



2022 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 IOM services. Payors or their local branches may have their own coding and reimbursement requirements. Providers are advised to contact the payor directly to determine if prior authorization is required.

Additional resources about billing and coding for IOM generally may be found on the American Academy of Neurology (AAN) website at aan.com (see in particular Principles of Coding for IOM and Testing, available at aan.com/practice/billing-and-coding/coverage-policies). Additional guidance about billing Medicare for remote IOM can be found at hhs.gov/guidance/?combine=G0453. 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.

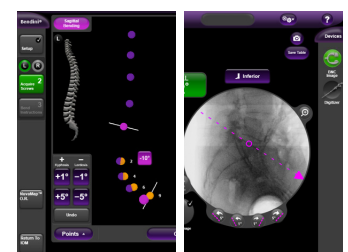
Overview of the NVM5 neuromonitoring and computer-assisted surgery platform

NuVasive NVM5 is an electromyography (EMG), motor evoked potentials (MEP) and somatosensory evoked potentials (SSEP) 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.

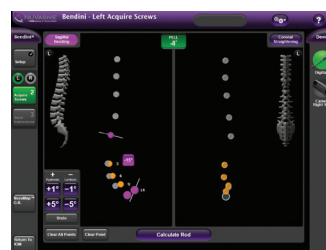
NVM5 combines intraoperative electrically stimulated EMG and spontaneous EMG activity to help the surgeon assess possible nerve root irritation or injury during spine surgery. Patented software algorithms help provide the surgeon with real-time data to assist with assessment of the patient's neurophysiological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

Coding 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.

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. G0453 is the only level II CPT code adopted by Medicare that is utilized for IOM billing.

Billing service codes 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 applicable 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 pages 11 and 12 of this document for a complete list of IOM HCPCS 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 (e.g., 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.

2022 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 IOM modalities:

CPT code ¹	Description	Common NuVasive disposable
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles or sphincters	EMG harness, probe, clip, I-PAS
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs	MEP/EMG harness
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	SSEP harness
95865	Needle electromyography; larynx	ET tube
61783	Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)	Bendini array

Please refer to pages 11 and 12 of this document for a complete list of IOM HCPCS codes commonly used with NVM5.

Add-on codes for professional oversight

Introduction

This section will discuss codes that may be utilized when professional oversight is employed. Coding is dependent on payor policy. For the most common scenarios—where professional oversight is provided from outside the operating room (OR)—one of the following will be used:

1. CPT 95941 for monitoring from outside the OR or
2. G0453 for monitoring from outside the OR, per patient, with attention directed exclusively to one patient.

If monitoring from inside the OR, the following codes apply:

1. CPT 95940 for monitoring in the OR of a single patient and
2. CPT 95941 for monitoring of more than one case while in the OR.

2022 IOM reimbursement coding (cont.)

Add-on CPT codes 95941 and 95940

CPT code 95941

Continuous intraoperative neurophysiologic monitoring, from outside the OR (remote or nearby) or for monitoring of more than one case while in the OR, per hour (list separately in addition to code for primary procedure)



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

Continuous intraoperative neurophysiology monitoring in the OR, one on one monitoring requiring personal attendance, each 15 minutes (list separately in addition to code for primary procedure)



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).
- Codes 95941 and 95940 include only the ongoing monitoring time distinct from performance of specific type(s) of baseline neurophysiologic study(s).
- Time spent after the procedure performing or interpreting neurophysiologic studies should not be counted as billable monitoring time.
- The monitoring professional must be monitoring in real-time and not engaging in clinical activities beyond the monitoring during the same period of time.

Medicare HCPCS code G0453

HCPCS code G0453

Continuous intraoperative neurophysiology monitoring, from outside the OR (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure).



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 four units per hour.

- The monitoring professional can only bill for the time directed exclusively to a single patient.
- The monitoring professional may add up non-continuous time directed at one patient to determine how many units may be billed.
- The monitoring professional must document and differentiate between the exclusive, continuous minutes of time spent monitoring a Medicare patient and other non-Medicare patient minutes when billing Medicare (i.e., the same time cannot be billed to G0453 and 95941).
- No more than four 15-minute units may be billed during a 60-minute period.

2022 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 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

When approving claims, a payor may require evidence of medical necessity and additional documentation.

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

- diagnosis code (ICD-10) and description of surgical procedure,
- description of the modalities monitored,
- duration of monitoring, and
- description of the results of monitoring.

Documentation is automatically captured in NVM5 reports.

- Modalities monitored
- Monitoring start/stop time
- Time-stamped waveforms
- Annotation logs

2022 IOM reimbursement coding (cont.)

Professional oversight considerations (cont.)

3. Place of service (POS)

The POS code must be reflected on the claim form and, unless payor policy requires otherwise, will reflect the place where the patient (beneficiary) receives the service (most commonly, inpatient hospital-POS code 21).

Common POS codes for IOM services include:

- 21—hospital inpatient,
- 22—hospital outpatient surgery center, and
- 24—ambulatory surgery center.

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/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.

2022 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.

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

2022 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 reach out to the NuVasive spine reimbursement support line regarding ICD-10 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

2022 IOM reimbursement coding (cont.)

Glossary of add-on CPT, base (primary) CPT and HCPCS codes

The professional and technical component listed is the national average 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	2022 Medicare national average payment ³	
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 for primary procedure)	N/A (see commercial contractor fee schedule)	
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one-on-one monitoring requiring personal attendance, each 15 minutes	\$32.88	
HCPCS Code ⁴	Description	2022 Medicare national average payment ³	
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 for primary procedure)	\$32.88	
EMG base (primary) codes		2022 Medicare national average payment ³	
CPT code ¹	Description	Professional component	Technical component
95860	Needle electromyography; one extremity with or without related paraspinal areas	\$51.56	\$65.75
95861	Needle electromyography; two extremities with or without related paraspinal areas	\$82.71	\$86.86
95863	Needle electromyography; three extremities with or without related paraspinal areas	\$100.36	\$121.12
95864	Needle electromyography; four extremities with or without related paraspinal areas	\$107.28	\$140.16
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles or sphincters	\$19.73	\$69.21
ET tube base (primary) codes		2022 Medicare national average payment ³	
CPT code ¹	Description	Professional component	Technical component
95865	Needle electromyography; larynx	\$83.75	\$74.06

2022 IOM reimbursement coding (cont.)

Glossary of add-on CPT, base (primary) CPT and HCPCS codes (cont.)

MEP base (primary) codes		2022 Medicare national average payment ³	
CPT code ¹	Description	Professional component	Technical component
95928	Central motor evoked potentials study (transcranial motor stimulation); upper limbs	\$80.29	\$163.69
95929	Central motor evoked potentials study (transcranial motor stimulation); lower limbs	\$80.29	\$170.61
95939	Central motor evoked potentials study (transcranial motor stimulation); in upper and lower limbs	\$120.08	\$443.65
SSEP base (primary) codes		2022 Medicare national average payment ³	
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; in upper limbs	\$29.07	\$160.92
95926	Short-latency somatosensory evoked potentials study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	\$28.03	\$136.35
95938	Short-latency somatosensory evoked potentials study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	\$46.03	\$327.03

Computer-assisted (navigational) CPT code—NVM5 alignment assessment, NVM5 rod bending and NVM5 guidance

NuVasive 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		2022 Medicare national average payment ³
CPT code ¹	Description	
61783	Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)	\$237.05

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 (e.g., 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?

No more than four 15-minute units of HCPCS code G0453 may be billed during a 60-minute time period. Total billed units for G0453 may not sum to more than the total time available. The monitoring professional's attention does not have to be continuous for a 15-minute block of time to be billed. The professional may add up any non-continuous time directed to a single patient to determine how many units of G0453 may be billed.

A monitoring professional may bill for one unit of G0453 if at least 8 minutes of service is provided, as long as no more than four units of G0453 are billed per hour.

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.

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 an A/B MAC."

—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 8 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 will, unless payor policy requires otherwise, reflect the place where the patient (beneficiary) receives the service (most commonly, inpatient hospital-POS code 21).</p> <p>The claim may be denied if the POS code used is not the same as that used by the surgeon/hospital for the same incident of care.</p>

2. What if my claim is denied? How should I appeal?

You may appeal by submitting an appeal letter directly to the payor. The information in the appeal you provide will depend on the reason for denial. Below is a list of information that you may need to be prepared to provide.

- 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 IOM, including administrative, personnel, equipment, and facility costs. All non-professional work.

References:

1. CPT codes, descriptions, and other data are copyright 2022 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. Medicare Physician Fee Schedule Final Rule CY2022 Effective through December 31, 2022. Conversion factor \$34.6062
4. Healthcare Common Procedure Coding System (HCPCS) Level II Expert Book. ©2022 AAPC. All rights reserved.

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