Medtronic

Intraoperative nerve monitoring for ENT surgery

Commonly Billed Codes

Effective January 1, 2025

US-ENT-2303151

Intraoperative nerve monitoring for ENT surgery – Effective January 1, 2025

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For questions please contact us at ent.us.reimbursement@medtronic.com

ICD-10-PCS procedure codes[1]

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

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 Vital™, NIM-Neuro™ 3.0, and NIM-Response™ 3.0 nerve monitoring systems for ENT surgery with accessories[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
NIM TriVantage™ 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 probes[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.

Coding and Payment – Effective January 1, 2025

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.

Hospitals use CPT codes for outpatient services. Under Medicare's APC (ambulatory payment classification) methodology for hospital outpatient payment, each CPT code is assigned to one of approximately 770 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.

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.[6,7,8]

		Office				Hospital Outpatient				Ambulatory Surgery	
Procedure	CPT code and description[9]	Total Non-Facility RVUs[10,11]	Total Facility RVUs[10,11]	Non-Facility Rate[12]	Facility Rate[12]	APC[6]	Status Indicator[6,13]	Relative Weight[6]	Payment[6,14]	Payment Indicator[6,7,8]	Payment[6,7,8]
Intraoperative nerve monitoring[15,16]	**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[19]	0.96	N/A	$31	N/A	N/A	N	N/A	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)[17]	N/A	N/A	N/A	N/A	N/A	N/A	N	N/A	N/A	N/A

Coding and Payment – continued

		Office				Hospital Outpatient				Ambulatory Surgery	
Procedure	CPT code and description[9]	Total Non-Facility RVUs[10,11]	Total Facility RVUs[10,11]	Non-Facility Rate[12]	Facility Rate[12]	APC[6]	Status Indicator[6,13]	Relative Weight[6]	Payment[6,14]	Payment Indicator[6,7,8]	Payment[6,7,8]
Intraoperative nerve monitoring[15,16]	**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)[17]	N/A	0.94	N/A	$30	N/A	N/A	N	N/A	N/A	N/A
	95865-26 Needle electromyography; larynx[18]	N/A	2.41	N/A	$78						
	95865-TC Needle electromyography; larynx					5734	Q1	1.4456	$129	N/A	N/A
	95868-26 Needle electromyography, cranial nerve supplied muscle(s), bilateral[18]	N/A	1.81	N/A	$59						
	95868-TC Needle electromyography, cranial nerve supplied muscle(s), bilateral					5722	S	3.4922	$311	N/A	N/A
	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[18]	N/A	0.58	N/A	$19						
	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					5734	Q1	1.4456	$129	N/A	N/A

Coding and Payment – continued

References:

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). https://www.cdc.gov/nchs/icd/icd-10-cm/files.html. Accessed October 25, 2024.
2. Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update. Accessed October 24, 2024.
3. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. Due to 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 October 25, 2024.
4. NIM-Vital™, NIM-Neuro™, NIM-Response™, NIM-TriVantage™, NIM Contact™, NIM™, and APS™ are 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.
6. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19; https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc. Accessed November 15, 2024.
7. 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.
8. For Medicare billing, ASCs use a CMS-1500 form.
9. CPT copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
10. Centers for Medicare & Medicaid Services Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2025; CMS-1807-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f. Accessed November 15, 2024. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.
11. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
12. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2025 is $32.3465. Centers for Medicare & Medicaid Services Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2025; https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-F.. Accessed November 15, 2024.
13. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; T = Significant procedure subject to multiple procedure discounting.
14. Medicare national average payment rate is determined by multiplying the APC weight by the conversion factor. The final conversion factor for 2025 is $89.169 as published in CMS-1809-FC. The conversion factor of 89.169 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Data https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc. Accessed November 11, 2024.
15. 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.
16. 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.
17. 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).
18. 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.
19. "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 a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate.

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

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