Frequently Asked Questions
Intraoperative Neurophysiologic Monitoring

Concurrent Cases

Can I code with G0453 for one Medicare case, and at the same time code 95941 for another (private insurance) case?

A: No. Code G0453 can only be used with “attention focused exclusively to one patient.”

In the situation of simultaneously monitoring one or more Medicare cases, and one or more private insurance cases, how do you suggest I bill?

A: You may choose not to code G0453 in this circumstance. You may still code the Medicare patient for baseline testing. In this circumstance, code for baselines in all the cases, and then code 95941 only for the private carriers. This effectively means that Medicare cases will not be coded, apart from baselines, when more than one case is monitored.

The situation could become confusing if more carriers require the use of the G-code, while others refuse to accept any G-codes. Please please pay attention to your local carrier medical policy bulletins. It may be confusing even more than that because code 95941 was not given wRVUs in the Medicare Fee Schedule. As a result, physicians may have to negotiate separately with each insurance company for the wRVU value.

What happens if I bill G0453 anyway when I am monitoring more than one case?

A: You can monitor more than one case. You cannot code for more than one case while using the G-code. For example, you can monitor several cases of any kind, and submit one G-code per 15 minutes for one Medicare patient. In that case, you may not submit either a G-code for any other patient or a CPT code for any patient for those same 15-minute periods of time.

Can I monitor one patient using G0453 while I am seeing patients in clinic?

A: No. When using G0453, your attention must be focused exclusively on monitoring one patient. You may not use the G-code when you are providing another billable service.

Please clarify that 95940 and 95941 are often billed together, make clear that the number of cases monitored at any one time varies, demonstrate that physicians have choice in how to bill based on whether a case is passed off to another physician or not.

A: The codes 95940-95941 require that ‘when monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual’s exclusive attention be required for
another procedure’. If you are monitoring multiple cases and go to the operating room of a single case for that time in the operating room you can either carry the remaining cases with you on a wireless device and continue to use 95941 for all the cases or transfer the remaining cases to a second monitoring professional and use 95940 for the case you are exclusively monitoring while in the operating room.

It is unrealistic to have the sentence "no other cases can be monitored at the same time" for 95940. If you are the only supervising MD what happen to the other cases you are responsible for? Can you bill 95941 for those other cases?

A: To monitor two or more cases simultaneously, use code 95941 for each case. You cannot bill 95940 in a case unless you are in the patient’s operating room and provide one-on-one monitoring.

For code 95941, in the third paragraph of header instructions describes, "... there must be the immediate ability to transfer patient monitoring to another monitoring professional". If only one supervising physician is available should the services not be rendered since the clause cannot be met at the outset. Can you transfer the responsibility to the anesthesiologist or the surgeon even though neither has the knowledge, experience or training to interpret the data?

A: The codes 95940-41 require that ‘when monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual’s exclusive attention be required for another procedure’. If you are monitoring multiple cases and go to the operating room of a single case for that time in the operating room you can either bring the remaining cases with you on an internet device and continue to use 95941 for all the cases, or transfer the remaining cases to a second monitoring professional and use 95940 for the case you are exclusively monitoring for the time while in the operating room. Transfer of monitoring should be to a physician who is competent to perform the service.

If two physicians are involved with a case and both have one-on-one as well as remote time during the case. Do you both bill 95940, 95941 for your respective times or do you bill under one physician only?

A: When two physicians share a service, aggregate their times and code under one physician’s name. Then make separate arrangements within the practice to reconcile the RVUs and income at a practice level. For example, Dr. Jones covers the case until noon and Dr. Smith covers after noon. Sum the time taken and submit the coding over one physician’s name.

How does one code if one is physically present in one OR room and monitoring another room next door (or in the same OR area) remotely?

A: Use 95941 for both rooms.

What happens if he or she is monitoring two OR rooms, then needs to leave the first OR room and go into a second?

A: Continue to use 95941 for both rooms.

Would it matter if the other case were at a different hospital?
A: The location does not matter.

Could one be physically present in one OR and be monitoring multiple other cases remotely?

A: Yes, use 95941 for each case.

Is there a limit on the number of cases that may be billed simultaneously?

A: There is a one-case limit for G0453 and 95940, but no limit is specified for 95941. Carriers may specify limits, so providers should check individual carrier policies.

Associated Monitoring Activities

How do I code for the evaluation of tests, planning of monitoring strategy, and other associated monitoring activities that may begin prior to incision?

A: Time spent monitoring (95940, 95941, G0453) excludes time to set up, record, and interpret the baseline studies, and to remove electrodes at the end of the procedure. Monitoring may begin prior to incision (e.g., when positioning on the table is a time of risk).

The term "ongoing neurophysiological monitoring" is misleading. Does that imply only the time after baselines are obtained count (excluding the time to interpret baselines)? There are a great deal of important things related to monitoring that happen before and after the actual waveforms. Should those times not be counted?

A: Time before incision counts as monitoring time when monitoring was needed and performed. These monitoring and base codes already include additional pre-service and post-service time to account for other time taken such as time to review charts or prepare reports. While you don’t count that time as monitoring time, the relative value unit system automatically compensates for those services.

What is the definition of the “other clinical activity” that is not allowed while monitoring?

A: Seeing patients in the clinic or hospital (E/M services) are typical examples of “other clinical activity”.

Please clarify when the billing time starts at the beginning of the case.

A: Time starts for G0453, 95940, or 95941 when monitoring the case starts after the baseline testing was accomplished.

When waiting for a case to start, can “waiting” or “standby” time be billed?

A: Yes, using the stand-by code (99360) per each 30 minutes waiting for monitoring to start.

Specific Coding Questions
What are the major differences between 95920 and G0453, 95940, 95941?

A: New codes G0453, 95940-95941 redefine the parameters for coding intraoperative neurophysiologic monitoring.

<table>
<thead>
<tr>
<th>Code</th>
<th>95920 Status as of 2013</th>
<th>G0453 Active for Medicare</th>
<th>95940 Active for all carriers</th>
<th>95941 Used by many commercial carriers; Not used by Medicare</th>
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</thead>
<tbody>
<tr>
<td>When can I use this code?</td>
<td>N/A</td>
<td>One on one monitoring, out of OR</td>
<td>One on one monitoring, in the OR</td>
<td>Monitoring outside the OR, or for multiple cases when in the OR</td>
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<td>wRVUs per 60 min</td>
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<td>0.50 per 15 min</td>
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<td>wRVU/hour</td>
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<tr>
<td>TC total RVU</td>
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<td>Not listed</td>
<td>Not listed</td>
<td>Not listed</td>
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</tbody>
</table>

Is EEG monitoring for after-discharges or epileptiform activity during the performance of cortical mapping reported under 95961-62, G0453, or 95940-41?

A: Use 95961 and 95962. That service is included in the procedure to localize functional cortical areas.

When reporting G0453, 95940-41, what code(s) can be used when reporting triggered EMG or pedicle screw testing?

A: Use one or more of the electromyography codes, 95860-95864, 95869-95870, or 95885-95886, when performing monitoring during pedicle screw placement or with other triggered EMG testing.

How do I code for direct nerve stimulation while performing intraoperative monitoring?

A: This sounds like stimulations of peripheral nerve, plexus, or root with recording at muscle. Use electromyography codes 95860-95864, 95869-95870, or 95885-95886.

How do I code for the initial pass through the psoas muscle during transpsoas surgery (XLIF)? Would the appropriate code be 95937 (neuromuscular junction testing)?

A: This sounds like stimulations of peripheral nerve, plexus, or root with recording at muscle. Use electromyography codes 95860-95861 or 95870. Do not use code 95937.

Do I use G0453 for Medicaid?

A: Every state has a different system. Please contact your local Medicaid carrier.

Automated Devices
Can G0453, 95940-41 be reported when an automated monitoring device is used in a conventional manner in which there is continuous attendance by a professional qualified to interpret and all other criteria of the CPT code(s) are met?

A: No, such a device is automated. It provides an automated result, rather than being interpreted. Automated devices are excluded from codes 95940 and 95941. “Interpretation” requires review of the neurophysiological waveform findings that require professional interpretations.

Baseline Tests

Since time spent interpreting baselines should not be included in the monitoring time reported for G0453, 95940, or 95941, how is this time determined? Is interpreting baselines based on the first modality interpreted, the last modality interpreted, the longest duration, or the cumulative time taken to interpret each modality?

A: Baseline performance or interpretation time is based on the clock time during which baseline modalities are performed or interpreted. If two modalities’ interpretation clock times overlap, they are not cumulative, i.e. they are not summed. For example, ongoing EMG baseline might be assessed while SEP is being collected. In general, the time accounting process is straightforward: monitoring time does not begin until baseline time stops. When baseline tests have been performed and interpreted, then monitoring time may begin.

The baseline testing also may occur in the middle of a case. When a modality’s baseline is established in the middle of a case, time to perform and to interpret that baseline is subtracted from the monitoring time.

For some studies, most if not all of the case is spent trying to improve the quality of the data being collected. At what point does baseline interpretation give way to monitoring for these studies?

A: Monitoring may begin even if the baseline results are technically suboptimal. It is appropriate to continue to improve the IOM quality during the monitoring time.

In another scenario, reliable SEP data may be obtained initially but baseline amplitude may be adjusted over an additional 20-30 minutes because of the effect of anesthesia. Is baseline time considered extended for the whole additional 20-30 minutes?

A: Anesthesia fade is a well know phenomenon that continues to some degree well into a case. Accounting for it is part of monitoring interpretation. The baseline is the initial set of tracings established at the beginning of the case. Anesthesia fade occurs for the most part after the baseline has been established. The additional 20-30 minutes is not in the baseline. It is part of monitoring time.

Can a specific generic amount of baseline interpretation time simply be used for all reporting?

A: No, use the actual time spent performing or interpreting baseline for the individual case.

Do you count any time before the baselines are obtained when using 95940 or 95941?
A: Time spent monitoring (95940, 95941) excludes time to set up, record, and interpret the baseline studies, and to remove electrodes at the end of the procedure. Monitoring may begin prior to incision (e.g., when positioning on the table is a time of risk).

Time spent before starting the case, e.g. reviewing the patient’s records or instructing the technologist on the modalities to use, is built into the code as pre-service time. That is not counted as monitoring time.

Time spent waiting for the case to start, e.g. waiting due to delays, may be coded with the stand-by code 99360.

Supervision

What happens to the direct supervision model? Can you bill for being available in the operating room?

A: That model has been retired. You cannot bill for being ‘available’ to monitor, only for the time actually spent monitoring.

What happens if you have only one physician providing the supervision and he or she is called to the OR? Do you stop billing for 95941 for as long as he or she is in the other room?

A: You have a choice. You may code 95940 for the in-OR time, and not code the second case. Or, you may code both cases using 95941 assuming that the physician continues to monitor both while in the OR.

Is the supervising physician still responsible for the other rooms, even though he is not watching?

A: If the monitoring physician is called to a specific room and stops supervising a different case for a while, he or she still remains responsible for that other case. He or she may transfer responsibility for the other case to another monitoring physician or will continue to monitor the other case while in the OR for the first case.

How does a supervising physician be responsible for the rooms he is not watching, but yet not reimbursed for those services?

A: He or she should make arrangements for a colleague to be on-call to pick up cases under those circumstances. In that way, cases are not left uncovered. The codes 95940-41 require that ‘when monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual’s exclusive attention be required for another procedure’. If you are monitoring multiple cases and go to the operating room of a single case for that time in the operating room you can either carry the remaining cases with you on an internet device and continue to use 95941 for all the cases or transfer the remaining cases to a second monitoring professional and use 95940 for the case you are exclusively monitoring while in the operating room.

Time Tracking
If you go in the OR 4 separate times: 2 min, 3 min, 15 min, then 25 min. Do you add those times (2+3+15+25=45 minutes) so the sum is 3 units of 95940; or do you count each as a separate visit so it is 4 units of 95940; or is it 5 units of 95940 since the last visit was for 25 minutes?

A: The amount of time spent in the operating room during a case is cumulative. In this case the four visits amount to 45 minutes or 3 units of 95940. Time spent using 95941 is also cumulative. The two times should not overlap for any individual case.

Add all the time increments provided at any time throughout the day. Divide the sum by 15. Round to the nearest integer. That is the number of units of service for 95940. The same rule applies for G0453. For code 95941, divide by 60.

For total daily times that sum to seven minutes or less, the sum rounds to zero units of service. The IOM codes 95940 or G0453 cannot be used for times of total daily times of seven minutes or less.

What happens if there are 10 different cases during the day, that have parts of them billed at 95941 and other parts billed under 95940. How do you keep track of 95940 and 95941 for all those operations?

A: It is admittedly a difficult accounting task to keep track of all the various minutes of time during the day. Spreadsheets may be the best solution.

If I go into the OR for only 5 minutes, does that count as a 1 unit of 95940 even though it was a less than 15 minutes?

A: Code 95940 requires at least 50% of 15 minutes in order to code for a unit of service. One unit of service of code 95940 requires at least 7.5 minutes.

The CPT code book contains a section on “Time” in the Introduction. Does this section apply to 95940 and 94941?

A: No, the Introduction language about Time specifies, “The following standards shall apply to time measurement, unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary.” Codes 95940 and 95941 do contain code-specific instructions about the use of time. Therefore, the code specific language for 95940 and 95941 supersedes Introduction language about Time. For example, the remote site of service language in 95941 supersedes the face-to-face Time requirement.

How are units of 95941 rounded?

A: For code 95941, 30 minutes or more is rounded up to one hour. The code guidelines state as follows: “Do not report 95941 if the monitoring lasts 30 minutes or less.” Accordingly, the first unit of 95941 is billed after 30 minutes of monitoring time has elapsed, after taking into account the time to perform and interpret baselines.

Since the setup and acquisition of a baseline is included in the base codes what is a reasonable period of time to allow for ‘interpretation’ of the baseline?
A: There is no specific preset time. It is whatever time it takes for that patient under those circumstances.

Do G0453, 95940, and 95941 apply to monitoring in radiological suites?

A: Yes, it applies wherever the patient is monitored. Complex procedures risking the brain or spinal cord injury can be performed in a hospital’s special MRI or fluoroscopy suite. The codes are not site specific. Codes G0453, 95940 and 95941 apply to procedures performed in interventional radiologic suites so long as a monitoring professional is required for performance or interpretation of the testing.

Technical Component

Can technologist set-up and break-down time outside of the real time supervision be reported for the technical component of 95940-95941?

A: Yes, the technologist’s time sometimes exceeds the professional’s time. Note that the set-up and break-down time are covered by the technical components of the baseline testing, which should be excluded from the technologist's technical component monitoring time in the same way as the performance and interpretation of the baseline tests are excluded from the physician’s professional component.

Can the technical component of G0453, 95940-95941 ever be reported without real time supervision?

A: Codes G0453, 95940, and 95941 never are used without a professional interpretation by a physician or other qualified professional during the case. Often the technical component and the professional component are billed separately. The technologist’s time often exceeds the professional’s time.

How does the term "ongoing neurophysiological monitoring" apply for both technical and professional component of the code?

A: ‘Ongoing neurophysiological monitoring’ refers to the time spent reacquiring or following the signals obtained at baseline. It applies to both the technical and professional components of the code.

Do technicians bill only for 95940-TC since they are present in the room? Would an IOM technician would ever find himself or herself in a situation to bill for 95941?

A: Codes 95940 and 95941 never are used without a professional interpretation by a physician or other qualified professional. Often the technical component and the professional component are billed separately. Technical time may occur for a longer time while physician monitoring occur for a shorter time. Whether the TC is 95940-TC or 95941-TC depends on the professional service rendered by the physician or other qualified professional.