



2019 NVM5[®] Intraoperative Neuromonitoring (IOM)

Reimbursement Guide



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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 neuromonitoring 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 neuromonitoring generally may be found on the American Academy of Neurology (AAN) website at www.aan.com (see in particular Principles of Coding for Intraoperative Neuromonitoring (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) codes¹ 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 Neuromonitoring (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® OR, 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.

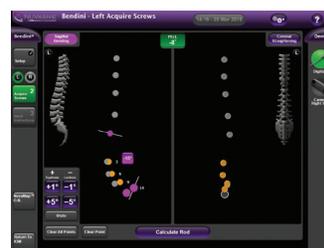
NVM5 combines intraoperative electrically stimulated EMG and spontaneous EMG activity to help the surgeon assess possible nerve root irritation or injury during spine surgery. Patented software algorithms help provide the surgeon with real-time data to assist with assessment of the patient's neurophysiological 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.



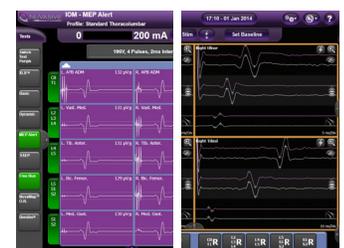
XLIF® Monitoring



Alignment Assessment



Rod Bending



Spinal Cord Monitoring



Screw Test and Nerve Monitoring

Purpose of This Guide

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

IOM Reimbursement Overview

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 neuromonitoring 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

2019 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 neuromonitoring modalities:

CPT Code ¹	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 neuromonitoring CPT codes commonly used with NVM5.

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 OR (95941, G0453)
2. Monitoring oversight within the OR (95940)

2019 IOM Reimbursement Coding (cont.)

Add-on CPT Codes 95941 and 95940:

CPT Code 95941

Professional Oversight from outside the OR (remote) or monitoring of more than one case while in the OR, 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

Professional Oversight from within the OR, 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

IOM from outside the OR (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.

2019 IOM Reimbursement Coding (cont.)

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)

The screenshot displays the NVM5 Summary Case Report interface. It includes a header with the NVM5 logo and NuVasive logo. The report details include:

- Summary Case Report**
- Start Date: 3/17/2015, Report Date: 3/17/2015
- Start Time: 10:04 AM, Report Time: 10:08 AM
- Duration: 00 Hours 01 Minutes
- Surgery Information**: Patient Name, Patient Number, Surgeon's Department, Technologist Name, Hospital Name, Operating Room Number, Case Synopsis, Diagnosis, Procedure, Lumber, Level(s), Anesthesia.
- Remote Monitoring**: Remote Physician, Billing Codes and Descriptions, Monitor Start, Monitor Stop, Modalities Used, Muscle Groups/Nerves Monitored, Primary Inserter.
- System Information**: NVM5 Serial Number, VM1001, Software Version, Version: 2.2.10.

The report also contains several tables and graphs:

- SSEP Key** table with columns: Modality Group, Start/Stop Time, Left Lower, Right Lower, Left Upper, Right Upper.
- SSEP Parameter Settings** table with columns: Parameter, STRATUM, STRATEGY, STRATEGY.
- RESPONSE** table with columns: TIME, STRATUM, POLICE, RESPONSE, LATENCY, RESPONSE, LATENCY, RESPONSE, LATENCY, RESPONSE, LATENCY.
- TIME** table with columns: TIME, LATENCY, SUB-OPTICAL.
- TIME** table with columns: TIME, LATENCY, SUB-OPTICAL.

Page 1 and Page 2 of 4 are indicated at the bottom of the report.

Documentation is automatically captured in NVM5 reports

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

2019 IOM Reimbursement Coding (cont.)

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

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 or her 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.

2019 IOM Reimbursement Coding (cont.)

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 Component	→ No modifier, global billing

2019 IOM Reimbursement Coding (cont.)

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 Neuromonitoring 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

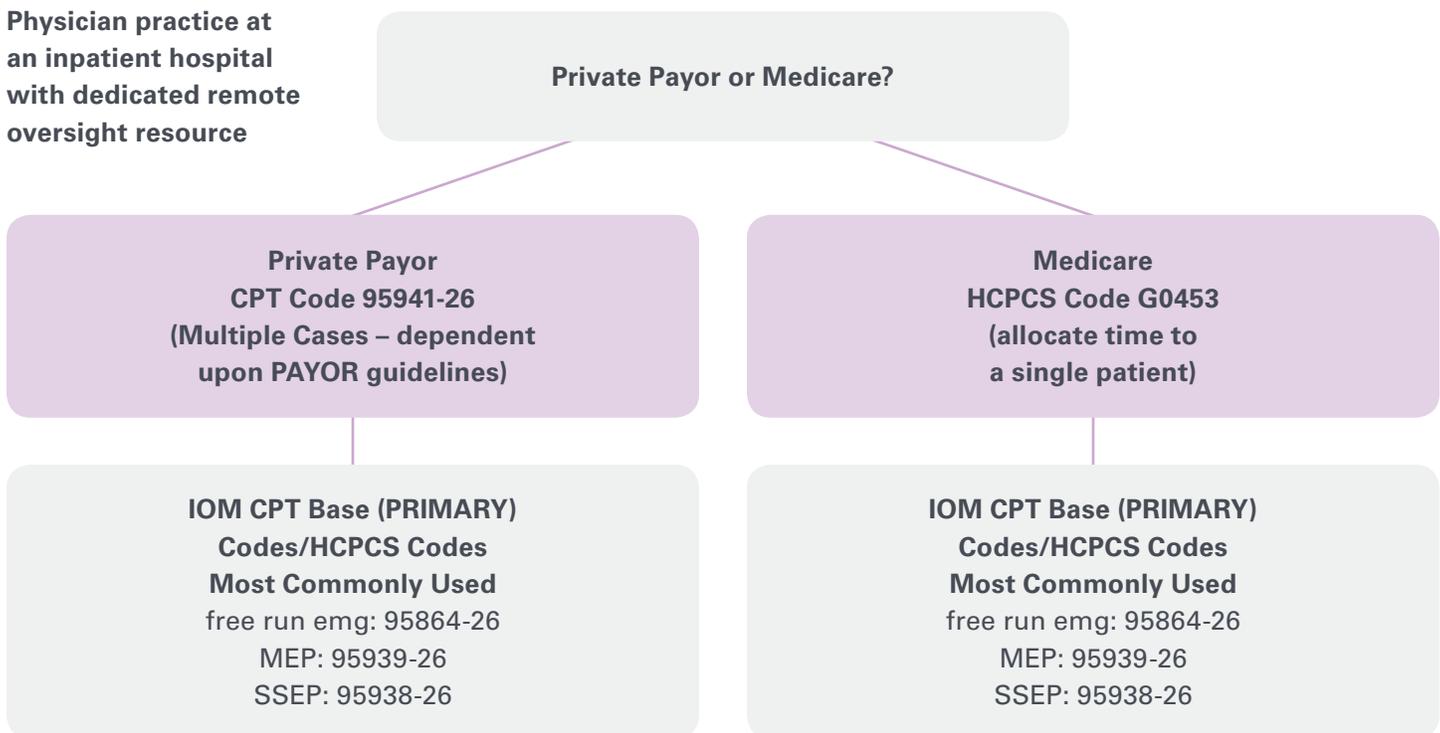
2019 IOM Reimbursement Coding (cont.)

Reimbursement Examples

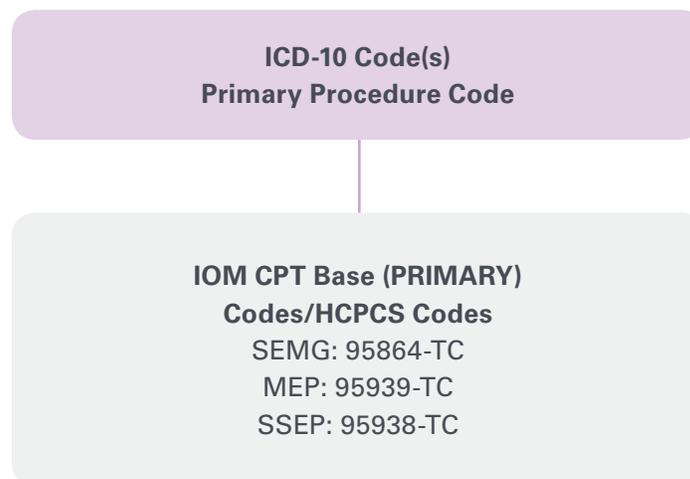
The following are examples of potential IOM billing scenarios. The CPT codes shown in the examples may be utilized for IOM billing in other surgical cases.

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



Hospital inpatient billing for a non-medicare payor with no dedicated remote oversight resource



*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.

2019 IOM Reimbursement Coding (cont.)

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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____		15. OTHER DATE MM DD YY QUAL _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. G. DAYS OF H. IFSPT (Family) I. ID. J. RENDERING			

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1	21	95941	26	1	NPI
2	21	95864	26	1	NPI
3	21	95939	26	1	NPI
4	21	95938	26	1	NPI
5					NPI
6					NPI

Place of Service → 21
Add-On Code → 95864
Modifier → 26
Base (Primary) Code → 95938

25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For group, contract, new hire) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. NPI _____		33. BILLING PROVIDER INFO & PH # ()	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

2019 IOM Reimbursement Coding (cont.)

Glossary of Add-on CPT, Base (Primary) PCPT, and HCPCS Codes

The Professional and Technical Component listed is the national Medicare reimbursement value³ 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.

CPT Code ¹	Description	2019 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	\$33.52
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HCPCS Code	Description	2019 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)	\$33.52

EMG Base (Primary) Codes

CPT Code ¹	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	\$52.98	\$70.64
95861	Needle electromyography; two extremities with or without related paraspinal areas Five or more muscles stimulated per extremity; use once for bilateral testing	\$85.05	\$91.54
95863	Needle electromyography; three extremities with or without related paraspinal areas Five or more muscles stimulated on three limbs	\$102.71	\$118.93
95864	Needle electromyography; four extremities with or without related paraspinal areas Five or more muscles on four limbs	\$109.82	\$144.88
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	\$20.54	\$72.44

ET Tube Base (Primary) Codes

CPT Code ¹	Description	Professional Component	Technical Component
95865	Needle electromyography; larynx	\$85.77	\$67.39

2019 IOM Reimbursement Coding (cont.)

Glossary of Add-on CPT, Base (Primary) PCPT, and HCPCS Codes (cont.)

EMG Base (Primary) Codes			
CPT Code ¹	Description	Professional Component	Technical Component
95928	Central motor evoked potentials study (transcranial motor stimulation); upper limbs	\$81.81	\$141.63
95929	Central motor evoked potentials study (transcranial motor stimulation); lower limbs	\$82.17	\$146.68
95939	Central motor evoked potentials study (transcranial motor stimulation); upper and lower limbs	\$123.25	\$401.12

ET Tube Base (Primary) Codes			
CPT Code ¹	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	\$28.41	\$105.95
95926	Short-latency somatosensory evoked potentials study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; lower limbs	\$28.11	\$101.99
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	\$45.57	\$305.25

Computer-Assisted (Navigational) CPT Code—NVM5 Alignment Assessment, NVM5 Rod Bending, and NVM5 Guidance

NuvaMap OR, an NVM5 software application, intraoperatively measures cervical, thoracolumbar, and pelvic parameters to assess patient alignment in real-time. This is done 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.

Computer-Assisted (Navigational) Code		
CPT Code ¹	Description	2019 National Medicare Coverage
61783	Scan Proc Spinal	\$245.07

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 (cont.)

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 Neuromonitoring 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 OR 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.

Frequently Asked Questions (cont.)

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.	<p>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.</p> <p>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.</p>

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 codes assigned to diagnoses and procedures associated with hospital inpatient admissions 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 or her 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 neuromonitoring, including administrative, personnel, equipment, and facility costs. All non-professional work.

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References:

1. CPT codes, descriptions, and other data are copyright 2018 American Medical Association. All rights reserved. Applicable FARS/DFARS clauses apply.
2. www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx
3. CMS 2018 PFS; Conversion Factor 36.0391

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