Intraoperative Neurophysiological Monitoring (IONM) and Testing

Policy Statement

Intraoperative neurophysiological monitoring (IONM) describes a group of procedures used during surgery to monitor neural pathways during high-risk neurosurgical, orthopedic, peripheral nerve, and vascular surgeries. These procedures assist surgeons in preventing damage and preserving functionality of the nervous system.[1]

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as InterQual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Intraoperative neurophysiological testing may be used to identify/prevent complications during surgery on the nervous system, its blood supply, or adjacent tissue. Monitoring can identify new

[1] Intraoperative Neurophysiological Monitoring Unit | Johns Hopkins Neurology and Neurosurgery (hopkinsmedicine.org)

neurologic impairment, identify or separate nervous system structures (e.g., around or in a tumor) and can demonstrate which tracts or nerves are still functional. Intraoperative neurophysiological testing may provide relative reassurance to the surgeon that no identifiable complication has been detected up to a certain point, allowing the surgeon to proceed further and provide a more thorough or careful surgical intervention than would have been provided in the absence of monitoring. Monitoring, if used to assess sensory or motor pathways, should assess the appropriate sensory or motor pathways. Incorrect pathway monitoring could miss detection of neural compromise and has been shown to have resulted in adverse outcomes.

This test must be ordered by the operating surgeon and the monitoring must be performed by a licensed physician who is a qualified neurologist other than:

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

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

CPT 95940 (All Lines of Business):

- CPT Code 95940 is reported per 15 minutes of service.
- CPT Code 95940 requires reporting only the portion of time the monitoring professional was physically present in the operating room providing one-on-one patient monitoring, and no other cases may be monitored at the same time.
- Time spent in the operating room is cumulative. To determine units of service of 95940, use the total minutes monitoring in the operating room one-on-one. Monitoring may begin prior to incision (e.g., when positioning on the table is a time of risk).
- Report continuous intraoperative neurophysiologic monitoring in the operating room (95940) in addition to the services related to monitoring from outside the operating room (G0453), and interpret the baseline studies, and to remove electrodes at the end of the procedure.

HCPC G0453 (All Lines of Business):

- Per CMS guidelines, G0453 must be billed only for undivided attention by a monitoring physician to a single patient, and not for simultaneous attention by the monitoring physician to more than one 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 be present via real-time remote device (no cell phones).

Per Centers for Medicare and Medicaid Services (CMS), Intraoperative neurophysiology testing (HCPCS/CPT codes 95940 and G0453) should not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package.

Codes 95940 and G0453 are performed in the hospital setting. Monitoring of a patient should use off campus-outpatient hospital (place of service 19), inpatient hospital (place of service 21), on campus-outpatient hospital (place of service 22), or ambulatory surgical center (place of service 24) even if the monitoring physician is located in an office.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

- All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
- The medical record documentation must support the medical necessity of the services.
- The medical record must support the time spent actively monitoring and correlate to the surgery being performed.
- Any documentation requests not submitted will be considered not meeting the medical necessity for the service and will be denied based on lack of verification of the service being done.
- If chat logs are available, they must include ongoing times of conversation and reflect the dedicated time for that particular beneficiary.
- If requested, records for a given day of practice should be available in order to determine if there was devoted time for a particular patient and not simultaneous services.
- When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the appeal request, this would include the formal baseline neurophysiologic study with requirements noted above.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Coding

Study/Testing Codes – modifier 26 must be appended on these codes when filed with Intraoperative neurophysiological monitoring (not an all-inclusive list):

CPT Code	Description
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report
95822	Electroencephalogram (EEG); recording in coma or sleep only
95824	Electroencephalogram (EEG); cerebral death evaluation only
95829	Electrocorticogram at surgery (separate procedure)
95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side
95857	Cholinesterase inhibitor challenge test for myasthenia gravis
95860	Needle electromyography; 1 extremity with or without related paraspinal areas

95861	Needle electromyography; 2 extremities with or without related paraspinal areas
95863	Needle electromyography; 3 extremities with or without related paraspinal areas
95864	Needle electromyography; 4 extremities with or without related paraspinal areas
95865	Needle electromyography; larynx
95866	Needle electromyography; hemidiaphragm
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868	Needle electromyography; cranial nerve supplied muscles, bilateral
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)
95870	Needle electromyography; 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
95907	Nerve conduction studies; 1-2 studies
95908	Nerve conduction studies; 3-4 studies
95909	Nerve conduction studies; 5-6 studies
95910	Nerve conduction studies; 7-8 studies
95911	Nerve conduction studies; 9-10 studies
95912	Nerve conduction studies; 11-12 studies
95913	Nerve conduction studies; 13 or more studies
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs

95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report
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
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs
95955	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)

Document History

Date	Action
10/01/2024	Policy Effective Date