Intraoperative Nerve Monitoring
REIMBURSEMENT CODING GUIDE

This document provides general reimbursement information to assist in obtaining coverage and reimbursement for healthcare services. These coding suggestions do not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures.


Please direct any questions to:

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## INTRAOPERATIVE NERVE MONITORING CODING GUIDE - JANUARY 2015

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>PHYSICIAN</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>+95940</td>
<td>Continuous intraoperative neurophysiology monitoring in the operating room, one-on-one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code of primary procedure)</td>
<td>.93</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$33</td>
<td>N Packaged</td>
</tr>
<tr>
<td>+95941</td>
<td>Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code of primary procedure)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NA</td>
<td>N Packaged</td>
</tr>
<tr>
<td>+G0453</td>
<td>Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes. (List separately in addition to code of primary procedure).</td>
<td>.93</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$33</td>
<td>N Packaged</td>
</tr>
<tr>
<td>95868</td>
<td>Needle electromyography, cranial nerve supplied muscle(s), bilateral</td>
<td>3.73</td>
<td>0218</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$133</td>
<td>S</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$159</td>
</tr>
<tr>
<td>95870</td>
<td>Needle electromyography, limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplies muscles, or splinters</td>
<td>2.49</td>
<td>0340</td>
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<tr>
<td></td>
<td></td>
<td>$89</td>
<td>S</td>
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<td></td>
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<td>$52</td>
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</table>

3. CMS Final 2015 Outpatient Rule - CMS-1613-FC.
4. Status indicator “N” means packaged and is not paid separately.
5. Status indicator “S” means “significant procedure not subject to multiple procedure discounting.”
ICD-9-CM provides a specific code for intraoperative nerve monitoring: 00.94 intra-operative neurophysiologic monitoring.

FREQUENTLY ASKED QUESTIONS

Q: What are changes for CPT codes for intraoperative monitoring?
A: CPT code 95920 has been deleted effective January 2013. Three new codes (95940, 95941, and G0453) have been added. New code 95940 is reported per 15 minutes of service and reports only the time monitoring provider was physically present in the operating room providing one-on-one patient monitoring. New code 95941 is reported for non-Medicare cases in which monitoring provider is not in the operating room or when provider is monitoring more than one case. These codes should be used in conjunction with the study performed: 92585, 95822, 95860-95870, 95907-95913, and 95925-95939. Do not report these codes for automated monitoring devices that do not require continuous attendance by a qualified professional to interpret the testing and monitoring.

Medicare Note: 95941 may not be used for Medicare beneficiaries because it allows a provider to remotely monitor several patients at the same time. CMS now allows a provider to monitor only one patient at a time, so G0453 is used for continuous remote monitoring for one patient (outside the operating room).

Q: How has Medicare changed its coverage policy for intraoperative monitoring?
A: Medicare will now allow a provider to monitor only one patient at a time (95940 if in the operating room and G0453 if outside the operating room). Time billed is based on actual monitoring time. Physicians may bill Medicare for one unit of G0453 if at least 8 minutes of service is provided as long as no more than 4 units of G0453 are billed for each 60 minutes.

Q: Who can bill for intra-operative nerve monitoring (IOM)?
A: Criteria for commercial payers may vary, so physicians should contact their provider-relations representative. Under Medicare rules, the operating surgeon is not paid separately for IOM. The following providers can bill if they have a separate provider number from the operating surgeon:

- A physician who is not performing the surgical procedure
- An audiologist trained and certified in electrophysiologic monitoring
- A physical therapist trained and certified in electrophysiologic monitoring
- A neurophysiologist, neurologist, or physiatrist

Q: If the operating surgeon’s partner performs the nerve monitoring, can this be billed separately?
A: In general, the operating surgeon’s partner cannot bill for nerve monitoring separately. From the payer perspective, a physician and the physician’s partners is the same person. Since the operating surgeon cannot bill nerve monitoring separately, a partner cannot bill separately. One common exception is when the operating surgeon and the partner are in different specialties, in which case some payers allow them to bill separately. (Medicare Claims Processing Manual, Chapter 12, 30.65.) Criteria for commercial payers may vary, so physicians should contact their provider-relations representative.

Q: Can hospital outpatient departments or ambulatory surgery centers bill for intra-operative nerve monitoring?
A: Under Medicare APCs, the hospital and/or ASC can bill for the technical component of the EMG codes, such as CPT 95867 or CPT 95868 and receive separate payment. However, Medicare considers the intraoperative nerve monitoring codes to be a “packaged” service. The hospital and/or ASC can and should submit the code, but payment for 95940, 95941, or G0453 will be included in the payment for the primary procedure, so no separate payment is made. Contact your commercial payers for specific payment information on intraoperative monitoring.
Q: Can a company that provides intraoperative nerve monitoring get reimbursed for the monitoring in a hospital or ASC?
A: A company that provides intra-operative nerve monitoring services that performs and bills for the nerve monitoring under its own Medicare provider number may be reimbursed. However, as of 2013, Medicare will only allow a provider to monitor one patient at a time (95940 if in the operating room and G0453 if outside the operating room).

Q: Which monitoring codes are used during thyroid surgery?
A: CPT code 95868 for bilateral cranial nerve monitoring is used because the EMG tube monitors the nerve bilaterally. However, if monitoring unilaterally, then CPT 95867 can be used. The nerve being monitored is a branch of a cranial nerve.

Q: What are the new codes for nerve conduction studies?
A: CPT codes 95900 through 95904 have been deleted and replaced with 7 new codes (95907-95913). The unit of service in codes 95907-95913 is the "number of nerve conduction studies performed." Unit of service in previous codes 95900-95904 was "per nerve." 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.

Q: Can an anesthesiologist bill for EMG tube placement?
A: No. Under Medicare rules, anesthesiologists cannot separately code or bill the use of a scope or laryngoscope in placing an endotracheal tube. This is considered integral to the anesthesia service. (Source: NCCI Policy Manual, version 16.3, Chapter 2, section B, no. 4.)