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.

POLICY COVERAGE CRITERIA
### Intraoperative Monitoring

<table>
<thead>
<tr>
<th></th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Somatosensory-evoked potentials</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Motor-evoked potentials using transcranial electrical stimulation</strong></td>
<td></td>
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<tr>
<td><strong>Brainstem auditory-evoked potentials</strong></td>
<td></td>
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<tr>
<td><strong>Electromyography (EMG) of cranial nerves</strong></td>
<td></td>
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<tr>
<td><strong>Electroencephalography</strong></td>
<td></td>
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<tr>
<td><strong>Electrocorticography</strong></td>
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</table>

Intraoperative neurophysiologic monitoring for ANY other indication, including during lumbar surgery below L1/L2 is considered not medically necessary.

<table>
<thead>
<tr>
<th></th>
<th>The types of Intraoperative neurophysiologic monitoring, listed on the left during surgery on the peripheral nerves are considered not medically necessary.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMG</strong></td>
<td></td>
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<tr>
<td><strong>Nerve conduction velocity monitoring</strong></td>
<td></td>
</tr>
<tr>
<td>Intraoperative Monitoring</td>
<td>Investigational</td>
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<td>--------------------------</td>
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<tr>
<td>• Somatosensory-evoked potentials</td>
<td>The types of Intraoperative neurophysiologic monitoring, listed on the left during the following surgical procedures are considered investigational:</td>
</tr>
<tr>
<td>• Motor-evoked potentials using transcranial electrical stimulation</td>
<td>• Esophageal surgeries</td>
</tr>
<tr>
<td>• Brainstem auditory-evoked potentials</td>
<td></td>
</tr>
<tr>
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<td>• Electrocorticography</td>
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</table>

<table>
<thead>
<tr>
<th>Visual-evoked potentials</th>
<th>Intraoperative monitoring of visual-evoked potentials is considered investigational.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Motor-evoked potentials using transcranial magnetic stimulation</th>
<th>Due to the lack of monitors approved by the U.S. Food and Drug Administration, intraoperative monitoring of motor-evoked potentials using transcranial magnetic stimulation is considered investigational.</th>
</tr>
</thead>
</table>

### Coding

### Medically Necessary

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>CPT</strong></td>
<td></td>
</tr>
<tr>
<td>95940</td>
<td>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)</td>
</tr>
<tr>
<td>95941</td>
<td>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)</td>
</tr>
<tr>
<td><strong>HCPCS</strong></td>
<td></td>
</tr>
<tr>
<td>G0453</td>
<td>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)</td>
</tr>
</tbody>
</table>

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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 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.

Intraoperative 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.

Intraoperative 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

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 (i.e,
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 further broken down into the following categories by type of simulation used.
**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 by pulsed magnetic stimulation provided by 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 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.\(^1-^7\) Additionally, this policy addresses on 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. A qualitative systematic review found moderate evidence that monitoring endotracheal cuff pressure reduced the incidence of vocal cord palsy, but there was insufficient data to recommend the routine use of electromyography. A 2016 meta-analysis found a high rate of RLN injury following revision anterior cervical discectomy and fusion, but the magnitude of the problem with current surgical procedures is uncertain. No studies were identified that evaluated whether IONM reduces RLN injury in anterior cervical spine surgeries. 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. There is insufficient evidence to evaluate 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.

In 2017, clinical input was also supportive of IONM of the RLN during anterior cervical spine surgery associated with any of the following increased risk situations:

- 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
- preexisting RLN pathology, when there is residual function of the RLN.

**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**

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
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<tr>
<td>NCT No.</td>
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<td>Completion Date</td>
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</tr>
<tr>
<td>NCT02395146</td>
<td>Intra-operative Monitoring of the External Branch of the Superior Laryngeal Nerve (EBSLN) During Thyroid Surgery: Does it Improve Voice Preservation?</td>
<td>60</td>
<td>Aug 2017</td>
</tr>
<tr>
<td>NCT01585727</td>
<td>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)</td>
<td>188</td>
<td>Dec 2017</td>
</tr>
<tr>
<td>NCT01630785</td>
<td>Observation of Neurosurgical Interventions With Intraoperative Neurophysiological Monitoring IONM</td>
<td>5000</td>
<td>Dec 2023</td>
</tr>
<tr>
<td>Unpublished</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02187653</td>
<td>Spine Registry Exposure for Lumbar and Cervical Surgery Utilizing IOM</td>
<td>10,000</td>
<td>Dec 2016 (unknown)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

*a* 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 provide appropriate reviewers who collaborate with and make recommendations during this process, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

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 of 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 Neuromuscular & Electrodiagnostic Medicine**

A 2013 position statement on somatosensory-evoked potentials (SSEPs) from the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) indicated that intraoperative sensory-evoked potentials (SEPs) are useful for monitoring of spinal cord, brainstem, brain sensory tracts and select spine surgeries where there is a risk of additional nerve root or spinal cord injury. 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 indicating:

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. 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 a model policy in 2012 on the value of IONM in averting neural injuries during surgery with the following summary

1. “Value of EEG Monitoring in Carotid Surgery. EEG monitoring is capable of detecting cerebral ischemia, a serious prelude to injury. 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. IOM [intraoperative neurophysiologic monitoring] using SEP reduced the risk of paraplegia by 60% in spinal surgeries. The incidence of false negative cases, (where an operative complication occurred without having been detected), was small: 0.06%.

3. Technology Assessment of Monitoring in Spinal Surgeries. Spinal IOM is capable of substantially reducing injury in surgeries that pose a risk to spinal cord integrity. It is recommended for all cases of spinal surgery for which there is a risk of spinal cord injury.

4. Value of Combined Motor and Sensory Monitoring. Both SEP and MEP monitoring have predicted adverse outcomes in post-surgical paraparesis and quadriparesis 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. 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. IOM accurately predicts risks for spinal cord ischemia associated with clamping the aorta or ligating segmental spinal arteries. The surgeon can then respond by raising blood pressure, implanting a shunt, re-implanting segmental vessels, draining spinal fluid, or other interventions.

6. Value of Spinal Monitoring using SSEP and MEPs. IOM is established as effective to predict an increased risk of the adverse outcomes of paraparesis, paraplegia, and quadriplegia in spinal surgery. 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)."

**Medicare National Coverage**

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.” Coverage determinations for other modalities were not identified.
In 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 (see Policy Guidelines section) 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.”

Regulatory Status

A number of electroencephalography and electromyography 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 of motor-evoked potentials using transcranial magnetic stimulation does not have FDA approval.

References

6. American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS). Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 15: electrophysiologic monitoring and


29. Centers for Medicare and Medicaid Services. National Coverage Determination (NCD) for Electroencephalographic Monitoring During Surgical Procedures Involving the Cerebral Vasculature (160.8). 2006; http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=77&ncdver=2&CovPageStoreKey=monitoring&KeyWordLookUp=Title&KeyWordLookUp=Title&KeyWordLookUp=Title&KeyWordSearchType=And&KeyWordSearchType=And&KeyWordSearchType=And&KeyWordLookUp=Title&KeyWordLookUp=Title&KeyWordSearchType=And&KeyWordSearchType=And&KeyWordSaveType=And&KeyWordSaveType=And&KeyWordSaveType=And&bc=gAAAACAAAAAA& Accessed November 2017.


necessary for high risk thyroid and anterior cervical spine surgeries

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
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</thead>
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<tr>
<td>04/01/18</td>
<td>Coding update, added CPT codes 95925, 95926, 95927, 95928, 95929, 95930, 95938, and 95939.</td>
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<tr>
<td>06/07/18</td>
<td>Coding updated, removed CPT codes 95925, 95926, 95927, 95928, 95929, 95930, 95938, and 95939, effective June 1, 2018. These codes do not relate specifically to the intent of the policy.</td>
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</table>

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  - Information written in other languages

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U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S09F, HHH Building

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Premera Blue Cross

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Română (Romanian):

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).

Tagalog (Tagalog):

ไทย (Thai):
ประกาศนี้มีข้อมูลสิทธิ์ที่สำคัญเกี่ยวกับการสมัครหรือขยายการประกันสุขภาพของคุณ Premera Blue Cross และการปฏิบัติการในกรณีที่คุณต้องการในสาระสำคัญที่มีผลกระทบต่อการประกันสุขภาพของคุณหรือการดูแลสุขภาพของคุณ ทั้งนี้มีสิทธิ์ที่จะได้รับข้อมูลที่มีความสำคัญและต้องการในภาษานี้ตามที่ต้องการ โดยโทรศัพท์ 800-722-1471 (TTY: 800-842-5357).

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує ймовірність 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):