Intraoperative Neurophysiologic Monitoring (IONM)

Date of Origin: 04/2015  Last Review Date: 05/27/2020  Effective Date: 06/01/2020

Dates Reviewed: 08/2016, 05/2018, 05/2019, 06/2019, 08/2019, 05/2020

Developed By: Medical Necessity Criteria Committee

I. Description

Intraoperative neurophysiologic monitoring includes a number of procedures performed to monitor the integrity of the nerve function during high-risk neurosurgical, orthopedic, or vascular surgeries.

For intraoperative monitoring during carotid endarterectomy, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. (RG A2) A retrospective study of 600 patients who underwent carotid endarterectomy utilizing intraoperative transcranial electrical stimulation and median nerve somatosensory evoked potentials to determine the need for intra-arterial shunt during cross clamping found that of the 29 patients who had shunt placement, 2 showed motor deficits after surgery that disappeared after 2 hours, and one suffered permanent hemiplegia. Overall failure rates were 1.0% for transcranial electrical stimulation and 1.2% for median nerve somatosensory evoked potentials.

For intraoperative monitoring during central nervous system tumor surgery, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. (RG A2) Evoked potentials are used for intraoperative monitoring of resection of supratentorial brain tumors, brainstem tumors, skull base tumors, cervicomedullary junction tumors, and spinal tumors. Speech mapping is used in cases where the tumor is near or within presumed speech areas. In a study of 150 consecutive patients with dominate hemisphere grade II gliomas, only 2% had long term residual speech deficits when using intraoperative speech mapping.

For intraoperative monitoring during intracranial aneurysm surgery, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. An observational study of 47 patients who underwent somatosensory and motor evoked potentials during intracranial aneurysm surgery found that all intracerebral ischemia could be detected by one of the monitoring techniques. Of the entire cohort, 8 patients developed postoperative new infarctions or motor impairment deficits, with ischemic event risk being related to increased time for the resumption of blood flow. There was no postoperative motor paresis in those patients who had normal evoked potentials.
For intraoperative monitoring during spinal surgery, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. Somatosensory evoked potentials and motor evoked potentials are typically used intraoperatively to monitor the integrity of the sensory and motor pathways. However, a systematic review determined that for routine surgical treatment of cervical spondylotic myelopathy or cervical radiculopathy, although intraoperative evoked potentials may serve as a sensitive means of diagnosing potential neurologic injury, evoked potential worsening is not specific and may not represent clinical worsening; also, its recognition does not necessarily prevent neurologic injury, and it has not been shown to date to result in improved outcomes.

II. Criteria: CWQI HCS-0153
A. Intraoperative neurophysiologic monitoring (IONM) is considered medically necessary and eligible for separate reimbursement for **ALL** of the following:
   a. It is performed by either a licensed physician trained in neurophysiology or a trained technologist who is practicing within the scope of his/her license/certification as defined by state law or appropriate authorities and is working under the direct supervision of a physician trained in neurophysiology.
   b. Intraoperative neurophysiologic monitoring is interpreted by a licensed physician trained in clinical neurophysiology, other than the operating surgeon, who is either in attendance in the operating suite or present by means of a real-time remote mechanism for neurophysiologic monitoring situations and is immediately available.
   c. Monitoring is conducted and interpreted real-time (either on-site or at a remote location) and continuously communicated to the surgical team.
   d. Intraoperative neurophysiologic monitoring is considered medically necessary and eligible for separate reimbursement for **One or more** of the following:
      i. Intraoperative neurophysiologic monitoring (IONM) using somatosensory evoked potential (SSEP) and/or motor evoked potential (MEP) for **One or more** of the following indications.
         1. Aortic or thoracic aneurysm repair
         2. Aortic cross-clamping
         3. Brachial plexus surgery
        4. Cerebral vascular surgery including **One or more** of the following:
           a. Carotid Endarterectomy
           b. Cerebral Aneurysm
           c. Intracranial arteriovenous malformation
           d. Hypothermic coronary bypass procedure
      5. Central nervous system tumor surgery
      6. Intracranial aneurysm clipping
      7. Intracranial surgeries
     8. Spinal surgery for **One or more** of the following indications:
        a. Arteriovenous malformation of the spinal cord
        b. Resection of spinal cord tumors or cysts
        c. Scoliosis correction
        d. Cervical or thoracic posterior instrumentation for placement of screws or implants
        e. Surgical stabilization of spine fracture or traumatic spine injury with or without spinal cord decompression
        f. Decompression of the cervical or thoracic spinal cord for symptoms of myelopathy with 1 or more of the following:
           1. Numbness/tingling in hands/fingers
2. Reduced fine motor skills, decreased grip strength
3. Reduced strength in arms, shoulders, hands or legs
4. Imbalance and coordination problems
5. Neck pain or stiffness

g. Decompression of the spinal cord where function of the spinal cord is at risk and ALL of the following:
   1. The IONM is requested for the lumbar spine at or above L1-L2 level.
   2. The requested IONM is NOT for the decompression of the cervical spine for radiculopathy as evidence does not support improved outcomes or prevent nerve injury.

9. Stereotactic surgery of the brain or brainstem, thalamus, or cerebral cortex
10. Thalamus tumor resection/thalamotomy
11. Thyroid surgery

ii. Intraoperative neurophysiologic monitoring using brainstem auditory evoked potential (BAEP) is medically necessary for One or more of the following:
   1. Acoustic neuroma
   2. Vestibular nerve section
   3. Vascular loop decompression
   4. Glomus tumor
   5. Auditory brainstem implant
   6. Posterior fossa procedures
   7. Functional localization of the cortex with direct cortical stimulation
   8. Assess auditory pathways within the brainstem
   9. Possible ischemia at the cochlea and eighth nerve

iii. Visual evoked potentials or response (VEP, VER) (CPT 95930) monitoring is medically necessary for monitoring the visual system during optic nerve (or related) surgery.

iv. Intraoperative electromyography (EMG) monitoring is medically necessary for One or more of the following indications:
   a. Microvascular decompression of the facial nerve for hemifacial spasm
   b. Surgery for acoustic neuroma congenital auricular lesions, or cranial base lesions
   c. Vestibular neurectomy for Meniere’s disease
   d. Surgical excision of neuromas of 1 or more of the following cranial nerves:
      1. Abducens nerve
      2. Glossopharyngeal nerve
      3. Oculomotor nerve
      4. Recurrent laryngeal nerve
      5. Spinal accessory
      6. Superior laryngeal
      7. Trochlear nerve
      8. Facial nerve

v. Intraoperative neurophysiologic monitoring using EMG for an indication NOT included in section II.A.d.iv.a-d is considered experimental and investigational. This includes, but is not limited to:
   1. Celiac plexus block
   2. Epidural injections
   3. Facet joint injections

vi. Intraoperative neurophysiologic monitoring using EMG combined with Somatosensory Evoked Potential (SEP) is considered NOT medically necessary.
vii. Intraoperative neurophysiologic monitoring using EMG for routine spinal surgery is considered experimental and investigational due to insufficient evidence that it improves outcomes.

**Please note:** If criteria are not met, the intraoperative neurophysiologic monitoring is considered not medically necessary. Professional charges will not be covered, and the associated facility charges are not considered eligible for separate reimbursement.

### III. Information Submitted with the Prior Authorization Request:
1. Chart notes and imaging studies with documentation of patient’s diagnosis
2. Operative Report
3. Intraoperative Neurophysiologic Monitoring records

### IV. CPT or HCPC codes covered:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>92585</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
</tr>
<tr>
<td>92586</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited</td>
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<tr>
<td>95867</td>
<td>Needle electromyography; cranial nerve supplied muscle(s), unilateral</td>
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<tr>
<td>95868</td>
<td>Needle electromyography; cranial nerve supplied muscles, bilateral</td>
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<tr>
<td>95887</td>
<td>Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)</td>
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<tr>
<td>95925</td>
<td>Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs</td>
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<tr>
<td>95926</td>
<td>Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs</td>
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<tr>
<td>95927</td>
<td>Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head</td>
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<tr>
<td>95930</td>
<td>Visual evoked potential (VEP) testing central nervous system, checkerboard or flash short-latency somatosensory evoked potential study, stimulation of any/all peripheral</td>
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<tr>
<td>95938</td>
<td>Nerves or skin sites, recording from the central nervous system; in upper and lower limbs</td>
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Central motor evoked potential study (Transcranial motor stimulation); in upper and lower limbs

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)

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)

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)

V. Annual Review History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Revisions</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>04/2015</td>
<td>New criteria</td>
<td>08/2015</td>
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<tr>
<td>08/2016</td>
<td>Annual Review: No changes</td>
<td>08/2016</td>
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<tr>
<td>05/2018</td>
<td>Annual Review: Updated to new template; reformatted – added exclusions for spine surgery to section II.A.d.i.7.a.v</td>
<td>05/23/2018</td>
</tr>
<tr>
<td>05/2019</td>
<td>Annual Review: No changes</td>
<td>06/01/2019</td>
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<tr>
<td>06/2019</td>
<td>Update: Specified indications considered E&amp;I for EMG monitoring (not an all-inclusive list)</td>
<td>07/01/2019</td>
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<td>08/2019</td>
<td>Update: corrected statement “INM using EMG combined with Somatosensory Evoked Potential (SEP) is considered NOT medically necessary”. Corrected numbering for clarity.</td>
<td>08/05/2019</td>
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<tr>
<td>05/2020</td>
<td>Annual Review: No content changes</td>
<td>06/01/2020</td>
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</table>
VI. References

7. American Academy of Neurology; Principles of coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing; Model coverage policy; February 2010
12. Physician Advisors

Appendix 1 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.
Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD)

<table>
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<tr>
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<th>NCD/LCD Document(s):</th>
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<tr>
<td></td>
<td>Noridian Local Coverage Determination (LCD) Sensory Evoked Potentials and Intraoperative Neurophysiologic Monitoring (L34072)</td>
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<td></td>
<td><a href="https://med.noridianmedicare.com/documents/10534/5321625/Local+Coverage+Determination+for+Sensory+Evoked+Potentials+%26+Intraoperative+Neurophysiology+Monitoring+%28L34072%29/6bf4542a-7655-4ba8-894e-7cf1851ff22f">https://med.noridianmedicare.com/documents/10534/5321625/Local+Coverage+Determination+for+Sensory+Evoked+Potentials+%26+Intraoperative+Neurophysiology+Monitoring+%28L34072%29/6bf4542a-7655-4ba8-894e-7cf1851ff22f</a></td>
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Medicare Part B Administrative Contractor (MAC) Jurisdictions

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<th>Contractor</th>
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<tr>
<td>F (2 &amp; 3)</td>
<td>AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ</td>
<td>Noridian Healthcare Solutions, LLC</td>
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