Priority Health	BILLING POLICY No. 138
INTRAOPERATIVE NEUROPHYSIOLOGICAL TESTING	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

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

MEDICAL POLICY

Interoperative Neurophysiological Monitoring - 91646

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Reimbursement specifics and Billing details

The intraoperative neurophysiology monitoring should not be reported by the physician performing the operative procedure since it is included in the global package for the surgery.

Coding specifics

CPT codes

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)

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)

Not payable:

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)

Limitations/exclusions:

1. Intraoperative neurophysiological monitoring must be requested by the operating surgeon and the monitoring must be performed by a physician, other than:
    - The operating surgeon
    - The technical/surgical assistant; or
    - The anesthesiologist rendering the anesthesia

Documentation requirements

The patient's medical record should document the time spent in monitoring in correlation to the surgery that was performed.

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

The use of modifiers 26 or TC do not apply to codes 95940 or G0453. These codes are add on codes therefore modifier overrides are not allowed.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

The American Academy of Neurology states that IONM services should be performed in Place of Service (POS) 19, 21, 22 or 24.

REFERENCES

- **https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57604&ver=16**
- **https://priorityhealth.stylelabs.cloud/api/public/content/97b28ae284fb446ca642e774681c348f?v=e6d22846**
- **Intraoperative Neurophysiological Testing. Local Coverage Determination (LCD) L34623. Wisconsin Physicians Service Insurance Corporation. Centers for Medicare & Medicaid Services (CMS)**
- **https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34623&ver=36&bc=0**
- **https://www.aan.com/siteassets/home-page/tools-and-resources/practicing-neurologist--administrators/billing-and-coding/model-coverage-policies/18iommodelpolicy_tr.pdf**

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and

Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made