INTRAOPERATIVE NERVE MONITORING

COMMONLY BILLED CODES

EFFECTIVE JANUARY 2018

Medtronic

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The following information is calculated per the footnotes included and does not take into effect Medicare payment reductions resulting from sequestration associated with the Budget Control Act of 2011. Sequestration reductions went into effect on April 1, 2013.

FOR QUESTIONS PLEASE CONTACT US AT **ENT.US.REIMBURSEMENT@MEDTRONIC.COM**

ICD-10-PCS[1] Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Intraoperative Nerve Monitoring	**4A1004G**	Monitoring of Central Nervous Electrical Activity, Intraoperative, Open Approach
	4A1034G	Monitoring of Central Nervous Electrical Activity, Intraoperative, Percutaneous Approach
	4A10X2Z	Monitoring of Central Nervous Conductivity, External Approach
	4A10X4G	Monitoring of Central Nervous Electrical Activity, Intraoperative, External Approach
	4A11029	Monitoring of Peripheral Nervous Conductivity, Sensory, Open Approach
	4A1102B	Monitoring of Peripheral Nervous Conductivity, Motor, Open Approach
	4A1104G	Monitoring of Peripheral Nervous Electrical Activity, Intraoperative, Open Approach
	4A11329	Monitoring of Peripheral Nervous Conductivity, Sensory, Percutaneous Approach
	4A1132B	Monitoring of Peripheral Nervous Conductivity, Motor, Percutaneous Approach
	4A1134G	Monitoring of Peripheral Nervous Electrical Activity, Intraoperative, Percutaneous Approach
	4A11X29	Monitoring of Peripheral Nervous Conductivity, Sensory, External Approach
	4A11X2B	Monitoring of Peripheral Nervous Conductivity, Motor, External Approach
	4A11X4G	Monitoring of Peripheral Nervous Electrical Activity, Intraoperative, External Approach

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HCPCS II Device Codes[2]

These codes are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers.

ASCs, however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.[3]

Device or Product	HCPCS	Description / Comment
NIM-Neuro® 3.0 Nerve Monitoring System for Neurotology with Accessories[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
NIM-Response® 3.0 Nerve Monitoring System for ENT Surgery with Accessories[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
NIM TriVantage®, NIM Contact® and NIM® EMG Endotracheal Tubes[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
Electrodes, including APS® Electrode, and Stimulating Probes [4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.

1. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System(ICD-10-PCS). https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-PCS-and-GEMs.html. Updated October 1, 2017. Accessed November 22, 2017.
2. Device C-codes are HCPCS Level II codes and are maintained by the Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html. Accessed November 14, 2017.
3. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 15, 2017. See also MLN Matters SE0742 p.9-10: Centers for Medicare and Medicaid Services. MLN Matters Number SE0742 Revised. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0742.pdf. Accessed November 15, 2017.
4. NIM-Neuro® NIM-Response® , NIM-TriVantage®, NIM Contact®, NIM®, and APS® are registered trademarks of Medtronic, Inc.
5. N/A indicates that CMS and other payers do not have a need for these items to be individually identified, although the associated charges must still be reported. When hospitals use a device or supply that does not have a HCPCS II code, they should report the charges in the general revenue code for the item, typically revenue code 270 for Medical-Surgical Supplies.

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Physician Coding and Payment — Effective January 1, 2018

CPT® Procedure Codes

Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT Code and Description[1]	Medicare RVUs[2]		Medicare National Average[3]	
		For physician services provided in:			
		Physician Office[4]	Facility	Physician Office[4]	Facility
Intraoperative Nerve Monitoring[5]	**95940** 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)	N/A	0.93	N/A	$33
	95941 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)[6]	N/A	N/A	N/A	N/A
	G0453 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)[6]	N/A	0.93	N/A	$33
	95865-26 Needle electromyography; larynx [7]	N/A	2.39	N/A	$86
	95868-26 Needle electromyography, cranial nerve supplied muscle(s), bilateral [7]	N/A	1.80	N/A	$65
	95870-26 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 [7]	N/A	0.57	N/A	$21

1. CPT copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare & Medicaid Services. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018. Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program Final Rule. 82 Fed. Reg. 52976-53371. https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf. Published November 15, 2017. Accessed November 15, 2017. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.
3. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2018 is $35.9996 per 82 Fed. Reg. 52976-53371. httpshttps://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf. Published November 15, 2017. Accessed November 15, 2017. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
4. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g. in hospital). Centers for Medicare & Medicaid Services. Details for Title: CMS-1676-F. CY 2018 PFS Final Rule Addenda. Addendum A: Explanation of Addendum B and C. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html . Released November 2, 2017. Accessed November 17, 2017.
5. The following providers may bill for intraoperative nerve monitoring when 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, or a neurophysiologist, neurologist, or physiatrist.
6. CPT 95941 may not be used for Medicare beneficiaries because it allows a provider to remotely monitor several patients at the same time. CMS only allows a provider to monitor one patient at a time, therefore G0453 is used for continuous remote monitoring for one patient (outside the operating room).
7. This assumes the service is occurring in a facility setting and provider is coding for professional interpretation only (26 modifier) therefore, only facility RVUs and payments are provided. CPT 95865 is considered mutually exclusive to CPT 95868 and 95870. These codes may be separately reported where modifier -59 is justified. For CPT codes 95865, 95868 & 95870, each type of nerve conduction study is reported only once regardless of the number of times performed on the same nerve in different areas.

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Hospital Outpatient Coding and Payment — Effective January 1, 2018

CPT® Procedure Codes

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one of approximately 710 ambulatory payment classes. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC.

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Intraoperative Nerve Monitoring[5]	**95940** 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)	N/A	N/A	N	N/A	N/A
	95941 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)[6]	N/A	N/A	N	N/A	N/A
	G0453 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)[6]	N/A	N/A	N	N/A	N/A
	95865-TC Needle electromyography; larynx	5734	Level 4 Minor Procedures	Q1	1.3358	$105
	95868-TC Needle electromyography, cranial nerve supplied muscle(s), bilateral	5721	Level1 Diagnostic Tests and Related Services	S	1.7335	$136
	95870-TC 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	5733	Level 3 Minor Procedures	Q1	0.7116	$56

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf Published November 13, 2017. Accessed November 16, 2017. Correction Notice CMS-1678-CN. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-CN.html . Published December 14, 2017. Accessed January 2, 2018.
3. Status Indicator (SI) shows how a code is handled for payment purposes: N = packaged service, no separate payment; Q1 = Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V" ; S = always paid at 100% of rate.
4. Medicare national average payment is determined by multiplying the APC weight by the conversion factor. The conversion factor for 2018 is $78.636. The conversion factor of $78.636 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf . Published November 13, 2017. Accessed November 16, 2017. Payment is adjusted by the wage index for each hospital's specific geographic locality so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. Under Medicare APCs, the hospital may bill for the technical component of the EMG codes, such as CPT 95865, 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.
6. CPT 95941 may not be used for Medicare beneficiaries because it allows a provider to remotely monitor several patients at the same time. CMS only allows a provider to monitor one patient at a time, therefore G0453 is used for continuous remote monitoring for one patient (outside the operating room).

ASC Coding and Payment — Effective January 1, 2018

There is no additional reimbursement for Intraoperative Nerve Monitoring procedure codes when performed in the ASC setting ; payment is packaged into the payment for the surgical procedure. [1,2,3]

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf . Published November 13, 2017. Accessed November 16, 2017. Correction Notice CMS-1678-CN. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-CN.html . Published December 14, 2017. Accessed January 2, 2018.
2. Medicare considers the intraoperative nerve monitoring codes to be a "packaged" service. The ASC may 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.
3. For Medicare billing, ASCs use a CMS-1500 form.

Rx only. Refer to product instruction manual/package insert for instructions, warnings, precautions and contraindications.

For further information, please call Medtronic ENT at 800.874.5797 and/or consult Medtronic ENT website at www.medtronicent.com.

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