Basics of Billing & Coding
Intraoperative NeuroMonitoring

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Reliant Billing
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PROCEDURES/ MODALITIES
CARRIER POLICIES
Centers for Medicare and Medicaid Services

National Coverage Determination
• The Centers for Medicare and Medicaid Services (CMS) publishes National Coverage Determination (NCD) manuals.
• In the case of intraoperative neurophysiological testing, no national coverage determination exists in the current manuals published by CMS.

Local Coverage Determination
• Medicare ‘carriers’ vary from state to state although some are common across states
• Each intermediary contracts to the Centers for Medicare and Medicaid Services
• Each individual carrier publishes policies which outline the rules and regulations regarding the use of a particular CPT code, indications and limitations of coverage and/or medical necessity and physician supervision.
Wisconsin Physician Service Health Insurance

Part A Provider
• Iowa, Kansas, Missouri, Nebraska, Indiana, Michigan

Part B Provider
• Iowa, Kansas, Missouri, Nebraska, Indiana, Michigan, Illinois, Minnesota, Wisconsin.

Local Coverage Determination
• L30721 Intraoperative Neurophysiological Testing
• Revision effective date 10/22/2012
• Limitations
  • ‘For reimbursement this test must be requested by the operating surgeon and the monitoring must be performed by a physician, other than: The operating surgeon; The technical/surgical assistant; or The anesthesiologist rendering the anesthesia.’
  • ‘It is also expected that a specifically trained technician, preferably registered with one of the credentialing organizations will be in continuous attendance in the operating room, recording and monitoring a single surgical case, with either the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology.’
Wisconsin Physician Service Health Insurance

Local Coverage Determination – Intraoperative Neurophysiological Testing

• Limitations (Continued)
  • Undivided attention to a unique patient may be required during some surgeries, such as during response to acute events or identification of the cerebral cortex to be resected or spared from resection. The monitoring physician must have a plan in place to transfer care to another physician of any other case during those times. When paying undivided attention to a unique patient, the physician must code and bill only for that one case during those times. For other medically necessary intraoperative neurophysiologic monitoring, a physician may code and bill for up to three cases simultaneously.

• ICD-9 Codes that Support Medical Necessity
Wisconsin Physician Service Health Insurance

Local Coverage Determination

• L31346 Nerve Conduction Studies and Electromyography

• Revision effective date 10/22/2012

• Limitations
  • Nerve Conduction Studies – ‘Each descriptor (code) from codes 95900, 95903, 95904, 95933, 95934, 95936, can be reimbursed only once per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve.’

• ICD-9 Codes that Support Medical Necessity
CMS Local Coverage Determination

Local Coverage Determination – Intraoperative Neurophysiological Testing

• L32491 – First Coast Service Options
  • Puerto Rico
  • Florida
  • Virgin Islands

• L32605 – Novitas Solutions Inc
  • Arkansas
  • Louisiana
  • Mississippi
  • Colorado
  • New Mexico
  • Oklahoma
  • Texas
CMS Local Coverage Determination

Local Coverage Determination – Intraoperative Neurophysiological Testing

- L31748– Trailblazer Health Enterprises LLC
  - Colorado
  - New Mexico
  - Oklahoma
  - Texas

- L31748– Palmetto GBA
  - South Carolina
  - West Virginia
  - North Carolina
  - Virginia
Commercial Carrier Policies

BLUE CROSS BLUE SHIELD - IL

Note:

To be a separate reimbursable service, Intraoperative Monitoring must:

A. 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

B. Have the interpreting physician physically in attendance in the operating suite; OR

C. Provide documentation from the operative report that 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 a 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.
  - A cell phone connection or cellular walkie-talkie is not considered adequate.
  - “Live” means contemporaneous monitoring by the physician during the surgery. Review of a CD or other documentation post-operatively does not constitute “live monitoring.”

ANTHEM BLUE CROSS BLUE SHIELD (MISSOURI)

• No IONM Coverage Policy
Commercial Carrier Policies

BLUE CROSS BLUE SHIELD – ALABAMA

Effective for dates of services on or after November 1, 2012:

Intraoperative monitoring, which includes somatosensory-evoked potentials, motor-evoked potentials using transcranial electrical stimulation, brainstem auditory-evoked potentials, EMG of cranial nerves, EEG, and electrocorticography (ECoG), meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage during spinal, intracranial, or vascular procedures when all the following criteria are met:

1. There is clinical data in the medical record to support the medical necessity of ordering the test. The data could include radiological, neurological, consultative notes, or physical exam documentation; and

2. A licensed physician other than the operating surgeon or performing anesthesiologist must monitor the procedure and the monitoring physician must be available to be in the operating room; and

3. The monitoring physician interprets no more than three cases concurrently.

Intraoperative monitoring of visual-evoked potentials does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and is considered investigational.

Intraoperative monitoring of motor-evoked potentials using transcranial magnetic stimulation does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and is considered investigational.

Intraoperative EMG and nerve conduction velocity monitoring during surgery on the peripheral nerves does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage.
Commercial Carrier Policies

BLUE CROSS BLUE SHIELD – ALABAMA

Effective for dates of services prior to November 1, 2012:

Intra-operative neurophysiologic monitoring, which includes somatosensory-evoked potentials, brainstem auditory-evoked potentials, EMG of cranial nerves, EEG, motor-evoked potentials using transcranial electrical stimulation, and electrocorticography (ECoG), meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage when the following conditions are met:

4. The monitoring is done during one of these spinal, intracranial, or vascular procedures:
   a. Acoustic neuroma
   b. Anterior cervical corpectomy
   c. Aortic arch, its branch vessels, thoracic aorta, or distal aorta
   d. Carotid endarterectomy
   e. Cerebral vascular aneurysms
   f. Cervical or thoracic myelopathy
   g. Cranial nerve tumors, including the optic, trigeminal, facial, or auditory nerves
   h. Dorsal rhizotomy
   i. Fracture of the spine
   j. Herniated nucleus propulsus with spinal cord compression and wedge graft surgery
   k. Scoliosis
   l. Spinal atrovenous malformation
   m. Spinal cord trauma or tumor
   n. Spinal stenosis
   o. Spondylolisthesis or spondylosis
   p. Syringomyelia
   q. Tethered cord
   r. Thoracic disc disease
   s. Tumor or AV malformation of the CNS

5. There is clinical data in the medical record to support the medical necessity of ordering the test. The data could include radiological, neurological, consultative notes, or physical exam documentation.

6. The monitoring is considered reimbursable as a separate service only when a licensed physician, other than the operating surgeon or performing anesthesiologists, personally performs the monitoring while in attendance in the operating room throughout the procedure. A licensed physician other than the operating surgeon or performing anesthesiologist must monitor the procedure and the monitoring physician must be available to be in the operating room.

7. The monitoring physician interprets no more than three cases concurrently.
Aetna considers intra-operative electromyographic (EMG) monitoring of the facial nerve medically necessary for members undergoing any of the following intra-cranial neuro-otological surgeries:

- Surgery for acoustic neuroma, cranial based lesions, or congenital auricular lesions; or
- Microvascular decompression of the facial nerve for hemifacial spasm; or
- Vestibular neurectomy for Meniere's disease; or
- Surgical excision of neuromas of the facial nerve.

Aetna considers the combined use of intra-operative EMG monitoring of facial nerve and intra-operative monitoring of somatosensory evoked potentials not medically necessary.

Aetna considers intra-operative EMG monitoring of the facial nerve during parotid gland surgery, tympanoplasty, or maxillofacial surgery experimental and investigational because its value for these indications has not been established.

Aetna considers intra-operative EMG monitoring of any of the following cranial nerves medically necessary for surgical excision of neuromas of these cranial nerves.

- Recurrent laryngeal nerve
- Superior laryngeal nerve
- Oculomotor nerve
- Trochlear nerve
- Abducens nerve
- Glossopharyngeal nerve
- Spinal accessory
- Hypoglossal nerve.

Aetna considers intra-operative EMG monitoring during spinal surgery experimental and investigational because there is insufficient evidence that this technique provides useful information to the surgeon in terms of assessing the adequacy of nerve root decompression or improving the reliability of placement of pedicle screws at the time of surgery.

Aetna considers intra-operative monitoring of the recurrent laryngeal nerve during thyroid surgery experimental and investigational because its clinical value has not been established.
Commercial Carrier Policies

COVENTRY GHP

Recommendation
Intraoperative monitoring of electromyographic responses is considered medically necessary for when the following conditions are met:
The surgical procedure poses significant risk of nerve or spinal cord injury such as (list may not be inclusive):
• Monitoring of the cranial nerves during head and/or neck surgery (i.e. resection of skull base tumor, thyroid tumor surgery, neck dissection)
• Monitoring of facial nerve function during surgery (i.e. acoustic neuroma, parotid tumor or decompression of facial nerve)
• Monitoring of nerve root function during spinal surgery
• Brachial or lumbar plexus surgery
• Pediatric cardiac surgery

Intraoperative monitoring of the recurrent laryngeal nerve during thyroid surgery is considered investigational/experimental.

• The monitoring must be performed by a licensed physician trained in clinical neurophysiology or a trained technologist who is practicing within the scope of his/her license/certification as defined by state law or appropriate authorities and is working under the direct supervision of a physician trained in neurophysiology.

The intraoperative monitoring (IOM) is interpreted by a licensed physician trained in clinical neurophysiology, other than the operating surgeon, who is either physically in attendance or in the operating suite or present by means of a real-time remote mechanism for all electrodiagnostic (END) monitoring situations and is immediately available to interpret the recording and advise the surgeon.

Monitoring is conducted and interpreted real-time (either on-site or at a remote location) and continuously communicated to the surgical team.
IOM consists of a physician monitoring not more than three cases simultaneously.
Commercial Carrier Policies

HUMANA

Coverage Determination

Humana members MAY be eligible under the Plan for intra-operative neurological monitoring (BAEP, EEG, EMG, MEP, SSEP) during spinal, neurologic, cranial, or vascular procedures that may compromise neurologic function when the following criteria are met:

• Monitoring MUST be conducted using a team approach. The team should be composed of surgeons, the monitoring team, and anesthesiologists, with the monitoring team having direct, real-time communication so that immediate feedback can be given to the surgical team should any unusual changes occur in recorded waveforms; AND

• Monitoring is performed by a specifically trained technologist or non-physician monitorist, in continuous attendance in the operating room, with either physical or electronic direct and real-time communication with a clinical neurophysiologist (the supervising physician); AND

• Monitoring period includes only intraoperative time. This time, however, may be cumulative, and does not have to be continuous, i.e., one-half hour of continuous attendance followed by another one-half hour of continuous attendance later in the procedure will constitute one hour of monitoring.

Examples of indications for which intra-operative monitoring MAY be utilized include, but are not limited to:

• Carotid artery endarterectomy; OR
• Correction of intracranial or spinal arteriovenous malformations; OR
• Correction of cerebral vascular aneurysms; OR
• Correction of scoliosis; OR
• Multi-level cervical fusions with instrumentation; OR
• Non-traumatic spinal cord lesions (e.g., cervical spondylosis); OR
• Removal of spinal cord tumors; OR
• Removal of tumors that affect the cranial nerves; OR
• Spinal cord trauma; OR
• Spinal procedures that pose a potential risk of significant damage to an essential central nervous system structure.

Note: Decompression or discectomy for disc herniation and laminectomy and decompression for stenosis should not require intraoperative neurological monitoring because monitoring is not likely to alter the surgical outcome for these conditions.
According to the American Academy of Neurology (AAN), IOM must be ordered and furnished by qualified personnel. The benefits of IOM are attainable under optimal recording and interpreting conditions. For example, the beneficial results of monitoring demonstrated by the 1995 multicenter study (Nuwer et al., 1995) were realized under the following conditions in a hospital setting:

- A well-trained, experienced technologist was present at the operating site recording and monitoring a single surgical case.
- A monitoring clinical neurophysiologist supervised the technologist, and supervised no more than three cases simultaneously.
- The surgical team and the monitoring staff were always in immediate contact.

The effectiveness of IOM performed under alternative conditions has not been established.

Deviations and variations from the aforementioned optimal conditions may compromise the standards and yield results of uncertain clinical value. (AAN, 2008) It is also expected that a specifically trained technologist or non-physician monitorist, preferably with credentials from the American Board of Neurophysiologic Monitoring or the American Board of Registration of Electrodiagnostic Technologists (ABRET), will be in continuous attendance in the operating room, with either the physical or electronic capacity for real-time communication with the supervising physician. (AAN, 2008)

Different levels of physician supervision apply to different kinds of IOM procedures. Direct supervision requires a monitoring physician who is either (a) immediately available nearby so as to be able to be in the operating room within minutes when needed, or (b) available on-line to review and supervise the procedure and review the tracings in real-time remotely with the ability to communicate to the technologist and surgeon as needed. Personal supervision requires a monitoring physician to be present in the operating room. General supervision requires the procedure be furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. (AAN, 2008)

The qualifications for the practice of electrodiagnostic medicine in a specific geographic area are dependent upon legislation enacted by the particular state or on interpretive rulings by appropriate authorities, such as the medical practice board or state attorney general.

**UNITED HEALTHCARE – Reimbursement Policy**

For services that are provided in a facility POS 21, 22, 23, 24, 26, 34, 51, 52, 56, or 61, and that are subject to the professional/technical concept or that have both professional and technical components according to the CMS PC/TC indicators list, UnitedHealthcare will reimburse the interpreting physician or other health care professional only the professional component as the facility is reimbursed for the technical component of the service. To be considered for professional component reimbursement, a service or procedure must have a:
CPT / ICD-9 CODES
CPT / ICD-9 Codes

CPT – Current Procedural Terminology

• A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers.

• Each procedure or service is identified with a five digit code.

• Inclusion of a descriptor and its associated five-digit code number is based on whether or not the procedure is consistent with contemporary medical practice in multiple locations.
CPT / ICD-9 Codes

95920 – Intraoperative Neurophysiological Monitoring (per hour)

• List separately in addition to primary code. Cannot be used by itself.

• Describes ongoing electrophysiologic testing and monitoring performed during surgical procedures.

• The time spent performing or interpreting the baseline electrophysiologic studies should not be counted as intra-operative monitoring, but represents separately reportable procedures.

• The supervision requirements for each underlying test vary, and must be met (Medicare Benefit Policy Manual).

• Code 95920 should not be reported by the surgeon or anesthesiologist performing an operative procedure.

• Code 95920 should be reported only once per hour.
CPT / ICD-9 Codes

95920 – Intraoperative Neurophysiological Monitoring (per hour)

- Code **95920** is used in conjunction with primary procedure code
  - 92585 – Auditory Evoked Potentials
  - 95822 – EEG; recording in coma or sleep only
  - 95860, 95861, 95870 – Spontaneous EMG
  - 95867, 95868 – Facial Nerve EMG
  - 95900, 95904 – Nerve Conduction Study
  - 95925-95937 – Evoked Potentials: SSEP, VEP, MEP, H-Reflex

- **51785** (Anal Sphincter EMG) is **NOT** included as being eligible as primary code with 95920.
CPT / ICD-9 Codes

99360 – Intraoperative Neurophysiological Monitoring Standby

- Code **99360** is used for time spent waiting on standby before monitoring

- Physician standby service, requiring prolonged physician attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)

- **Cannot be monitoring other cases during ‘standby’ time.**
CPT / ICD-9 Codes

Evoked Potentials and Reflex Tests Codes:

- **95925**: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from all the central nervous system; in upper limbs
  - **95926**: in lower limbs
  - **95938**: in upper and lower limbs (New in 2012)
    - Do not report 95938 in conjunction with 95925, 95926
  - **95927**: in trunk or head

- **92585**: Auditory evoked potentials

- **95928**: Central motor evoked potential study (transcranial motor stimulation); upper limbs
  - **95929**: in lower limbs
  - **92939**: in both upper and lower limbs (New in 2012)
    - Do not report 95939 in conjunction with 95928, 95929

- **95930**: Visual evoked potentials, checkerboard or flash

- **95933**: Orbicularis oculi (blink) reflex

- **95937**: Neuromuscular junction testing (Train of Four)
CPT / ICD-9 Codes

Evoked Potentials and Reflex Tests Codes:

• These codes can only be used once per operative session and are considered the ‘baseline’ primary codes for the procedure.

• Each of these codes requires that an appropriate ICD-9 code, indicating medical necessity for the modality, be associated or payment may be denied.
CPT / ICD-9 Codes

Intraoperative Electromyography Codes:

- **95860**: Needle electromyography; 1 extremity with or without related paraspinal areas
  - **95861**: 2 extremities with or without related paraspinal areas
  - **95863**: 3 extremities with or without related paraspinal areas
  - **95864**: 4 extremities with or without related paraspinal areas
  - **95865**: larynx

- **95867**: Cranial nerves supplied muscle(s); unilateral
- **95868**: Cranial nerves supplied muscle(s); bilateral
- **95869**: Thoracic paraspinal muscle (Excluding T1 or T12)

- **95870**: limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters.
CPT / ICD-9 Codes

Coding Spontaneous and Triggered Cranial Nerve EMG

- **95867**: Cranial nerves supplied muscle(s); **unilateral**

- **95868**: Cranial nerves supplied muscle(s); **bilateral**

  - These codes should be billed only *one time per procedure* along with code 95920 add-on for per hour IOM
  - These codes should **NOT** be billed per muscle monitored
CPT / ICD-9 Codes

Coding Spontaneous and Triggered Nerve Root EMG

- **95860**: Needle electromyography; 1 extremity with or without related paraspinal areas
- **95861**: 2 extremities with or without related paraspinal areas
- **95863**: 3 extremities with or without related paraspinal areas
- **95864**: 4 extremities with or without related paraspinal areas
- **95869**: Thoracic paraspinal muscle (Excluding T1 or T12)
- **95870**: limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters.

- To report a complete study of the extremities (5 or more muscle groups each), use 95860-95864

- Each of these codes should be used one time per procedure (exception 95870), not per screw or nerve tested, and code 95920 should be used as the add-on to represent time spent in the OR.

- Code 95870 represents less than 5 muscle groups and is a per extremity code.
Intraoperative EEG Codes:

- **95822;** Electroencephalogram recording in coma or sleep only
  - Can be used with 95920
  - With direct physician supervision

- **95955;** Electroencephalogram during nonintracranial surgery
  - Cannot be used with 95920
  - With general physician supervision

- **95812;** Electroencephalogram extended monitoring; 41-60 minutes
  - Cannot be used with 95920

- **95813; Electroencephalogram** extended monitoring; greater than 1 hour
  - Cannot be used with 95920

- These codes are not hourly codes and cannot be billed in multiple units
CPT / ICD-9 Codes

NEW CPT CODES IN 2013

- Nerve Conduction Tests
  - 95900, 95903 and 95904 will be deleted
  - 95905: Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-way study when performed, with interpretation and report;
    - Report only once per limb
  - 95907; Nerve conduction studies; 1-2
  - 95908; 3-4 studies
  - 95909; 5-6 studies
  - 95910; 7-8 studies
  - 95911; 9-10 studies
  - 95912; 11-12 studies
  - 95913; 13 or more studies

- Each code is listed only once per procedure and can be used with add on code 95940, 95941
NEW CPT CODES IN 2013

• Intraoperative Neurophysiology
  • 95920 will be deleted
  • 95940: Continuous intraoperative neurophysiology monitoring in the operating room, one-on-one monitoring requiring personal attendance, each 15 minutes (list separately in addition to code for primary procedure)
  • 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)

• Use 95940, 95941 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939)
CPT MODIFIERS

26 – Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC – Technical Component: Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

59 – Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
CPT / ICD-9 Codes

ICD-9: INTERNATIONAL CLASSIFICATION OF DISEASES, v. 9

- The oldest method of tracking diseases and mortality in the world.
- Adopted by the United States in 1979.
- Updated at least annually based on input of providers, payers and others.
- Diseases or pathologies are identified by a 3, 4, or 5 digit code.
- ICD-10 will replace ICD-9 – should be released October 1, 2014.
CPT / ICD-9 Codes

ICD-9: INTERNATIONAL CLASSIFICATION OF DISEASES, v. 9

- Not all ICD-9 codes which may describe a particular procedure are automatically reimbursed.

- Most carrier policies include “medically necessary” IOM diagnosis codes.
Intraoperative testing may be indicated with the following types of surgery:

1. Surgery of the aortic arch, its branch vessels, or thoracic aorta, including internal carotid artery surgery, when there is risk of cerebral ischemia;
2. Resection of epileptogenic brain tissue or tumor;
3. Resection of brain tissue close to the primary motor cortex and requiring brain mapping.
4. Protection of cranial nerves:
   a. tumors that are optic, trigeminal, facial, auditory nerves
   b. cavernous sinus tumors
   c. oval or round window graft
   d. endolymphatic shunt for Ménière's disease
   e. vestibular section for vertigo
   f. microvascular decompression of cranial nerves
5. Correction of scoliosis or deformity of spinal cord involving traction on the cord;
6. Protection of spinal cord where work is performed in close proximity to cord as in the removal of old hardware or where there have been numerous interventions
7. Spinal instrumentation requiring pedicle screws or distraction
8. Decompressive procedures on the spinal cord or cauda equina carried out for myelopathy or claudication where function of spinal cord or spinal nerves is at risk;
WPS Local Coverage Determination for Intraoperative Neurophysiological Testing

Intraoperative testing may be indicated with the following types of surgery:

9. Resection of:
   a. Spinal cord tumors;
   b. Neuromas of peripheral nerves or brachial plexus, when there is risk to major sensory or motor nerves;
10. Surgery for:
    a. intracranial AV malformations;
    b. arteriovenous malformation of spinal cord;
    c. surgery for intractable movement disorders;
    d. cerebral vascular aneurysms
    e. surgery for intractable movement disorders
11. Arteriography, during which there is a test occlusion of the carotid artery;
12. Circulatory arrest with hypothermia;
13. Distal aortic procedures, where there is risk of ischemia to spinal cord; and
14. Leg lengthening procedures, where there is traction on sciatic nerve or other nerve trunks;
15. Basil ganglia movement disorders
16. Surgery as a result of traumatic injury to spinal cord/brain
17. Deep brain stimulation
CPT / ICD-9 Codes

ICD-9: INTERNATIONAL CLASSIFICATION OF DISEASES, v. 9

WPS Local Coverage Determination for Intraoperative Neurophysiological Testing

ICD-9 that Support Medical Necessity

170.2  MALIGNANT NEOPLAS OF VERTEBRAL COLUMN EXCLUDING SACRUM AND COCCYX
192.0-192.9  MALIGNANT NEOPLASM OF CRANIAL NERVES-MALIGNANT NEOPLASMS OF NERVOUS SYSTEM
193  MALIGNANT NEOPLASM OF THYROID GLAND
237.5  NEOPLASM OF UNCERTAIN BEHAVIOR OF BRAIN AND SPINAL CORD
239.6  NEOPLASM OF UNSPECIFIED NATURE OF BRAIN
721.1  CERVICAL SPONDYLOSIS W/ MYELOPATHY
721.41-721.42  SPONDYLOSIS W/ MYELOPATHY THORACIC REGION – SPONDYLOSIS W/ MYELOPATHY LUMBAR REGION
806.4  CLOSED FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
806.9  OPEN FRACTURE OF UNSPECIFIED VERTEBRA WITH SPINAL CORD INJURY

•  STENOSIS, DEGENERATIVE DISC DISEASE, AND HERNIATED DISCS are NOT on the list of supported ICD-9 codes as listed by the WPS Local Coverage Determination for Intraoperative Neuro Monitoring.
CPT / ICD-9 Codes

ICD-9: INTERNATIONAL CLASSIFICATION OF DISEASES, v. 9

WPS Local Coverage Determination for Nerve Conduction Studies and Electromyography

ICD-9 that Support Medical Necessity

170.2 ----- MALIGANT NEOPLAS OF VERTEBRAL COLUMN EXCLUDING SACRUM AND COCCYX
192.0-192.9 MALIGANT NEOPLASM OF CRANIAL NERVES-MALIGANT NEOPLAS OF NERVOUS SYSTEM
193 ----- MALIGANT NEOPLASM OF THYROID GLAND
237.5 ----- NEOPLASM OF UNCERTAIN BEHAVIOR OF BRAIN AND SPINAL CORD
239.6 ----- NEOPLASM OF UNSPECIFIED NATURE OF BRAIN
721.1      CERVICAL SPONDYLOSIS W/ MYELOPATHY
721.41-721.42 SPONDYLOSIS W/ MYELOPATHY THORACIC REGION – SPONDYLOSIS W/ MYELOPATHY LUMBAR REGION
722.52      DEGENERATIVE OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.70-722.73 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY UNSPECIFIED REGION – INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
723.0      SPINAL STENOSIS OF THE CERVICAL REGION
724.2      LUMBAGO
724.4      THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.5      BACKACHE UNSPECIFIED
806.4      CLOSED FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
806.9      OPEN FRACTURE OF UNSPECIFIED VERTEBRA WITH SPINAL CORD INJURY

• STENOSIS, DEGENERATIVE DISC DISEASE, AND HERNIATED DISCS ARE on the list of supported ICD-9 codes as listed by the WPS Local Coverage Determination for NCS and EMG.
MAXIMUM REIMBURSEMENT
Maximum Reimbursement

• Research
• Denial Reports
• Explanation of Benefits
• Adjustments
• Managed Care Contracts
  • Is it worth fighting for?
TOOLS

• American Academy of Neurology Principles for Coding Intraoperative Neurophysiologic Monitoring and Testing
  http://www.aan.com/globals/axon/assets/9339.pdf

• Coding Today  www.codingtoday.com

• Centers for Medicare and Medicaid Services  www.cms.gov

• Wisconsin Physician Services  www.wpsmedicare.com

• American Academy of Professional Coders  www.aapc.com

• Blue Cross Blue Shield  www.bcbsil.com/provider/

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