



December 2019

As many of our members are aware, there are Current Procedural Terminology (CPT) coding changes related to Long-Term Monitoring (LTM) that will go into effect on January 1, 2020. In anticipation of this, ASET has assembled the following frequently asked questions (FAQs) to use as a reference.

FAQs

What codes are no longer being used?

Several codes will be deleted as of 12/31/2019. Codes being deleted are: 95827, 95950, 95951, 95953, 95956.

What are the new codes?

There are multiple new codes for LTM; there will be separate codes for technical and professional services. The codes are further delineated by whether the study includes video or not, the length of the recording, and the level of monitoring provided.

Technical Component Codes

95700*- (Setup code) Performed in person by the EEG technologist(s) and includes setup, takedown, and patient education. Can only be used once. Same code is used with or without video. Code can be used at any site of service.

*95999- For setup performed by non-EEG technologist. Also used for patient-placed electrode sets.

| Recording Type | Duration | Unmonitored | Intermittent | Continuous |
|-----------------------|-----------------|--------------------|---------------------|-------------------|
| EEG | 2-12 hours | 95705 | 95706 | 95707 |
| EEG | 12-26 hours | 95708 | 95709 | 95710 |
| EEG with Video | 2-12 hours | 95711 | 95712 | 95713 |
| EEG with Video | 12-26 hours | 95714 | 95715 | 95716 |

What is the difference between unmonitored, intermittent, and continuous?

- Unmonitored- EEG is reviewed by an EEG technologist retrospectively or a real-time review that occurs at more than 2-hour intervals. Unmonitored also applies if the technologist is monitoring more than 12 patients. If the criteria for intermittent or continuous monitoring are not met (more than a 12:1 patient to tech ratio or EEG is not reviewed at least every 2 hours), then the study is considered an unmonitored study.
- Intermittent- Requires an EEG technologist to perform and document real-time *review of data at least every two hours* during the entire recording period to ensure the integrity and quality of the recording (i.e. EEG, VEEG), identify the need for maintenance, and, as needed, alert the

physician or other qualified health care professional of critical issues. For intermittent monitoring, a single EEG technologist may *monitor a maximum of 12 patients concurrently*. The monitoring can be done on-site or remotely. If the number of intermittently monitored patients exceeds 12, then all of the studies are reported as unmonitored.

- Continuous- Requires all elements of intermittent monitoring. Additionally, the EEG technologist performs and documents *real-time monitoring of the EEG data and video (when performed) during the entire recording period*. The EEG technologist identifies when events occur and alerts, as needed, the physician or other qualified healthcare professional of critical issues. For continuous monitoring, a single EEG technologist may *monitor a maximum of four patients concurrently (4:1 patient to tech ratio)*. The monitoring can be done on-site or remotely. If the number of concurrently monitored patients exceeds four, then all of the studies are reported as either unmonitored or intermittent studies. If there is a break in the real-time monitoring of the EEG recording, the study is intermittent.

Professional Component Codes (for physician work only)

One day codes*

| Recording Type | Duration | Real-time, daily review and report |
|-----------------------|-----------------|---|
| EEG | 2-12 hours | 95717 |
| EEG | 12-26 hours | 95719 |
| EEG with Video | 2-12 hours | 95718 |
| EEG with Video | 12-26 hours | 95720 |

*Requires real-time, daily review and reports completed. Requires final summary at the conclusion of recording.

Multi-day codes*

| Recording Type | 36-60 hours typically, 2 days | 60-84 hours typically, 3 days | Greater than 84 hours typically, 4 days |
|-----------------------|--------------------------------------|--------------------------------------|--|
| EEG | 95721 | 95723 | 95725 |
| EEG with Video | 95722 | 95724 | 95726 |

*Used one time for retrospective review. Requires one report at the conclusion of monitoring which summarizes all days. These codes will typically be used for ambulatory studies.

Are there changes to the routine EEG codes used?

For the most part, routine codes used for studies recorded for less than 2 hours remain the same. The one exception is 95813 is now described as an EEG that is 61-119 minutes in duration.

Do these codes apply to pediatric and adult patients?

Yes, these codes will be used for all patient populations.

Does a R. EEG T. have to perform the study?

The AMA 2020 Coding book defines an EEG technologist as follows, “An individual who is qualified by education, training, licensure/certification/regulation (when applicable) in seizure recognition. An EEG technologist(s) performs EEG setup, takedown when performed, patient education, technical description, maintenance, and seizure recognition when within his or her scope of practice and as allowed by law, regulation, and facility policy (when applicable).”

Will reimbursement change?

Since these are new codes the level of reimbursement will be based on contractor pricing in 2020 for the technical component codes. Rates will be set by regional Medicare Administrative Contractors (MAC) for services when applicable. Private payers will be able to negotiate fee structure.

It is important to note, hospitals will continue to be paid by the Diagnosis-Related Group (DRG) for inpatient services. However, many hospitals use these codes for budgeting and allocating resources so appropriate use is still necessary.

CMS has established national pricing for the professional component codes. Visit the resources listed below for specific details.

What can I do to prepare?

This is not meant as an exhaustive list but a starting point. Talk to your administrator and billing department. You need to make sure everyone is aware of the coding changes. The new codes need to be added to your electronic medical record for ordering, billing, and reporting purposes. Ensure you have documentation tools in place to meet the technical requirements. Discuss staffing needs. Meet with your physicians to evaluate how their workload and reporting times will change. We encourage you to be collaborative within your organization as this will be the best way to ease this transition.

What is ASET doing?

Throughout this year ASET has been very active in monitoring and responding to the proposed coding changes. We have worked in conjunction with industry and physician groups to stay abreast of the changes. We issued several website updates in addition to blast emails and a social media campaign with a “Call to Action”. Once the final rule was made public, we updated our website and sent the update to our membership. We have generated this document in response to members’ concerns. We have a free, recorded webinar available on our website with details on the new codes. Additionally, we have an extended webinar scheduled on *January 15, 2020* to provide more information. Lastly, since these codes are new, we will continue to monitor any changes and update our membership.

Additional resources:

ASET- The Neurodiagnostic Society

www.aset.org

American Academy of Neurology (AAN)

<https://www.aan.com/tools-and-resources/practicing-neurologists-administrators/billing-and-coding/cpt-em/>

American Epilepsy Society (AES)

https://www.aesnet.org/clinical_resources/practice_management/billing_coding

National Association of Epilepsy Centers (NAEC)

<https://www.naec-epilepsy.org/naec-updates-resources/>

Centers for Medicare and Medicaid Services (CMS) code (Pages 738 to 784 pertain to EEG codes)

<https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other>