Part B Insider (Multispecialty) Coding Alert

NEUROLOGY: 8 Tips For Full Intraoperative Monitoring Payment

Hint: Surgeon and monitoring physician can't be the same person

If you're befuddled by intraoperative monitoring, you're not alone. The procedure has lots of elements that can confuse: You have to bill for baseline studies such as sleep EEG, EMG, nerve conduction studies or evoked potentials. And then you have to bill a time-based add-on code, **CPT 95920** , in one-hour units.

To help ease the task, our experts offer these straightforward tips:

1. Read the CPT book. The descriptor for 95920 includes a list of all the baseline studies codes that you can bill along with this code, advises **Laureen Jandroep**, director and senior instructor for CRN Institute in Absecon, NJ.

Note: You can't bill 95920 without one of those baseline studies, because those codes tell the carrier which studies the physician is monitoring.

2. Use the 26 modifier (Professional component) along with 95920 when you're billing for intraoperative monitoring in a facility setting, says Jandroep.

3. Make sure the diagnosis for 95920 and the baseline studies matches the diagnoses the surgeon uses for the surgery. The condition your neurologist is monitoring will almost always be the same as the one the surgeon is operating on, says Jandroep.

4. Document the monitoring time exactly. You bill 95920 in one-hour units, explains **Tiffany Schmidt**, policy director with the **American Association of Neuromuscular & Electrodiagnostic Medicine**. You can't start billing 95920 until immediately after the physician has completed the baseline studies.

Example: The **Univ. of Pittsburgh Department of Neurosurgery** has time-stamped information on all its procedures, says Administrator **David Bissonette**. And the monitoring physician provides a narrative summary of the monitoring, complete with the time spent, to the requesting surgeon.

5. You don't need to make sure the monitoring physician is there the whole time. The **Centers for Medicare & Medicare Services** "allows for remote monitoring as long as the physician is readily available by phone or pager," says Schmidt.

6. Talk to your carrier. Pittsburgh neurosurgeons were having problems with monitoring reimbursement until they scheduled a talk with their carrier and local **Blue Cross/Blue Shield,** says Bissonette. After Pittsburgh described its setup, the carrier not only allowed remote monitoring, but also permitted monitoring of more than one case at a time.

Here's how: Pittsburgh will assign a technician to each patient and constantly present in the operating room, and one PhD will supervise all the technicians in each building. Then the monitoring physician will watch several screens at once, explains Bissonette.

7. Don't try to bill for your surgeon's monitoring. Some manufacturers are selling devices that they claim will allow the neurosurgeon to perform spine surgery and monitor the patient at the same time. But Medicare will only pay for intraoperative monitoring if someone other than the surgeon performs it, says Schmidt.

Be wary: If a manufacturer's rep tells you Medicare will pay a surgeon separately for intraoperative monitoring, then he

is probably blowing smoke, says one coder whose office obtained one of these devices. Obtain reimbursement assurances from the manufacturer in writing, but be aware that Medicare won't pay neurosurgeons to do their own monitoring, the coder warns.

8. Be aware that other payors may differ. Some private managed care plans will pay the neurosurgeon for intraoperative monitoring using one of these new devices, says consultant **Ken Lobo** with **Lobo Solutions** in Poway, CA. "**United Healthcare** pays, **Blue Cross** pays, but **Aetna** will not pay," he reports.