

## MEDICAL POLICY – 7.01.562

## Intraoperative Neurophysiologic Monitoring

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Effective Date: Oct. 1, 2018

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Replaces: N/A

RELATED MEDICAL POLICIES:

None

Select a hyperlink below to be directed to that section.

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## Introduction

Tests can be done on specific nerves during complex brain, spine, and neck surgeries to help make sure the nerves are not being harmed. This is known as intraoperative neurophysiologic monitoring (IONM). There are a number of ways to perform this monitoring. It often involves the use of sophisticated medical devices to assess the muscle or electrical response when a nerve is stimulated. The goal is to provide the surgeon with immediate feedback about whether a nerve is at risk of being injured. The surgeon can make a correction right away to avoid permanent damage. This type of monitoring is well proven in specific types of surgeries. Some surgeons are using IONM during surgery for nerves located outside of the brain and spinal cord (the peripheral nerves). There is not enough medical evidence to show whether IONM leads to better health results when used for the peripheral nerves. For this reason, IONM is considered not medically necessary for peripheral nerve surgery.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Intraoperative Monitoring	Medical Necessity
<ul style="list-style-type: none"> <li>• Somatosensory-evoked potentials</li> <li>• Motor-evoked potentials using transcranial <u>electrical</u> stimulation</li> <li>• Brainstem auditory-evoked potentials</li> <li>• Electromyography (EMG) of cranial nerves</li> <li>• Electroencephalography</li> <li>• Electrocorticography</li> </ul>	<p><b>The types of Intraoperative neurophysiologic monitoring, listed on the left, may be considered medically necessary when there is significant risk of nerve or spinal cord injury during the following spinal, intracranial, vascular or recurrent laryngeal nerve surgical procedures: (this list may not be all inclusive)</b></p> <ul style="list-style-type: none"> <li>• Aortic, thoracic, and abdominal aneurysm repair</li> <li>• Aortic cross-clamping</li> <li>• Arteriovenous malformation repair of the spinal cord</li> <li>• Brachial plexus surgery</li> <li>• Cerebral vascular surgery (eg, carotid endarterectomy, cerebral aneurysm)</li> <li>• Clipping of intracranial aneurysms</li> <li>• Cortical localization</li> <li>• Interventional neuroradiology</li> <li>• Pelvic fracture surgery</li> <li>• Release of a tethered cord</li> <li>• Repair of coarctation of the aorta</li> <li>• Resection of fourth ventricular cyst</li> <li>• Resection of intracranial vascular lesions</li> <li>• Resection of spinal cord tumor, cyst, or vascular lesion</li> <li>• Scoliosis correction with instrumentation</li> <li>• Surgical stabilization of spine fractures</li> <li>• Stereotactic surgery of the brain or brain stem, thalamus, or cerebral cortex</li> <li>• Thalamus tumor resection or thalamotomy</li> <li>• Thyroid surgery</li> <li>• Anterior cervical spinal fusions</li> <li>• Thoracic spine surgery</li> </ul> <p><b>Intraoperative neurophysiologic monitoring for ANY other indication, including during lumbar surgery below L1/L2 is considered not medically necessary. (see <a href="#">Related Information</a>)</b></p>
<ul style="list-style-type: none"> <li>• EMG</li> </ul>	<p><b>The types of intraoperative neurophysiologic monitoring,</b></p>



Intraoperative Monitoring	Medical Necessity
<ul style="list-style-type: none"> <li>Nerve conduction velocity monitoring</li> </ul>	<p>listed on the left during surgery on the peripheral nerves are considered not medically necessary.</p>

Intraoperative Monitoring	Investigational
<ul style="list-style-type: none"> <li>Somatosensory-evoked potentials</li> <li>Motor-evoked potentials using transcranial electrical stimulation</li> <li>Brainstem auditory-evoked potentials</li> <li>Electromyography (EMG) of cranial nerves</li> <li>Electroencephalography</li> <li>Electrocorticography</li> </ul>	<p>The types of intraoperative neurophysiologic monitoring, listed on the left during the following surgical procedure is considered investigational:</p> <ul style="list-style-type: none"> <li>Esophageal surgeries</li> </ul>
<p>Motor-evoked potentials using transcranial <u>magnetic</u> stimulation</p>	<p>Due to the lack of monitors approved by the U.S. Food and Drug Administration, intraoperative monitoring of motor-evoked potentials using transcranial <u>magnetic</u> stimulation is considered investigational.</p>

## Coding

Medically Necessary	
Code	Description
<b>CPT</b>	
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)
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)
<b>HCPCS</b>	



Medically Necessary	
Code	Description
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)

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

## Related Information

These policy statements refer only to use of these techniques as part of intraoperative monitoring. Other clinical applications of these techniques, such as visual-evoked potentials and EMG, are not considered in this policy.

Intraoperative neurophysiological monitoring is indicated in select spine surgeries when there is risk for additional spinal cord injury. Intraoperative monitoring has not been shown to be of clinical benefit for routine lumbar or cervical nerve root decompression (AANEM 2014), or during routine lumbar or cervical laminectomy or fusion (AANEM, 1999a) in the absence of myelopathy or other complicating conditions, which could increase the potential risk of damage to the nerve root or spinal cord, Resnick et al (2005) in published guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine reported that based on the medical evidence of the literature reviewed there did not appear to be support for the hypothesis that any form of intraoperative monitoring improves patient outcomes following lumbar decompression or fusion procedures for degenerative spinal disease. The authors concluded in a 2014 update there was no evidence that intraoperative monitoring can prevent injury to the nerve roots.

Intraoperative neurophysiologic monitoring including somatosensory-evoked potentials and motor-evoked potentials using transcranial electrical stimulation, brainstem auditory-evoked potentials, electromyography of cranial nerves, electroencephalography, and electrocorticography has broad acceptance, particularly for spine surgery and open abdominal aorta aneurysm repairs. Additionally, this policy addresses monitoring of the recurrent laryngeal nerve during neck surgeries and monitoring of peripheral nerves.



Intra-operative monitoring is considered reimbursable as a separate service only when a licensed physician, other than the operating surgeon, performs the monitoring while in attendance in the operating room or present by means of a real-time remote mechanism and is immediately available to interpret the recording and advise the surgeon throughout the procedure.

Intra-operative monitoring consists of a physician monitoring not more than three cases simultaneously.

Constant communication between surgeon, neurophysiologist, and anesthetist are required for safe and effective intraoperative neurophysiologic monitoring.

## Evidence Review

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### Description

Intraoperative neurophysiologic monitoring (IONM) describes a variety of procedures used to monitor the integrity of neural pathways during high-risk neurosurgical, orthopedic, and vascular surgeries. It involves the detection of electrical signals produced by the nervous system in response to sensory or electrical stimuli to provide information about the functional integrity of neuronal structures. This policy does not address established neurophysiologic monitoring (ie, somatosensory-evoked potentials, motor-evoked potentials using transcranial electrical stimulation, brainstem auditory-evoked potentials, electromyography of cranial nerves, electroencephalography, electrocorticography), during spinal, intracranial, or vascular procedures.

### Background

#### *Intraoperative Neurophysiologic Monitoring*

The principal goal of intraoperative neurophysiologic monitoring (IONM) is identification of nervous system impairment on the assumption that prompt intervention will prevent permanent deficits. Correctable factors at surgery include circulatory disturbance, excess compression from retraction, bony structures, hematomas, or mechanical stretching. The technology is continuously evolving with refinements in equipment and analytic techniques, including



recording, with several patients monitored under the supervision of a physician who is outside the operating room.

The different methodologies of monitoring are described next.

### **Sensory-Evoked Potentials**

Sensory-evoked potential (SEP) describes the responses of the sensory pathways to sensory or electrical stimuli. Intraoperative monitoring of SEPs is used to assess the functional integrity of central nervous system (CNS) pathways during surgeries that put the spinal cord or brain at risk for significant ischemia or traumatic injury. The basic principles of SEP monitoring involve identification of a neurologic region at risk, selection and stimulation of a nerve that carries a signal through the at-risk region, and recording and interpretation of the signal at certain standardized points along the pathway. Monitoring of SEPs is commonly used during the following procedures: carotid endarterectomy, brain surgery involving vasculature, surgery with distraction compression or ischemia of the spinal cord and brainstem, and acoustic neuroma surgery. SEPs can be categorized by type of simulation used, as follow.

### **Somatosensory-Evoked Potentials**

Somatosensory-evoked potentials (SSEPs) are cortical responses elicited by peripheral nerve stimulations. Peripheral nerves, such as the median, ulnar, or tibial nerves, are typically stimulated, but, in some situations, the spinal cord may be stimulated directly. Recording is done either cortically or at the level of the spinal cord above the surgical procedure. Intraoperative monitoring of SSEPs is most commonly used during orthopedic or neurologic surgery to prompt intervention to reduce surgically induced morbidity and/or to monitor the level of anesthesia. One of the most common indications for SSEP monitoring is in patients undergoing corrective surgery for scoliosis. In this setting, SSEP monitors the status of the posterior column pathways and thus does not reflect ischemia in the anterior (motor) pathways. Several different techniques are commonly used, including stimulation of a relevant peripheral nerve with monitoring from the scalp, from interspinous ligament needle electrodes, or from catheter electrodes in the epidural space.



### ***Brainstem Auditory-Evoked Potentials***

Brainstem auditory-evoked potentials (BAEPs) are generated in response to auditory clicks and can define the functional status of the auditory nerve. Surgical resection of a cerebellopontine angle tumor, such as an acoustic neuroma, places the auditory nerves at risk, and BAEPs have been extensively used to monitor auditory function during these procedures.

### ***Visual-Evoked Potentials***

Visual-evoked potentials (VEPs) with light flashes are used to track visual signals from the retina to the occipital cortex. VEP monitoring has been used for surgery on lesions near the optic chiasm. However, VEPs are very difficult to interpret due to their sensitivity to anesthesia, temperature, and blood pressure.

### ***Motor-Evoked Potentials***

Motor-evoked potentials (MEPs) are recorded from muscles following direct or transcranial electrical stimulation of motor cortex or pulsed magnetic stimulation provided using a coil placed over the head. Peripheral motor responses (muscle activity) are recorded by electrodes placed on the skin at prescribed points along the motor pathways. MEPs, especially when induced by magnetic stimulation, can be affected by anesthesia. The Digitimer **electrical** cortical stimulator received U.S. Food and Drug Administration (FDA) premarket approval in 2002. Devices for transcranial **magnetic** stimulation have not been approved by the FDA for this use.

Multimodal IONM, in which more than 1 technique is used, most commonly with SSEPs and MEPs, has also been described.

### ***Electromyogram Monitoring and Nerve Conduction Velocity Measurements***

Electromyography (EMG) monitoring and nerve conduction velocity measurements can be performed in the operating room and may be used to assess the status of the cranial or peripheral nerves (eg, to identify the extent of nerve damage before nerve grafting or during resection of tumors). For procedures with a risk of vocal cord paralysis due to damage to the recurrent laryngeal nerve (ie, during carotid artery, thyroid, parathyroid, goiter, or anterior cervical spine procedures), monitoring of the vocal cords or vocal cord muscles has been performed. These techniques may also be used during procedures proximal to the nerve roots



and peripheral nerves to assess the presence of excessive traction or other impairment. Surgery in the region of cranial nerves can be monitored by electrically stimulating the proximal (brain) end of the nerve and recording via EMG activity in the facial or neck muscles. Thus, monitoring is done in the direction opposite that of SEPs, but the purpose is similar—to verify that the neural pathway is intact.

## **Electroencephalogram Monitoring**

Spontaneous electroencephalography (EEG) monitoring can also be used during surgery and can be subdivided as follows:

- EEG monitoring has been widely used to monitor cerebral ischemia secondary to carotid cross-clamping during a carotid endarterectomy. EEG monitoring may identify those patients who would benefit from the use of a vascular shunt during the procedure to restore adequate cerebral perfusion. Conversely, shunts, which have an associated risk of iatrogenic complications, may be avoided in those patients with a normal EEG. Carotid endarterectomy may be done with the patient under local anesthesia so that monitoring of cortical function can be directly assessed.
- Electrocorticography (ECoG) is the recording of the EEG activity directly from a surgically exposed cerebral cortex. ECoG is typically used to define the sensory cortex and map the critical limits of a surgical resection. ECoG recordings have been most frequently used to identify epileptogenic regions for resection. In these applications, ECoG does not constitute monitoring, per se.

Intraoperative neurophysiologic monitoring, including SSEPs and MEPs using transcranial electrical stimulation, BAEPs, EMG of cranial nerves, EEG, and ECoG, has broad acceptance, particularly for spine surgery and open abdominal aorta aneurysm repairs. These indications have long been considered standard of care, as evidenced by numerous society guidelines, including those from the American Academy of Neurology, American Clinical Neurophysiology Society, American Association of Neurological Surgeons, Congress of Neurologic Surgeons, and American Association of Neuromuscular & Electrodiagnostic Medicine.<sup>1-7</sup> Additionally, this policy addresses monitoring of the recurrent laryngeal nerve during neck and esophageal surgeries and monitoring of peripheral nerves.





## Summary of Evidence

For individuals who are undergoing thyroid or parathyroid surgery and are at high risk of injury to the recurrent laryngeal nerve (RLN) who receive intraoperative neurophysiologic monitoring (IONM), the evidence includes a large randomized controlled trial (RCT) and systematic reviews. Relevant outcomes are morbid events, functional outcomes, and quality of life. The strongest evidence on neurophysiologic monitoring derives from an RCT of 1000 patients undergoing thyroid surgery. This RCT found a significant reduction in RLN injury in patients at high risk for injury. High risk in this trial was defined as surgery for thyroid or parathyroid cancer, thyrotoxicosis, retrosternal or giant goiter, or thyroiditis. The high-risk category may also include patients with prior thyroid or parathyroid surgery or total thyroidectomy. A low volume of surgeries might also contribute to a higher risk for RLN injury. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are undergoing anterior cervical spine surgery and are at high risk of injury to the RLN who receive IONM, the evidence includes systematic reviews of case series and cohort studies. Relevant outcomes are morbid events, functional outcomes, and quality of life. The evidence on the use of IONM to reduce RLN injury during cervical spinal surgery includes a 2017 systematic review and a meta-analysis. Of the 10 studies assessed in the systematic review, two compared the risk of nerve injury with use of IONM vs no IONM and found no difference. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are undergoing esophageal surgery who receive IONM, the evidence includes a nonrandomized comparative study. Relevant outcomes are morbid events, functional outcomes, and quality of life. One nonrandomized comparative study on surgery for esophageal cancer was identified. Interpretation of this study is confounded because only those patients who had visual identification of the nerve underwent neurophysiologic monitoring. Current evidence is not sufficiently robust to determine whether neurophysiologic monitoring reduces RLN injury in patients undergoing surgery for esophageal cancer. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are undergoing surgery proximal to a peripheral nerve who receive IONM, the evidence includes case series and a controlled cohort study. Relevant outcomes are morbid events, functional outcomes, and quality of life. Surgical guidance with peripheral IONM and the predictive ability of monitoring of peripheral nerves have been reported. No prospective comparative studies were identified that assessed whether outcomes are improved with neurophysiologic monitoring. The evidence is insufficient to determine the effects of the technology on health outcomes.



## Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in [Table 1](#).

**Table 1. Summary of Key Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<b>Ongoing</b>			
<a href="#">NCT02395146</a>	Intra-operative Monitoring of the External Branch of the Superior Laryngeal Nerve (EBSLN) During Thyroid Surgery: Does it Improve Voice Preservation?	60	Aug 2017 (unknown)
<a href="#">NCT01585727</a>	Continuous Intraoperative Monitoring of the Pelvic Autonomic Nerves During Total Mesorectal Excision (TME) for the Prevention of Urogenital and Anorectal Dysfunction in Patients With Rectal Cancer (NEUROS)	188	Dec 2018
<a href="#">NCT01630785</a>	Observation of Neurosurgical Interventions With Intraoperative Neurophysiological Monitoring IONM	5000	Dec 2023
<b>Unpublished</b>			
<a href="#">NCT02187653</a> <sup>a</sup>	Spine Registry Exposure for Lumbar and Cervical Surgery Utilizing IOM	10,000	Dec 2016 (unknown)

NCT: national clinical trial.

<sup>a</sup> Denotes industry-sponsored or cosponsored trial.

## Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.



## *2017 Input*

In response to requests, clinical input on intraoperative neurophysiologic monitoring (IONM) of the recurrent laryngeal nerve for individuals undergoing cervical spine surgery was received from 5 specialty society-level response while this policy was under review in 2017.

Based on the evidence and independent clinical input, the clinical input supports that the following indication provides a clinically meaningful improvement in the net health outcome and is consistent with generally accepted medical practice:

- Use of IONM of the recurrent laryngeal nerve for individuals undergoing cervical spine surgery with:
  - prior anterior cervical surgery, particularly revision anterior cervical discectomy and fusion, revision surgery through a scarred surgical field, reoperation for pseudarthrosis, or revision for failed fusion;
  - multilevel anterior cervical discectomy and fusion; and
  - preexisting recurrent laryngeal nerve pathology, when there is residual function of the recurrent laryngeal nerve

## *2014 Input*

In response to requests, input was received from 5 physician specialty societies (7 responses) and 2 academic medical centers while this policy was under review in 2014. Input agreed that intraoperative neurophysiologic monitoring (IONM) with somatosensory-evoked potentials, motor-evoked potentials (MEPs) using transcranial **electrical** stimulation, brainstem auditory-evoked potentials, electromyography of cranial nerves, electroencephalography, or electrocorticography may be medically necessary during spinal, intracranial, or vascular procedures. There was general agreement that IONM of visual-evoked potentials and MEPs using transcranial magnetic stimulation is investigational. Input was mixed on whether IONM of peripheral nerves would be considered medically necessary. Some reviewers recommended monitoring some peripheral nerves during spinal surgery (eg, nerve roots, percutaneous pedicle screw placement, lateral transpsoas approach to the lumbar spine). Other reviewers suggested use of IONM during resection of peripheral nerve tumors or surgery around the brachial plexus or facial/cranial nerves.



## Practice Guidelines and Position Statements

### *American Association of Neurological Surgeons and Congress of Neurological Surgeons*

The 2012 position statement on electrophysiologic neurophysiologic monitoring (IONM) during routine spinal surgery by the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), updated in 2014, has stated that IONM may assist in diagnosing the neurologic injury.<sup>5</sup> However, AANS and CNS found no evidence that such monitoring either (1) reduces the incidence of neurologic injury or (2) mitigates the severity of it. The position taken by AANS and CNS indicated that routine use of IONM is neither warranted nor recommended, although IONM should be performed if the diagnostic information gained is of value, particularly in high-risk cases such as deformity, gross instability, navigation through or around peripheral nerves, or intramedullary procedures. In the 2014 update, AANS and CNS found no evidence that would conflict with their previous recommendations for IONM for lumbar fusion.<sup>24</sup> These societies found no evidence that IONM can prevent injury to the nerve roots. They found limited evidence that IONM can indicate a medial pedicle breach by a pedicle screw, but once a nerve root injury has taken place, changing the direction of the screw does not alter the outcome.

### *American Association of Neuromuscular & Electrodiagnostic Medicine*

A 2014 position statement on somatosensory-evoked potentials (SSEPs) from the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) has indicated that intraoperative sensory-evoked potentials (SEPs) have demonstrated usefulness for monitoring of spinal cord, brainstem, and brain sensory tracts.<sup>7</sup> AANEM stated that intraoperative SEP monitoring is indicated for select spine surgeries in which there is a risk of additional nerve root or spinal cord injury. Indications for SEP monitoring may include, but are not limited to, complex, extensive, or lengthy procedures, and when mandated by hospital policy. However, intraoperative SEP monitoring may not be indicated for routine lumbar or cervical root decompression.

### *American Clinical Neurophysiology Society*

In 2009, the American Clinical Neurophysiology Society (ACNS) published recommended standards for IONM.<sup>4</sup> Guideline 11A included the following statement<sup>25</sup>:



The monitoring team should be under the direct supervision of a physician with training and experience in NIOM [neurophysiologic intraoperative monitoring]. The monitoring physician should be licensed in the state and privileged to interpret neurophysiologic testing in the hospital in which the surgery is being performed. He/she is responsible for real-time interpretation of NIOM data. The monitoring physician should be present in the operating room or have access to NIOM data in real-time from a remote location and be in communication with the staff in the operating room. There are many methods of remote monitoring, however any method used must conform to local and national protected health information guidelines. The monitoring physician must be available to be in the operating room, and the specifics of this availability (ie, types of surgeries) should be decided by the hospital credentialing committee. In order to devote the needed attention, it is recommended that the monitoring physician interpret no more than three cases concurrently.

### ***American Academy of Neurology***

The American Academy of Neurology (AAN) published an assessment of IONM in 1990, with an evidence-based guideline update in 2012 by the AAN and ACNS.<sup>1,2</sup> The 1990 assessment indicated that monitoring requires a team approach with a well-trained physician-neurophysiologist to provide or supervise monitoring. Electroencephalography (EEG) monitoring is used during carotid endarterectomy or for other similar situations in which cerebral blood flow is at high risk. Electrocorticography from surgically exposed cortex can help to define the optimal limits of surgical resection or identify regions of greatest impairment, while sensory cortex SSEPs can help to localize the central fissure and motor cortex. Auditory-evoked potentials, along with cranial nerve monitoring can be used during posterior fossa neurosurgical procedures. Spinal cord SSEPs are frequently used to monitor the spinal cord during orthopedic or neurosurgical procedures around the spinal cord, or cross-clamping of the thoracic aorta. Electromyographic monitoring during procedures near the roots and peripheral nerves can be used to warn of excessive traction or other impairment of motor nerves. At the time of the 1990 assessment, motor-evoked potentials (MEPs) were considered investigational by many neurophysiologists. The 2012 update, which was endorsed by AANEM, concluded that the available evidence supported IONM using SSEPs or MEPs when conducted under the supervision of a clinical neurophysiologist experienced with IONM. Evidence was insufficient to evaluate IONM when conducted by technicians alone or by an automated device.



The American Academy of Neurology (AAN) published a model policy on principles of coding for IONM and testing in 2012.<sup>26</sup> The background section of this document provides the following information on the value of IONM in averting neural injuries during surgery:

1. "Value of EEG Monitoring in Carotid Surgery. Carotid occlusion, incident to carotid endarterectomies, poses a high risk for cerebral hemispheric injury. EEG monitoring is capable of detecting cerebral ischemia, a serious prelude to injury. Studies of continuous monitoring established the ability of EEG to correctly predict risks of postoperative deficits after a deliberate, but necessary, carotid occlusion as part of the surgical procedure. The surgeon can then respond to adverse EEG events by raising blood pressure, implanting a shunt, adjusting a poorly functioning shunt, or performing other interventions.
2. Multicenter Data in Spinal Surgeries. An extensive multicenter study conducted in 1995 demonstrated that IOM [intraoperative neurophysiologic monitoring] using SEP reduced the risk of paraplegia by 60% in spinal surgeries. The incidence of false negative cases, wherein an operative complication occurred without having been detected by the monitoring procedure, was small: 0.06%.
3. Technology Assessment of Monitoring in Spinal Surgeries. A technology assessment by the McGill University Health Center reviewed 11 studies and concluded that spinal IOM is capable of substantially reducing injury in surgeries that pose a risk to spinal cord integrity. It recommended combined SEP/MEP monitoring, under the presence or constant availability of a monitoring physician, for all cases of spinal surgery for which there is a risk of spinal cord injury.
4. Value of Combined Motor and Sensory Monitoring. Numerous studies of post-surgical paraparesis and quadriparesis have shown that both SEP and MEP monitoring had predicted adverse outcomes in a timely fashion. The timing of the predictions allowed the surgeons the opportunity to intervene and prevent adverse outcomes. The two different techniques (SEP and MEP) monitor different spinal cord tracts. Sometimes, one of the techniques cannot be used for practical purposes, for anesthetic reasons, or because of preoperative absence of signals in those pathways. Thus, the decision about which of these techniques to use needs to be tailored to the individual patient's circumstances.
5. Protecting the Spinal Cord from Ischemia during Aortic Procedures. Studies have shown that IOM accurately predicts risks for spinal cord ischemia associated with clamping the aorta or ligating segmental spinal arteries. IOM can assess whether the spinal cord is tolerating the degree of relative ischemia in these procedures. The surgeon can then respond by raising blood pressure, implanting a shunt, re-implanting segmental vessels, draining spinal fluid, or through other interventions.



6. Value of EMG [electromyography] Monitoring. Selective posterior rhizotomy in cerebral palsy significantly reduces spasticity, increases range of motion, and improves functional skills. Electromyography during this procedure can assist in selecting specific dorsal roots to transect. EMG can also be used in peripheral nerve procedures that pose a risk of injuries to nerves.
7. Value of Spinal Monitoring using SSEP and MEPs. According to a recent review of spinal monitoring using SSEP and MEPs by the Therapeutics and Technology Assessment Subcommittee of AAN and ACNS, IOM is established as effective to predict an increased risk of the adverse outcomes of paraparesis, paraplegia, and quadriplegia in spinal surgery (4 Class I and 7 Class II studies). Surgeons and other members of the operating team should be alerted to the increased risk of severe adverse neurologic outcomes in patients with important IOM changes (Level A)."

The AAN model policy also offered guidance on personnel and monitoring standards for IONM and SSEP.

### ***American Society of Neurophysiological Monitoring***

In 2013, the American Society of Neurophysiological Monitoring published practice guidelines on the supervising professional on IONM.<sup>3</sup> The Society's 2013 position statement on intraoperative MEP monitoring indicated that MEPs are an established practice option for cortical and subcortical mapping and monitoring during surgeries risking motor injury in the brain, brainstem, spinal cord or facial nerve.<sup>27</sup>

### ***National Institute for Health and Care Excellence***

A 2008 guidance from the National Institute for Health and Care Excellence on IONM during thyroid surgery found no major safety concerns.<sup>28</sup> Regarding efficacy, IONM was indicated as helpful "in performing more complex operations such as reoperative surgery and operations on large thyroid glands."

## **Medicare National Coverage**

The Centers for Medicare & Medicaid Services has indicated that EEG monitoring "may be covered routinely in carotid endarterectomies and in other neurological procedures where



cerebral perfusion could be reduced. Such other procedures might include aneurysm surgery where hypotensive anesthesia is used or other cerebral vascular procedures where cerebral blood flow may be interrupted.”<sup>29</sup> Coverage determinations for other modalities were not identified.

For 2013, the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule Final Rule discussed payment of neurophysiologic monitoring. The rule states that CPT code 95940, which is reported when a physician monitors a patient directly, is payable by Medicare. CPT code 95941, which is used for remote monitoring, was made invalid for submission to Medicare.

In the Final Rule, CMS established a HCPCS G code for reporting physician monitoring performed from outside of the operating room (nearby or remotely). HCPCS code G0453 “may be billed only for undivided attention by the monitoring physician to a single beneficiary [1:1 technologist to oversight physician billing], and not for simultaneous attention by the monitoring physician to more than one patient.”<sup>30</sup>

## Regulatory Status

A number of electroencephalography (EEG) and electromyography (EMG) monitors have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. FDA product code: GWQ.

Intraoperative neurophysiologic monitoring (IONM) of motor-evoked potentials (MEPs) using transcranial **magnetic** stimulation does not have FDA approval.

## References

1. American Academy of Neurology. Assessment: intraoperative neurophysiology. Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology*. Nov 1990;40(11):1644-1646. PMID 2234418
2. Nuwer MR, Emerson RG, Galloway G, et al. Evidence-based guideline update: intraoperative spinal monitoring with somatosensory and transcranial electrical motor evoked potentials: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the American Clinical Neurophysiology Society. *Neurology*. Feb 21 2012;78(8):585-589. PMID 22351796
3. Skinner SA, Cohen BA, Morledge DE, et al. Practice guidelines for the supervising professional: intraoperative neurophysiological monitoring. *J Clin Monit Comput*. Apr 2014;28(2):103-111. PMID 24022172
4. American Clinical Neurophysiology Society. ACNS Guidelines and Consensus Statements. 2009; <http://www.acns.org/practice/guidelines> Accessed September 2018.





5. American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS). AANS/CNS Joint Section on disorders of the spine and peripheral Nerves. Updated Position Statement: Intraoperative electrophysiological monitoring. 2014; <http://www.spinesection.org/files/pdfs/IOM%20Position%20Statement%2004.24.2014.pdf> Accessed September 2018.
6. Resnick DK, Choudhri TF, Dailey AT, et al. Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 15: electrophysiological monitoring and lumbar fusion. *J Neurosurg Spine*. Jun 2005;2(6):725-732. PMID 16028743
7. Sharan, A, Resnick, DK, et al, Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 15: electrophysiological monitoring and lumbar fusion. *J Neurosurg Spine*. Jul 2014; 21 (1): 102-105. PMID 24980592.
8. American Association of Neuromuscular & Electrodiagnostic Medicine. Position Statement: Recommended Policy for Electrodiagnostic Medicine. 2014; <http://www.aanem.org/getmedia/884f5b94-a0be-447e-bdae-20d52aaf8299/Recommended-Policy-for-Electrodiagnostic-Medicine.pdf> Accessed September 2018.
9. American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM). Position Statement. Technologists conducting nerve conduction studies and somatosensory evoked potential studies independently to be reviewed by a physician at a later time. Approved by the American Association of Electrodiagnostic Medicine May 1999b. Copyright ©1995- 2010; by the AANEM.
10. Henry BM, Graves MJ, Vikse J, et al. The current state of intermittent intraoperative neural monitoring for prevention of recurrent laryngeal nerve injury during thyroidectomy: a PRISMA-compliant systematic review of overlapping meta-analyses. *Langenbecks Arch Surg*. Jun 2017;402(4):663-673. PMID 28378238
11. Pisanu A, Porceddu G, Podda M, et al. Systematic review with meta-analysis of studies comparing intraoperative neuromonitoring of recurrent laryngeal nerves versus visualization alone during thyroidectomy. *J Surg Res*. May 1 2014;188(1):152-161. PMID 24433869
12. Sun W, Liu J, Zhang H, et al. A meta-analysis of intraoperative neuromonitoring of recurrent laryngeal nerve palsy during thyroid reoperations. *Clin Endocrinol (Oxf)*. Nov 2017;87(5):572-580. PMID 28585717
13. Pardal-Refoyo JL, Ochoa-Sangrador C. Bilateral recurrent laryngeal nerve injury in total thyroidectomy with or without intraoperative neuromonitoring. Systematic review and meta-analysis. *Acta Otorrinolaringol Esp*. Mar-Apr 2016;67(2):66-74. PMID 26025358
14. Barczynski M, Konturek A, Cichon S. Randomized clinical trial of visualization versus neuromonitoring of recurrent laryngeal nerves during thyroidectomy. *Br J Surg*. Mar 2009;96(3):240-246. PMID 19177420
15. Vasileiadis I, Karatzas T, Charitoudis G, et al. Association of intraoperative neuromonitoring with reduced recurrent laryngeal nerve injury in patients undergoing total thyroidectomy. *JAMA Otolaryngol Head Neck Surg*. Oct 1 2016;142(10):994-1001. PMID 27490310
16. Ajiboye RM, Zoller SD, Sharma A, et al. Intraoperative neuromonitoring for anterior cervical spine surgery: What is the evidence? *Spine (Phila Pa 1976)*. Mar 15 2017;42(6):385-393. PMID 27390917
17. Erwood MS, Hadley MN, Gordon AS, et al. Recurrent laryngeal nerve injury following reoperative anterior cervical discectomy and fusion: a meta-analysis. *J Neurosurg Spine*. Aug 2016;25(2):198-204. PMID 27015129
18. Zhong D, Zhou Y, Li Y, et al. Intraoperative recurrent laryngeal nerve monitoring: a useful method for patients with esophageal cancer. *Dis Esophagus*. Jul 2014;27(5):444-451. PMID 23020300
19. Kneist W, Kauff DW, Juhre V, et al. Is intraoperative neuromonitoring associated with better functional outcome in patients undergoing open TME? Results of a case-control study. *Eur J Surg Oncol*. Sep 2013;39(9):994-999. PMID 23810330
20. Kneist W, Kauff DW, Rubenwolf P, et al. Intraoperative monitoring of bladder and internal anal sphincter innervation: a predictor of erectile function following low anterior rectal resection for rectal cancer? Results of a prospective clinical study. *Dig Surg*. Feb 2013;30(4-6):459-465. PMID 24481247



21. Clarkson JH, Ozyurekolu T, Mujadzic M, et al. An evaluation of the information gained from the use of intraoperative nerve recording in the management of suspected brachial plexus root avulsion. *Plast Reconstr Surg.* Mar 2011;127(3):1237-1243. PMID 21364425
22. Zhang W, Chen M, Zhang W, et al. Use of electrophysiological monitoring in selective rhizotomy treating glossopharyngeal neuralgia. *J Craniomaxillofac Surg.* Jul 2014;42(5):e182-185. PMID 24095216
23. Ochs BC, Herzka A, Yaylali I. Intraoperative neurophysiological monitoring of somatosensory evoked potentials during hip arthroscopy surgery. *Neurodiagn J.* Dec 2012;52(4):312-319. PMID 23301281
24. Jahangiri FR. Multimodality neurophysiological monitoring during tibial/fibular osteotomies for preventing peripheral nerve injuries. *Neurodiagn J.* Jun 2013;53(2):153-168. PMID 23833842
25. Nagda SH, Rogers KJ, Sestokas AK, et al. Neer Award 2005: Peripheral nerve function during shoulder arthroplasty using intraoperative nerve monitoring. *J Shoulder Elbow Surg.* May-Jun 2007;16(3 Suppl):S2-8. PMID 17493556
26. Sharan A, Groff MW, Dailey AT, et al. Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 15: electrophysiological monitoring and lumbar fusion. *J Neurosurg Spine.* Jul 2014;21(1):102-105. PMID 24980592
27. American Clinical Neurophysiology Society. Guideline 11A: Recommended Standards for Neurophysiologic Intraoperative Monitoring – Principles. 2009; <https://www.acns.org/pdf/guidelines/Guideline-11A.pdf> Accessed September 2018.
28. American Academy of Neurology. Model Coverage Policy: Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing. 2012; [https://www.aan.com/siteassets/home-page/tools-and-resources/practicing-neurologist--administrators/billing-and-coding/model-coverage-policies/16iommodelpolicy\\_tr.pdf](https://www.aan.com/siteassets/home-page/tools-and-resources/practicing-neurologist--administrators/billing-and-coding/model-coverage-policies/16iommodelpolicy_tr.pdf) Accessed September 2018.
29. Macdonald DB, Skinner S, Shils J, et al. Intraoperative motor evoked potential monitoring - A position statement by the American Society of Neurophysiological Monitoring. *Clin Neurophysiol.* Dec 2013;124(12):2291-2316. PMID 24055297
30. National Institute for Health and Care Excellence (NICE). Intraoperative nerve monitoring during thyroid surgery [IPG255]. 2008; <https://www.nice.org.uk/guidance/ipg255/chapter/1-guidance> Accessed September 2018.
31. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Electroencephalographic Monitoring During Surgical Procedures Involving the Cerebral Vasculature (160.8). 2006; <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=77&ncdver=2&CoverageSelection=National&Keyword=monitoring&KeywordLookUp=Title&KeywordLookUp=Title&KeywordLookUp=Title&KeywordSearchType=And&KeywordSearchType=And&KeywordSearchType=And&bc=gAAAACAAAA&>. Accessed September 2018.
32. Centers for Medicare & Medicaid Services. Billing Medicare for Remote Intraoperative Neurophysiology Monitoring in CY 2013. 2012; <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Remote-IONM.pdf> Accessed September 2018.

## History

Date	Comments
11/01/17	New policy, approved October 10, 2017, effective February 2, 2018. This policy was previously archived and is now reinstated. Add to Surgery section. Literature review through October 2016. Intraoperative monitoring is considered medically necessary for high risk thyroid and anterior cervical spine surgeries



Date	Comments
12/01/17	Interim Review, approved November 14, 2017, effective February 2, 2018. Identified spinal, intracranial and vascular, and recurrent laryngeal nerve surgical procedures that meet policy criteria. References 31-36 added. Removed CPT codes 92585 - 95939 and 95955.
04/01/18	Coding update, added CPT codes 95925, 95926, 95927, 95928, 95929, 95930, 95938, and 95939.
07/01/18	Annual Review, approved June 5, 2018. Policy updated with literature review through February 2018; references 8, 10, and 14 added; references 6-7 updated. Removed statement that ION of visual evoked potentials is investigational. Otherwise, policy statements unchanged. Removed CPT codes 95925, 95926, 95927, 95928, 95929, 95930, 95938, and 95939.
08/01/18	Interim Review, approved July 25, 2018. Minor edit. Thoracic spine surgery added to list of medically necessary surgical procedures for ION.
10/01/18	Interim Review, approved September 20, 2018. References 7 and 9 added. Content added to Related Information for greater clarification of not medically necessary policy statement.

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2018 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.



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Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

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Civil Rights Coordinator - Complaints and Appeals  
PO Box 91102, Seattle, WA 98111  
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357  
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services  
200 Independence Avenue SW, Room 509F, HHH Building  
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Getting Help in Other Languages**

**This Notice has Important Information.** This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

**አማርኛ (Amharic):**

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀዳሾች ሊኖሩ ይችላሉ። የጤና ሽፋንዎን ለመጠበቅና በአስፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና የለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መሰታወቅ አለዎት። በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

**العربية (Arabic):**

يحتوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تزيد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تاريخ معينه للحفاظ على تغطيتك الصحية أو المساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ 800-722-1471 (TTY: 800-842-5357)

**中文 (Chinese):**

**本通知有重要的訊息。**本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

**Oromoo (Cushite):**

**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

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**Cet avis a d'importantes informations.** Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

**Kreyòl ayisyen (Creole):**

**Avi sila a gen Enfòmasyon Enpòtan ladann.** Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resewva enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

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**Diese Benachrichtigung enthält wichtige Informationen.** Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

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**Tsawb ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tej zaum tsawb ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam hnu ntawm Premera Blue Cross. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas pab kom koj ua tsis pub dhau cov caij nyuog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

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**ភាសាខ្មែរ (Khmer):**

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរៀបចំរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាព ដល់កិច្ចការផ្ទៃក្នុងដូចជា ធានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងអនាគតរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

**ਪੰਜਾਬੀ (Punjabi):**

ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਨਵ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਰਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਢੁੱਝ ਖਾਸ ਕਰਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੋਂ ਅਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

**فارسی (Farsi):**

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کلیران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

**Polskie (Polish):**

To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

**Português (Portuguese):**

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

**Română (Romanian):**

Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența provizorie la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

**Русский (Russian):**

Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

**Fa'asamoa (Samoan):**

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

**Español (Spanish):**

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

**Tagalog (Tagalog):**

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganiitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

**ไทย (Thai):**

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับกาการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

**Український (Ukrainian):**

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страховального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

**Tiếng Việt (Vietnamese):**

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).