2016

NVM5® Intraoperative Monitoring (IOM) Reimbursement Guide

NuVasive®
Speed of Innovation®

CONTENTS

DISCLAIMER

The information provided in this Guide is intended to provide general guidance about coding for services provided using the NuVasive® NVM5® system. It is not intended as a comprehensive guide to coding for intraoperative monitoring services. Payors or their local branches may have their own coding and reimbursement requirements. Before rendering IOM services, Providers should obtain preauthorization from the payor, if required.

Additional resources about billing and coding for intraoperative monitoring generally may be found on the American Academy of Neurology (AAN) website at www.aan.com (see in particular Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing, available at https://www.aan.com/practice/billing-and-coding/coverage-policies). For reimbursement questions related to NVM5 system use, please contact **NuVasive Spine Reimbursement Support by emailing reimbursement@nuvasive.com**.

Although the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) Current Procedural Terminology (CPT®) codes[1] were the primary source of the information contained in this Guide, NuVasive does not represent or guarantee that the information is complete, accurate, or applicable to any particular patient or third-party payor. NuVasive disclaims all liability for any consequence resulting from any reliance on the information contained in this Guide. The decision to bill for any service must be made by the healthcare Provider considering the medical necessity of the service rendered.

OVERVIEW OF THE NVM5 NEUROMONITORING AND COMPUTER-ASSISTED SURGERY PLATFORM

NuVasive® NVM5 is an EMG (electromyography), MEP (motor evoked potentials), and SSEP (somatosensory evoked potentials) Intraoperative Monitoring (IOM) system that assists with implant placement and surgical technique by monitoring nerve and spinal cord activity throughout the surgical procedure. Bendini® is a computer-assisted NVM5 rod bending system used to bend rods to specific implant locations for spinal surgery applications. The system uses a digitizer, an infrared camera, software, and a mechanical rod bender to expedite manual rod manipulation. NuvaMap™ O.R., an NVM5 software application, is the industry's only real-time intraoperative assessment of various patient anatomical parameters through the use of a lateral fluoroscopic image. Intuitive software displays the comparison of intraoperative anatomical values to preoperative and planned patient measurements.

NVM5 combines intraoperative electrically stimulated EMG and spontaneous EMG activity to help the surgeon assess possible nerve root irritation or injury during spine surgery. Patented software algorithms help provide the surgeon with real-time data to assist with assessment of the patient's neurophysiological status. Motor pathways of the cord are monitored using MEP, whereby a controlled stimulation elicits a motor response that is transmitted through the cord and measured at muscle recording sites. Electrodes record muscle activity during the procedure, allowing for intraoperative assessment of spinal cord and motor pathway integrity. Sensory pathways are monitored using SSEP by stimulating peripheral nerves and recording the responses at various points leading up to the sensory cortex of the brain.

XLIF® Monitoring

Screw Test and Nerve Monitoring

Alignment Assessment

Spinal Cord Monitoring

Rod Bending
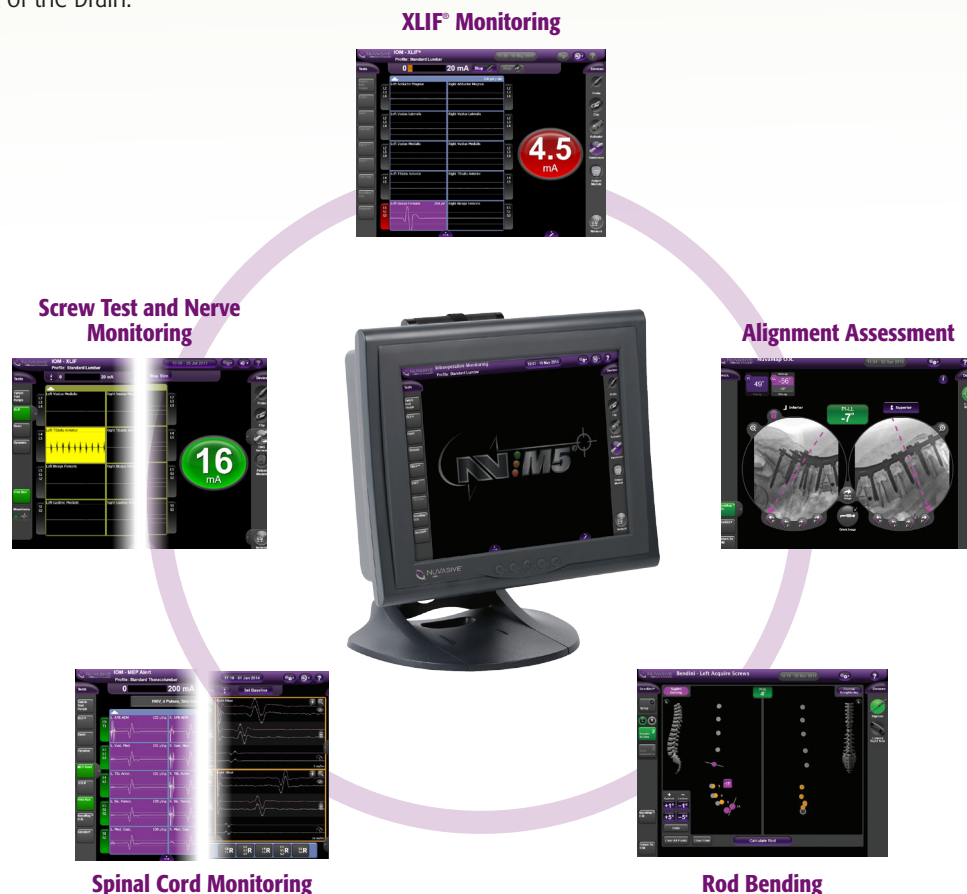
PURPOSE OF THIS GUIDE

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NuVasive® has prepared this Intraoperative Monitoring (IOM) Reimbursement Guide to assist hospitals and professionals in properly billing for the use of the NVM5® Intraoperative Monitoring system. This Guide presents pertinent information regarding IOM coding and payment.

IOM REIMBURSEMENT OVERVIEW

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When professionals bill for services performed, they use the Healthcare Common Procedure Coding System (HCPCS). HCPCS is a collection of standardized codes that represent medical procedures, supplies, products, and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers. Medicare can also create its own HCPCS code set for professional billing, often in the form of G-codes.

HCPCS is divided into two categories, Level I and Level II. Level I consists of CPT® codes — five-digit numbers accompanied by narrative descriptions. The CPT codes are created and maintained by the AMA, and reviewed and revised on an annual basis. Level II HCPCS codes identify products, supplies, and services not included in CPT and may be adopted by CMS for a number of reasons.

Each CPT code and G-code have an assigned number of relative value units (RVUs) that are designed to compare the professional work, malpractice insurance costs, and practice expenses associated with a given procedure or service to those associated with all other procedures or services. RVUs vary by region. Medicare annually revises a dollar conversion factor that, when multiplied by the RVUs of the CPT code or G-code, results in the national Medicare reimbursement for that specific code. Commercial payors may also consider the RVUs of the CPT code when establishing professional fee schedules.

Please refer to page 12 of this document for a complete list of intraoperative monitoring CPT codes commonly used with NVM5.

SUMMARY OUTLINE OF CODING CONSIDERATIONS WHEN USING NVM5

1   **NVM5 MONITORING IS USED DURING THE SPINE PROCEDURE**

2   **BASE (PRIMARY) CODES ARE USED TO CAPTURE THE IOM MODALITIES PERFORMED (FOR EXAMPLE, THERE ARE CODES FOR EMG, MEP, AND SSEP)**

3   **IF PROFESSIONAL OVERSIGHT IS PERFORMED, ADDITIONAL ADD-ON CODES MAY BE APPLIED TO THE BASE (PRIMARY) CODE TO DESCRIBE THE SERVICES PERFORMED**

2016 IOM REIMBURSEMENT CODING

BASE (PRIMARY) CODES

A base (primary) code is used to represent the modalities that were performed during the procedure. Below are the most common codes used to describe the use of NVM5 intraoperative monitoring modalities:

COMMON BASE (PRIMARY) CODES APPLIED WITH NVM5		
CPT®	DESCRIPTION	COMMON NUVASIVE® DISPOSABLE
95864	EMG, four extremities (five or more muscles)	EMG Harness
95870	Stimulated EMG (four or fewer muscles in 1 extremity), commonly used for pedicle screw testing	EMG Harness, Probe, Clip, I-PAS™
95939	MEP, upper and lower limbs	MEP/EMG Harness
95938	SSEP, upper and lower limbs	SSEP Harness
95865	EMG, RLN	ET Tube
61783	Computer-assisted Surgery	Bendini® Array

Please refer to page 12 of this document for a complete list of intraoperative monitoring CPT codes commonly used with NVM5.

2016 IOM REIMBURSEMENT CODING

ADD-ON CPT® CODES FOR PROFESSIONAL OVERSIGHT

INTRODUCTION

This section will discuss codes that may be utilized when professional oversight is employed. Professional oversight of IOM may be provided in two different ways:

1. Monitoring oversight remotely from outside the O.R. (95941, G0453)
2. Monitoring oversight within the O.R. (95940)

ADD-ON CPT CODES 95941 AND 95940:

CPT CODE **95941**

60 MIN.

- **Professional Oversight from outside the O.R.** (remote) or monitoring of more than one case while in the O.R., per hour.
- Billed in whole units and should be rounded up to the next unit if at least 31 minutes of service is provided.

CPT CODE **95940**

15 MIN.

- **Professional Oversight from within the O.R.**, one-on-one monitoring, per 15 minutes, even if multiple nerve studies are performed.
- Billed in whole units and should be rounded to the next unit if at least 8 minutes of service is provided.

- Codes 95941 and 95940 must always be billed in conjunction with the applicable base (primary) procedure code(s).
- Each base (primary) code should be applied once per operative session.
- Time spent after the procedure performing or interpreting neurophysiologic studies should not be counted as IOM, but reported as a separate procedure.
- The monitoring professional must be monitoring in real-time and be solely dedicated to performing the monitoring.
- The monitoring professional must have the capacity for continuous or immediate contact with the operating room at all times.

MEDICARE HCPCS CODE G0453:

HCPCS CODE **G0453**

15 MIN.

- **IOM from outside the O.R.** (remote), monitoring professional can only bill for exclusive time spent monitoring one Medicare patient, per 15 minutes.
- HCPCS code G0453 is billed in whole units and should be rounded up to the next unit if at least 8 minutes of service is provided, not to exceed 4 units per hour.

- Multiple cases may be monitored simultaneously, but the monitoring professional can only bill one case at a time.
- Monitoring professionals may use the method of their choice to allocate time to patients being simultaneously monitored, but only one unit of service can be billed for one patient for a 15-minute time period.
- The monitoring professional may add up non-continuous time directed at one patient to determine how many units may be billed.
- Monitoring professionals must account for the exclusive, non-continuous time spent monitoring Medicare patients when billing Medicare.

2016 IOM REIMBURSEMENT CODING

PROFESSIONAL OVERSIGHT CONSIDERATIONS

REIMBURSEMENT FOR IOM REQUIRES CONSIDERATION OF THE FOLLOWING:

1

MONITORING PROVIDED BY A SECOND PROFESSIONAL (NOT THE OPERATING SURGEON)

The professional being reimbursed for monitoring cannot be the operating surgeon, as monitoring by the primary surgeon is considered a bundled component of the surgery, according to National Correct Coding Initiative (NCCI) edits and the description of CPT® codes 95941 and 95940.

A qualified remote monitoring professional must typically be licensed to practice in the state and possess hospital credentials or privileges where the surgery is taking place.

The professional being reimbursed for monitoring shall have a distinct National Provider Identifier (NPI). If not, the payor may consider the operating surgeon and monitoring professional to be the same and may not reimburse for the remote monitoring service. Note that the Taxpayer Identification Number for the operating surgeon and monitoring professional may be the same if they both belong to the same practice.

Many Medicare local coverage determinations (LCDs) or other payor coverage guidelines restrict billing by anesthesiologists, technical/surgical assistants, nurses, or other professionals employed by the hospital or practice.

Providers should contact their Medicare contractor or payor regarding specific questions related to these policies.

2

DOCUMENTATION OF MONITORING

In order for neurophysiologic monitoring to be a reimbursable event, the medical need for monitoring is documented by a written order in the patient's chart. Additional documentation may also be included in the monitoring report.

The following information may be considered for inclusion in the monitoring report:

- Description of the modalities monitored
- Clinical information illustrating how the monitoring assisted with the surgical procedure
- Duration of monitoring
- Location of the interpreting professional during monitoring (e.g., on site or remote)
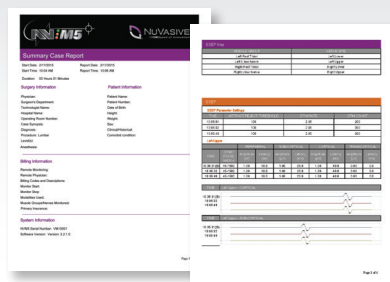
DOCUMENTATION IS AUTOMATICALLY CAPTURED IN NVM5 REPORTS

- Modalities Monitored
- Monitoring Start/Stop Time
- Time-Stamped Waveforms
- Chat Logs

2016 IOM REIMBURSEMENT CODING

PROFESSIONAL OVERSIGHT CONSIDERATIONS (CONT.)

3 PLACE OF SERVICE

Place of service (POS) code for remote monitoring performed at the professional's office depends on the policy of the payor. Either POS code 11 (office) or 21 (inpatient hospital) may be appropriate. POS code 21 should be used for Medicare claims.

In general, the POS code reflects the place where the patient (beneficiary) receives the face-to-face service (inpatient hospital – POS code 21). When using POS code 21, the remote professional should report the address and zip code of his or her office on the claim form.

PAYOR POLICIES REGARDING PLACE OF SERVICE MAY VARY.

• Inpatient Hospital – POS code 21   • Office – POS code 11

4 BUSINESS ARRANGEMENTS

Business arrangements must comply with the federal Stark and Anti-kickback Laws.

STARK LAW

The federal Stark Law was created to protect patients of Medicare or Medicaid from professional self-referral. Professional self-referral occurs when a professional refers a patient to a facility in which the professional has a financial interest. The Stark Law prohibits a professional from referring a patient to a medical facility with which the professional or his immediate family has a financial relationship. This includes ownership, investment, or a structured compensation agreement. This does not apply when the professional is employed by a hospital or has hospital privileges.

ANTI-KICKBACK LAW

The federal Anti-kickback Law's main purpose is to protect patients and federal healthcare programs from fraud and abuse by containing the influence of money on healthcare decisions. The law states that anyone who receives or pays to influence the referral of federal healthcare program business can be charged with a felony.

QUESTIONS? CONTACT NUVASIVE® SPINE REIMBURSEMENT SUPPORT BY EMAILING reimbursement@nuvasive.com. THE INFORMATION PROVIDED IS GENERAL CODING INFORMATION ONLY; IT IS NOT ADVICE ABOUT HOW TO CODE, COMPLETE, OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS, AND BILLS FOR THE SERVICES THAT WERE RENDERED. PAYORS OR THEIR LOCAL BRANCHES MAY HAVE THEIR OWN CODING AND REIMBURSEMENT REQUIREMENTS. BEFORE RENDERING IOM SERVICES, PROVIDERS SHOULD OBTAIN PREAUTHORIZATION FROM THE PAYOR.

7

2016 NVM5® Intraoperative Monitoring (IOM) Reimbursement Guide
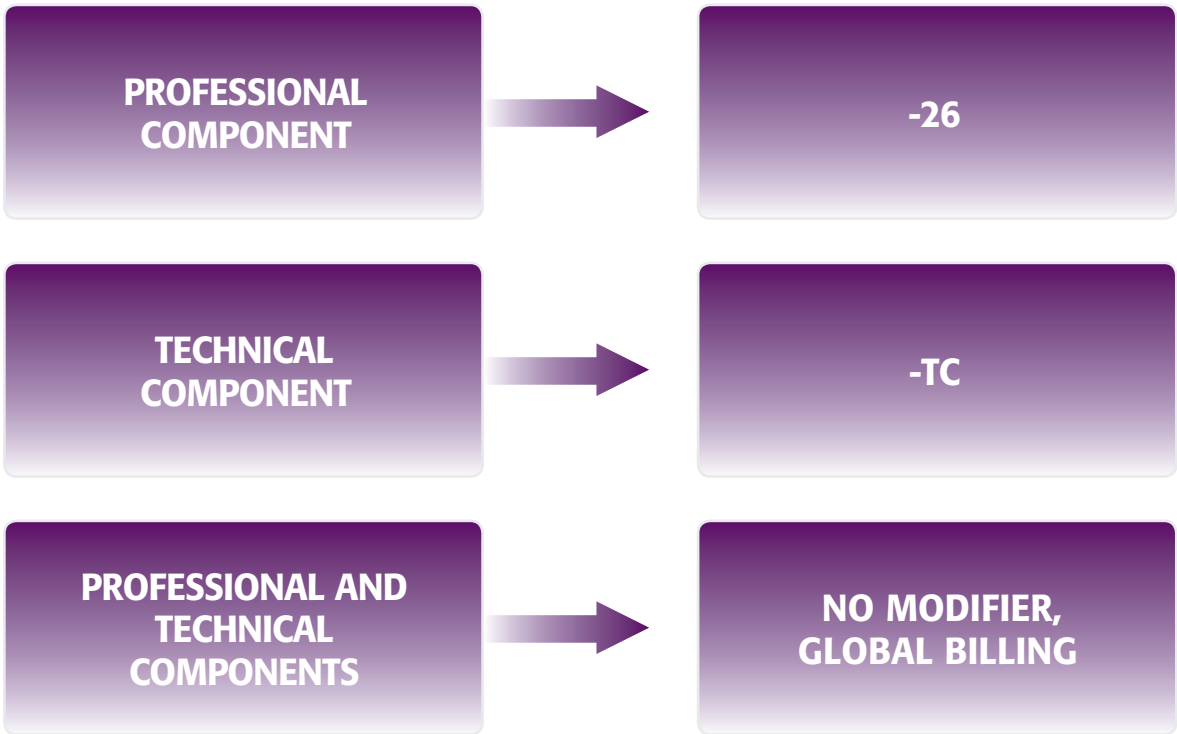
2016 IOM REIMBURSEMENT CODING

MODIFIERS

IOM modifiers are used with base (primary) codes to denote either a professional or technical component of the service, when both components are not billed.

Medicare does not recognize the use of modifiers to represent technical or professional component to add-on CPT® code 95940 or HCPCS code G0453. The use of modifiers with add-on CPT code 95941 is dependent on payor policy. Modifiers may also be used with base (primary) code(s).

If both technical and professional components are utilized, no modifier is necessary. When modifiers are not utilized, global billing is inferred for the procedure. Please refer to the Health Insurance Claim Form on page 11 for examples of use.

COMMON MODIFIERS USED WITH IOM	
MODIFIER	DESCRIPTION
-26	**Professional Component:** used to reflect the professional's interpretation of the diagnostic test.
-TC	**Technical Component:** used to reflect administrative, personnel, equipment, and facility costs. All non-professional work.

PROFESSIONAL COMPONENT	→	-26
TECHNICAL COMPONENT	→	-TC
PROFESSIONAL AND TECHNICAL COMPONENTS	→	NO MODIFIER, GLOBAL BILLING

2016 IOM REIMBURSEMENT CODING

HOSPITAL INPATIENT

Payment under Medicare for inpatient hospital services is based on a classification system determined by patient diagnosis known as Medicare Severity Diagnosis Related Groups (MS-DRGs). Under MS-DRGs, a hospital is paid at a predetermined, specific rate for each Medicare discharge. Fixed prices are established for hospital services based on the patient diagnosis and are paid regardless of the actual costs the hospital incurs when providing the services.

The MS-DRG payment system is based on averages. Payment is determined by treatment required for the average Medicare patient for a given set of diseases or disorders. This includes the length of stay, the number of services provided, and the intensity of services. Only one MS-DRG is assigned to a patient for a particular hospital admission. These admissions are determined by the patient's diagnosis and procedure code(s).

ICD-10

Hospitals should code nerve monitoring in addition to the primary surgical procedures with ICD-10 (Clinical Modification) procedure codes to ensure tracking of the use of these services. The tracking is used to develop future payments.

NOTE

Please reference the NuVasive® Reimbursement Guide for a comprehensive list of ICD-10 Intraoperative Neurophysiologic Monitoring procedure codes.

If the hospital provides the technical component of the IOM service or pays an outsourced Provider for the technical service, the hospital may seek reimbursement. Note that Medicare and several other payors do not reimburse separately for the technical component. The technical component (-TC) of IOM (i.e., use of the NVM5® system) is considered by Medicare to be part of the inpatient service and is not reimbursed separately from the MS-DRG.

- IOM IS USUALLY BUNDLED INTO THE OVERALL PAYMENT FOR THE HOSPITAL STAY AND IS NOT PAID SEPARATELY UNDER MS-DRGs (MEDICARE).
- ONLY ONE MS-DRG IS ASSIGNED TO A PATIENT PER HOSPITAL ADMISSION.
- HOSPITALS SHOULD CODE IOM IN ADDITION TO THE PRIMARY SURGICAL PROCEDURE WITH ICD-10 PROCEDURE CODES.

It is important to check your Medicare contractor's LCDs to ascertain specific contractor requirements for remote monitoring.[2]
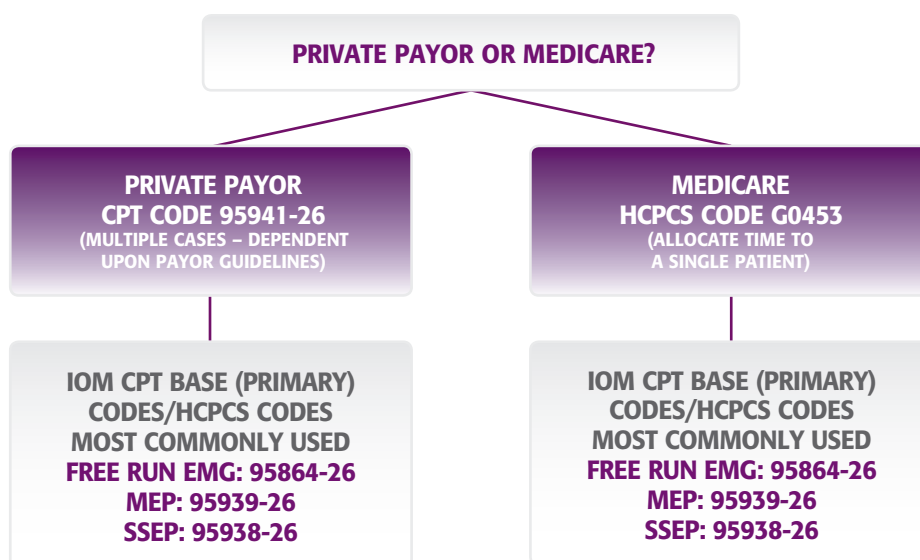
2016 IOM REIMBURSEMENT CODING

REIMBURSEMENT EXAMPLES

The following are examples of potential IOM billing scenarios. The CPT® codes shown in the examples may be utilized for IOM billing in other surgical cases.
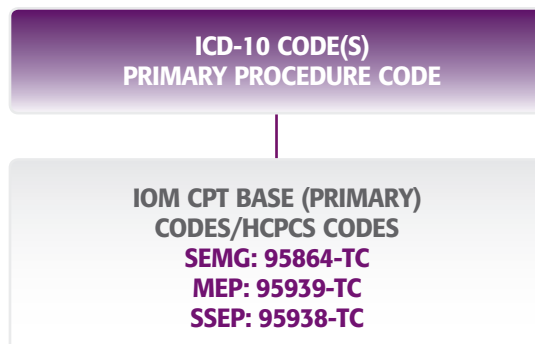
CASE TYPE:

ANTERIOR CERVICAL DISCECTOMY FUSION WITH MULTI-MODALITY MONITORING ON ALL FOUR LIMBS WHEN FIVE OR MORE MUSCLES ARE TESTED (FREE RUN EMG, MEP, SSEP).

PHYSICIAN PRACTICE AT AN INPATIENT HOSPITAL WITH DEDICATED REMOTE OVERSIGHT RESOURCE

PRIVATE PAYOR OR MEDICARE?

PRIVATE PAYOR
CPT CODE 95941-26
(MULTIPLE CASES – DEPENDENT UPON PAYOR GUIDELINES)

MEDICARE
HCPCS CODE G0453
(ALLOCATE TIME TO A SINGLE PATIENT)

IOM CPT BASE (PRIMARY)
CODES/HCPCS CODES
MOST COMMONLY USED
FREE RUN EMG: 95864-26
MEP: 95939-26
SSEP: 95938-26

IOM CPT BASE (PRIMARY)
CODES/HCPCS CODES
MOST COMMONLY USED
FREE RUN EMG: 95864-26
MEP: 95939-26
SSEP: 95938-26

HOSPITAL INPATIENT BILLING FOR A NON-MEDICARE PAYOR WITH NO DEDICATED REMOTE OVERSIGHT RESOURCE

ICD-10 CODE(S)
PRIMARY PROCEDURE CODE

IOM CPT BASE (PRIMARY)
CODES/HCPCS CODES
SEMG: 95864-TC
MEP: 95939-TC
SSEP: 95938-TC

*Applicable if the hospital is not receiving payment for IOM services elsewhere. Billing for IOM (including use of code 95941 or G0453) is dependent on individual payor policy and may be contract-specific. Providers and hospitals should refer to individual payor and payor contract for further information.

2016 IOM REIMBURSEMENT CODING

HEALTH INSURANCE CLAIM FORM EXAMPLE

PHYSICIAN PRACTICE AT AN INPATIENT HOSPITAL WITH DEDICATED REMOTE OVERSIGHT RESOURCE: PRIVATE PAYOR WITH MULTI-MODALITY MONITORING ON ALL FOUR LIMBS (FREE RUN EMG, MEP, SSEP)

*Payment is not guaranteed by following this example.

Health Insurance Claim Form sample (FORM SAMPLE) showing claim lines:

Line	Place of Service	Procedure	Modifier	Days/Units
1	21	95941	26	1
2	21	95864	26	1 — ADD-ON CODE
3	21	95939	26	1 — MODIFIER
4	21	95938	26	1

BASE (PRIMARY) CODE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

2016 NVM5® Intraoperative Monitoring (IOM) Reimbursement Guide

2016 IOM REIMBURSEMENT CODING

GLOSSARY OF ADD-ON CPT®, BASE (PRIMARY) CPT, AND HCPCS CODES

The Professional and Technical Component listed is the national Medicare reimbursement value[3] for that particular code. Actual reimbursement values will vary, depending on geography and payor. Providers should contact their Medicare contractor or individual payor regarding specific professional fee schedules.

INTRAOPERATIVE NEUROMONITORING ADD-ON CODES		
CPT	DESCRIPTION	2016 NATIONAL MEDICARE COVERAGE
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	See Commercial Contractor Fee Schedule
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one-on-one monitoring requiring personal attendance, each 15 minutes	$33.30
HCPCS	DESCRIPTION	2016 NATIONAL MEDICARE COVERAGE
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 in addition to primary procedure)	$33.30

EMG BASE (PRIMARY) CODES			
CPT	DESCRIPTION	PROFESSIONAL COMPONENT	TECHNICAL COMPONENT
95860	Needle electromyography; one extremity with or without related paraspinal areas *Five or more muscles stimulated per extremity; use once for bilateral testing*	$52.63	$70.89
95861	Needle electromyography; two extremities with or without related paraspinal areas *Five or more muscles stimulated per extremity; use once for bilateral testing*	$84.50	$89.15
95863	Needle electromyography; three extremities with or without related paraspinal areas *Five or more muscles stimulated on three limbs*	$101.68	$113.86
95864	Needle electromyography; four extremities with or without related paraspinal areas *Five or more muscles on four limbs*	$110.28	$133.19
95870	*Commonly used for pedicle screw testing* Needle electromyography; limited study of muscles in one extremity or nonlimb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters *Four or fewer muscles stimulated per extremity; use once for each extremity tested*	$20.05	$74.11

ET TUBE BASE (PRIMARY) CODE			
CPT	DESCRIPTION	PROFESSIONAL COMPONENT	TECHNICAL COMPONENT
95865	Needle electromyography; larynx	$86.29	$59.79

[3]CMS 2016 PFS; conversion factor 35.8043.

2016 IOM REIMBURSEMENT CODING

GLOSSARY OF ADD-ON CPT®, BASE (PRIMARY) CPT, AND HCPCS CODES (CONT.)

MEP BASE (PRIMARY) CODES			
CPT	**DESCRIPTION**	**PROFESSIONAL COMPONENT**	**TECHNICAL COMPONENT**
95928	Central motor evoked potentials study (transcranial motor stimulation); upper limbs	$81.63	$145.72
95929	Central motor evoked potentials study (transcranial motor stimulation); lower limbs	$82.35	$146.80
95939	Central motor evoked potentials study (transcranial motor stimulation); upper and lower limbs	$122.09	$384.90

SSEP BASE (PRIMARY) CODES			
CPT	**DESCRIPTION**	**PROFESSIONAL COMPONENT**	**TECHNICAL COMPONENT**
95925	Short-latency somatosensory evoked potentials study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; upper limbs	$28.64	$128.90
95926	Short-latency somatosensory evoked potentials study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; lower limbs	$27.93	$111.35
95938	Short-latency somatosensory evoked potentials study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; upper and lower limbs	$46.90	$298.97

COMPUTER-ASSISTED (NAVIGATIONAL) CPT CODE – NVM5® ALIGNMENT ASSESSMENT, NVM5 ROD BENDING, AND NVM5 GUIDANCE

NuvaMap™ O.R., an NVM5 software application, intraoperatively measures lumbar lordosis and pelvic incidence to assess patient alignment in real-time through the use of a lateral fluoroscopic image to support surgical decision making. The NVM5 Bendini® rod bending system expedites manual rod manipulation via computer-assisted bend instructions. NVM5 Guidance combines 2D fluoro-based navigation technology with an oblique or "owl's eye" technique to enable lumbar pedicle cannulation.

COMPUTER-ASSISTED (NAVIGATIONAL) CODE		
CPT	**DESCRIPTION**	
61783	Scan Proc Spinal	$245.26

KEY DESCRIPTORS OF CPT CODE 61783

- Includes spinal applications, which allow for navigation using an image-guided technique to identify anatomy for precise treatments and for avoidance of vital structures.
- The application of the procedure is to help identify anatomy, and more specifically, to aid with instrument placement.
- Not applicable for spinal decompression for degenerative spine disease or disc replacement (codes 63030, 63042, and 63047). Exceptions could include tumor-related surgeries.
- Possible primary procedure codes for use with 61783 include 22600, 22610, and 22612. These are subject to payor-specific coverage guidelines.

FREQUENTLY ASKED QUESTIONS

BILLING

1. WHAT IS THE DIFFERENCE BETWEEN PRIMARY PROCEDURE CODES AND ADD-ON CODES?

Primary procedure codes are used to describe the monitoring modalities performed (e.g., EMG, SSEPs, MEPs). Add-on codes 95940, 95941 and G0453 are used to describe the ongoing monitoring time and must be billed with a primary procedure code.

2. CAN MORE THAN ONE PRIMARY NERVE TEST CODE BE BILLED ON A CLAIM (FOR EXAMPLE, 95938 (SSEP) AND 95939 (MEP) FOR ONE CASE)?

Yes, multiple base (primary) CPT® codes can be billed together if multiple modalities were performed.

3. CAN THE TECHNICAL COMPONENT BE BILLED WHEN OVERSIGHT IS NOT UTILIZED?

Yes, if the hospital provides the technical component of the IOM service or pays an outsourced Provider for the technical service, the hospital may seek reimbursement. Note that Medicare and several other payors do not reimburse separately for the technical component.

4. STIMULATED EMG IS OFTEN USED AS A TOOL TO CHECK THE PLACEMENT OF PEDICLE SCREWS IN SPINAL PROCEDURES. IS THERE A CPT CODE TO CAPTURE THIS TEST?

There is no CPT code with a descriptor that specifically refers to pedicle screw testing. According to the AMA's 2005 CPT Q&A, pedicle screw testing should be coded as follows:

> "For pedicle screw stimulation, the individual performing the intraoperative electrophysiologic monitoring is usually evaluating Free Run and triggered electromyography. (The triggered electromyography is when the pedicle screw is stimulated.) CPT code 95870 [Needle electromyography; limited study of muscles in one extremity or nonlimb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters] should be reported for Free Run and triggered electromyography testing… Two units of 95870 may be reported if stimulating each leg. If five or more muscles have been stimulated, then it would be appropriate to report code 95861 [Needle electromyography; two extremities with or without related paraspinal areas]."

5. HOW MANY UNITS OF HCPCS CODE G0453 MAY BE BILLED PER HOUR?

Under Medicare, total billed units for HCPCS code G0453 may not sum to more than the total time available. Monitoring professionals may bill 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 across all Medicare patients. Professionals may use the method of their choice to allocate time to patients being simultaneously monitored, subject to the above restriction (only one unit of service can be billed for a 15-minute increment of time).

The monitoring professional's attention does not have to be continuous for a 15-minute block of time; the professional may add up any non-continuous time directed at one patient to determine how many units of HCPCS code G0453 may be billed. If Medicare and non-Medicare patients are being seen, professionals must account for the exclusive, non-continuous time spent monitoring Medicare patients when billing Medicare.

6. CAN A MONITORING COMPANY BILL THE HOSPITAL A FEE FOR MONITORING AND ALSO SUBMIT FOR GLOBAL IOM PAYMENT TO THE PAYOR?

No, this is considered double billing and may be illegal.

FREQUENTLY ASKED QUESTIONS

BILLING (CONT.)

7. HOW WOULD AN INPATIENT HOSPITAL SUBMIT AN IOM CLAIM TO A PRIVATE PAYOR AND MEDICARE? (NON-OVERSIGHT) BASE (PRIMARY)

Private Payor ICD-10 Code(s) + Base (Primary) Codes with TC modifier (many payors will not pay for the TC component for 95941).

Medicare ICD-10 Code(s) + Base (Primary) Codes with NO modifier (no technical component; it is paid as part of the DRG).

8. DOES THE HOSPITAL REPORT ICD-10 CODE(S) ON EVERY IOM CLAIM?

ICD-10 Code(s) are used to report the performance of IOM in the inpatient setting and should be included on every claim.

Please reference the NuVasive® Reimbursement Guide for a comprehensive list of ICD-10 Intraoperative Neurophysiologic Monitoring procedure codes.

PROFESSIONAL OVERSIGHT

1. CAN THE MONITORING PROFESSIONAL MONITOR MULTIPLE CASES AT THE OFFICE?

Yes, the monitoring professional can monitor multiple cases. HCPCS code G0453 only allows for one case at a time to be billed.

2. CAN THE MONITORING PROFESSIONAL MULTITASK?

The professional must be solely dedicated to performing monitoring and have the capacity for continuous or immediate contact with the operating surgeon. It is always best to seek specific guidance from the individual payors as reimbursement policies vary.

3. CAN A PHYSICIAN BILL FOR MONITORING PERFORMED BY NON-PHYSICIAN STAFF?

For Medicare, physicians cannot bill insurers for the professional component of monitoring performed by O.R. technicians, nurses, or other professionals employed by the hospital. In addition, physicians cannot bill insurers for the professional component of monitoring performed by others employed by the physician, including nurses or physician assistants.

> "For hospital patients…there is no Medicare Part B coverage of the services of professional-employed auxiliary personnel or services incident to professionals' services…. Such services can be covered only under the hospital or skilled nursing facility (SNF) benefit and payment for such services can be made only to the hospital or SNF by a Medicare intermediary."
> –Medicare Benefit Policy Manual (Chapter 15, 60.1B)

Generally, arrangements regarding the provision of IOM services involve other federal and state laws and regulations (including Stark and anti-kickback self-referral statutes – see page 7 for more information), and should be carefully arranged. Because remote monitoring often involves reimbursement by Medicare for a service provided by a third-party company, business arrangements must be considered to verify that they comply with federal anti-self-referral and anti-kickback regulations.

QUESTIONS? CONTACT NUVASIVE® SPINE REIMBURSEMENT SUPPORT BY EMAILING reimbursement@nuvasive.com. THE INFORMATION PROVIDED IS GENERAL CODING INFORMATION ONLY; IT IS NOT ADVICE ABOUT HOW TO CODE, COMPLETE, OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS, AND BILLS FOR THE SERVICES THAT WERE RENDERED. PAYORS OR THEIR LOCAL BRANCHES MAY HAVE THEIR OWN CODING AND REIMBURSEMENT REQUIREMENTS. BEFORE RENDERING IOM SERVICES, PROVIDERS SHOULD OBTAIN PREAUTHORIZATION FROM THE PAYOR.   15

FREQUENTLY ASKED QUESTIONS

DENIAL

1. WHAT ARE SOME COMMON DENIAL REASONS? WHAT ACTION(S) SHOULD BE TAKEN?

Common reasons for denials and recommended actions are listed below. These actions do not guarantee payment.

DENIAL	ACTION
Monitoring Performed by Operating Surgeon The insurer believes the operating surgeon is performing the monitoring services.	It is important to illustrate and support with documentation that the interpretive professional component was performed by a professional other than the operating surgeon. The professional being reimbursed for monitoring needs to have a distinct National Provider Identifier (NPI).
Not Medically Necessary (per ICD-10 diagnosis code) The diagnostic code does not support the use of the test as a medical necessity.	Use the most specific diagnosis code that is appropriate for the condition. Example: Instead of using the code for general spinal stenosis, use the code for lumbar spinal stenosis to support IOM for a lumbar fusion.
Place of Service (POS) The wrong POS code was used in the claim.	The POS code for remote monitoring performed at the professional's office depends on the policy of the payor. Either POS code 11 (office) or 21 (inpatient hospital) may be appropriate. POS code 21 should be used for Medicare claims. In general, the POS code reflects the place where the patient (beneficiary) receives the face-to-face service (inpatient hospital – POS code 21). When using POS code 21, the remote professional should report the address and zip code of his or her office on the claim form.

2. WHAT IF MY CLAIM IS DENIED? HOW SHOULD I APPEAL?

You may appeal by submitting an appeal letter directly to the payor. Be sure to include the following information:

- Patient information (DOB, name, ID number)
- Surgeon who requested monitoring (operating surgeon)
- Codes billed
- An attached copy of the findings (IOM tests and results)
- An attached copy of the operative report where the monitoring was requested and a list of modalities used
- Date of service
- Monitoring professional
- The reasons for the appeal
- An attached copy of the Medicare LCD or payor policy (if available)
- The specific denial reason (i.e., not medically necessary, integral to the primary procedure, etc.)

DEFINITIONS

A

Add-On Code: An HCPCS/CPT® code that describes a service always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same professional.

American Medical Association (AMA): Creates, maintains, reviews and revises CPT codes on an annual basis.

Anti-Kickback Law: The federal anti-kickback law's main purpose is to protect patients and federal healthcare programs from fraud and abuse by containing the influence of money on healthcare decisions. The law states that anyone who receives or pays to influence the referral of federal healthcare program business can be charged with a felony.

B

Base (Primary) Procedure Code: The CPT code to describe and bill for the primary procedure performed. Add-on codes may be billed in tandem with the primary procedure code.

C

Centers for Medicare and Medicaid Services (CMS): Utilizes Level I and II HCPCS codes.

Current Procedural Terminology (CPT): Five-digit numbers accompanied by narrative descriptions used to describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation/management services of professionals, hospitals, and other healthcare Providers. CPT codes are created and maintained by the AMA, and reviewed and revised on an annual basis.

H

Healthcare Common Procedure Coding System (HCPCS): A collection of standardized codes that represent medical procedures, supplies, products, and services. Professionals use HCPCS to bill for services performed. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers. Medicare can also create its own HCPCS code set for professional billing, often in the form of G-codes.
  - Level I – CPT codes
  - Level II – Identifies products, supplies, and services not included in CPT and may be adopted by CMS for a number of reasons. Medicare uses one of these codes for IOM services (G0453).

I

ICD-10 Codes: The primary procedure codes assigned to diagnoses and procedures associated with hospital utilization in the United States. ICD-10 replaced ICD-9 as the code set to describe diagnosis and inpatient procedure codes.

M

Medicare Severity Diagnosis Related Groups (MS-DRGs): The classification system determined by patient diagnosis used to define the payment under Medicare for inpatient services.

Modifiers: Used with primary codes to denote either a professional or technical component of the service.

P

Professional Component: Denotes the professional component reflecting the professional's interpretation of the diagnostics test.

R

Relative Value Units (RVUs): A number assigned to each CPT or G-code that compares the professional work, malpractice cost, and practice expenses associated with all other procedures or services. Medicare annually revises a dollar conversion factor that, when multiplied by the RVUs of the CPT code or G-code, results in the national Medicare reimbursement for that specific code. Commercial payors may also consider the RVUs of the CPT code when establishing professional fee schedules.

S

Stark Law: The federal Stark Law was created to protect patients of Medicare or Medicaid from professional self-referral. Professional self-referral occurs when a professional refers a patient to a facility in which the professional has financial interest. Unless an exemption applies, the Stark Law prohibits a professional from referring a patient to a medical facility with which the professional or his immediate family has a financial relationship. This includes ownership, investment, or a structured compensation agreement. This does not apply when the professional is employed by the hospital or has hospital privileges.

T

Technical Component: Represents the component of intraoperative monitoring, including administrative, personnel, equipment, and facility costs. All non-professional work.

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