Intraoperative neurophysiology monitoring.1 Part A/B

RETIRE
FIRST COAST SERVICE OPTIONS
MAC - PART A/B
LOCAL COVERAGE DETERMINATION

LCD Database ID Number
L33379

Contractor Name
First Coast Service Options, Inc.

Contractor Number
09101 – Florida
09201 – Puerto Rico/Virgin Islands
09102 – Florida
09202 – Puerto Rico
09302 – Virgin Islands

LCD Title
Intraoperative Neurophysiology Monitoring

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CMS National Coverage Policy

Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

CMS On line Manual, Medicare Program Integrity Manual, Pub. 100-08, Chapter 13, Section 13.5.1

Primary Geographic Jurisdiction

Florida
Puerto Rico/Virgin Islands
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Oversight Region

Region I

Original Determination Effective Date

10/01/2015

Original Determination Ending Date

08/11/2017

Revision Effective Date

N/A

Revision Ending Date

N/A

Indications and Limitations of Coverage and/or Medical Necessity

Intraoperative neurophysiology monitoring (IONM) is the use of electrophysiology methods to test the functional integrity of certain neural structures (e.g., nerves, spinal cord, and part of the brain) during certain surgeries. The principle goal of IONM is the identification of nervous system impairment in the hope that prompt intervention will prevent permanent deficits such as muscle weakness, loss of sensation, hearing loss, and impairment of other bodily functions, and/or to provide functional guidance to the surgeon and anesthesiologist. Secondly, the mapping techniques used to identify critical structures in the nervous system are identified electrophysiologically; the surgeon avoids these structures to prevent neurological damage from occurring. Correctable factors that can occur during surgery include circulatory disturbance, excess compression from retraction, bony structures or hematomas, or mechanical stretching.

IONM can be performed by a qualified technologist, neurologist, or other physician who has training in electrophysiology testing and the fundamentals of clinical neurophysiology. Though the intraoperative monitoring of a patient via a qualified MD/DO's direct supervision of a qualified technologist may be acceptable care in certain situations, MAC J9 only covers the medically reasonable and necessary time for one-on-one monitoring by the MD/DO (face to face by the qualified MD/DO in the operating room or via real-time recordings viewed by the MD/DO when a qualified technician is in continuous attendance in the operating room). Currently, CPT code 95940 and HCPCS Code G0453 is a time based physician service and does not describe physician supervision of multiple patients simultaneously.

Reimbursement is not provided for “incident-to” care in the hospital setting for this service. The claims for physician services must be submitted for the medically reasonable and necessary time devoted to an individual patient by the monitoring physician. This time may be cumulative and does not have to be continuous. For example, one half hour of continuous attendance followed by another one half hour later in the procedure will constitute one hour of monitoring. However, participating in two or more simultaneous surgeries may not meet the intent of the one-on-one physician [monitoring described by CPT code 95940 and HCPCS code G0453, given monitoring of multiple patients simultaneously is not described by the code and is not a covered physician service. Therefore, two surgical procedures could have overlapping time related to start/stop times given the length of certain neurosurgical procedures, but the intraoperative neurophysiology monitoring time cannot be overlapped between the patients.

Coverage for IONM for the following types of surgery will be allowed:

- Surgery of the aortic arch, its branch vessels or thoracic aorta, including internal carotid artery surgery, when there is risk of cerebral ischemia
- Resection of epileptogenic brain tissue or tumor
- Protection of cranial nerves:
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- Resection of tumors involving the cranial nerves
- Microvascular decompressive surgeries (i.e., trigeminal neuralgia surgery)
- Skull base surgery in the vicinity of the cranial nerves and surgeries of the foramen magnum
- Cavernous sinus tumors
- Oval or round window graft
- Endolympatic shunt for Meniere's disease
- Vestibular section for vertigo

- Correction of scoliosis or deformity of spinal cord involving traction on the cord
- Decompressive procedures on the spinal column or cauda equina performed for myelopathy or claudication where the function of spinal cord or spinal nerves is at risk
- During placement of internal spinal fixation devices, i.e., pedicle screws where nervous system function is at risk
- Spinal cord tumors and spinal fractures (with the risk of cord compression)
- Neuromas or tumors of peripheral nerves or brachial plexus when there is a risk to major sensory or motor nerves
- Surgery or embolization for intracranial Arterio-Venous Malformations (AVMs)
- Embolization of bronchial artery AVMs or tumors
- During resection of cerebral lesion for the purpose of identifying and sparing eloquent structures (e.g. speech or motor cortex)
- Arteriography during which there is a test occlusion of the carotid artery
- Distal aortic procedures when there is risk of ischemia to spinal cord
- Leg lengthening procedures when there is traction on the sciatic nerve
- Circulatory arrest with hypothermia

Due to the nature of these services and the potential for significant morbidity in some procedures these services are considered reasonable and necessary in the inpatient setting only requiring IONM. As the level of anesthesia may significantly impact the ability to interpret intraoperative studies, continuous communication between the anesthesiologist, operating surgeon(s) and the monitoring physician is expected when medically indicated. It is also expected that a specifically trained technician, registered with one of the credentialing organizations such as the American Society of Neurophysiologic Monitoring or the American Society of Electrodiagnostic Technologists, will be in continuous attendance in the operating room, with either the physical or electronic capacity for real-time communication with the monitoring neurologist or other physician trained in neurophysiology. Also, due to the potential risk for morbidity with many of the above-noted surgeries and the need for explicit and focused attention to both the monitoring and the procedure, it is not expected that operating surgeons or attending anesthesiologists would submit claims for this code.

Limitations of Coverage

IONM must be ordered by the operating surgeon, and the monitoring must be performed by a qualified physician who is other than:

- the operating surgeon,
- the technical/surgical assistant, or
- the anesthesiologist rendering the anesthesia

One-on-one monitoring may be performed from a remote site, ONLY if a trained technician is in continuous attendance in the operating room with either the physical or electronic capacity for real-time communication with the monitoring physician.

Mandatory technical criteria include but are not limited to the following:

- 16-channel monitoring, minimum real-time auditory, with possible addition of video connectivity between monitoring staff, operating surgeon, and anesthesiologist.
- The equipment must provide all monitoring modalities that may be applied with codes 95940 and G0453 Auditory-evoked response, electroencephalography/electrocorticography, electromyography and nerve conduction, and somatosensory-evoked response.

IONM is not medically necessary in situations where historical data and current practices reveal no potential for damage to neural integrity during surgery. Monitoring under these circumstances will exceed the patient's medical need.

Credentials/Qualifications:
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- The neurologist, or other physician trained in neurophysiology, must have appropriate hospital staff privileges to perform services at the facility.
- A trained technician registered with one of the credentialing organizations such as the American Society of Neurophysiologic Monitoring or the American Society of Electrodiagnostic Technologists must be in continuous attendance in the operating room, with the physical or electronic capacity for real-time communication with the neurologist or other physician trained in neurophysiology.

Type of bill Code

11x Hospital inpatient (including Medicare Part A)
12x Hospital inpatient (Medicare Part B only)

Revenue Codes

0360 Operating room services – general classification
0740 EEG (Electroencephalogram) – general classification
0960 Professional fees – general classification
0975 Professional fees – operating room

CPT/HCPCS Codes

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)

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)

ICD-10 Codes that Support Medical Necessity

Inpatient only ICD-10 CM procedure codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4A1004G</td>
<td>Monitoring of central nervous electrical activity, intraoperative, open approach</td>
</tr>
<tr>
<td>4A1034G</td>
<td>Monitoring of central nervous electrical activity, intraoperative, percutaneous approach</td>
</tr>
<tr>
<td>4A10X2Z</td>
<td>Monitoring of central nervous conductivity, external approach</td>
</tr>
<tr>
<td>4A10X4G</td>
<td>Monitoring of central nervous electrical activity, intraoperative, external approach</td>
</tr>
<tr>
<td>4A11029</td>
<td>Monitoring of peripheral nervous conductivity, sensory, open approach</td>
</tr>
<tr>
<td>4A1102B</td>
<td>Monitoring of peripheral nervous conductivity, motor, open approach</td>
</tr>
<tr>
<td>4A1104G</td>
<td>Monitoring of peripheral nervous electrical activity, intraoperative, open</td>
</tr>
<tr>
<td>4A11329</td>
<td>Monitoring of peripheral nervous conductivity, sensory, percutaneous approach</td>
</tr>
<tr>
<td>4A1132B</td>
<td>Monitoring of peripheral nervous conductivity, motor, percutaneous approach</td>
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<tr>
<td>4A1134G</td>
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</tbody>
</table>

Diagnoses that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity
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N/A

Documentation Requirements

Medical record documentation supporting the need for IONM must be maintained in the patient's medical record and made available to the contractor upon request. When the documentation does not establish the medical necessity, services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

The patient’s medical record must indicate the start and stop time for every monitoring interval for which the physician provided one-on-one monitoring during the procedure. The total time billed to Medicare for one-on-one monitoring for each patient must be supported in that patient’s record.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Only the physician time devoted to an individual patient should be billed, and each minute of the physician’s time should be billed once.

IONM should not be reported by the physician performing the operative procedure since it is included in the global package for the surgery.

Sources of Information and Basis for Decision

FCSO reference LCD number(s) – L32489


LCDs and policies from other Medicare contractors and private insurers


Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

04/01/2014

Revision History
Intraoperative neurophysiology monitoring.1 Part A/B

Revision History Number: R1
Revision Number: 1
Publication: August 2017 Connection
LCR A/B2017-035

Explanation of revision: Based on data analysis review of the local coverage determination (LCD), it was determined that the LCD is no longer required and, therefore, is being retired. The effective date of this LCD retirement is based on date of service.

Revision Number: Original

This LCD replaces all previous LCD versions (refer to “Sources of Information and Basis for Decision” section of the LCD) and publications on this subject to comply with ICD-10-CM based on Change Request 8112. The effective date of this LCD is based on date of service.

Related Documents

N/A

LCD Attachments

Coding Guidelines

Document formatted: 08/04/2017 (RA/dc)