes, F waves, and other tests. There are no indications for the use of SEMG in the diagnosis and treatment of disorders of nerve or muscle.
- Current perception threshold (CPT) / sensory nerve conduction threshold (SNCT) (G0255) is **experimental / investigational**. This test diagnoses sensory neurological impairments caused by various pathological conditions or toxic substance exposures. It is a noninvasive test that uses transcutaneous electrical stimulus to evoke a sensation. CPT/SNCT methods quantitate the level of sensory deficit by comparing current output to the nerve conduction threshold, but has the problem, however, that significant variability occurs associated with changing skin resistance.

Policy Guidelines

- Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not medically necessary.

2. When exceeding the allowed unit limit, the professional provider should use modifier 22 and submit supplementary documentation to justify the additional testing (AANEM estimates this may occur in 10% of cases).
3. It is inappropriate to bill more than one unit for "inching" or studying the same nerve by moving the stimulating electrode closer to the recording electrode.

Utilization

1. Repeat testing will be considered for reimbursement in the following clinical situations:
 - a. When seen for new symptoms or additional diagnosis we would consider another evaluation for the determination of a second diagnosis. When a diagnosis such as amyotrophic lateral sclerosis (ALS) is suspected, but testing is inconclusive, additional testing may be warranted.
 - b. When the disease process is one of rapid change, such as Guillain-Barré syndrome, it may be necessary for monitoring patient progress.
 - c. Recovery from injury may warrant retesting to help determine need for surgery and when surgery should be performed.
2. The claim must be submitted with medical record documentation to support medical necessity of repeat testing. Professional providers should report modifier 22.

CODING

The following codes for treatment and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CPT/HCPCS

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| 51785 | Needle electromyography studies (EMG) of anal or urethral sphincter, any technique |
| 95860 | Needle electromyography; one (1) extremity with or without related paraspinal areas |
| 95861 | Needle electromyography; two (2) extremities with or without related paraspinal areas |
| 95863 | Needle electromyography; three (3) extremities with or without related paraspinal areas |
| 95864 | Needle electromyography; four (4) extremities with or without related paraspinal areas |
| 95865 | Needle electromyography; larynx |
| 95866 | Needle electromyography; hemidiaphragm |
| 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 T-1 or T-12) |
| 95870 | Needle electromyography; 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 |

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| 95872 | Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied |
| 95900 | Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study |
| 95903 | Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study |
| 95904 | Nerve conduction, amplitude and latency/velocity study, each nerve; sensory |
| 95921 | Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio |
| 95922 | Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt |
| 95923 | Testing of autonomic nervous system function; sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential |
| 95925 | Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs |
| 95926 | Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs |
| 95927 | Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head |
| 95933 | Orbicularis oculi (blink) reflex, by electrodiagnostic testing |
| 95934 | H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle |
| 95936 | H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle |
| 95937 | Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method |
| G0255 | Current perception threshold/sensory nerve conduction threshold (SNCT) per limb, any limb |
| S3900 | Surface electromyography (EMG) |

DIAGNOSIS

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|-------------|--|
| 192.2-192.3 | Malignant neoplasm of other and unspecified parts of nervous system |
| 249.60 | Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified |
| 249.61 | Secondary diabetes mellitus with neurological manifestations, uncontrolled |
| 250.61 | Diabetes with neurological manifestations; type I [juvenile type], not stated as uncontrolled |
| 250.63 | Diabetes with neurological manifestations; type I [juvenile type], uncontrolled |
| 269.1 | Deficiency of other vitamins |
| 272.5 | Lipoprotein deficiencies |

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| 333.6 | Genetic torsion dystonia |
| 333.83 | Spasmodic torticollis |
| 335.0 | Werdnig-Hoffmann disease |
| 335.11-335.19 | Spinal muscular atrophy |
| 335.20-335.23 | Motor neuron disease |
| 335.24 | Primary lateral sclerosis |
| 335.8 | Other anterior horn cell diseases |
| 336.0 – 336.8 | Other diseases of spinal cord |
| 337-337.1 337.3 | Disorders of autonomic nervous system |
| 341.0-341.1 | Other demyelinating disease of central nervous system |
| 344.60-344.61 | Cauda equina syndrome |
| 344.89 | Other specified paralytic syndrome |
| 350.2 | Atypical face pain |
| 351.0 | Bell's palsy |
| 351.8 | Other facial nerve disorders |
| 352.3-352.6 | Disorders of other cranial nerves |
| 353.0-353.8 | Nerve root and plexus disorders |
| 354.0-354.8 | Mononeuritis of upper limb and mononeuritis multiplex |
| 355.0-355.79 | Mononeuritis of lower limb |
| 356.0-356.8 | Hereditary and idiopathic peripheral neuropathy |
| 357.0-357.89 | Inflammatory and toxic neuropathy |
| 358.00-359.89 | Myoneural disorders |
| 478.31-478.34 | Paralysis of vocal cords or larynx |
| 625.6 | Stress incontinence, female |
| 710.3-710.5 | Diffuse diseases of connective tissue |
| 721.0-721.42 | Spondylosis and allied disorders |
| 722.0-722.11 722.4-722.52 722.70-722.73 722.81-722.83 722.91-722.93 | Intervertebral disc disorders |
| 723.0, 723.4 | Other and unspecified disorders of cervical region |
| 724.01-724.3 | Other and unspecified disorders of back |
| 728.0 | Infective myositis |
| 729.2 | Neuralgia, neuritis, and radiculitis, unspecified |
| 729.5 | Pain in limb |
| 736.05-736.06 736.09 | Acquired deformities of forearm, excluding fingers |
| 736.79 | Other acquired deformities of ankle and foot |
| 781.4 | Transient paralysis of limb |
| 781.7 | Tetany |
| 782.0 | Disturbance of skin sensation |
| 784.49 | Voice disturbance; other |
| 787.6 | Incontinence of feces |
| 788.21 | Incomplete bladder emptying |
| 788.31-788.37 | Urinary incontinence |
| 952.01-952.8 | Spinal cord injury without evidence of spinal bone injury |

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| 953.0-953.8 | Injury to nerve root and spinal plexus |
| 954.0-954.8 | Injury to other nerve(s) of trunk, excluding shoulder and pelvis girdles |
| 955.0-955.8 | Injury to peripheral nerve(s) of shoulder girdle and upper limb |
| 956.0-956.8 | Injury to peripheral nerve(s) of pelvic girdle and lower limb |

REVISIONS

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| 02-17-2006 | To the "Policy" section, #7 changed SMEG from 'not medically necessary' to 'experimental/investigational' per Medical Director. |
| | To the "Coding" title, added "NOTE: Use of any diagnosis code does not guarantee reimbursement. Medical necessity will be based on documentation in the clinical record." |
| | To the "Coding" CPT/HCPCS section, added HCPCS code G0255 as experimental/investigational per consultant review. |
| | To the "Reference", Government Agency; Medical Society; and Other Authoritative Publications section, added BCBSKS Medical Consultant (356). |
| 03-07-2006 | In "Policy" #6 added the table "Maximum Number of Studies" and the statement below the table "Additional testing may be indicated in patients with a differential diagnosis, which includes peripheral neuropathy, cervical radiculopathy, brachial plexopathy, or more proximal median neuropathy." |
| | In "Policy" #8 added, "Equipment shall have FDA clearance for performance of nerve conduction studies. The device must be capable of electrically stimulating a nerve and recording the resultant response at a second location on that nerve (sensory study) and /or in a muscle innervated by the stimulated nerve (motor study)." |
| | In "Policy" added #9 "It is inappropriate to bill more than one unit for "inching" or studying the same nerve by moving the stimulating electrode closer to the recording electrode." |
| | In "Policy" added #10 "List of Nerves with Added Specificity." |
| | To the "Coding" title, deleted "NOTE: Use of any diagnosis code does not guarantee reimbursement. Medical necessity will be based on documentation in the clinical record." |
| | In "Coding" CPT/HCPCS, 95900 comments section, removed "include moving the electrodes to different locations" and added "are" after branches. |
| | In "Coding" Covered Diagnosis deleted ICD-9 codes 250.60, 250.62, 265.1, 335.10, 335.9, 336.9, 337.2, 337.9, 334.9, 351.9, 353.9, 354.9, 355.8, 355.9, 358.9, 359.9, 348.0, 478.30, 722.2, 722.6, 722.80, 723.5, 724.00, 724.4, 724.5, 728.9, 788.30, 952.00, 952.05, 952.10, 952.15, 952.9, 957.0, 957.1, and 957.8. |
| | In "Reference" moved 1-4 to the Government Agency; Medical Society; and Other Authoritative Publications section and added #1. |
| | In "Reference" Government Agency; Medical Society; and Other Authoritative Publications section added #1-4 from the reference section and AANEM recommended policy for 2006. |
| | 08-09-2006 effective 12-01-2006 |
| In "Policy" section, new #6 "EDX unit limits are discussed in the 'Coding' section of this document. When exceeding the normal unit limit, the provider should submit supplementary documentation to justify the additional testing (American Association of Neuromuscular and Electrodiagnostic Medicine [AANEM] estimates this may occur in 10% of cases)." and added "Additional testing may be indicated in patients with a differential diagnosis, which includes peripheral neuropathy, cervical radiculopathy, brachial plexopathy, or more proximal median neuropathy." at Medical Director's request. | |

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| | <p>In "Policy" section, deleted "Maximum Number of Studies" and added #11, "For list of <u>Maximum Number of Studies</u> refer to AANEM web site, http://www.aanem.org/practiceissues/recPolicy/recommended_policy_6.cfm" at Medical Director's request.</p> |
| | <p>In "Policy" section, added #12, "For <u>List of Nerves with Added Specificity</u> refer to AANEM web site, http://www.aanem.org/practiceissues/recPolicy/listofNerves.cfm", at Medical Director's request.</p> |
| | <p>In "Coding" CPT/HCPCS, added CPT codes 95865 and 95866 due to CPT Coding changes of 1-1-06.</p> |
| 11-12-2008 | <p>In Header section:</p> <ul style="list-style-type: none"> ▪ Replaced previous title of "Electrodiagnostic (EDX) Medicine and Related Services" with current title. <p>In Description section:</p> <ul style="list-style-type: none"> ▪ Expanded to include definition of electrodiagnostic medicine and provided descriptions for identified services. <p>In Policy section regarding #1 through #12:</p> <ul style="list-style-type: none"> ▪ Removed the following: <ol style="list-style-type: none"> 1. EDX testing should be medically indicated. EDX examinations include history taking, appropriate physical examination, and the design, performance, and interpretation of EDX studies. 3. The number of tests performed should be the minimum needed to establish an accurate diagnosis. 4. A specialty-trained provider should perform NCS. 5. A provider specialty trained in electrodiagnostic medicine must perform the needle EMG examination as these tests are simultaneously performed and interpreted. 8. Examination using portable hand-held devices, which are incapable of waveform analysis, will not be paid. Equipment shall have FDA clearance for performance of nerve conduction studies. The device must be capable of electrically stimulating a nerve and recording the resultant response at a second location on that nerve (sensory study) and /or in a muscle innervated by the stimulated nerve (motor study). Psychophysical measurements (current, vibration, and thermal perceptions) even though they may involve delivery of a stimulus, are not recognized for payment. 10. Determining the proper number of units for nerve conduction studies 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). 11. For list of <u>Maximum Number of Studies</u> refer to AANEM web site, http://www.aanem.org/practiceissues/recPolicy/recommended_policy_6.cfm 12. For <u>List of Nerves with Added Specificity</u> refer to AANEM web site, http://www.aanem.org/practiceissues/recPolicy/listofNerves.cfm <ul style="list-style-type: none"> ▪ Replaced, "6. EDX unit limits are discussed in the 'Coding' section of this document. When exceeding the normal unit limit, the provider should use modifier 22 and submit supplementary documentation to justify the additional testing (American Association of Neuromuscular and Electrodiagnostic Medicine [AANEM] estimates this may occur in 10% of cases). Additional testing may be indicated in patients with a differential diagnosis, which includes peripheral neuropathy, cervical radiculopathy, brachial plexopathy, or more proximal median neuropathy." with current #1. <ul style="list-style-type: none"> ▪ Added AANEM Recommended Maximum Number of Studies chart. ▪ Added Maximum Number of Studies for Additional Codes chart. ▪ Previous #7 became current #2. ▪ Added new #3. |

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| | <ul style="list-style-type: none"> ▪ Previous #2 and #9 became current #1 and #3 in Policy Guideline subsection. ▪ The following wording from previous #6 "When exceeding the normal unit limit, the provider should use modifier 22 and submit supplementary documentation to justify the additional testing AANEM estimates this may occur in 10% of cases)" became current #2 in Policy Guideline subsection. ▪ Removed Documentation subsection which stated: <ol style="list-style-type: none"> 1. Documentation should explain what differential diagnostic problems needed to be ruled out in that particular situation. In some patients, multiple diagnoses will be established by EDX testing. It should be noted that in some situations it is necessary to test an asymptomatic contralateral limb to establish normative values for an individual patient. Normal values based on the general population alone are less sensitive than this approach; therefore restrictions on contralateral asymptomatic limb testing will reduce the sensitivity of electrodiagnostic tests. 2. Contralateral (bilateral) extremity counterparts may be billed separately as noted in the Blink Reflexes section. Contralateral means opposite sides of the body, not opposite sides of an extremity. When billing, indicate right (RT) and left (LT). 3. Any services exceeding the unit limit listed by the code must be submitted with medical record documentation to support medical necessity of increased units. Professional providers should report modifier 22. ▪ Removed from Utilization subsection: <ol style="list-style-type: none"> 1. Units exceeding the unit maximum must have medical records submitted with the claims or the additional units will be denied. Professional providers should report modifier 22. 2c. Polymyositis and myasthenia gravis and other such diseases usually have a course that is not stable and do not respond to treatment consistently; in these cases monitoring of the patient's condition may be needed to monitor disease progress and therapeutic intervention responses. 2d. It may be necessary to retest when a course of a disease changes unexpectedly. <ul style="list-style-type: none"> ▪ In Utilization subsection 2b. replaced "early treatment to begin with preliminary testing with additional testing for prognosis and status of patient." with "monitoring patient progress." ▪ In Utilization subsection 3 replaced "Repeat EDX is sometimes necessary and when supported by medical documentation will be allowed. The claim must be submitted with medical record documentation to support medical necessity of repeat testing. Professional providers should report modifier 22. Common frequency testing for these diagnosis for a 12 month period, per provider are: a. Two (2) tests - Carpal tunnel-unilateral, carpal tunnel-bilateral, radiculopathy, mononeuropathy, poly-neuropathy, myopathy, and neuromuscular junction (NMJ) disorders. b. Three (3) tests - Motor neuronopathy and plexopathy." with "The claim must be submitted with medical record documentation to support medical necessity of repeat testing. Professional providers should report modifier 22." |
| | <p>In Coding section:</p> <ul style="list-style-type: none"> ▪ Replaced Code/Unit charts reflecting descriptions, units, guidelines, and comments with traditional CPT/HCPCS nomenclature. ▪ Units for codes 95860-95864, 95867-95870, 95900, 95903, 95904, 95934, 95936, and 95937 were updated to be in accordance with AANEM guidelines and reflected in the AANEM Recommended Maximum Number of Studies chart. ▪ Units for codes 95865, 95866, 95872, 95921, 95922, 95923, 95925, 95926, 95927, and 95933 were unchanged and reflected in the Maximum Number of Studies for Additional Codes chart. ▪ Replaced individual diagnosis codes with code ranges where applicable. <p>No CPT/HCPCS or Diagnosis codes were removed or added.</p> |

REFERENCES

1. Kimura J. *Electrodiagnosis in Diseases of Nerve and Muscle: Principles and Practice*, 3rd Edition. Oxford University Press 2001. Chapter 5 (Principles and Variations of Nerve Conduction Studies).

Government Agency; Medical Society; and Other Authoritative Publications

1. American Association of Neuromuscular and Electrodiagnostic Medicine, American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation. Recommended Policy for Electrodiagnostic Medicine. 2002.
2. American Association of Neuromuscular and Electrodiagnostic Medicine, Recommended Policy for Electrodiagnostic Medicine. 2006.
3. American Physical Therapy Association. Position Statement Re: Practice of Electrophysiologic Testing By Physical Therapists.
4. BCBSKS Medical Consultant, Practicing Board Certified Neurologist (356), January 13, 2006
5. CPT Assistant. Coding Communication: Proper Use of Needle EMG CPT Codes 95860-95870. Volume 14, Issue 2, February 2004.
6. International Academy of Clinical Neurology. Recommended Policy for Electrodiagnostic Medicine.
7. Medicare Part B – Kansas/Nebraska/Western Missouri. Nerve Conduction Studies and Electromyography. 02-12-2003.
8. Section on Clinical Electrophysiologic of the American Physical Therapy Association Task Force on Guidelines for Clinical Electromyography. Guidelines for Clinical Electromyography. 2003.

Web site

1. American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), Recommended Policy for Electrodiagnostic Medicine, Accessed July 2008:
http://www.aanem.org/practiceissues/recPolicy/recommended_policy_1.cfm