

Mobile Nerve-Testing: Practical Considerations

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Electrodiagnostic (EDX) testing can serve as an integral component in assessing function, directing care decisions and rendering a prognosis for many neuromuscular conditions seen in everyday practice. However, before integrating testing into practice, doctors should be aware of the pitfalls associated with some "mobile testing companies" that have aggressively marketed their services to health care practitioners under the guise of creating an additional profit center, increasing the level of patient service and providing objective justification of care. While many of these arrangements seem appealing at first glance, they can have several downsides. In addition to inherent clinical limitations, these business arrangements can present as potential red flags for fraud, abuse and overutilization.

Diagnostic Capabilities

For the vast majority of mobile testing companies, a technician (rather than a doctor) is sent to the "host" office to perform the actual EDX testing. Technicians are not qualified or licensed to perform needle EMG analysis, so performed studies are primarily limited to nerve conduction (NCV) and evoked potentials, such as SSEP. Surface EMG is no substitute for needle EMG, nor is diagnostic ultrasound. Unfortunately, performing a NCV in isolation does not do the patient justice, as an incomplete study limits the ability to accurately diagnose the patient's condition.

For example, it is impossible to reliably differentiate between a cervical radiculopathy, brachial plexopathy or peripheral neuropathy without performing needle EMG in conjunction with NCV. What happened to the idea of "increased level of patient service"? Likewise, how can you "objectively justify care" when you are unable to adequately document the condition you claim to be treating?

Business Ethics

From a business standpoint, many of these companies incorporate complicated business agreements such as leases in which the "host" doctor is paid a per diem fee for the use of office space. The host doctor then refers patients to the company working out of the doctor's office, and the testing company performs and bills for the studies. Days in which no patients are referred for testing result in no rental fees paid. This particular arrangement may be viewed as a potential kickback, as there is financial incentive for the doctor to keep the testing company busy.

Another common scenario involves the testing company "leasing" a technician and related equipment to a host doctor. The host doctor then refers their own patients for testing in-house and "oversees" the tests being conducted by the leased technician. The testing company has an offsite doctor interpret and sign off on the study, and bills for the professional component of the study while the supervising host bills separately for the technical component of the services rendered.

This arrangement has several downsides as well. Insurance carriers often consider separate billing of PC and TC components as a red flag for overutilization. Plus, having a host doctor bill for their direct

oversight of a technician may be seen as inappropriate when the host doctor has little, if any, actual training in the field they are claiming to oversee.

Clinical Limitations

Business matters aside, mobile testing has inherent clinical limitations in and of itself. The most important thing to consider is that electrodiagnostic studies are most beneficial when they serve as an extension of the patient history and physical examination process. The EDX study typically evolves while it is underway and is most beneficial when performed after a focused clinical examination has been performed. The ability to accurately determine the longitudinal level of the lesion and assess its severity, phase of healing and prognosis requires clinical examination and needle EMG. When a study is performed in an isolated manner, its clinical value vastly diminishes.

As mentioned earlier, most technicians are unable to perform the needle EMG component of the study, nor are they typically capable of performing an examination and modifying the EDX study to fit the unique set of circumstances with which a patient may present. Instead, the NCV/SSEP portions are performed in a standardized fashion as an "upper" or "lower" study, and the waveforms are e-mailed to a physician who then attempts to interpret the limited study. The disadvantaged physician reading and signing off on the study has no history, examination findings or EMG findings to correlate with the waveforms. Reports ultimately include the name of an interpreting physician who never saw the patient. Third-party payers are wising up to these schemes and will often deny payment for NCV studies performed in isolation without needle EMG on the same date of service.

What to Look For

So, what should a clinician take into consideration before bringing electrodiagnostic testing in-house? First of all, the person performing the testing should be a doctor licensed to perform needle EMG. They should be capable of performing an adequate history and examination to form a differential diagnosis, and proficient in interpreting the results of the study as it occurs in real time.

The person performing the study should have the right to modify the extent of the study as needed in order to tailor it to the patient's unique situation and case-specific differentials. The doctor performing the study should have the right to decline the performance of the study if it is determined to be clinically inappropriate in light of the patient's situation. Payment arrangements should avoid conditions that might be perceived as kickbacks, volume incentives or overutilization enticements.

As always, it is advisable for doctors to discuss the specifics of their situation with legal counsel before entering into any agreement. There should be open communication in advance between the treating physician and the doctor performing the study regarding referral criteria such as indications, contraindications and injury time frames relative to testing. There should be a mechanism in place to make pertinent history, prior examination and imaging results available at the time of testing. A quality report should include a brief history and pertinent examination findings to support medical necessity and copies of the actual waveforms generated. Most importantly, the impression should provide a sense of clinical direction to the referring physician.

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