



Medtronic

NIM-ECLIPSE™

Spinal System

Reimbursement Guide



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NIM-ECLIPSE™ Spinal System

The NIM-ECLIPSE™ Spinal System is the next generation of surgeon-directed and professionally supported spinal neuromonitoring technology, which allows for as many as 32 channels of simultaneous electroencephalography (EEG), evoked potentials (EP), and electromyography (EMG) monitoring. The NIM-ECLIPSE™ Spinal System also provides for automatic pedicle screw monitoring with direct nerve and screw stimulation. During surgery, the NIM-ECLIPSE™ Spinal System may allow physicians to monitor critical neural pathways, which helps prevent postoperative neurological deficits.

Accessories for the NIM-ECLIPSE™ Spinal System include a Ball-Tip Probe, which provides full control from the sterile field. Additional accessories include several other precision surgical instruments. The NIM Pedicle Access Needle enables percutaneous screw placement and is available with a bevel or trocar tip. The X-PAK Probe aids in monitoring the direct lateral approach. For open pedicle screw placement, pedicle probes are available in straight, thoracic, and lumbar tips.

There is some controversy over reimbursement of intraoperative nerve monitoring. The information in this guide summarizes what we have gathered from the Centers for Medicare and Medicaid Services (CMS), commercial payers, and healthcare consultants familiar with coding rules, reimbursement, and medical policies.

Physician Reimbursement

Current Procedural Terminology (CPT) codes are used by physicians for all services and by hospitals for outpatient services.

Use of CPT codes is governed by various coding guidelines published by the American Medical Association (AMA) and other major sources such as professional medical societies (for physicians) and the American Hospital Association (for hospitals). In addition, the National Correct Coding Initiative (NCCI), a set of CPT coding edits created and maintained by CMS, has become a national standard.

Medicare Physician Fee Schedule

Medicare and most indemnity insurers use a fee schedule to pay physicians for their professional services, assigning a flat payment amount to each CPT code. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then multiplied by a flat conversion factor to determine the physician payment. Many other payers use Medicare's RBRVS fee schedule or some variation on it. Industrial or work-related injury cases are usually reimbursed according to the official fee schedule for each state.

Physician Reimbursement

Medicare's RVUs and RBRVS payments are listed below. Select the most appropriate code(s).

CPT	Description	Professional Component (RVUs)	Technical Component (RVUs)	Global Payment (RVUs)	Physician Supervision of Diagnostic Procedures
51785	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique	\$80 (2.21)	\$138 (3.82)	\$218 (6.03)	03
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	\$27 (0.70)	\$74 (2.04)	\$99 (2.74)	09
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	—	—	\$60 (1.66)	09
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	\$54 (1.49)	\$208 (5.77)	\$262 (7.26)	01
95813	Electroencephalogram (EEG) extended monitoring; greater than one hour	\$86 (2.38)	\$228 (6.32)	\$314 (8.70)	01
95816	Electroencephalogram (EEG); including recording awake and drowsy	\$54 (1.49)	\$187 (5.17)	\$240 (6.66)	01
95819	Electroencephalogram (EEG); including recording awake and asleep	\$54 (1.49)	\$210 (5.82)	\$264 (7.31)	01
95822	Electroencephalogram (EEG); recording in coma or sleep only	\$54 (1.49)	\$200 (5.54)	\$254 (7.03)	01
95860	Needle electromyography; one extremity with or without related paraspinal areas	\$49 (1.36)	\$34 (0.94)	\$83 (2.30)	6A
95861	Needle electromyography; two extremities with or without related paraspinal areas	\$78 (2.17)	\$42 (1.17)	\$121 (3.34)	6A
95863	Needle electromyography; three extremities with or without related paraspinal areas	\$94 (2.61)	\$51 (1.40)	\$145 (4.01)	6A
95864	Needle electromyography; four extremities with or without related paraspinal areas	\$101 (2.79)	\$61 (1.69)	\$162 (4.48)	6A
95865	Needle electromyography; larynx	\$80 (2.23)	\$32 (0.90)	\$113 (3.13)	6A
95866	Needle electromyography; hemidiaphragm	\$64 (1.77)	\$31 (0.87)	\$95 (2.64)	6A
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	\$40 (1.11)	\$33 (0.91)	\$73 (2.02)	6A
95868	Needle electromyography; cranial nerve supplied muscles, bilateral	\$60 (1.65)	\$40 (1.10)	\$99 (2.75)	6A
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	\$19 (0.52)	\$31 (0.86)	\$50 (1.38)	6A
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 (0.52)	\$30 (0.82)	\$48 (1.34)	6A
95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	\$21 (0.59)	\$33 (0.91)	\$54 (1.50)	7A
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study	\$30 (0.83)	\$31 (0.87)	\$61 (1.70)	7A

Physician Reimbursement

Medicare's RVUs and RBRVS payments are listed below (continued).

CPT	Description	Professional Component (RVUs)	Technical Component (RVUs)	Global Payment (RVUs)	Physician Supervision of Diagnostic Procedures
95920	Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)	\$105 (2.92)	\$44 (1.21)	\$149 (4.13)	09
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	\$27 (0.75)	\$102 (2.83)	\$129 (3.58)	09
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	\$27 (0.75)	\$99 (2.75)	\$126 (3.50)	21
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	\$27 (0.76)	\$96 (2.66)	\$123 (3.42)	21
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	\$75 (2.07)	\$128 (3.54)	\$202 (5.61)	21
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	\$75 (2.08)	\$139 (3.85)	\$214 (5.93)	21
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	\$18 (0.49)	\$95 (2.62)	\$112 (3.11)	09
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	\$30 (0.82)	\$36 (1.01)	\$66 (1.83)	7A
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle	\$26 (0.71)	\$25 (0.68)	\$50 (1.39)	09
95936	H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle	\$27 (0.76)	\$16 (0.43)	\$43 (1.19)	09
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	\$33 (0.92)	\$25 (0.69)	\$58 (1.61)	09
95955	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)	\$50 (1.38)	\$93 (2.58)	\$143 (3.96)	02
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance	\$150 (4.15)	\$79 (2.19)	\$229 (6.34)	03
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance	\$160 (4.44)	\$51 (1.42)	\$211 (5.86)	03

* 2010 Medicare Physician Fee Schedule. Federal Register, 11/25/09. No geographic adjustment. Department of Defense Appropriations Act of 2010.

Note: These codes are not always separately codable with the primary spinal procedure. In addition to checking NCCI edits, please see the section titled "Separate Reimbursement for Intraoperative Nerve Monitoring" for more information.

Physician Reimbursement

Physician Supervision of Diagnostic Procedures

The Medicare Benefit Policy Manual (Chapter 15, section 80) describes the levels of physician supervision required for furnishing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient or outpatient. Section 410.32(b) of the Code of Federal Regulations (CFR) requires that diagnostic tests covered under §1861(s)(3) of the Act and payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician (§1861(r) of the Act) to be considered reasonable and necessary and, therefore, covered under Medicare.

Each CPT code in the Medicare Physician Fee Schedule (MPFS) is assigned a numerical level to define the level of physician supervision required for that particular diagnostic test. The following numerical levels are identified in the MPFS for the diagnostic tests that may be performed with the NIM-ECLIPSE™ Spinal System:

- 1 Procedure must be performed under the general supervision of a physician.
- 2 Procedure must be performed under the direct supervision of a physician.
- 3 Procedure must be performed under the personal supervision of a physician.
- 5 Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.
- 6 Procedure must be performed by a physician or by a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law.
- 6a Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.
- 7a Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.
- 9 Concept does not apply.
- 21 Procedure must be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.
- 22 Procedure may be performed by a technician with on-line real-time contact with a physician.
- 66 Procedure must be performed by a physician or by a PT with ABPTS certification and certification in this specific procedure.
- 77 Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

Physician Reimbursement

General Coding Guidelines for Neural Integrity Monitoring

According to the CPT manual notes, code 95920 describes:

“Ongoing electrophysiologic testing and monitoring performed during surgical procedures. Code 95920 is reported per hour of service, and includes only the ongoing electrophysiologic monitoring time distinct from performance of specific type(s) of baseline electrophysiologic study(s) (95860, 95861, 95867, 95868, 95870, 95900, 95904, 95928, 95929, 95933-95937) or interpretation of specific type(s) of baseline electrophysiologic study(s) (92585, 95822, 95870, 95925-95928, 95929, 95930). The time spent performing or interpreting the baseline electrophysiologic study(s) should not be counted as intraoperative monitoring, but represents separately reportable procedures. Code 95920 should be used once per hour even if multiple electrophysiologic studies are performed. The baseline electrophysiologic study(s) should be used once per operative session.”

These CPT manual notes have coding and billing implications, as outlined below:

- » Code 95920 represents only the intraoperative nerve monitoring component of the study. It is an add-on code and cannot be billed alone. Rather, it must always be billed together with the code for the primary EMG or MEP procedure, to identify the specific study performed.

- » One unit of code 95920, which is defined as “per hour,” is added for each 60 minutes of intraoperative monitoring. Note that time spent interpreting the primary EMG and MEP tests does not count toward the time for 95920. Only the additional time spent for nerve monitoring is counted.
- » To show intraoperative nerve monitoring of less than an hour, modifier –52 is not used with 95920. Instead, units are submitted by whole numbers and portions of an hour are counted only if the time exceeds 30 minutes. For example,

3 to 3½ hours of intraoperative neurophysiology testing is billed as 3 units. More than 3½ hours but less than 4 hours is billed as 4 units.

It is also important for the provider to thoroughly review NCCI edits when reporting 95920 with spinal procedures. Starting with Version 10.1, which became effective April 1, 2004, intraoperative nerve monitoring is bundled with a variety of spinal procedures and cannot be reported separately. NCCI edits are updated quarterly and new edits may be developed.

Coding Example

Surgical codes (billed by operating surgeon)

63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy, cervical, single interspace
22554-51	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression), cervical below C2
22845	Anterior instrumentation, 2 to 3 vertebral segments
20931	Allograft for spine surgery only, structural

Neural Integrity Monitoring codes

(billed by neurologist or neurophysiologist providing monitoring)

95864	Needle electromyography, four extremities with or without related paraspinal areas
95928	Central motor evoked potential study (transcranial motor stimulation), upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation), lower limbs
95920	Intraoperative neurophysiology testing, per hour

Physician Reimbursement

Documentation

The medical necessity for nerve monitoring for the individual patient should be documented. It is helpful to include this in the operative report itself, so all documentation related to monitoring can be found in one place.

The operative report should clearly and specifically document the use of nerve monitoring, including the clinical information provided by the monitoring and how this facilitated the surgical dissection. The operative report should also document that the nerve monitoring was performed throughout the surgical procedure, as appropriate. Further, the operative documentation should note if the physician was on site at all times or monitoring remotely by video camera or laptop.

Diagnosis Codes

Each claim must be submitted with the ICD-9-CM codes that reflect the highest level of specificity of the condition of the patient.

Medicare Local Coverage Decisions for nerve monitoring may have a specific list of ICD-9-CM codes that support medical necessity for nerve monitoring. Nerve monitoring billed with ICD-9-CM diagnosis codes not on the list will be denied. Review the Medicare nerve monitoring local coverage decisions for the area where you are located to see if the ICD-9-CM diagnosis codes being used are on the covered list.

Technical and Professional Components

Code 95920 for intraoperative nerve monitoring is designated a “diagnostic test” by CMS, as are all of the codes listed on pages 3 and 4. Among other things, this means that 95920 and the other codes have both a professional component and a technical component.

The professional component reflects a physician’s interpretation of the diagnostic test. It is shown by appending modifier –26 to the CPT code for the test, e.g., 95920–26. The professional component is separately valued under RBRVS reimbursement and includes the physician work, associated practice expenses, and professional liability insurance costs.

The technical component of a service includes the cost of equipment, supplies, and technician salaries. It is shown by appending modifier –TC to the CPT code for the test, e.g., 95920–TC. The technical component is also separately valued under RBRVS reimbursement.

Combined, the professional component and the technical component equal the global service for the code.

Professional Services in a Facility Setting

For services provided in a facility setting, including those to hospital inpatients and to hospital outpatients, the physician should bill only for the professional component by using modifier –26. There are several reasons for this, all related to statutes or Medicare coverage policy. In essence, only the hospital can provide the technical portion of a hospital service and a physician can provide only the professional portion of the diagnostic tests when they are provided in the facility setting. (Please see the section titled “Separate Reimbursement for Intraoperative Nerve Monitoring” for more information.)

Technical Billing in a Facility Setting

Billing for the technical component is an issue primarily for the office setting. The Medicare Physician Fee Schedule does not recognize the –TC modifier in the facility setting for major spine procedures.

Global Billing in a Facility Setting

The global code is reported when the physician provides both the professional and technical components of the test. On a practical basis, as with the technical component, billing the global service is largely an issue for the office setting. The Medicare Physician Fee Schedule does not recognize global billing in the facility setting for major spinal procedures.

Physician Reimbursement

Coverage and Payment for Intraoperative Nerve Monitoring

The following is based on Medicare policies, coding guidelines, and edits. Many commercial payers follow the same practices as the national standard. However, some commercial payers may have a different interpretation and physicians should contact local payers for verification and guidance.

Monitoring Performed by the Operating Physician

Medicare does not pay for nerve monitoring when performed by the operating surgeon, i.e., the same surgeon who performs the primary procedure.

Specifically, Medicare coverage policies for CPT code 95920 state the following:

“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”

Wisconsin Physician Services Insurance, Local Coverage Determination for Intraoperative Neurophysiological Testing

Moreover, the NCCI policy states:

“Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing since they are also included in the global package.”

National Correct Coding Policy Manual, Chapter 11, version 15.3, pages XI-21

Furthermore, consultants have advised us that 95920 as well as codes 95860, 95861, 95863, 95864, 95865, 95869, 95928, and 95929 were created and assigned RVUs on the basis of being performed by a physician other than the operating surgeon. Therefore, our best understanding of this issue is that the operating surgeon should not separately report any of these codes.

Additional information on this topic is available by contacting your local Medicare carrier or the AMA.

Monitoring Performed by Another Physician

As previously noted, the NCCI and Medicare coverage policies specifically state: “when performed by a different physician during the procedure, it is separately reportable by the second physician.”

Although the operating surgeon may not report codes for intraoperative nerve monitoring, EMG or MEP codes, a second physician, such as a neurologist or neurophysiologist who performs these services during a procedure, may report and be reimbursed for them.

Physician Reimbursement

Physicians in Group Practice

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one service may be reported unless the services are for unrelated problems.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

Medicare Claims Processing Manual, Chapter 12, 30.6.5

If the subspecialists within the group practice have separate tax identification numbers for their subspecialty, different from that of the general group tax identification number, then the patient receiving professional services from the subspecialist may be considered a new patient.

It is important to familiarize yourself with the various reporting and reimbursement policies of the payers in your area regarding professional services provided by different specialties and subspecialties in the same group.

CPT Assistant, New vs. Established Patient, June 1999

Physician Billing for Monitoring Performed by Others

Under §1861(s)(2)(A) of the Social Security Act, there is no Medicare physician coverage for services rendered by auxiliary personnel to hospital patients. For inpatients, these services can be covered only under the hospital benefit, so Medicare can make payment only to the hospital. For outpatients, according to the Medicare Benefit Policy Manual (Chapter 15, 60.B), Medicare can also only make payment to the hospital.

This means that the physician cannot bill the payer for monitoring performed by an OR technician, nurse, physical therapist or any other professional employed by the hospital, regardless of the degree of physician supervision.

In the facility setting, the physician also cannot bill the payer for monitoring by others even if they are employed by the physician:

“For hospital patients...there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians’ services under §1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.”

Medicare Benefit Policy Manual (Chapter 15, 60.1.B)

Although the physician cannot bill the payer in these circumstances, it should be noted that if the physician provides the equipment or employs the technician, he or she may be able to look to the hospital for additional reimbursement under a separate arrangement.

www.aanem.org/aaem/Practiselssues/coding/coding_faqs.cfm

Remote Monitoring

In a typical scenario, the monitoring physician is present in the room where the testing is being performed. However, this is not always required. Some carriers expressly allow remote monitoring, by digital transmission or closed circuit television, for example, as long as certain conditions are met.

Generally, the physician performing the service remotely must be monitoring in real time and must be solely dedicated to performing this service. The physician monitoring remotely must also have the capacity for continuous or immediate contact with the operating surgeon.

For carriers that allow simultaneous monitoring of more than one patient, only the time spent uniquely for each patient is counted. However, the time does not necessarily need to be continuous. Physicians should identify applicable medical policies and contact their local carrier for specific guidance.

TrailBlazer LCD L26800, Intraoperative Neurophysiological Monitoring

Physician Reimbursement

Separate Billing by Non-Physician Practitioners

As previously noted, the physician cannot bill for the monitoring services of non-physician practitioners, such as Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists, who perform nerve monitoring. However, when these non-physician practitioners personally perform diagnostic tests as provided under §1861(s)(2)(K) of the Act, they may perform diagnostic tests pursuant to State scope of practice laws and may bill payers separately under their own provider numbers.

Medicare Benefit Policy Manual (Chapter 15, 80)

Intraoperative Monitoring Provided by Third Party Suppliers

Some hospitals do not have the equipment or technicians available to perform intraoperative monitoring. Instead, they make arrangements with third-party suppliers to provide this service. In some situations, the third-party supplier provides the monitoring equipment only. In others, the third-party supplier provides both the equipment and the services of either a certified technician or a physician. Note that these arrangements go through the hospital, not the operating surgeon. How hospitals and the supplier handle the billing depends partly on the payer.

Medicare has a long history of allowing equipment services to be obtained by a hospital under a “purchased service” agreement. In Medicare’s view, the hospital is furnishing the technical component of the service to the patient, not the third-party supplier. Since the hospital is held to have provided the service, the hospital codes and bills for it.

Indeed, Medicare rules require that purchased services be billed by the hospital, with reimbursement to the hospital as an operating expense. As part of its arrangement, the supplier must then look to the hospital for payment of this component.

For the professional component, physicians and technicians, practicing within state scope of practice laws, provided by the third-party supplier can bill Medicare directly.

Billing for commercial payers varies, because these payers may contract directly with the third-party supplier, often for global services. In that situation, the third-party supplier bills the payer directly for the technical and professional components. Because the hospital has not rendered the service and has incurred no expense, the hospital should not code or bill for it.

Facility Reimbursement

For facilities, coding and reimbursement depend on the setting, inpatient or outpatient, and the type of facility, hospital or Ambulatory Surgery Center (ASC).

Also note that facilities do not append a –TC modifier to the CPT codes. It is understood that the facility is billing for the technical component.

Hospital Inpatient

Hospitals use ICD-9-CM procedure codes to report inpatient services. For these services, hospitals should code nerve monitoring separately with ICD-9-CM procedure code 00.94.

00.94 Intra-operative
Neurophysiologic Monitoring

Medicare uses the DRG payment methodology to reimburse hospitals for inpatient services. Each inpatient stay is assigned to one of about 745 payment groups, based on the ICD-9-CM codes assigned to the major diagnoses and procedures. Each DRG group has a flat payment rate that bundles the reimbursement for all services the patient received during the inpatient stay.

Some non-Medicare insurers also use the DRG payment methodology. Many other insurers use per diem or per case methods depending on their contract with the hospital.

The use of the NIM-ECLIPSE™ Spinal System is not paid separately under DRGs and most other inpatient reimbursement methodologies. Instead, it is bundled into the overall payment for the inpatient stay. However, hospitals must still accurately charge for the use of the NIM-ECLIPSE™ Spinal System because this data is often used to develop future payment rates.

Bill Type Code

11X Hospital Inpatient

Revenue Code

0920 Other Diagnostic Services
0922 Electromyogram

Hospital Outpatient

Hospitals use CPT/HCPCS (Healthcare Common Procedure Coding System) codes to report outpatient services.

Under Medicare's Ambulatory Payment Classifications (APC) methodology for hospital outpatient payment, each HCPCS code is assigned to one of about 879 payment classes. Each APC class has a relative weight that is multiplied by a flat conversion factor to determine the hospital payment. An APC and payment amount are assigned to each significant service. Although some services are bundled and not separately payable, total payment to the hospital is the sum of the APC amounts for the services provided during the outpatient encounter.

Many payers use Medicare's APC methodology or a similar type of fee schedule to reimburse hospitals for outpatient services. Other payers use a percent of charges mechanism, depending on their contract with the hospital.

Facility Reimbursement

CPT	Description	APC	APC Title	Status Indicator	2010 Relative Weight	2010 APC Payment
Select most appropriate code(s):						
95860	Needle electromyography; one extremity with or without related paraspinal areas	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95861	Needle electromyography; two extremities with or without related paraspinal areas	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95863	Needle electromyography; three extremities with or without related paraspinal areas	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95864	Needle electromyography; four extremities with or without related paraspinal areas	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95865	Needle electromyography; larynx	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95867	Needle electromyography; cranial nerve supplied muscle(s) unilateral	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95868	Needle electromyography; cranial nerve supplied muscle(s) bilateral	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	0215	Level II Nerve and Muscle Tests	S	0.6135	\$41.35
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	0215	Level III Nerve and Muscle Tests	S	0.6135	\$41.35
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	0218	Level III Nerve and Muscle Tests	S	1.1965	\$80.65
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	0218	Level II Nerve and Muscle Tests	S	1.1965	\$80.65
95920	Intraoperative neurophysiology testing, per hour (list separately in addition to code for primary procedure)			N	—	—

Source: Medicare Hospital Outpatient Prospective Payment System, Final Rule. Federal Register, November 20, 2009.

Facility Reimbursement

Status Indicators

Each HCPCS code in the Outpatient Prospective Payment System (OPPS) is assigned a status indicator to signify whether a discount (payment reduction) applies to the respective APC payment. The following two status indicators are represented in these procedures:

- N – Items and services packaged into APC Rates (paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.)
- S – Significant procedures, not discounted when multiple.

Note: Selected NCCI edits apply to CPT codes billed by hospitals for outpatient services.

Bill Type Code

13X Hospital Outpatient

Revenue Code

0920 Other Diagnostic Services
0922 Electromyelogram

Coverage of Spinal Fusions in the Outpatient Setting

Medicare does not cover instrumented spinal fusions in the outpatient setting. However, commercial payers may allow for these procedures to be performed in this setting. In these cases, hospitals will want to contact the payer and review their payer contracts to ensure they provide adequate payment for this procedure in the outpatient setting.

Ambulatory Surgery Center

Medicare's Ambulatory Surgical Center (ASC) List of Covered Procedures includes only primary surgical procedures. Nerve monitoring and other ancillary procedures are not assigned to ASC Groups and are not separately payable to the facility. The single payment made to the ASC for the primary surgical procedure includes all other facility services furnished by the ASC in connection with it.

Commercial payer reimbursement may vary depending on the ASC's individual provider contract and the patient's benefits. You should contact your local payers to verify coverage and appropriate coding.

Frequently Asked Questions

Question

Can we use “prolonged services” codes, such as 99356–99359, to represent the time for setting up equipment?

Answer

No. Technically, the prolonged services codes are “add-on” codes and, as defined, must always be submitted with other Evaluation and Management (E&M) codes. The nerve monitoring codes are in the Medicine section of CPT and don’t qualify as proper companion codes with 99356–99359. On a practical basis, many payers do not reimburse the prolonged services codes separately. Medicare does, but imposes several strict criteria including an up-front loss threshold of 30 minutes that must be passed before the prolonged services can be used. As a general point, it should also be noted that setting up equipment is integral to performing any procedure or test.

Question

During spinal surgery, pedicle screw testing is performed by stimulating the screw and checking for a motor nerve response. How is pedicle screw testing coded and billed?

Answer

Pedicle screw testing usually involves evaluating free-running and triggered EMG. The triggered EMG is when the screw is stimulated. According to published materials from the AMA, pedicle screw testing is coded 95870 for limited EMG, plus 95920 for each 60 minutes of intraoperative monitoring beyond the baseline test. Two units of 95870 are reported when each leg is stimulated. However, if five or more muscles are stimulated, use code 95861 for EMG of two extremities.

CPT Assistant, American Medical Association, June 2005

Question

If the operating surgeon’s partner performs the nerve monitoring, can this be billed separately?

Answer

In general, the operating surgeon’s partner cannot bill for nerve monitoring separately. From the payer perspective, a physician and the physician’s partners are the same person. Since the operating surgeon cannot bill nerve monitoring separately, a partner cannot either. One common exception is when the operating surgeon and the partner are in different specialties, in which case some payers allow them to bill separately.

Medicare Claims Processing Manual, Chapter 12, 306.5

Frequently Asked Questions

Question

Can physicians bill nerve monitoring for reviewing the tape at the end of the procedure or afterwards if they are available by phone during the procedure?

Answer

No, most payers require that interpretation take place in real time while the procedure is being performed. From the payer perspective, there is no professional component when interpretation takes place afterwards.

Question

How should physicians bill for nerve monitoring provided during cases in which the physicians are the operating surgeons and also own the nerve monitoring service and are furnishing it to the hospital?

Answer

In this situation and all other complex billing scenarios, the physician is well-advised to seek guidance from legal counsel. Particularly, because there may be points involving “incident to” requirements and self-referral issues, complex billing scenarios should be reviewed with an experienced healthcare attorney.

Question

What HCPCS codes should be reported when billing for the Ball-Tip Probe and other disposables related to the NIM-ECLIPSE™ Spinal System?

Answer

HCPCS Level II codes are used to report the supplies, durable medical equipment, and certain medical services provided on an outpatient basis. Since the procedures performed with the NIM-ECLIPSE™ Spinal System are performed in an inpatient setting, no HCPCS Level II codes apply.

Supplies used during a Part A covered stay for hospital inpatients are included in the DRG payment and are not separately billable.

Medicare Claims Processing Manual, Chapter 20, 01 Forward, page 1

Question

What place of service (POS) code should I use if I am performing remote monitoring in my office?

Answer

Place of service (POS) codes are used to identify where a procedure is performed. If remote monitoring was performed at the physician’s office, this would be the site of service and code 11 would be appropriate.

Medicare Claims Processing Manual, Chapter 12, 20.4.2 Site of Service Payment Differential

Quick Summary of Neural Integrity Monitoring Coding Basics

- » CPT code 95920 is used for intraoperative nerve monitoring. It is an add-on code and cannot be billed alone; it must always be billed with the codes for the EMG, SSEP, and MEP tests performed.
- » One unit of code 95920 is billed for each 60 minutes of intraoperative monitoring. However, time spent interpreting the EMG, SSEP, and MEP tests does not count toward the time for 95920.
- » The intraoperative nerve monitoring codes are bundled with many of the spinal procedure codes and cannot be reported separately. It is important for the physician and hospital to thoroughly review the NCCI edits when reporting intraoperative monitoring with spinal procedures.
- » Medicare does not pay separately for nerve monitoring when it is performed by the operating surgeon or when it is performed by the surgical assistant or the anesthesiologist. However, a second physician, such as a neurologist or neurophysiologist, may bill separately for nerve monitoring.
Medicare Claims Processing Manual, Chapter 12, 30.6.5
- » Some carriers allow remote monitoring by digital transmission or closed circuit television as long as the remote physician is monitoring in real-time, is dedicated exclusively to the monitoring, and has the ability to immediately contact the operating surgeon.
- » For services provided in a facility setting, including those to hospital inpatients and hospital outpatients, the physician should bill only for the professional component, using modifier –26.
- » In the facility setting, the physician cannot bill the payer for monitoring performed by an OR technician, nurse, physical therapist, or any other professional employed by the hospital, regardless of the degree of physician supervision.
- » In the facility setting, the physician cannot bill the payer for monitoring performed by others even if they are employed by the physician. However, if the physician provides the equipment or employs the technician, the physician may be able to look to the hospital for additional reimbursement under a separate arrangement.
www.aanem.org/aaem/Practitioner/coding/coding_faqs.cfm
- » Non-physician practitioners who maintain separate provider numbers can be considered physician equivalents and may bill payers separately under their own provider numbers, as permitted within the scope of their licenses and as permitted by state law.
Medicare Benefit Policy Manual, Chapter 15, 80
- » If the hospital contracts with a third-party supplier to provide intraoperative nerve monitoring, billing depends on the payer. For Medicare patients, the hospital bills for the technical component and physicians and non-physician practitioners provided by the supplier may bill Medicare for the professional component.
- » For hospital inpatients, nerve monitoring is usually bundled into the overall payment for the stay and is not paid separately under DRGs and other inpatient reimbursement methodologies. It is still important to record charges accurately because the data is often used to develop future payment rates.
- » For hospital outpatients, Medicare has packaged the payment for nerve monitoring into the payment for the surgical procedure. However, commercial payer reimbursement may vary depending on the provider's contract with the payer. Contact your payers to verify coverage and payment.

Coding Assistance, The Learning SeriesSM, and HES

Coding and Reimbursement Assistance

SPINELINE®

Physician/Hospital Coding and Reimbursement Support Line

The SPINELINE® Support Line provides support for coding, billing, and reimbursement assistance for spinal procedures performed using Medtronic products.

Phone:

877-690-5353

Internet:

<http://www.medtronicsofamordanek.com/spineline>

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The Spine Academy Learning SeriesSM

It's no longer necessary to travel to a classroom in order to stay abreast of changes in the industry. Now it's possible to go online and learn about the latest developments in the business of spine care, coding changes, regulations, and documentation requirements because Medtronic provides live interactive programs free of charge throughout the year.

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Healthcare Economic Strategies (HES) works with physicians and hospital staffs to resolve issues and facilitate communication. This process may involve contract negotiations, the design and implementation of a Spine Center, education on the latest technologies and their clinical implications, or other physician and provider challenges. With our experience and access to business tools, every challenge becomes an opportunity.

HES provides:

- » Insights into successful spine service line management
- » Strategies for better communication with payers
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- » Measurement of both clinical and economic outcomes
- » Collaboration with you to understand your unique issues and market dynamics.

Your Medtronic Spinal and Biologics representative can schedule a convenient time for you to speak with a Healthcare Economic Strategies Director, or call (800) 876-3133.

Notes

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