Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing

American Academy of Neurology Professional Association

Model Medical Policy

Background

Intraoperative neurophysiologic monitoring (IOM) and testing are medical procedures that have been in standard practice for almost 30 years. The procedures allow monitoring of neurophysiologic signals during a surgical procedure whenever the neuroaxis is at risk as a consequence of either the surgical manipulation or the surgical environment. IOM is an umbrella monitoring term and includes electroencephalography (EEG), cranial nerve evoked potentials (EPs), brain-stem auditory EPs (BAEPs), motor EPs (MEP), somatosensory EPs (SEP), nerve conduction, and electromyography (EMG) signals. Much like the other instrumental clinical monitoring technologies, such as cardiac or capnic monitoring, randomized controlled trials establishing efficacy of IOM have not been done. Current best data, accumulated over the past two decades, have been derived through comparisons with historical controls and in the number of complications avoided through IOM. This status is not unlike that of intraoperative transesophageal echocardiography (TEE), another widely-endorsed monitoring technology (Memtsoudis et. al., 2006). Both neurophysiologic IOM and TEE are recognized medical practice standards reliant on experience, case series and retrospective analyses.

IOM is of value in surgeries at diverse locations. The types of diseases for which monitoring is helpful also vary. For instance IOM may be necessary for carotid endarterectomies, removal of cortical-hemispheric lesions, extirpation of epileptic foci, brain stem surgeries, spinal corrections and peripheral nerve repairs to name some examples. IOM is used in neurosurgery, orthopedic, vascular, cardiothoracic and other surgical specialties. A compilation of recent reviews for these various areas is available (Nuwer, 2008). This policy addresses only surgical intraoperative monitoring and does not address monitoring performed in radiologic suites. The quality, extent and type of monitoring are dependent on the nature and location of the lesions. The utility of monitoring is exquisitely reliant on the rigors of the monitoring procedure and protocols, and the clinical expertise of the monitoring physician. We list below several significant publications each of which has independently demonstrated the value of IOM in averting neural injuries during surgery.

1. Value of EEG Monitoring in Carotid Surgery

Carotid occlusion, incident to carotid endarterectomies, poses a high risk for cerebral hemispheric injury. EEG monitoring is capable of detecting cerebral ischemia, a serious prelude

to injury. Studies of continuous monitoring established the ability of EEG to correctly predict risks of postoperative deficits after deliberate carotid occlusion (Redekop & Ferguson, 1992; Cloughesy et al., 1993; Woodworth et al., 2007). The surgeon can respond to adverse EEG events by raising blood pressure, implanting a shunt, adjusting a poorly functioning shunt, or performing other interventions.

2. Multicenter Data in Spinal Surgeries

An extensive multicenter study conducted in 1995 demonstrated that IOM using SEP reduced the risk of paraplegia by 60% in spinal surgeries (Nuwer et al., 1995). The incidence of false negative cases, wherein an operative complication occurred without having been detected by the monitoring procedure, was small: 0.06% (Nuwer et al., 1995).

3. Technology Assessment of Monitoring in Spinal Surgeries

A technology assessment by the McGill University Health Center (Erickson et al., 2005) reviewed 11 studies and concluded that spinal IOM is capable of substantially reducing injury in surgeries that pose a risk to spinal cord integrity. It recommended combined SEP/MEP monitoring, under the presence or constant availability of a monitoring physician, for all cases of spinal surgery for which there is a risk of spinal cord injury.

4. Value of Combined Motor and Sensory Monitoring

Numerous studies of post-surgical paraparesis and quadriparesis have shown that both SEP and MEP monitoring had predicted adverse outcomes in a timely fashion (Schwartz et al., 2007; Lee et al., 2006; Nuwer et al., 1995; Jones et al., 2003; Meyer et al., 1988; Pelosi et al., 2002; Hilibrand et al., 2004; Langeloo et al. 2003; Mostegl et al. 1988; Eggspuehler et al 2007; Leung et al. 2005; Khan et al., 2006; Sutter et al., 2007; Weinzieri et al., 2007). The timing of the predictions allowed the surgeons the opportunity to intervene and prevent adverse outcomes. The two different techniques (SEP and MEP) monitor different spinal cord tracts. Sometimes, one of the techniques cannot be used for practical purposes, for anesthetic reasons, or because of pre-operative absence of signals in those pathways. Thus, the decision about which of these techniques to use needs to be tailored to the individual patient's circumstances.

5. Protecting the Spinal Cord from Ischemia during Aortic Procedures

Studies have shown that IOM accurately predicts risks for spinal cord ischemia associated with clamping the aorta or ligating segmental spinal arteries (MacDonald & Janusz, 2002; Jacobs et al., 2000; Cunningham et al., 1987; Kaplan et al., 1986; Leung et al., 2005). IOM can assess whether the spinal cord is tolerating the degree of relative ischemia in these procedures. The surgeon can then respond by raising blood pressure, implanting a shunt, re-implanting segmental vessels, draining spinal fluid, or through other interventions.

6. **Common Types of Alerting Events Observed During Monitoring**

Another recent study (Lee et al., 2006) described types of neurophysiologic alerts and correlated them with postoperative neurological deficits that occurred during the course of 267 procedures involving anterior cervical spine surgery utilizing EMG, transcranial electrical motor and somatosensory evoked potential monitoring. In this study, 18.4 % of cases resulted in at least one intraoperative neurophysiologic alert; and major alerts believed to be related to specific intraoperative surgical maneuvers were identified in 4.6% of the patients monitored. In 88% of

the patients with relevant amplitude loss that was thought to be related to the surgical procedure, the signal response returned once appropriate intraoperative corrective measures were taken.

7. Value of EMG Monitoring
Selective posterior rhizotomy in cerebral palsy significantly reduces spasticity, increases range of motion, and improves functional skills (Staudt et al., 1995). Electromyography during this procedure can assist in selecting specific dorsal roots to transect. EMG can also be used in peripheral nerve procedures that pose a risk of injuries to nerves (Nuwer, 2008).

8. Futility of Monitoring Inappropriate Pathways
In order to be useful, monitoring should assess the appropriate sensory or motor pathways. Incorrect pathway monitoring could miss detection of neural compromise. Examples of "wrong pathway" monitoring have been shown to have resulted in adverse outcomes (Lesser et al., 1986).

Neurophysiologic Techniques Used in IOM

Several neurophysiologic testing modalities are useful during IOM. The location and type of surgery determine the chosen testing modality. The tests and codes listed here may be used individually or in combination.

- Electroencephalography (EEG);
  - With direct physician supervision, use codes 95822 plus 95920
  - With general physician supervision, use code 95955
- Electrocorticography (ECoG);
  - Use code 95829
- Direct cortical stimulation to localize function;
  - Use codes 95961, 95962
- Deep brain stimulation electrode placement
  - Use codes 95961, 95962
- Pallidotomy site testing;
  - Use codes 95961, 95962
- Somatosensory evoked potential (SEP) monitoring
  - Use codes 95925, 95926, and/or 95927 plus 95920
- Intraoperative SEP identification of the sensorimotor cortex
  - Use codes 95925 and/or 95926 plus 95920
- Motor evoked potentials (MEP)
  - Use codes 95928 and/or 95929 plus 95920
- Mapping the descending corticospinal tract
  - Use codes 95928 and/or 95929 plus 95920
- Brainstem auditory evoked potentials
  - Use code 92585 plus 95920
- Peripheral nerve stimulation and recording
  - Use codes 95900 and/or 95904 plus 95920
- Oculomotor, facial, trigeminal and lower cranial nerve monitoring

    - Use codes 95867, 95868 and/or 95933 plus 95920
- EMG monitoring and testing of peripheral limb pathways
    - Use codes 95860, 95861, or 95870 plus 95920
- Pedicle screw stimulation
    - Use codes 95860, 95861, or 95870 plus 95920
- Selective dorsal rhizotomy rootlet testing;
    - Use codes 95860, 95861, or 95870 plus 95920
- Transcranial electrical MEPs (tecMEPs) for external anal and urethral sphincter muscles monitoring.
    - Use code 95870 plus 95920

Limitations on Coverage

To derive optimal benefits from this technology it is incumbent on the IOM team to understand the limits of the technology. We list them here.

1. Current Evidence for Benefit
IOM must be ordered and furnished by qualified personnel. The benefits of IOM are attainable under optimal recording and interpreting conditions. For instance, 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.

2. Effects of the Depth of Anesthesia and Muscle Relaxation
The level of anesthesia may also significantly impact on the ability to interpret intraoperative studies; therefore, continuous communication between the anesthesiologist and the monitoring physician is expected when medically indicated.

3. Recording Conditions
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.

4. Monitoring Necessity
Intraoperative monitoring 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 patient's medical need (Social Security Act (Title XVIII); Medicare Benefit Policy Manual).

5. Communications
Monitoring may be performed from a remote site, as long as a well-trained technologist (see detail above) is in continuous attendance in the operating room, with either the physical or electronic capacity for real-time communication with the supervising monitoring physician.

6. Supervision Requirements
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.

Code 95920 may be performed by a technician with on-line real-time contact with the physician. Otherwise, the supervising physician is nearby and immediately available. Codes 95961-95962 (Functional cortical localization with brain stimulation) require personal supervision. For the services 95920, or 95961-62, the physician supervision referred to by these regulations is the physician who provides, supervises, and codes for the intraoperative monitoring. The regulation is not satisfied by the presence of the operating surgeon or anesthesiologist (Medicare Benefit Policy Manual).

Use of 95920 and its Base Procedure Codes

1. IOM is a procedure that describes ongoing electrophysiologic testing and monitoring performed during surgical procedures. It includes only the time spent during an ongoing, concurrent, real time electrophysiologic monitoring.

2. Time spent in activities other than those above should not be billed under 95920. The time spent performing or interpreting the baseline electrophysiologic studies should not be counted as intra-operative monitoring, but represents separately reportable procedures.

> For example, 95920 is distinct from performance of specific types of pre-procedural baseline electrophysiologic studies (95860, 95861, 95867, 95868, 95900, 95904, 95933, 95934, 95936, 95937) or other interpretation of specific types of baseline electrophysiologic studies (95985, 95922, 95925, 95928, 95927, 95928, 95929, 95930).
>
> The supervising physician time spent in the operating room includes the time from entering until leaving the operating room, except for the time spent interpreting the baseline testing. For remote monitoring, it includes time from initiating to discontinuing monitoring except for the time spent interpreting the baseline testing.

3. Note that the supervision requirements for each underlying test vary, and must be met (Medicare Benefit Policy Manual).

Supervision requirements apply also for each of the primary test modalities. EEG, evoked potential or EMG carry their own supervision requirements.

5. Code 95920 should not be reported by the surgeon or anesthesiologist performing an operative procedure, since it is included in the global package if they serve as the IOM supervising physician. Code 95920 is bundled into most surgeries by National Correct Coding Initiative edits. The surgeon performing an operative procedure should not bill other 90000 series neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package (Medicare Benefit Policy Manual). However, when IOM or baseline procedures are performed by a different, monitoring physician during the procedure, it is separately reportable by the monitoring supervising physician.

6. Code 95920 is performed in the hospital setting. Monitoring of a patient with code 95920 should use Hospital site of service (site 21), or Hospital Outpatient surgery center (site 22), even if the monitoring physician is located in an office. When supervising and interpreting IOM on a hospitalized patient, the supervising physician codes using modifier -26.

7. Claims for physician services for code 95920 must be submitted for no more than three

patients simultaneously. The relative value units for this code were set assuming a specified

number of simultaneous cases.

CPT/HCPCS Codes

95920 Intraoperative neurophysiology testing, per hour (List separately in addition to base code for primary procedure)

Codes for Primary procedures used as base codes for 95920

92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
95822 Electroencephalogram (EEG); recording in coma or sleep only
95860 Needle electromyography; one extremity with or without related paraspinal areas
95861 Needle electromyography; two extremities with or without related paraspinal areas
95867 Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868 Needle electromyography; cranial nerve supplied muscles, bilateral
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
95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
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
95933 Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95934 H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936 H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle
95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

Use of Other Procedures Codes for IOM or Testing

<u>Implanted Device Neurophysiology Codes</u>
Codes for use with implanted devices (95961, 96962, 95970-95979)
Two series of codes are used to locate the proper sites for deep brain or spinal cord implanted devices and to test the device's integrity.

Codes 96961 (first hour) and 96962 (additional hours) are used for intraoperative testing of electrode placement. Code 95970 is used to check a device's integrity. Rarely, the devices are

also programmed while in the operating room, and when done those services are coded using 95971 through 95979. These codes are:

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

95973 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

95974 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

95975 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

95978 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

95979 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Functional Cortical Mapping Codes

95829 Electrocorticogram at surgery (separate procedure)

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

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 (List separately in addition to code for primary procedure)

Three codes are used in the operating room to locate abnormal regions or regions that serve key brain functions. This includes the electrocorticography (ECoG) code 95829, which is used the record EEG directly from the exposed brain. This is used to find areas of cortex that are damaged or that may be the source of epileptic seizures. This also includes the functional cortical stimulation codes 95961 (first hour) and 95962 (additional hours). Most often those codes are used when the brain is stimulated electrically and the results are monitored behaviorally in a patient who is awake during neurosurgery. These guide the surgeon as to which portions of the exposed brain could or should be removed or which should be preserved.

Appendix A – Diagnoses that Support Medical Necessity

170.2 Malignant neoplasm of vertebral column excluding sacrum and coccyx
192.0 Malignant neoplasm of cranial nerves
192.1 Malignant neoplasm of cerebral meninges
192.2 Malignant neoplasm of Spinal cord
192.3 Malignant neoplasm of Spinal meninges
192.8 Malignant neoplasm of other specified sites of nervous system
192.9 Malignant neoplasm of nervous system part unspecified
198.3 Secondary malignant neoplasm of brain and Spinal cord
198.4 Secondary malignant neoplasm of other parts of nervous system
225.0 Benign neoplasm of brain
225.1 Benign neoplasm of cranial nerves
225.2 Benign neoplasm of cerebral meninges
225.3 Benign neoplasm of Spinal cord
225.4 Benign neoplasm of Spinal meninges
225.8 Benign neoplasm of other specified sites of nervous system
225.9 Benign neoplasm of nervous system part unspecified
237.0 Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1 Neoplasm of uncertain behavior of pineal gland
237.5 Neoplasm of uncertain behavior of brain and Spinal cord
237.6 Neoplasm of uncertain behavior of meninges
237.70 Neurofibromatosis unspecified
237.71 Neurofibromatosis type 1 von recklinghausen's disease
237.72 Neurofibromatosis type 2 acoustic neurofibromatosis
237.9 Neoplasm of uncertain behavior of other and unspecified parts of nervous system
239.6 Neoplasm of unspecified nature of brain
324.1 Intraspinal abscess
343.8 Other specified infantile cerebral palsy
343.9 Infantile cerebral palsy unspecified
348.4 Compression of brain
350.1 Trigeminal neuralgia
350.2 Atypical face pain
352.9 Unspecified disorder of cranial nerves
353.0 Brachial plexus lesions
353.1 Lumbosacral plexus lesions
353.2 Cervical root lesions not elsewhere classified
353.3 Thoracic root lesions not elsewhere classified

353.4 Lumbosacral root lesions not elsewhere classified
385.3 Cholesteatoma of middle ear and mastoid
430 Subarachnoid hemorrhage
431 Intracerebral hemorrhage
432.0 Nontraumatic extradural hemorrhage
432.1 Subdural hemorrhage
432.9 Unspecified intracranial hemorrhage
433.00 Occlusion and stenosis of basilar artery without cerebral infarction
433.01 Occlusion and stenosis of basilar artery with cerebral infarction
433.10 Occlusion and stenosis of carotid artery without cerebral infarction
433.11 Occlusion and stenosis of carotid artery with cerebral infarction
433.20 Occlusion and stenosis of vertebral artery without cerebral infarction
433.21 Occlusion and stenosis of vertebral artery with cerebral infarction
433.30 Occlusion and stenosis of multiple and bilateral precerebral arteries without cerebral infarction
433.31 Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
433.80 Occlusion and stenosis of other specified precerebral artery without cerebral infarction
433.81 Occlusion and stenosis of other specified precerebral artery with cerebral infarction
433.90 Occlusion and stenosis of unspecified precerebral artery without cerebral infarction
433.91 Occlusion and stenosis of unspecified precerebral artery with cerebral infarction
434.0 Cerebral thrombosis
434.01 Cerebral thrombosis with cerebral infarction
434.1 Cerebral embolism
434.11 Cerebral embolism with cerebral infarction
434.9 Cerebral artery occlusion, unspecified
434.91 Cerebral artery occlusion, unspecified with cerebral infarction
435.0 Basilar artery syndrome
435.1 Vertebral artery syndrome
435.2 Subclavian steal syndrome
435.3 Vertebrobasilar artery syndrome
435.6 Other specified transient cerebral ischemias
435.8 Other specified transient cerebral ischemias
435.9 Unspecified transient cerebral ischemia
437.3 Cerebral aneurysm nonruptured
437.5 Moyamoya disease
441.00 Dissection of aorta aneurysm unspecified site
441.01 Dissection of aorta thoracic
441.02 Dissection of aorta abdominal
441.03 Dissection of aorta thoracoabdominal

441.1 Thoracic aneurysm ruptured
441.2 Thoracic aneurysm without rupture
441.3 Abdominal aneurysm ruptured
441.4 Abdominal aneurysm without rupture
441.5 Aortic aneurysm of unspecified site ruptured
441.6 Thoracoabdominal aneurysm ruptured
441.7 Thoracoabdominal aneurysm without rupture
441.9 Aortic aneurysm of unspecified site without rupture
443.2 Other arterial Dissection
443.21 Dissection of carotid artery
443.24 Dissection of vertebral artery
443.29 Dissection of other artery
721.1 Cervical spondylosis with myelopathy
721.41 Spondylosis with myelopathy thoracic region
721.42 Spondylosis with myelopathy lumbar region
721.91 Spondylosis of unspecified site with myelopathy
722.70 Intervertebral disc disorder with myelopathy unspecified region
722.71 Intervertebral disc disorder with myelopathy cervical region
722.72 Intervertebral disc disorder with myelopathy thoracic region
722.73 Intervertebral disc disorder with myelopathy lumbar region
737.10 Kyphosis (acquired) (postural)
737.11 Kyphosis due to radiation
737.12 Kyphosis postlaminectomy
737.19 Other kyphosis acquired
737.20 Lordosis (acquired) (postural)
737.22 Other postsurgical lordosis
737.30 Scoliosis (and kyphoscoliosis) idiopathic
737.31 Resolving infantile idiopathic scoliosis
737.32 Progressive infantile idiopathic scoliosis
737.33 Scoliosis due to radiation
737.34 Thoracogenic scoliosis
737.39 Other kyphoscoliosis and scoliosis
737.40 Unspecified curvature of spine associated with other conditions
737.41 Kyphosis associated with other conditions
737.42 Lordosis associated with other conditions
737.43 Scoliosis associated with other conditions
737.8 Other curvatures of spine associated with other conditions
741.00 Spina bifida unspecified region with hydrocephalus

741.01 Spina bifida cervical region with hydrocephalus
741.02 Spina bifida dorsal (thoracic) region with hydrocephalus
741.03 Spina bifida lumbar region with hydrocephalus
741.90 Spina bifida unspecified region without hydrocephalus
741.91 Spina bifida cervical region without hydrocephalus
741.92 Spina bifida dorsal (thoracic) region without hydrocephalus
741.93 Spina bifida lumbar region without hydrocephalus
747.81 Anomalies of cerebrovascular system
747.82 Spinal vessel anomaly
767.4 Injury to spine and Spinal cord
767.5 Facial nerve injury
767.6 Injury to brachial plexus
767.7 Other cranial and peripheral nerve injuries
806.01 Closed fracture of c1-c4 level with complete lesion of cord
806.02 Closed fracture of c1-c4 level with anterior cord syndrome
806.03 Closed fracture of c1-c4 level with central cord syndrome
806.04 Closed fracture of c1-c4 level with other specified spinal cord injury
806.05 Closed fracture of c5-c7 level with unspecified spinal cord injury
806.06 Closed fracture of c5-c7 level with complete lesion of cord
806.07 Closed fracture of c5-c7 level with anterior cord syndrome
806.08 Closed fracture of c5-c7 level with central cord syndrome
806.09 Closed fracture of c5-c7 level with other specified spinal cord injury
806.10 Open fracture of c1-c4 level with unspecified spinal cord injury
806.11 Open fracture of c1-c4 level with complete lesion of cord
806.12 Open fracture of c1-c4 level with anterior cord syndrome
806.13 Open fracture of c1-c4 level with central cord syndrome
806.14 Open fracture of c1-c4 level with other specified spinal cord injury
806.15 Open fracture of c5-c7 level with unspecified spinal cord injury
806.16 Open fracture of c5-c7 level with complete lesion of cord
806.17 Open fracture of c5-c7 level with anterior cord syndrome
806.18 Open fracture of c5-c7 level with central cord syndrome
806.19 Open fracture of c5-c7 level with other specified spinal cord injury
806.20 Closed fracture of T1-T6 level with unspecified spinal cord injury
806.21 Closed fracture of T1-T6 level with complete lesion of cord
806.22 Closed fracture of T1-T6 level with anterior cord syndrome
806.23 Closed fracture of T1-T6 level with central cord syndrome
806.24 Closed fracture of T7-T12 level with other specified spinal cord injury
806.25 Closed fracture of T7-T12 level with unspecified spinal cord injury

806.26 Closed fracture of T7-T12 level with complete lesion of cord
806.27 Closed fracture of T7-T12 level with anterior cord syndrome
806.28 Closed fracture of T7-T12 level with central cord syndrome
806.29 Closed fracture of T7-T12 level with other specified spinal cord injury
806.30 Open fracture of T1-T6 level with unspecified spinal cord injury
806.31 Open fracture of T1-T6 level with complete lesion of cord
806.32 Open fracture of T1-T6 level with anterior cord syndrome
806.33 Open fracture of T1-T6 level with central cord syndrome
806.34 Open fracture of T7-T12 level with other specified spinal cord injury
806.35 Open fracture of T7-T12 level with unspecified spinal cord injury
806.36 Open fracture of T7-T12 level with complete lesion of cord
806.37 Open fracture of T7-T12 level with anterior cord syndrome
806.38 Open fracture of T7-T12 level with central cord syndrome
806.39 Open fracture of T7-T12 level with other specified spinal cord injury
806.4 Closed fracture of lumbar spine with spinal cord injury
806.5 Open fracture of lumbar spine with spinal cord injury
806.70 Open fracture of sacrum and coccyx with unspecified spinal cord injury
806.71 Open fracture of sacrum and coccyx with complete cauda equina lesion
806.72 Open fracture of sacrum and coccyx with other cauda equina injury
806.79 Open fracture of sacrum and coccyx with other spinal cord injury
806.8 Closed fracture of unspecified vertebra with spinal cord injury
806.9 Open fracture of unspecified vertebra with spinal cord injury
850.4 Concussion with prolonged less of consciousness without return to pre-existing conscious level
953.0 Cervical root
953.1 Dorsal root
953.2 Lumbar root
953.3 Sacral root
953.4 Brachial plexus
953.5 Lumbosacral plexus
953.8 Multiple sites
953.9 Unspecified site
955.0 Axillary nerve
955.1 Median nerve
955.2 Ulnar nerve
955.3 Radial nerve
955.4 Musculocutaneous nerve
955.5 Cutaneous sensory nerve, upper limb
955.6 Digital nerve

955.7 Other specified nerve(s) of shoulder girdle and upper limb

955.8 Multiple nerves of shoulder girdle and upper limb

955.9 Unspecified nerve of shoulder girdle and upper limb

956.0 Sciatic nerve

956.1 Femoral nerve

956.2 Posterior tibial nerve

956.3 Peroneal nerve

956.4 Cutaneous sensory nerve, lower limb

956.5 Other specified nerve(s) of pelvic girdle and lower limb

956.6 Multiple nerves of pelvic girdle and lower limb

956.8 Multiple nerves of pelvic girdle and lower limb

956.9 Unspecified nerve of pelvic girdle and lower limb

Applicable Social Security and Medicare Regulations

1. Social Security Act (Title XVIII) Standard References, Sections:

Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim. (Individual sections are available at http://www.cms.hhs.gov/)

2. Medicare Benefit Policy Manual – and Medicare National Coverage Determinations Manual

(1). Pub. 100-08 Medicare Program Integrity.
5.1 – *Reasonable and Necessary* Provisions in *LCD*s
http://www.cms.hhs.gov/transmittals/Downloads/R63PI.pdf

(2). CHAP 4.doc Version 13.3 NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/manual.zip

3. Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services, 80 80 - Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests.

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.

Of the three levels of supervision, General, Direct and Personal, the add-on code 95920 requires that this "Procedure may be performed by a technician with on-line real-time contact with physician." (Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services, 80 80 - Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests.,
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf
http://www.access.gpo.gov/nara/cfr

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Approved by the Board of Directors
April 23, 2008 (AANPA Policy 2008-09) [MGS:20080428]