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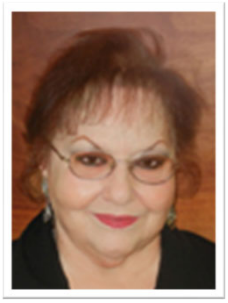

Maxine Collins, MBA,
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Billing for Intraoperative Neuromonitoring

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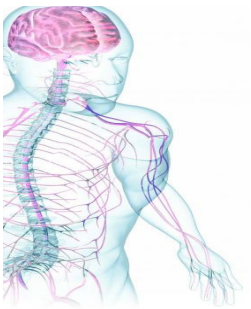

Billing for Intraoperative Neurophysiological Monitoring

Presented by
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INTRODUCTION: BRIEF HISTORY OF INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING (IONM)

- **The use of *electrophysiological methods* to**:
  - **Monitor functional integrity of neural structures during complex surgical procedures**
  - Reduce the risk of *iatrogenic* damage to the nervous system and
  - Provide important information to the Surgical team to identify and prevent complications to the nervous system, blood supply or other surrounding tissues during invasive procedures.

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BRIEF HISTORY (CONTINUED)

- IONM is now an integral part of specific complex surgeries all over the world and has provided a critical element of safety and quality for those patients having to undergo invasive procedures.
- CMS specifically states that some patients should not have the surgery without the IONM.
- The use of IONM dates back to the 1930's.
  - It is believed to have been first used "when direct cortical stimulation was performed to identify motor cortex of patients with epilepsy". ("Intraoperative Neurophysiologic Monitoring: Basic Principles and Recent Update"; (Source:Sung-Min Kim,1 Seung Hyun Kim,2 Dae-Won Seo,3 and Kwang-Woo Lee. corresponding author1; September 2013.)
- By the 1980's, however, the IOM equipment was further developed, resulting in the technique becoming widely used.
- In the 1990's, the industry saw transcranial motor evoked potentials used to monitor corticospinal tract activity in addition to effectively identifying and preventing post-operative adverse conditions/events.

Source: "History of IONM"; Share this post; https://specialtycareus.com/history-of-ionm/

Source: "**intraoperative neurophysiological monitoring**";**Richard P Knudsen MD CNP** ; **Bernard L Maria MD**, editor; *Originally released November 15, 1999; last updated July 2, 2019; expires July 2, 2022;* https://www.medlink.com/article/intraoperative_neurophysiological_monitoring

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REIMBURSEMENT PROBLEMS

- The technology, training and usage in complex surgical procedures has continually advanced over the last several years.
- Today, no one would want their loved one going through such complex surgery without the Intraoperative Neurophysiological Monitoring protection!
- It is a “no-brainer”.
- However, most insurance companies do not understand our operations (a large number of which is mobile) or the impact on quality of care and patient safety.
- To this day, we have several issues in obtaining equitable reimbursement for our service.

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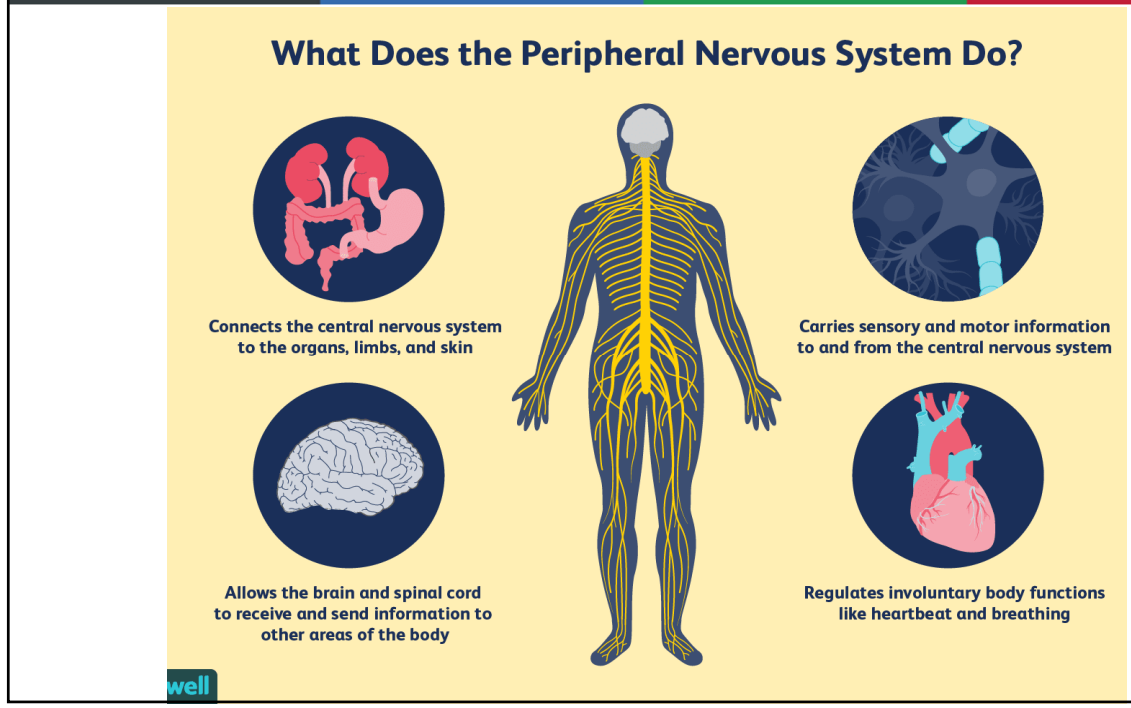

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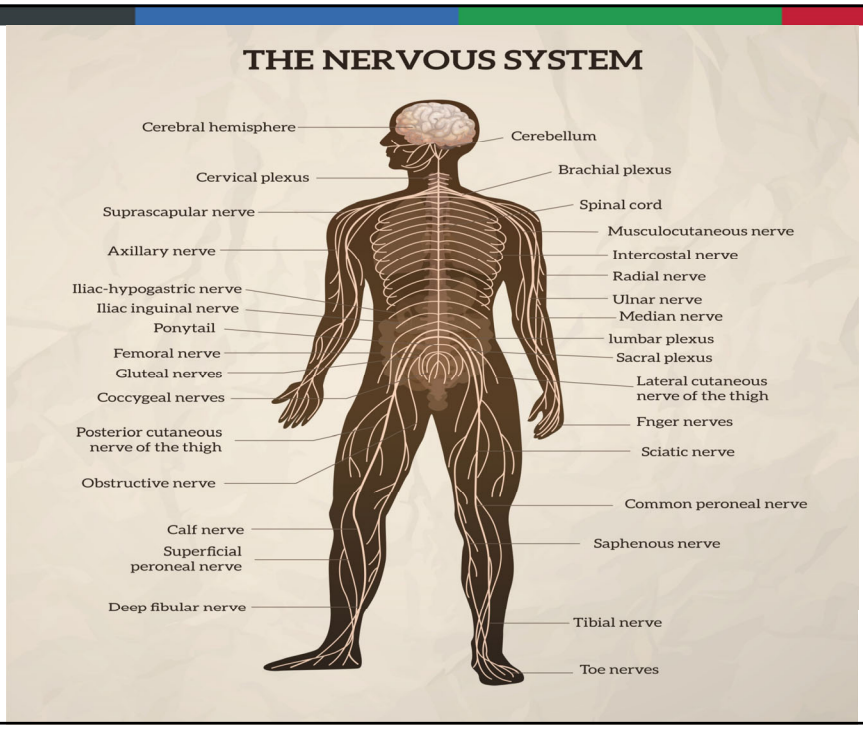

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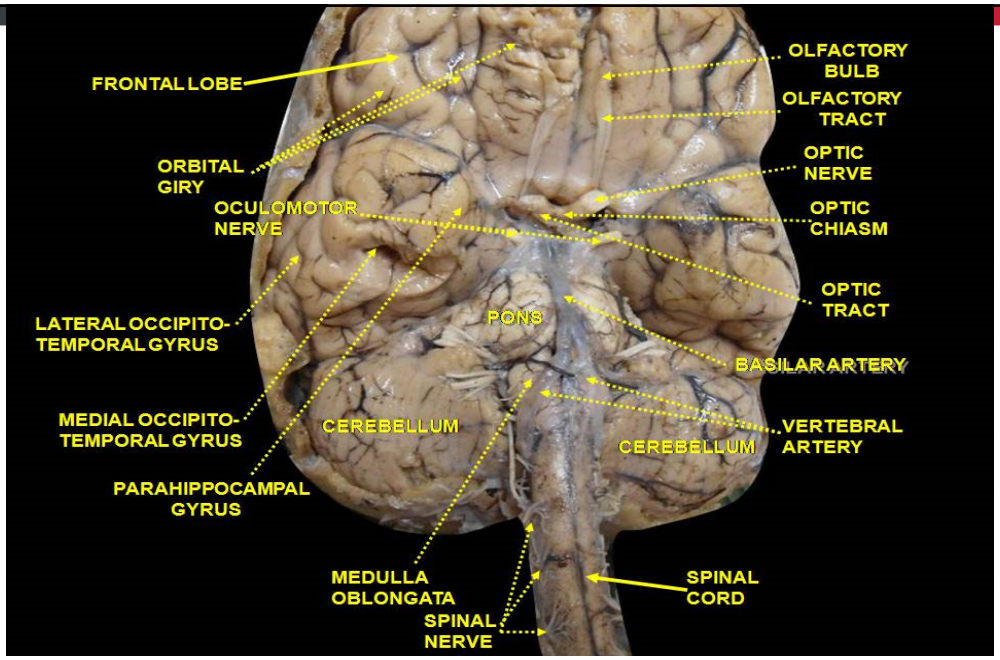

Häggström, M (2014). "Medical gallery of Mikael Häggström 2014". *WikiJournal of Medicine* 1 (2). doi:10.15347/wjm/2014.008. ISSN 2002-4436. Creative Commons CC0 1.0 Universal Public Domain Dedication. Used with permission.

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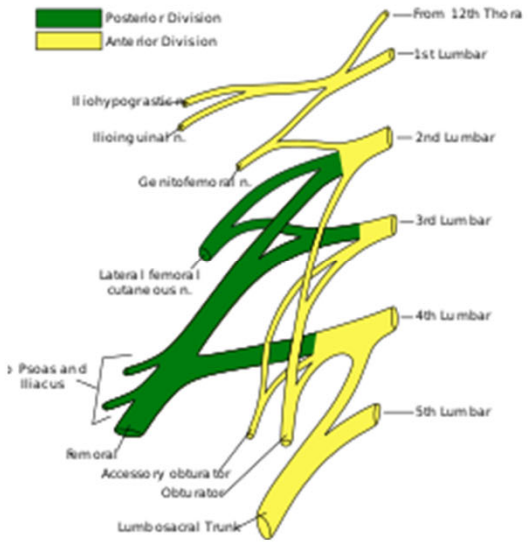

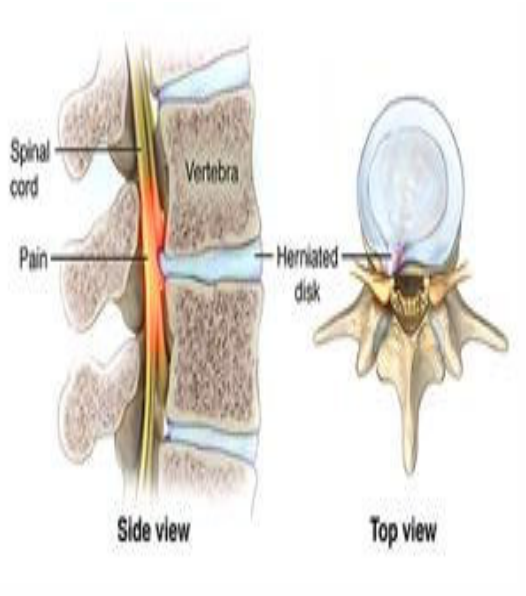

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CMS – FROM NOVITAS MAC's LOCAL COVERAGE DETERMINATION (LCD)

- According to CMS (Novitas MAC LCD) – "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."
- **"Some high-risk patients may be candidates for a surgical procedure only if MONITORING is available."**

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BACK IN THE DAY
CPT 95920 - PC/TC INDICATOR - 1

Diagnostic Tests for Radiology Services –

- Identifies codes that describe diagnostic tests.
- Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy.
- **These codes have both a professional and technical component.**
- **Modifiers 26 and TC can be used with these codes.**
- The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.
- The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only.
- The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.

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EVOLUTION OF IONM CPT CODE(S)

- **95920- WARNING: Code Deleted 2013-01-01**
- **Code deleted, see 95940, 95941**
- 95920 - Intraoperative neurophysiology testing, **per hour** (List separately in addition to code for primary procedure)
- AMA Guidelines: (95920 has been deleted. To report, see 95940, 95941)
- **PC/TC indicator (26, TC) = 1 - Diagnostic Tests for Radiology Services**

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ASNM NOTICE TO MEMBERS

- **"By way of background, 2013 AMA CPT codes were announced on September 17, 2012 for implementation effective January 1, 2013."**
- "The familiar 95920 code utilized in intraoperative monitoring is being deleted and **replaced with 2 codes based upon location of service."**
- **"AMA CPT replacement codes are 95940 and 95941."**
- "Code 95940 would be utilized by **one supervising professional in the operating room** monitoring one patient continuously."
- "Code 95941 would be utilized **for offsite (remote or nearby) monitoring of more patients simultaneously."**

  – Source: The American Society of Neurophysiological Monitoring; https://cdn.ymaws.com/www.asnm.org/resource/resmgr/docs/asnm_cms_code_alert.pdf

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THE NEXT SERIOUS BLOW - ASNM TO MEMBERS – CONTINUED

- "CMS made a determination that the AMA-CPT code recommendations for code 95941 were not acceptable for Medicare patients."
- "In the November 1 issue of the Federal Register CMS put forth code **G0453, which will replace 95941 and will become effective January 1, 2013 (95940 remains intact** "For monitoring Medicare patients outside the operating room (nearby or remote), code G0453 would require continuous monitoring of **one patient-attention devoted exclusively to one patient.")." (Created a problem)**
- **"Unlike 95920 (the deleted code) G0453 is billed in 15 minute units; however, only one Medicare beneficiary can be billed for that 15 minute increment."**
- "The AMA-CPT code 95941 would have allowed multiple Medicare beneficiaries to be billed for the same 15 minute increment."

Source: The American Society of Neurophysiological Monitoring; https://cdn.ymaws.com/www.asnm.org/resource/resmgr/docs/asnm_cms_code_alert.pdf

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QUICK LOOK AT MOST COMMON CODES - CPT MANUAL
WE ARE PAID UNDER THE PHYSICIAN FEE SCHEDULE

- **+ 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)
- AMA Guidelines:
  - (Use 95940 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939)
  - Code is out of numerical sequence. See 95921-95943
  - Medicare allowable – Non-facility - $ 32.81; Facility - $ 32.81
  - PC/TC indicator (26, TC) = 0 - Physician Service Code

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CONTINUOUS INTRAOPERATIVE NEUROPHSIOLOGY MONITORING

- **+95941** - Continuous intraoperative neurophysiology monitoring, **from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room**, **per hour** (List separately in addition to code for primary procedure)

- **AMA Guidelines:**
  - (Use 95941 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939)
  - (For time spent waiting on standby before monitoring, use 99360)
  - (For electrocorticography, use 95829)
  - (For intraoperative EEG during nonintracranial surgery, use 95955)
  - (For intraoperative functional cortical or subcortical mapping, see 95961-95962)
  - (For intraoperative neurostimulator programming, see 95971, 95972, 95976, 95977, 95983, 95984)
- Medicare allowable: Non-Facility - $ 0.00; Facility - $ 0.00.

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+ 95941 – TC/PC INDICATOR = 0

Physician Service Codes –

- Identifies codes that describe physician services.
- Examples include visits, consultations, and surgical procedures.
- The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes.
- The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

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IONM PROCEDURE CODES

- **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)
- Medicare allowable: Non-facility - $ 32.81; Facility - $ 32.81.

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ELECTROPHYSIOLOGICAL METHODS

- **Electroencephalogram (EEG)** –
  - A test that indicates abnormalities in the electrical activity of the brain (brain waves).
  - Uses small metal electrodes with thin wires attached to scalp.
  - An abnormal EEG shows a problem in brain activity and can be used to assess and monitoring neurological conditions or abnormalities during the procedure to prevent post-operative deficits.

  - **95822** - Electroencephalogram (EEG); recording in coma or sleep only
  - AMA Guidelines:
    - (Do not report 95822 in conjunction with 95700-95726)
    - Medicare allowable: Non-Facility - $ 380.16; Facility - $ 380.16
    - For both N-F and F - (26 -$ 57.99; TC - $322.17)

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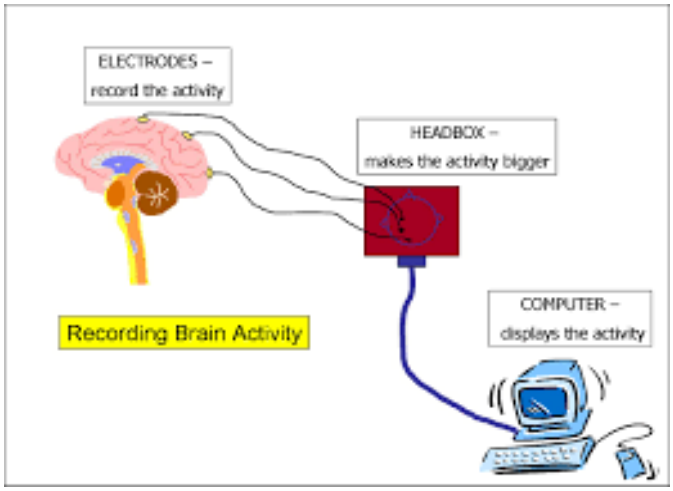
EEG – CPT 95822



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Medicare Physician Fee Schedule (MPFS) Indicators

Apc status indicator	APC S Significant Procedure, Not Discounted when Multiple
status code	A - Active Code
global days	XXX - Global Concept Does Not Apply
pc/tc indicator (26, tc)	1 - Diagnostic Tests for Radiology Services
multiple procedures (51)	0 - No payment adjustment rules for multiple procedures apply.
bilateral surgery (50)	0 - 150% payment adjustment for bilateral procedures does NOT apply.
physician supervisions	09 - Concept does not apply.
Mod TC:	09 - Concept does not apply.
Mod 26:	09 - Concept does not apply.
assistant surgeon (80, 82)	0 - Payment restriction for assistants at surgery applies to this procedure...
co-surgeons (62)	0 - Co-surgeons not permitted for this procedure.
team surgery (66)	0 - Team surgeons not permitted for this procedure.
type of service (tos):	5 - Diagnostic Laboratory
berenson-eggers tos (betos)	T2D - Other tests - other
diagnostic imaging family	99 - Concept Does Not Apply
clia waived (qw)	
non-facility mues	1
facility mues	1
CCS Clinical Classification:	199 - Electroencephalogram (EEG)

SOURCE: FIND-A-CODE; https://www.findacode.com/code.php?set=CPT&c=95822

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95822 - Electroencephalogram (EEG); recording in coma or sleep only - **PC/TC INDICATOR - 1**

"Diagnostic Tests for Radiology Services –

- Identifies codes that describe diagnostic tests.
- Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy.
- **These codes have both a professional and technical component.**
- **Modifiers 26 and TC can be used with these codes.**
- **PC/TC indicator (26, TC) - 1 - Diagnostic Tests for Radiology Services**
- **Physician Supervisions 09 - Concept does not apply.**
  - **Mod TC: 09 - Concept does not apply.**
  - **Mod 26: 09 - Concept does not apply.**

SOURCE: FIND-A-CODE; https://www.findacode.com/code.php?set=CPT&c=95822

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NOW HOW DID AMBULATORY GET THE TECHNOLOGIST RECOGNIZED?

- Code Added 2020-01-01
- **95707** - Electroencephalogram (EEG), without video, review of data, **technical description by EEG technologist, 2-12 hours;** with continuous, real-time monitoring and maintenance
- **"Definitions":**
  - ***"EEG technologist:*** An individual who is qualified by education, training, licensure/certification/regulation (when applicable) in seizure recognition. An EEG technologist(s) performs EEG setup, take down when performed, patient education, technical description, maintenance, and seizure recognition when within his or her scope of practice and as allowed by law, regulation, and facility policy (when applicable)."
  - ***Setup:*** Performed in person by the EEG technologist(s) and includes preparing supplies and equipment and securing electrodes using the 10/20 system. Code 95700 is reported only once per recording period on the date the setup was performed. "In person" means that the EEG technologist(s) must be physically present with the patient.

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CPT 95700 - INTERESTING

- 95700 - Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels.
- AMA Guidelines:
  - (95700 should be reported once per recording period)
  - (For EEG using patient-placed electrode sets, use 95999)
  - (For setup performed by non-EEG technologist or remotely supervised by an EEG technologist, use 95999)

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Setup

- Performed in person by the EEG technologist(s) and includes preparing supplies and equipment and securing electrodes using the 10/20 system.
- Code 95700 is reported only once per recording period on the date the setup was performed.
- "In person" means that the EEG technologist(s) must be physically present with the patient.

Source: Find-A-Code https://www.findacode.com/code.php?set=CPT&c=95726 and the CPT Manual

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MORE DETAILS OF NEW CODES FOR EEGs

- The set of codes that describe long-term continuous recording EEG services (95700-95726) is divided into two major groups:
  (1) **technical services, and**
  (2) **professional services.**
- Codes 95700-95726 may be reported for any site of service.
- The technical component of the services is reported with 95700-95716.
- The professional component of the services is reported with 95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726.
- Diagnostic EEG recording time of less than 2 hours (ie, 1 minute, up to 1 hour and 59 minutes) is not reported separately as a long-term EEG service.

Source: Find-A-Code https://www.findacode.com/code.php?set=CPT&c=95726 and the CPT Manual.

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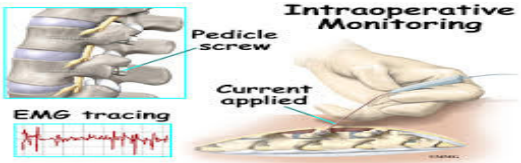
ELECTROMYOGRAPHY



- **EMG** – Testing to study nerve and muscle function.
  - **Free-run** monitoring of EMG activity during surgery – continuous monitoring throughout procedure
  - **Stimulus-triggered** EMG from anatomically appropriate muscles – commonly used during placement of pedicle screws during spinal surgery to assess whether a screw has breached pedicle wall and poses a risk of nerve damage.
  - To detect nerve injury/damage
  - **Per Cigna:** "Although both techniques can be used to monitor lumbar, thoracic and cervical fusion procedures, in addition to cranial nerve function to detect nerve root injury, stimulus- triggered EMG does not meet the criteria of concurrent, ongoing intraoperative neurophysiologic monitoring and when performed by the surgeon is incidental to the surgical procedure."

Source:
https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0509_coveragepositioncriteria_intraoperativemonitoring.pdf

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EMG TESTING

- **95860 -** Needle electromyography; 1 extremity with or without related paraspinal areas
- PC/TC indicator (26, TC) -1 - Diagnostic Tests for Radiology Services
- Physician Supervisions 09 - Concept does not apply.
  - Mod TC: 6A - Supervision standards for level 66 apply; in addition...
  - Mod 26: 09 - Concept does not apply.
  - Medicare allowable: Non-Facility - $ 117.48; Facility - $ 117.48
  - For both NF & Fac. - 26 - $ 52.30; TC - $ 65.19)

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CPT CODE	DESCRIPTION	MEDICARE ALLOW. NF & FAC	26	TC
95861	NDL EMG 2 XTR W/WO REL. PARASPINAL AREAS	$ 166.65	$ 82.86	$ 85.59
95863	NDL EMG 3 XTR W/WO REL. PARASPINAL AREAS	$ 208.49	$ 100.24	$ 108.25
95864	NDL EMG 4 XTR W/WO REL. PAPASPINAL AREAS	$ 244.51	$ 106.87	$ 137.64
95865	NDL EMG LARYNX	$ 150.50	$ 84.29	$ 66.21
95866	NDL EMG HEMIDIAPHRAGM	$ 132.73	$ 67.20	$ 65.53
95867	NDL EMG CRANIAL NRV/MUSCLE UNI	$ 105.19	$ 42.74	$ 62.40
95868	NDL EMG CRANIAL NRV/MUSCLE BI	$ 138.41	$ 63.31	$ 75.10
95869	NDL EMG PARASPIMAL MUSC EXCLUDING T1/T12	$ 93.04	$ 20.00	$ 73.05
95870	NDL EMG LMTD STD MUSC 1 XTR/NON-LIMB UNI/BI	$ 87.92	$ 20.00	$ 67.92
95872	NDL EMG W/1 FIBER ELECTRODE QUAN MES. JITTER	$ 197.65	$ 152.97	$ 44.68
95885	NLD EMB EA XTR W/PARASPINAL AREA LIMITED	$ 61.07	$ 18.69	$ 42.38
95886	NDL EMG EA XTR W/PARASPINAL AREA COMPLETE	$ 95.36	$ 46.14	$ 49.21
95887	NDL EMG NONXTR MUSCLES W/NERVE CONDUCTION	$ 83.10	$ 37.99	$ 45.11

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EMG MONITORING AND NERVE CONDUCTION STUDIES (NCVs)

- Performed in the OR to:
  - Monitor procedures involving nerve roots and peripheral nerves
  - Monitor status of cranial and peripheral nerves
  - To verify the neural pathway is intact.

- Nerve conduction studies

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≥ STUDIES

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CPT 95907 - Nerve conduction studies; 1-2 studies

- **Performed to:**
  - Evaluate, Record and Diagnose nerve disorders and damage.

How?

- Electrodes (flat metal disk-like) are attached to the skin with paste or tape.
- Shock-emitting electrode is placed over the nerve to be studied and another recording electrode is placed over the innervated muscle.
- Electrical pulses are then sent through the shock-emitting electrode.
- The conduction time (time that it takes for for the muscle to contract in response to the shock), is recorded.
- The amplitude or strength of the response as well as the speed (latency or velocity) of the response is also recorded.
- The physician reviews the recordings and provides a written report of findings.

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According to CPT®

- Use 95907 for 1-2 nerve conduction studies;
- 95908 for 3-4 nerve conduction studies;
- 95909 for 5-6 studies;
- 95910 for 7-8 studies;
- 95911 for 9-10 studies;
- 95912 for 11-12 studies; and
- 95913 for 13 studies or more.
- "For purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H reflex test. "
- "Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use."

Source: CPT Manual, Professional Edition, 2019

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NERVE CONDUCTION STUDIES

CPT CODE	MEDICARE ALLOW NON-FAC & FACILITY	PC 26	TC
95907	$ 93.98	$ 54.08	$ 39.89
95908	$ 119.40	$ 67.55	$ 51.86
95909	$ 143.03	$ 80.92	$ 62.11
95910	$ 188.14	$ 108.26	$ 79.88
95911	$ 225.66	$ 134.16	$ 91.50
95912	$ 258.47	$ 159.88	$ 98.59
95913	$ 299.34	$ 189.82	$ 109.52

Source: WWW.CMS.GOV PHYSICIAN FEE SCHEDULE LOOK-UP

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NERVE CONDUCTION STUDIES

- **Electrodes** are placed:
  - On or under skin
  - Various locations along a nerve pathway
  - Electrodes connected to a computer that monitors and analyzes information
  - Nerve is stimulated by electrical impulse briefly with a low amount of electrical current
  - After stimulation, nerve is assessed as electrodes record the time taken for the impulse to travel between the nerve pathways (speed calculated). (**Nerve conduction** velocity (NCV)
  - **Baseline information** gathered prior to surgery provides the basis **for comparison to data monitored during procedure**
  - If signal becomes slower or weaker, this indicates a problem with the nerve – such as compression.
  - **The interpreting Physician and the trained technician can then alert the Surgeon so that corrective action is taken prior to causing possible permanent nerve damage.**

Source: https://www.chattneuro.com/spinal-treatment-options/intraoperative-nerve-monitoring/

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NERVE CONDUCTION STUDIES

PC/TC indicator (26, TC) - 1 - Diagnostic Tests for Radiology Services

- Physician supervisions 09 - Concept does not apply.
- Mod TC: 7A - Supervision standards for level 77 apply; in addition...
  - **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.
- **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.**
  - Mod 26: 09 - Concept does not apply.

Source: Find-A-Code; https://www.findacode.com/code.php?set=CPT&c=95913

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EVOKED POTENTIALS AND REFLEX TESTS - CPT MANUAL

- **95925** - Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; **in upper**
- AMA Guidelines:
  - (Do not report 95925 in conjunction with 95926)
- Somatosensory evoked potentials:
  - Electrical signals generated by afferent peripheral nerve fibers in response to sensory stimuli
  - SEPs are divided into three categories:
    - Short-latency,
    - Middle-latency, and
    - Long-latency.
  - "A somatosensory evoked potential test (SEP) studies the relay of body sensations to your brain and how the brain receives those sensations."
  - "A stimulating electrode is placed on your arm or leg, and it generates an electrical signal." "Recording electrodes are placed on your head and/or spine."
  - Somatosensory Evoked Potential test (SEP) | University of Iowahttps://uihc.org/health-topics/somatosensory-evoked-potential-test#:~:
  - "Responses from the electrodes are recorded. The time between the stimulation and the response is called **the latency**, which indicates the speed at which the nerves pass a signal." (https://www.uofmhealth.org/health-library/hw190600)
  - Used to evaluate differences in cortical activity associated with a spinal manipulation (SM) intervention

Source: AMA CPT Manual, Professional Edition, 2019

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OTHER METHODS OF MONITORING TO PROTECT THE PATIENT DURING SURGERY

- **Motor Evoked Potentials (MEPS):**
  - "Allows signals sent **from the brain** to specific muscle groups to be monitored".
- **Somatosensory Evoked Potentials**/Dermatome Evoked Potentials (SSEP/DEPS)
  - "Allows signals **sent to the brain from specific sensory areas** to be monitored"
- **Electromyography, (EMG):**
  - "Allows signals **within certain muscle groups** to be monitored during spine surgery."
  - "EMG monitors **nerves controlling muscle groups** on the part of the spine that controls the muscles.
  - For example:
    - "During neck, or cervical, surgery - nerves in the arm muscles are monitored."
    - "During mid-back, or thoracic, surgery - nerves in the abdominal muscles are monitored."
    - "During low back, or lumbar, surgery - nerves in leg muscles are monitored."

Source: https://www.chattneuro.com/spinal-treatment-options/intraoperative-nerve-monitoring/

37

SHORT-TERM LATENCY SOMATOSENSORY EP

- 95925 SHORT-LATENCY SOMATOSENS EP STD UPR LIMBS (MCR ALLOW-N-F & FAC - $ 35.57; (26- $ 28.10; TC - $ 107.47)
- 95926 SHORT-LATENCY SOMATOSENS EP STD LWR LIMBS (MCR ALLOW – N-F & FAC. - $ 129.17 (26 $ 27.51; TC $ 101.66)
- 95927 SHORT-LATENCY SOMATOSENS EP STD TRNK/HEAD (MCR ALLOW – N-F & FAC - $ 128.73 (26 $ 27.16; TC $ 101.57)
- 95938 SHORT-LATENCY SOMATOSENS EP STD UPR & LOW LIMB (MCR ALLOW – N-F & FAC – $ 220.27 (26 $ 80.24; TC $ 140.03)

38

SSEPs

- **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**
  - AMA Guidelines: (Do not report 95938 in conjunction with 95925, 95926) Code is out of numerical sequence. See 95925-95939
  - (MCR ALLOW. – N-F & FAC - $ 338.38 (26 $ 46.29; TC - $ 292.09)
- **95939** - **Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs**
- AMA Guidelines: (Do not report 95939 in conjunction with 95928, 95929) Code is out of numerical sequence. See 95925-95939
  - (MCR ALLOW. – N-F & FAC - $ 510.19 (26 $ 120.91; TC - $ 390.18)

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95938, 95939

- **PC/TC indicator (26, TC) - 1 - Diagnostic Tests for Radiology Services**
- **Physician Supervisions 09 - Concept does not apply.**
  - Mod TC: 21 - Procedure may be performed by a technician with certification under general supervision of a physician...
  - Mod 26: 09 - Concept does not apply.
  - Central Motor Evoked Potential (MEP):
  - Uses electrical **stimulation of the motor area of the cerebral cortex** with **recording from peripheral muscles in the extremities**
  - To evaluate **motor pathway function.**

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CPT Assistant Archives
Jump to highlighted terms • 95940
August 2017 page 8
Coding Correction: Reporting Codes 95940 and 95941

"In the FAQ section in the April 2014, *CPT Assistant* (page 11), the Medicine: Neurology and Neuromuscular Procedures Q&A incorrectly recommended appending modifier 26, *Professional Component,* to codes 95940 and 95941, as well as appending modifier TC for the technical component."

"However, the use of either modifier 26 or TC does not apply to code 95940 or 95941."

Source: https://www.findacode.com/newsletters/ama-cpt-assistant/index.php?i=14944&hl=95940

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95940, 95941 – CPT ASSISTANT

- "Recording and testing are performed either personally or by a technologist who is physically present with the patient during the service."
- " Supervision is performed either in the operating room (OR) or by real-time connection outside the OR."
- "The monitoring professional must be solely dedicated to performing the intraoperative neurophysiologic monitoring and must be available to intervene at all times during the service, as necessary, for the reported time period(s)."
- "For any given period of time spent providing these services, the service takes full attention and, therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period of time."

42

CPT ASSISTANT, AUGUST 2017

- "The procedures represented by codes 95940 and 95941 have remained classified as global "complete" services and have not been split into professional and technical component services by the Center of Medicare & Medicaid Services (CMS)."
- "A complete service, as defined by CMS, is one in which the physician provides the entire service, including equipment, supplies, technical personnel, and the physician's professional services."
- "Therefore, the complete service is divided into a technical and professional component."
- "For codes 95940 and 95941, the differentiation of the technical and professional component has not been applied by CMS because of the creation of codes 95940 to report the professional face-to-face services and 95941 to report the technician-assisted services."

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CPT ASSISTANT, AUGUST 2017

- "The guidelines for codes 95940 and 95941 indicate that code 95940 is only reported for "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 (*CPT Prof 2017,* page 650);" while code 95941 is reported "for all cases in which there was no physical presence by the monitoring professional in the operating room during the monitoring time or when monitoring more than one case in an operating room (*CPT Prof 2017,* page 650).""

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CPT ASSISTANT, AUGUST 2017

The following is the corrected Q&A.

- ***"Question:*** *It is my understanding that code 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), and code 95941, Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure), contain both a professional and technical portion of the services. Is it appropriate to append modifier 26 to codes 95940 and 95941? Is the technical portion of the testing part of the monitoring or part of the study it is associated with?"*

45

95940, 95941 CPT ASSISTANT

Answer:

- "No, it is not appropriate to append modifier 26, *Professional Component,* to codes 95940 and 95941."
- "In addition, it is also inappropriate to append modifier TC for the technical portion of the services."
- "Code 95940 describes the service of providing one-on-one patient monitoring by a professional in the operating room while
- Code 95941 describes the patient monitoring of more than one patient from a location outside the operating room."
- **" In either case, the cost of clinical staff, supplies and equipment are separately reported by the facility through a facility fee."**

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REALLY?

PAYMENT TO FACILITY?

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PCS FOR IONM – 00.94 – BACK IN ICD-9-PCS DAYS

ICD-9 PROCEDURAL CODING SYSTEM FOR INPATIENT CODING - 00.94 - Intra-operative neurophysiologic monitoring

- **Includes:**
  - Cranial nerve, peripheral nerve and spinal cord testing performed intra-operatively
    Intra-operative neurophysiologic testing
    IOM
    Nerve monitoring
    Neuromonitoring
    That by:
  - brainstem auditory evoked potentials [BAEP]
    electroencephalogram [EEG]
    electromyogram [EMG]
    motor evoked potentials [MEP]
    nerve conduction study
    somatosensory evoked potentials [SSEP]
    transcranial Doppler
- **Excludes:**
  - brain temperature monitoring (01.17)
    intracranial oxygen monitoring (01.16)
    intracranial pressure monitoring (01.10)
    plethysmogram (89.58)

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O.R. STATUS?

- ***O.R. Status:*** **This code (00.94) does NOT qualify as an Operating Room procedure.**
- **This code (00.94) is not found in any DRGs.**
- **CONVERTING ICD-9PCS TO Map 00.94 to ICD-10 PCS:**
  - **Peripheral Nervous 4A11 >**
    - 4A11 Peripheral Nervous >
    - 4A110 Open >
    - 4A1102 Conductivity >
    - 4A11029 Monitoring of Peripheral Nervous Conductivity, Sensory, Open Approach
    - **4A1034G - Monitoring of Central Nervous Electrical Activity, Intraoperative, Percutaneous Approach**

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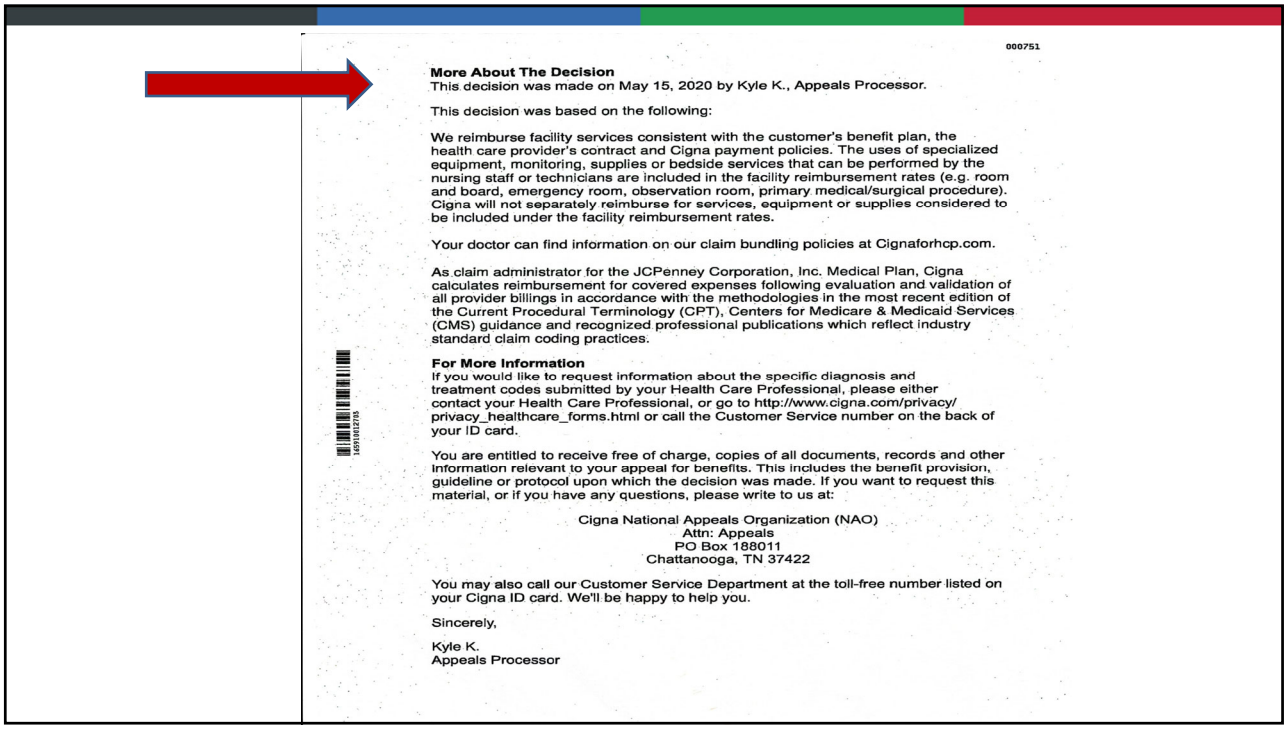
4A1134G – O.R. STATUS

- **O.R. Status: This code (4A1134G) does NOT qualify as an Operating Room procedure.**
- **This code (4A1134G) is not found in any DRGs.**

50



000751

More About The Decision
This decision was made on May 15, 2020 by Kyle K., Appeals Processor.

This decision was based on the following:

We reimburse facility services consistent with the customer's benefit plan, the health care provider's contract and Cigna payment policies. The uses of specialized equipment, monitoring, supplies or bedside services that can be performed by the nursing staff or technicians are included in the facility reimbursement rates (e.g. room and board, emergency room, observation room, primary medical/surgical procedure). Cigna will not separately reimburse for services, equipment or supplies considered to be included under the facility reimbursement rates.

Your doctor can find information on our claim bundling policies at Cignaforhcp.com.

As claim administrator for the JCPenney Corporation, Inc. Medical Plan, Cigna calculates reimbursement for covered expenses following evaluation and validation of all provider billings in accordance with the methodologies in the most recent edition of the Current Procedural Terminology (CPT), Centers for Medicare & Medicaid Services (CMS) guidance and recognized professional publications which reflect industry standard claim coding practices.

For More Information
If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to http://www.cigna.com/privacy/privacy_healthcare_forms.html or call the Customer Service number on the back of your ID card.

You are entitled to receive free of charge, copies of all documents, records and other information relevant to your appeal for benefits. This includes the benefit provision, guideline or protocol upon which the decision was made. If you want to request this material, or if you have any questions, please write to us at:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422

You may also call our Customer Service Department at the toll-free number listed on your Cigna ID card. We'll be happy to help you.

Sincerely,

Kyle K.
Appeals Processor

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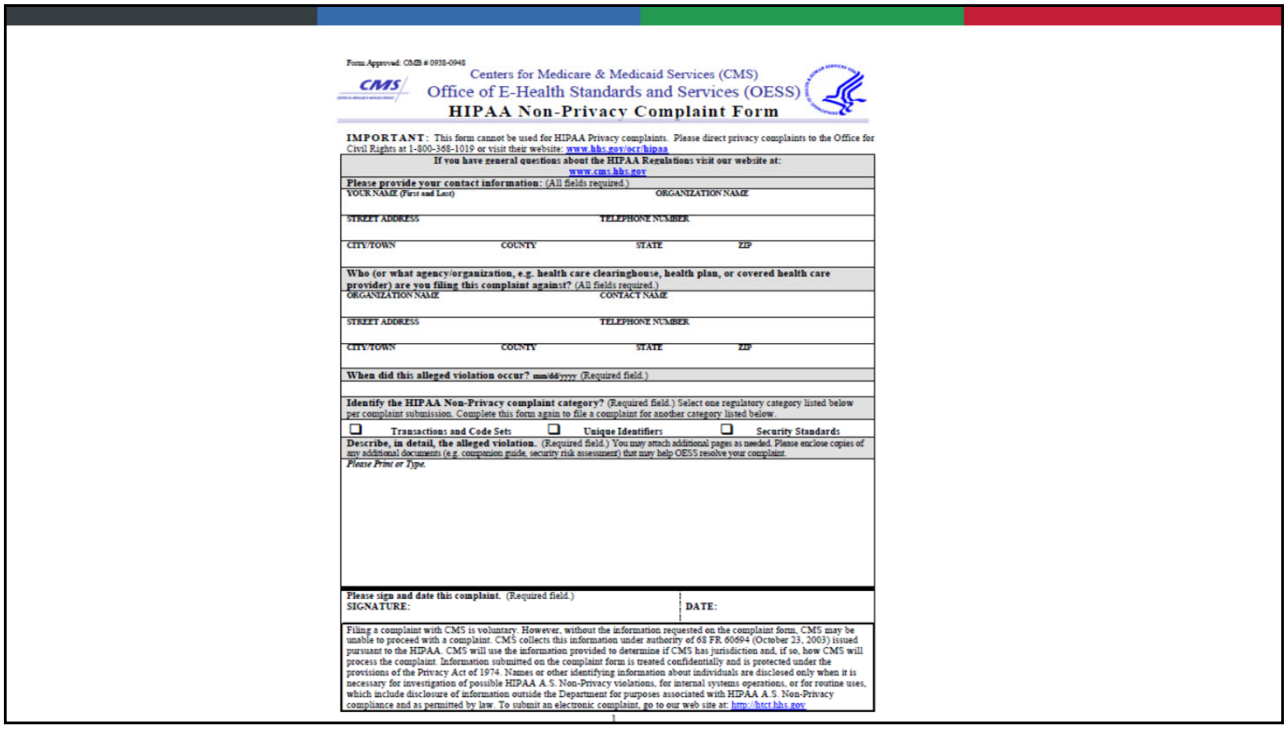

Form Approved: OMB # 0938-0948

Centers for Medicare & Medicaid Services (CMS)
Office of E-Health Standards and Services (OESS)
HIPAA Non-Privacy Complaint Form

IMPORTANT: This form cannot be used for HIPAA Privacy complaints. Please direct privacy complaints to the Office for Civil Rights at 1-800-368-1019 or visit their website: www.hhs.gov/ocr/hipaa.

If you have general questions about the HIPAA Regulations visit our website at: www.cms.hhs.gov

Please provide your contact information: (All fields required.)
YOUR NAME (First and Last) | ORGANIZATION NAME
STREET ADDRESS | TELEPHONE NUMBER
CITY/TOWN | COUNTY | STATE | ZIP

Who (or what agency/organization, e.g. health care clearinghouse, health plan, or covered health care provider) are you filing this complaint against? (All fields required.)
ORGANIZATION NAME | CONTACT NAME
STREET ADDRESS | TELEPHONE NUMBER
CITY/TOWN | COUNTY | STATE | ZIP

When did this alleged violation occur? mm/dd/yyyy (Required field.)

Identify the HIPAA Non-Privacy complaint category? (Required field.) Select one regulatory category listed below per complaint submission. Complete this form again to file a complaint for another category listed below.

☐ Transactions and Code Sets ☐ Unique Identifiers ☐ Security Standards

Describe, in detail, the alleged violation. (Required field.) You may attach additional pages as needed. Please enclose copies of any additional documents (e.g. companion guide, security risk assessment) that may help OESS resolve your complaint.
Please Print or Type.

Please sign and date this complaint. (Required field.)
SIGNATURE: | **DATE:**

Filing a complaint with CMS is voluntary. However, without the information requested on the complaint form, CMS may be unable to proceed with a complaint. CMS collects this information under authority of 68 FR 60694 (October 23, 2003) issued pursuant to the HIPAA. CMS will use the information provided to determine if CMS has jurisdiction and, if so, how CMS will process the complaint. Information submitted on the complaint form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed only when it is necessary for investigation of possible HIPAA A.S. Non-Privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with HIPAA A.S. Non-Privacy compliance and as permitted by law. To submit an electronic complaint, go to our web site at: http://htct.hhs.gov

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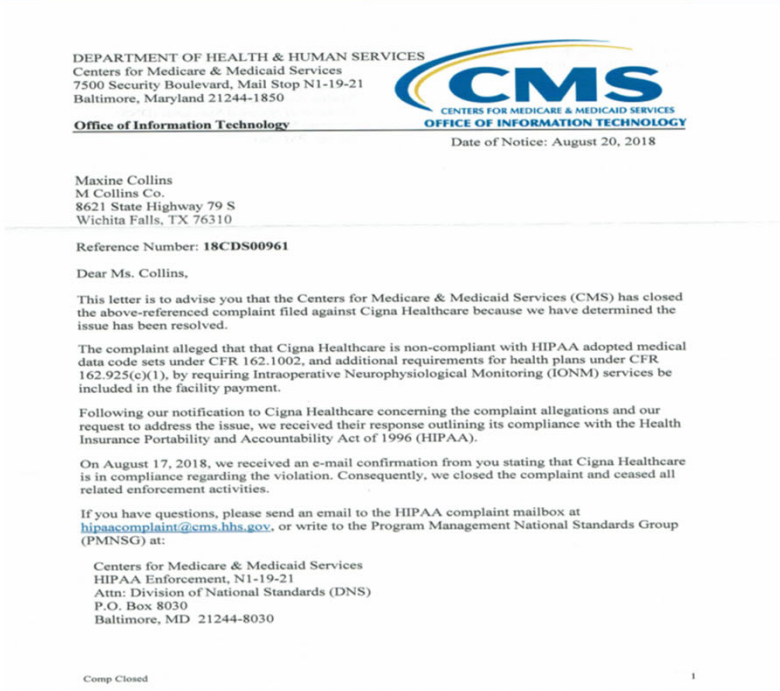
A VICTORY IN THIS DECISION!
NOTICE THIS IS FROM CMS!



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N1-19-21
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION TECHNOLOGY

Office of Information Technology

Date of Notice: August 20, 2018

Maxine Collins
M Collins Co.
8621 State Highway 79 S
Wichita Falls, TX 76310

Reference Number: **18CDS00961**

Dear Ms. Collins,

This letter is to advise you that the Centers for Medicare & Medicaid Services (CMS) has closed the above-referenced complaint filed against Cigna Healthcare because we have determined the issue has been resolved.

The complaint alleged that that Cigna Healthcare is non-compliant with HIPAA adopted medical data code sets under CFR 162.1002, and additional requirements for health plans under CFR 162.925(c)(1), by requiring Intraoperative Neurophysiological Monitoring (IONM) services be included in the facility payment.

Following our notification to Cigna Healthcare concerning the complaint allegations and our request to address the issue, we received their response outlining its compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

On August 17, 2018, we received an e-mail confirmation from you stating that Cigna Healthcare is in compliance regarding the violation. Consequently, we closed the complaint and ceased all related enforcement activities.

If you have questions, please send an email to the HIPAA complaint mailbox at hipaacomplaint@cms.hhs.gov, or write to the Program Management National Standards Group (PMNSG) at:

Centers for Medicare & Medicaid Services
HIPAA Enforcement, N1-19-21
Attn: Division of National Standards (DNS)
P.O. Box 8030
Baltimore, MD 21244-8030

Comp Closed

1

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WHEN DID PLACE OF SERVICE BECOME A MAJOR ISSUE?

MLN – APRIL 1, 2013

54

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM7631 | **Related Change Request (CR) #: 7631**

Related CR Release Date: March 29, 2013 | **Effective Date: April 1, 2013**

Related CR Transmittal #:R2679CP | **Implementation Date: April 1, 2013**

Revised and Clarified Place of Service (POS) Coding Instructions

Note: This article was revised on April 28, 2016, to add a link to a related article (SE1604) that summarizes the available substance abuse treatment services and provides reference links to other online Medicare information with further details about these services. All other information remains the same

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Provider Types Affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare Administrative Contractors (A/B MACs)) for services paid for under the Medicare Physician Fee Schedule (MPFS). Clarification on the place of service for pathology and laboratory services will be provided through another Change Request and subsequent provider education article.

What You Need to Know

This article is based on Change Request (CR) 7631. It revises and clarifies national policy for POS code assignment. Instructions are provided in CR7631 regarding the assignment of POS for all services paid under the MPFS and for certain services provided by independent laboratories. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation or Professional Component (PC) and the Technical Component (TC) of diagnostic tests. Please make sure your billing staff is aware of these changes.

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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MLN Matters® Number: MM7631 **Related Change Request Number: 7631**

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the paper CMS 1500 Claim Form (or its electronic equivalent). While CMS currently maintains the National POS code set, it is used by all other public and private health insurers, including Medicaid.

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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MLN MATTERS – ISSUE CENTERED ON PHYSICIAN-OWNED ASCs

The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from Calendar Year (CY) 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services. This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in Ambulatory Surgical Centers (ASCs). In a sample of paid services (for services possessing both non-facility and facility practice expenses), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the Medicare contractor at the non-facility rate -- rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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MLN MATTERS (TO "TRIGGER" FACILTY PAYMENT UNDER MPFS)

The OIG has called on CMS to strengthen the education process and reemphasize to physicians (including non-physician practitioners and other suppliers) and their billing agents the importance of correctly coding the POS. Consequently, CR7631 adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospitals and ASCs.

A previous CMS instruction, Transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering the service in this instance, the POS code corresponded to the service location. (CMS 1500 Claim Form Items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable "locality" and Geographic Practice Cost Index (GPCI)-adjusted payment for each service paid under the MPFS.

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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MLN MATTERS

CR7631 establishes that for all services – with two (2) exceptions -- paid under the MPFS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner will be the setting in which the beneficiary received the (Technical Component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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MLN MATTERS

Facility and Non-Facility Payment Assignments

The list of settings where a physician's services are paid at the facility rate include:

- Inpatient Hospital (POS code 21)
- Outpatient Hospital (POS code 22)
- Emergency Room-Hospital (POS code 23)

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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Special Considerations for Services Furnished to Registered Inpatients

When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, will, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

SOURCE: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

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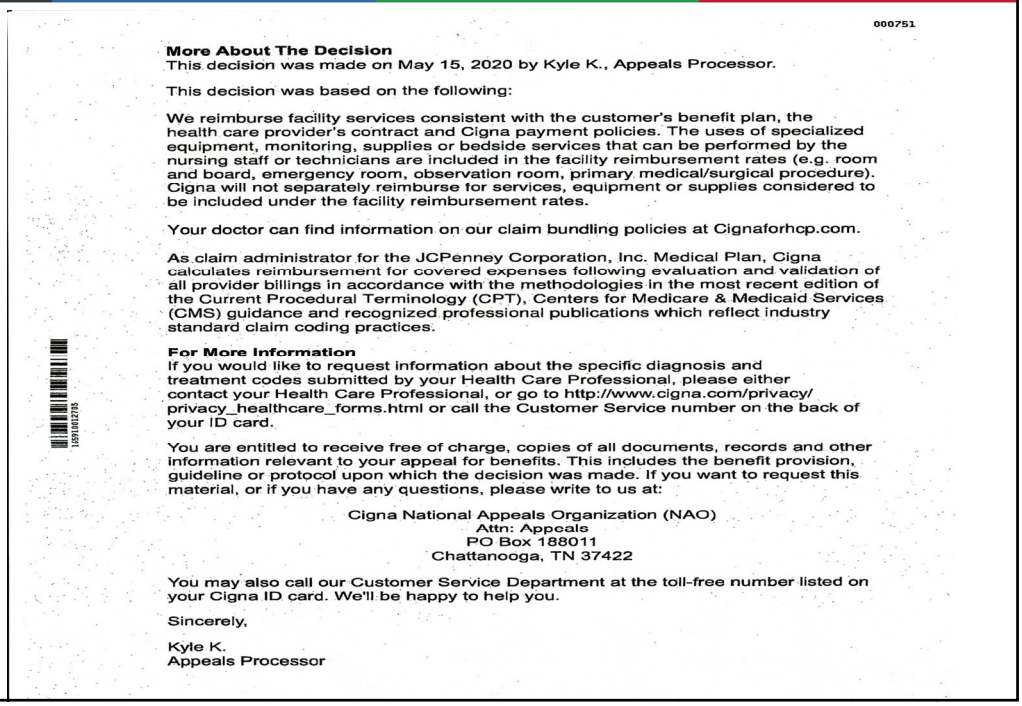
CIGNA

BACK TO OLD TRICKS – CURRENT CIGNA DENIAL



000751

More About The Decision
This decision was made on May 15, 2020 by Kyle K., Appeals Processor.

This decision was based on the following:

We reimburse facility services consistent with the customer's benefit plan, the health care provider's contract and Cigna payment policies. The uses of specialized equipment, monitoring, supplies or bedside services that can be performed by the nursing staff or technicians are included in the facility reimbursement rates (e.g. room and board, emergency room, observation room, primary medical/surgical procedure). Cigna will not separately reimburse for services, equipment or supplies considered to be included under the facility reimbursement rates.

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For More Information
If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to http://www.cigna.com/privacy/privacy_healthcare_forms.html or call the Customer Service number on the back of your ID card.

You are entitled to receive free of charge, copies of all documents, records and other information relevant to your appeal for benefits. This includes the benefit provision, guideline or protocol upon which the decision was made. If you want to request this material, or if you have any questions, please write to us at:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422

You may also call our Customer Service Department at the toll-free number listed on your Cigna ID card. We'll be happy to help you.

Sincerely,

Kyle K.
Appeals Processor

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OUT OF NETWORK ISSUES

PROVIDERS APPEALING CLAIMS

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OUT-OF-NETWORK

A REGULAR ASSIGNMENT OF BENEFITS IS NOT AN AUTHORIZATION FOR YOU TO REPRESENT THE PATIENT. THIS AUTHORIZATION MUST BE EXPLICIT STATEMENT WITH SPECIFIC WORDING!

- When insurers carriers do not accept assignment of benefits (AOB):
  - Check goes to patient
  - Some carriers have policies that all AOBs are rejected. Provider then has to collect from patient which could result in increasing debt collection policies - which could result in public relations problems
  - Therefore, some practice just “write-off” balances to bad debt – which could impact revenue
  - Health insurers state that it is simply a contract issue, insisting they cannot accept an AOB because of the lack of privity of contract with the provider; that privity only exists between the patient and their own members.

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UHC – OXFORD PLAN NOTICE

POLICY

Assignment of Benefits

Many plans do not allow Assignment of Benefits. However, if a member requests that Oxford make payment directly to a non-participating provider or facility Oxford may honor this assignment and issue reimbursement as requested by the member. Oxford reserves the right to reimburse the member directly even in instances where the member requested the non-participating provider be reimbursed. Refer to the Procedures and Responsibilities section below for additional information.

Balance Billing

Participating Providers

The instances in which a Participating Provider is authorized to balance bill an Oxford member are listed in the Procedures and Responsibilities section below. Providers are still required to follow Oxford's privileging, referral and/or precertification requirements.

Assignment of Benefits and Balance Billing
UnitedHealthcare Oxford Administrative Policy

Page 1 of 4
Effective 06/01/2020

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WHAT ABOUT "FAIR" PAYMENT?

AND NETWORK INADEQUACY?

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"Attorney General Cuomo Announces Historic Nationwide Reform Of Consumer Reimbursement System For Out-Of-Network Health Care Charges"

Post date: October 27, 2009

"SYRACUSE, N.Y. (October 27, 2009) - Attorney General Cuomo today announced historic nationwide reform of the consumer reimbursement system for out-of-network health care charges."

"A new not-for-profit company, FAIR Health, Inc., and an upstate research network headquartered at Syracuse University will develop a new independent database for consumer reimbursement and a new website where for the first time, consumers can compare prices before they choose their doctors."

Source: https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-reform-consumer

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NEW YORK CASE

- Andrew Cuomo, New York State Attorney General in 2008, conducted an investigation into what he believed to be "under-reimbursement of out-of-network claims" by most insurers.
  - Investigated "industry-wide" – "typical, customary and reasonable underpayments that were impacting consumers in New York state and nationwide.
  - Mr. Cuomo referred to the information that was gathered as: " (a) scheme by health insurers to defraud consumers by manipulating reimbursement rates by using a defective and manipulated database (Ingenix)."
  - He also stated that the insurers were using this flawed database with full knowledge that it artificially and intentionally well below "reasonable and customary" reimbursement rates.

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NEW YORK CASE (CONTINUED)

- Investigation found that by using the database which distorted "reasonable and necessary" the insurers were able to keep reimbursements artificially low and force patients to absorb a higher share of the costs.
- Mr. Cuomo stated, "getting insurance companies to keep their promises and cover medical costs can be hard enough as it is, but when insurers create convoluted and dishonest systems by determining the rate of reimbursement, real people get stuck with excessive bills and are less likely to seek the care the care they need".
- He published a document referred to as "Code Blue"

Source: http:www.swcribd.com/doc/16807960/Health-Care-Report-The-Consumer-Reimbursement=System-is-Code-Blue.

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Result?

- "Mr. Cuomo spearheaded multi-million-dollar settlements with most of the major insurance companies, with those funds to be applied to a replacement database to calculate out-of-network payments more consistently with the actual prevailing rates and reasonable and necessary standard."
  - "U.S. Senator John Rockefeller, chairman of the Senate Commerce, Science and Transportation Committee at that time solicited information for 18 different insurance companies that used the Ingenix database. (Ingenix is owned by United Healthcare)."

Source: http:www.swcribd.com/doc/16807960/Health-Care-Report-The-Consumer-Reimbursement=System-is-Code-Blue.

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AMERICAN MEDICAL ASSOCIATION

- In January 2009, the American Medical Association announced a settlement of its massive class-action federal lawsuit against UHC for $350 million.
- A non-profit organization called FAIR Health was established to work with leading academic researchers to create an enhanced database utilizing a fair and open methodology for collecting and analyzing healthcare provider charges. Website: www.fairhealthconsumer.org.
- Tools and data developed by FAIR should provide realistic and more competetive out-of-network reimbursement rates.
- Are the insurers using these?

Source: Archives: "How to Obtain Increased Reimbursement on Your Out-of-Network Claims", by Thomas J. Force, Esq, Created on Monday June,13, 2011)

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WHAT CAN PROVIDERS DO?

1. "Appeal **all** out-of-network claims!"
2. "Cite the precedents created by:
   - The former New York Attorney General's Investigation and settlements (the Code Blue Report);
   - Senator Rockefeller's investigation and report findings
   - The UHC AMA settlement, and
   - The various class actions that have emerged since the UHC AMA settlement"
3. "Realize if your Out-of-Network Claims are being under-reimbursed and if increased payment is warranted."
4. "Unique", he states, "to appeal claims with providers generally used to appealing only denials."
   - Mr. Forces states "practitioners should appeal all out-of-network paid medical claims, without exception. You will be surprised by the results." "My clients frequently receive 80 to 100% of charges after appeal."

Source: Updated on January 30, 2013 How to Obtain Increased Reimbursement on Your Out-of-Network Claims by Thomas J. Force, Esq.
Original story posted on June 13, 2011; https://www.racmonitor.com/how-to-obtain-increased-reimbursement-on-your-out-of-network-claims

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Texas fines Humana $700K for network inadequacy, underscoring complexities of surprise billing

by Evan Sweeney | Oct 15, 2018 8:44am

- "Texas regulators fined Humana $700,000 for network adequacy deficiencies, an unusual step that could signal state regulators are more willing to wade into concerns about surprise billing."
- "The fine came months after the Texas Department of Insurance (TDI) learned that Humana canceled network contracts with anesthesiologists in three of the most-populated counties in Texas."
- " That dispute meant customers couldn't get anesthesiology services at 20 hospitals and surgical centers in the state's three largest metro areas, according to TDI's announcement."

Source: https://www.fiercehealthcare.com/payer/texas-fines-humana-for-network-adequacy-violations-underscoring-complexities-surprise-billing

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HEALTH INSURANCE PAYER POLICIES

UHC

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UnitedHealthcare

Commercial Reimbursement Policy
CMS 1500
Policy Number 2020R5008C

Intraoperative Neuromonitoring Policy, Professional

Policy Overview:

- **This policy addresses the reimbursement of Intraoperative Neuromonitoring (IONM) services.**
- Reimbursement Guidelines Per the American Medical Association, Intraoperative Neuromonitoring (IONM) is the use of electrophysiological methods to monitor the functional integrity of certain neural structures during surgery.
- The purpose of IONM is to reduce the risk of damage to the patient's nervous system and to provide functional guidance to the surgeon and anesthesiologist.
- IONM codes are reported based upon the time spent monitoring only, and not the number of baseline tests performed or parameters monitored.
- In addition, time spent monitoring excludes time to set up, record, and interpret the baseline studies, and to remove electrodes at the end of the procedure.
- Time spent performing or interpreting the baseline neurophysiologic study(ies) should not be counted as intraoperative monitoring, as it represents separately reportable procedures.
- According to The 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.

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UnitedHealthcare

Commercial Reimbursement Policy
CMS 1500
Policy Number 2020R5008C

Intraoperative Neuromonitoring Policy, Professional

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

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Place of Service:

- The American Academy of Neurology states IONM services should be performed in Place of Service (POS) 19, 21, 22 or 24.
- Therefore, UnitedHealthcare will only reimburse 95940 and G0453 services when reported with POS 19, 21, 22 and 24.
- Reporting of Modifiers The use of either modifier 26 or TC does not apply to IONM codes 95940 or G0453.
- The IONM codes are add on codes therefore modifier overrides are not allowed.
- The technical component (modifier TC) of study codes reported with IONM services (95940 and G0453) in POS 24 on the same DOS will be denied.
- The technical component (modifier TC) of study codes reported with IONM services (95940 and G0453) in a non-facility POS on the same DOS will be denied.
- The professional component (modifier 26) of study codes reported with IONM services (95940 and G0453) in a nonfacility POS on the same DOS will be denied. Study codes without a TC or 26 modifier reported with IONM services (95940 and G0453) in any POS on the same DOS will be denied.

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UHC

Study Codes:

- 92585 95865 95907 95913 95930
- 95822 95866 95908 95925 95933
- 95860 95867 95909 95926 95937
- 95861 95868 95910 95927 95938
- 95863 95869 95911 95928 95939
- 95864 95870 95912 95929

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Questions and Answers

1. **Q: Will IONM services be reimbursed when reported with POS 15 (mobile unit)?**
   - **A:** No. Services furnished in a mobile unit are often provided to serve an entity for which another POS code exists. When this is the case, the POS for that entity should be reported. UnitedHealthcare will only allow reimbursement for IONM services when reported with POS 19, 21, 22 and 24.
2. **Q: Why isn't IONM code 95941 addressed in this policy?**
   - **A:** Consistent with CMS guidance, status "I" codes are not reimbursable. Code 95941 is considered invalid for reimbursement purposes. For more information please review other reimbursement policies, including but not limited to the Replacement Codes Policy.

Resources: American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services American Academy of Neurology Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

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CURRENT ISSUES IN REIMBURSEMENT

- The IONM industry struggles with the following:
  - Inconsistent guidelines
  - Getting paid for damages to nerve root below L-2.
  - ICD-10 Codes accepted and non-accepted
  - Including reimbursement in Facility DRGs
  - Out-of-network problems and network inadequacy
  - ERISA plan denials
  - Appeals
  - Fair and consistent reimbursement for all components provided in our services to cover cost. Do you know the cost of performing each procedure provided?
  - Should IONM be stated as an appropriate Standard of Medical Care?
  - Matching to the Surgeon's report (If surgeon does not get paid, high likelihood that IONM will not be paid.)
  - Current emphasis on in-network physicians referring to OON providers
  - Failed attempts to become "in-network providers" in many areas
  - Industry must stick together and support one another for achieving success in the areas!

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QUESTIONS?

- COMMENTS?
- THANK YOU!
- PLEASE STAY SAFE AND WELL.
- CONTACT INFORMATION
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  - maxinecollinsco@gmail.com

"A day without laughter is a day wasted."**– Charlie Chaplin**

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