

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Check out How to Code These 4 Common EEG Scenarios

Here's how to differentiate 'drowsy' or 'asleep' choice.

Electroencephalograms (EEGs) can be some of the most common procedures your neurologist performs ☐ but how well do you know the ins and outs of the codes? Test yourself by reading these common questions and expert answers.

Question 1: What's the Difference Between 'Drowsy' and Asleep'?

Typically, neurologists use 95816 (Electroencephalogram [EEG]; including recording awake and drowsy) and 95819 (Electroencephalogram [EEG]; including recording awake and asleep) to identify abnormalities associated with the transition from awake to sleep or vice versa.

The key: When trying to choose between 95816 and 95819, let the circumstances that prevail during testing determine the code you report.

For instance, a patient comes to see a neurologist because of seizures (780.39, Other convulsions). The neurologist orders an awake and asleep study (95819) because changes commonly associated with seizure disorders such as epilepsy tend to occur during those periods of transition.

Important: As with any type of coding you do, don't automatically report the procedure the neurologist orders without verifying the details. If you review the test results for the example above and the person was awake and asleep, bill 95819; if the patient didn't fall asleep, bill 95816 instead.

Remember E/M: Watch for opportunities to report services in addition to the EEG. If the neurologist provided a separate E/M service on the same day (such as 99204, Office or other outpatient visit for the evaluation and management of a new patient ...), you can report the appropriate E/M code in addition to the EEG code. You might need to append modifier 25 (Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code to show the two services were separate and distinct from one another.

"There isn't a coding edit between the two EEG codes and either the new or established patient E/M codes," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, of MJH Consulting in Denver, Co. "Some commercial payers, however, may use their own proprietary bundling edits that may require use of the 25 modifier."

Another possibility: CPT® includes a third code for EEG, 95822 (Electroencephalogram [EEG]; recording in coma or sleep only). As seen by the descriptor, only report the "sleep only" code for patients who are comatose, anesthetized or neonates.

Question 2: What Qualifies as 'Extended'?

A "typical" EEG (for example, 95816, 95819 or 95822) lasts about 20-40 minutes, according to CPT® guidelines. For monitoring that lasts 41 minutes to one hour, submit 95812 (Electroencephalogram [EEG] extended monitoring; 41-60 minutes). For monitoring of an hour or more, report 95813 (...greater than one hour).

Caution: Do not report an extended EEG and a routine EEG on the same claim. The extended EEG codes are not add-on codes, but are designed to replace 95816, 95819, or 95822 for diagnostic EEG testing lasting 40 minutes or more.

Example: The neurologist meets with a new patient, who complains of memory loss (780.93). The neurologist performs a 50-minute EEG to determine the nature and cause of the memory loss. In this case, report 95812 for the EEG and the appropriate E/M code, with modifier -25 appended, for the initial office visit. Attach diagnosis 780.93 to both codes.

Question 3: When Can We Report Long-Term EEG?

To report long-term monitoring (95950-95951, 95953, 95956), the neurologist first must have conducted conventional EEG studies (such as 95816, 95819, 95822 or 95827) to determine medical necessity for the more extensive tests, according to Medicare and most third-party payer guidelines. A typical Medicare coverage policy states simply, "Reimbursement [for long-term EEG monitoring] is limited to patients in whom a seizure disorder is suspected, but unconfirmed by conventional EEG studies."

Long-term EEGs are "seizure-focus" in nature, meaning the neurologist orders the tests to track and analyze brain seizures, such as those common in epilepsy patients. Specifically, these tests allow neurologists to pinpoint the reasons for seizures and to help them localize the portion of the brain affected.

Example: A patient has extended convulsive seizures (or status epilepticus, 345.3) □ confirmed during previous testing □ that require surgery to correct. To find the exact location in the brain where the seizures originate, the neurologist orders a long-term study (95951, Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic [EEG] and video recording and interpretation [e.g., for presurgical localization], each 24 hours).

Question 4: What Happens When the Tests Lasts Less Than 24 Hours?

When monitoring tests less than 24 hours, you may still be able to report the appropriate long-term monitoring code, although you may need to append modifier -52 (Reduced services), depending on exactly how long the monitoring lasted. According to current CPT® guidelines, "Codes 95950-95953 and 95956 are used per 24 hours of recording. For recording more than 12 hours, do not use modifier 52. For recording 12 hours or less, use modifier 52."