BlueCross BlueShield of Illinois

If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Intraoperative Neurophysiology Monitoring (IONM) Coding and Reimbursement Guideline

Policy Number: CPCP032

Version 3.0

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Description

This policy serves as a guideline to address coding and reimbursement for Intraoperative Neuromonitoring (IONM) services, including Evoked Potentials. This policy is not intended to impact care decisions or medical practice. Additionally, this policy applies to In-Network and Out-of-Network professional providers and facilities.

Intraoperative neurophysiologic monitoring (IONM) describes a variety of procedures used to monitor the integrity of neural pathways during high-risk neurosurgical, orthopedic, and vascular surgeries. It involves the detection of electrical signals produced by the nervous system in response to sensory or electrical stimuli to provide information about the functional integrity of neuronal structures.

The principal goal of IONM is the identification of nervous system impairment on the assumption that prompt intervention will prevent permanent deficits. Correctable factors at surgery include circulatory disturbance, excess compression from retraction, bony structures, hematomas, or mechanical stretching. The technology is continuously evolving with refinements in equipment and analytic techniques, including recording, with several patients monitored under the supervision of a physician who is outside the operating room. Intraoperative neurophysiologic monitoring includes Somatosensory-evoked potentials (SSEP), Motor-evoked potentials (MEP) (using transcranial electrical stimulation), Brainstem auditory-evoked potentials (BAEP), Electromyogram monitoring (EMG) of cranial nerves, Electroencephalogram Monitoring (EEG) and Electrocorticography (EcoG) and may be medically necessary during spinal, intracranial or vascular procedures.

Evoked potentials (EP) are responses (electrical signals) produced by the nervous system in response to a stimulus. These types of monitoring help diagnose nerve disorders, determine the location of the site of nerve damage and help evaluate the member's condition after treatment or during surgery.

Some of the different methodologies of monitoring are listed below and are further discussed in **Medical Policy MED205.011**. These services may be considered medically necessary as outlined in the medical policy. Reminder, services that are **not** considered medically necessary or experimental, investigational or unproven (EIU) **may be denied**. Providers are urged to review Plan documents for eligible coverage for services rendered.

Reimbursement Information:

Supervision Requirements, Provider Responsibilities & Documentation

Supervision requirements and provider responsibilities for each procedure vary and must be met by the appropriate provider type. The responsibilities of an IONM provider may include, but are not limited to:

1. Have readily available data that is essential for evaluation of the member;
2. Evaluate and interpret baseline signals and request any changes in the monitoring procedures of the member that are required;
3. Interpret all changes from baseline recordings in real time;
4. In real time, will evaluate data and recommend or suggest the anatomical areas of the injury in the context of the surgical procedure when possible.

Documentation should be submitted in the event/chat log during monitoring of the member to determine the appropriate reimbursement. Documentation can include, but is not limited to:

1. Event/Chat log of what occurred during monitoring of the member, such as:
    a. The operating surgeon (ordering physician) requesting an IONM service by a licensed physician, separate from the surgical team;
    b. An audio and video connection was established in accordance with requirements outlined in Medical Policy MED205.011;
    c. The monitoring physician completed a baseline review verbally with the surgeon using the audio connection;
    d. The monitoring physician communicated any events to the surgeon verbally using the audio connection;
    e. The monitoring physician completed a closing review verbally with the surgeon;

f. The professional component of monitoring and test interpretation;
g. Start and stop times of the services provided;
h. What was communicated during the service, who was it communicated by, how it was communicated and any other information during the monitoring;
i. Name of technologist and their credentials.

Separately Reimbursable Services for IONM, Billing Requirements

Eligibility for coverage as separately reimbursable service(s) for intraoperative monitoring must meet the following criteria as outlined in Medical Policy MED205.011:

- Must be provided to the operating surgeon (ordering physician) by a licensed physician separate from the surgical team (operating surgeon, assistant surgeons, and/or anesthesiologists); and
- Must have the interpreting physician physically in attendance in the operating suite; or
- Must have the interpreting physician be present by means of a real-time remote mechanism for all electro neurodiagnostic (END) monitoring situations with the following stipulations:
    - The interpreting physician is constantly available to interpret the recording and advise the surgeon; and
    - There is live video representation of the END monitoring (identical to the information seen by the technician) with a high-quality bi-directional live audio connection that allows the remote interpreting physician to converse with the operating surgeon at any time. (Cell phone connection or cellular walkie-talkie is not considered adequate. Additionally, "live" means contemporaneous monitoring by the physician during the surgery. Review of a CD or other documentation post-operatively does not constitute "live monitoring".)
- Note, the services of the technician in the room and the monitoring equipment are not separately payable from the reimbursement to the monitoring physician (or the monitoring company). Reimbursement for technician services and equipment may be negotiated directly with the facility.

CPT Codes 95940 & 95941

Intraoperative Neurophysiology CPT codes **95940** and **95941** are used for ongoing neurophysiologic monitoring, testing, and data interpretation distinct from performance of specific type(s) of baseline neurophysiologic study(s) performed during surgical procedures to a single member.

- Professional provider services are included in the primary service of the procedure when services are rendered by the surgeon or anesthesiologist and should not be reported separately.
- Recording and testing is performed either personally or by a technologist who is physically present with the member during the service.
- Supervision is performed either in the operating room or by real time connection outside the operating room.
- The monitoring professional must be solely dedicated to performing the intraoperative neurophysiologic monitoring and must be available to intervene at all times during the service as necessary, for the reported time period(s). These codes are reported based on the time spent for monitoring only, and not for the number of baseline tests that are rendered, or the parameters monitored. The time spent

monitoring excludes time to set up, record and interpret the baseline study, and to remove electrodes at the end of the procedure.

- Report CPT code 95940 for each set of 15-minutes that the monitoring is done from within the operating room in a one-on-one setting. This code should not be used if more than 1 member is monitored or if the services were rendered remotely.
- Report CPT code 95941 for each hour of monitoring done from a remote or nearby location for one or more overlapping operative sessions. Note, this code cannot be billed for 30-minutes or less.
- Units for IONM code 95940 must be billed for time spent for one-on-one monitoring to a single member. Units for these codes must reflect the total duration of one-on-one monitoring even if that time is not in a single continuous block.
- Modifier(s) TC and 26 do not apply to CPT code 95941.
- Intraoperative neurophysiology monitoring may not be billed by the physician performing an operative or anesthesia procedure as this is included in the global surgical package. (Note, this includes, but not limited to, the neurophysiology testing CPT codes 90000 series for intraoperative neurophysiology testing (e.g., 92585, 95822-95870, 95907-95913, 95925-95929, 95930-95939).

Additional criteria when billing CPT codes **95940** and **95941**, can be found in the most recent CPT code book.

HCPCS Code G0453

HCPCS code **G0453** should be billed only for undivided attention by a monitoring provider to a single member and not for simultaneous attention by the monitoring provider to more than one member. This code can be billed in multiple units to account for the cumulative time spent exclusively monitoring a single member. Therefore, CPT code **G0453** can be billed for 15-minutes of continuous monitoring of the member followed by an additional 15-minutes later in the same members procedure, equal to a total of 30-minutes or two units. Note, this code is reported based on the time spent for monitoring only, and not for the number of baseline tests that are rendered, or the parameters monitored.

- Units for IONM code G0453 must be billed for time spent for one-on-one monitoring to a single member. Units for these codes must reflect the total duration of one-on-one monitoring even if that time is not in a single continuous block.
- Modifier(s) TC and 26 do not apply to HCPCS code G0453.
- Intraoperative neurophysiology monitoring may not be billed by the physician performing an operative or anesthesia procedure as this is included in the global surgical package.

Coding Tips

- Baseline studies (e.g., EMGs, NCVs), should not be billed more than one time per operative session.
- IOMN monitoring time is counted from the incision time or the time when the baseline interpretation is communicated to the surgeon by the monitoring physician (whichever is later) to the closing time or monitoring end (whichever is earlier).
- Modifier -26 must be appended for the professional component of monitoring and test interpretation

only. Documentation must support appropriate separately reimbursable IONM services for eligible reimbursement. The technical component is the responsibility of the facility.

- Additional timed codes may not be billed such as 95961; instead bill the code that does not require time. For example, 95822.
- The place of service (POS) billed should be the location of the member, such as POS 19, 21, and 22.
- IONM services should be billed to the BCBS plan where provider rendering the IONM services is physically located/present at the time of service. The provider's billing office address does NOT determine the BCBS plan where services should be billed.
- Train-of-four (TOF) monitoring should not be separately billed as it is considered integral to intraoperative monitoring and/or the administration of anesthesia and is primarily done to prevent or avoid permanent neurological injury. Therefore, TOF monitoring or any type of neuromuscular blockade testing, is not separately reimbursed.

Billing Examples

1. **Question***: Is it appropriate to report, for example, CPT codes 95937 or 95999 for train-of-four testing during intraoperative neural monitoring?* **Answer:** *Train-of-four monitoring is considered integral to intraoperative neuromonitoring and/or administration of anesthesia and, therefore, is not separately reportable. Train-of-four monitoring does not fit the criteria for CPT codes 95937 nor 95999.*

2. **Question:** *Is it appropriate to bill CPT code 95940 for remote or nearby monitoring of multiple patients at the same time?* **Answer:** *No, CPT code 95940 is used for monitoring a single member with the monitoring physician physically in attendance in the operating suite.*

3. **Question:** *How many units of HCPCS code G0453 can be billed for 37 minutes?* **Answer:** *2 units should be billed. A unit of time is attained when the mid-point has passed. A 3rd unit cannot be billed unless the monitoring time reached 38 minutes.*

4. **Question:** *How many units of CPT code 95941 can be billed for 2 hours and 30 minutes?* **Answer:** *2 units should be billed. A unit of time is attained when the mid-point has passed. A 3rd unit cannot be billed unless the monitoring time reached 2 hours and 31 minutes.*

5. **Question:** *Is the time spent performing or interpreting the baseline neurophysiologic study counted as intraoperative monitoring?* **Answer:** *No, this is covered in a separately reportable procedure.*

6. **Question:** *Can I bill the professional component for monitoring and test interpretation separately during an IONM service?* **Answer:** *Yes, the only separately reimbursable IONM service is the professional component of the monitoring and test interpretation if it is billed with the appropriate documentation.*

7. **Question:** *Is the time spent setting up equipment, removing equipment or preparing the patient counted in the IONM time and included when calculating units?* **Answer:** *No, billing for time spent for these scenarios in addition to the IONM is considered inappropriate and should not be included in the units billed.*

8. **Question:** *What type of format is required to submit a recording?* **Answer:** *Recordings do not need to be submitted to the Plan. The medical records submitted should contain documentation of what occurred during the monitoring, e.g. event/chat logs.*

9. **Question:** *Is the bi-directional live audio connection, that allows the remote interpreting physician to converse with the operating surgeon at any time, required for a certain amount of time for the procedure or the entire procedure?* **Answer:** *The remote interpreting physician must have high-quality bi-directional live audio connection that allows the remote interpreting physician to converse with the operating surgeon at any time. The interpreting physician must be constantly available to interpret and advise the surgeon.*

10. **Question***: If a provider is physically located in one state and rendering a service for a member in another state, which state should I submit the claim to?* **Answer***: The claim should be submitted to the state plan where the provider is physically located at the time the service is rendered. For example, provider who is physically located in OK provides a service for a member who is in TX. The provider should submit the claim to the BCBSOK plan.*

The plan reserves the right to request supporting documentation. Claim(s) that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. Claims may be reviewed on a case by case basis. For additional information related to this policy, please refer to the Plan's website or contact your Network Management Office.

References:

Centers for Medicaid and Medicare Services (CMS), Billing Medicare for Remote Intraoperative Neurophysiology Monitoring (HCPCS Code G0453) https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-remote-ionm.pdf

Medical Policy MED205.011 Intraoperative Neurophysiologic Monitoring (IONM)

Policy Update History:

7/20/2021	New policy
7/30/2021	Added billing example