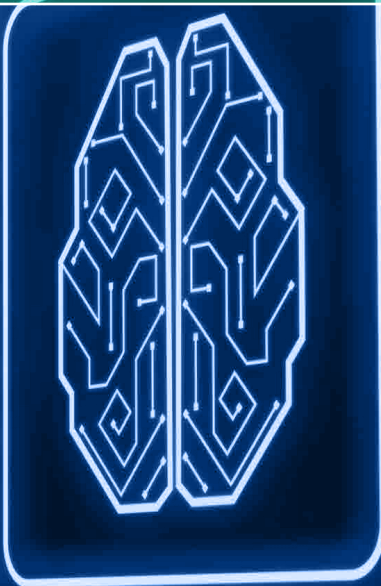


EEG CPT Codes

**A Guide to Surviving and Thriving
in the New EEG Economy**



Imagine EEG Anywhere

Updated August 2021



Dear Reader,

I embarked on this journey to better understand and educate others about the new 2020 CPT© code and to advocate for epilepsy patients, many of whom are underserved. Ensuring patients have access to the diagnosis and care they so desperately need is critical. Along the way, I've learned a great deal about EEG medical coding and participated with other EEG industry leaders to help lobby Congress and CMS to reconsider the AMA's CPT coding for long-duration EEG technical and physician reimbursement.*

The good news is that our elected leaders listened in 2020 and are continuing to listen in 2021. There was an initial reprieve to the proposed severe cuts to the technical codes, and while there is a level of consistency and predictability concerning reimbursement across the nation, it is not applied in all areas.

The COVID-19 pandemic of 2020/21 has taught us that there is a growing need and requirement for quality long-term EEG services to be provided outside of the hospital setting. The need became more urgent when epilepsy monitoring units were closed due to demand for Covid beds - and we are seeing this happen again with the current Delta variant. It has also emphasized the need for remote EEG monitoring from any location providing social distancing between the staff and patient.

During my national speaking engagements on the topic, I've had numerous requests for more information. This guide provides timely, actionable information those in the EEG community can act upon now. By raising our voices to our elected officials and understanding how CPT codes have been impacted, we can ensure reimbursement levels are maximized to ensure patients get the neurodiagnostic care they need.

To learn more, I strongly recommend purchasing a copy of the latest CPT© Professional Edition available from the AMA.

Thank you for your interest, and please reach out if I can answer any further questions.

Regards,

Simon Griffin,

Founder and Board Member [Lifelines Neuro](#)

[ASET Foundation Board Member](#)

[BioLOGIC Foundation Board Member](#)

Simon.Griffin@lifelinesneuro.com

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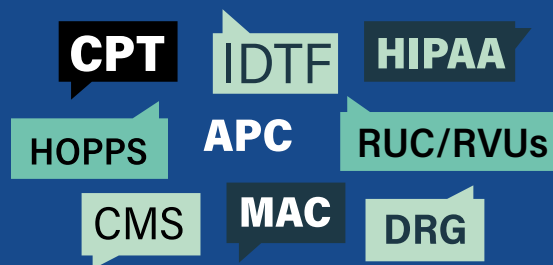
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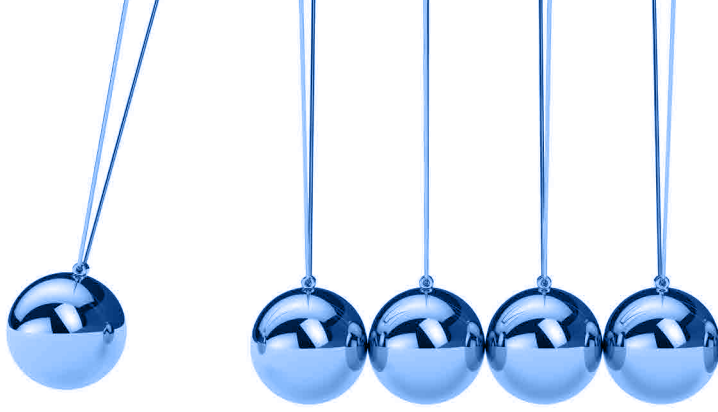
CPT Coding Terminology

Acronyms and how they will change your life!

While most of us are familiar with CMS and HIPAA, there are a few more to define when it comes to medical coding.



CMS	Centers for Medicare and Medicaid Services CMS is the government agency that administers Medicare and Medicaid, setting the rules for CPT coding.
HIPAA	HIPAA is the rule set that establishes protections for a patient’s personal health information, among many other things. The changes in CPT coding will impact HIPAA.
CPT	Current Procedural Terminology CPT© codes (copyright protected by the American Medical Association) are a structured and detailed set of codes that describe all medical procedures across all medical specialties.
IDTF	Independent Diagnostic Testing Facility IDTFs are independent diagnostic testing facilities that are able to perform diagnostic procedures and bill Medicare for these services. Video EEG service providers are such a business.
HOPPS	Hospital Outpatient Prospective Payment System HOPPS is used by CMS to reimburse for hospital outpatient services.
APC	Ambulatory Payment Classification APC is a series of classification codes, very similar, but not identical to CPT that is used to identify work that will be paid via the HOPPS system
DRG	Diagnosis Related Group DRG is the way in which a hospital receives payment for a patient that is admitted into the hospital as an inpatient. The hospital is paid based on the diagnosis of the patient regardless of the work that is performed in the care of that patient.
MAC	Medicare Administrative Contractor There are 12 regional MAC contractors that administer payments on behalf of Medicare.
RUC/ RVUs	AMA/Specialty Society RVS Update Committee (RUC) is a committee that describes the resources required to provide physician services which CMS considers in developing Relative Value Units (RVUs). RVUs are the measure of value Medicare uses for reimbursing physician services.



THE IMPACT

- Impacts on staffing levels
- Licensure and accreditation
- Reimbursement
- Physicians' professional reimbursement
- Impacts on regulatory and reporting
- Patient access and availability
- Inconsistent national payment structure

How Have 2020 CPT Coding Changes Impacted EEG Providers?

Everyone in the neurodiagnostic community has been impacted by the changes to the long-duration EEG codes introduced in 2020. Hospitals, IDTFs and private practices have all been scrambling to match staffing levels to the demands of the new coding. Patient access is at risk, more so in some areas of the country where reimbursement remains lower than average. It may be financially unfeasible to perform EEG studies in distant rural communities, threatening access. Evidence abounds that innovative solutions are being developed to extend the scope of care, however questions remain:

- Has this placed more requirements on the need for licensure and accreditation or has there been little change from the previous coding environment?
- What has been the impact of reimbursement change?
- Where fees have been reduced, have the services been stopped or is work being performed more efficiently in new ways?
- Physician professional reimbursement for reading and interpreting long-term EEG has been reduced. How have physicians responded to compensate for this reduced income?
- With these new rules came new requirements for documentation and regulatory control. What is going to be needed to justify and validate work performed in this new environment?
- What new tools can increase productivity without impacting patient care?
- What happens if all the testing is driven into the hospital, how will departments cope when they already have long waiting lists?

This has impacted everyone.

CPT Code Changes 2020

There are three key changes that impact long-duration EEG. The existing codes that have been in use for decades are deleted.

OLD GLOBAL CPT CODES

Technical & Professional CPT Codes
95950, 95951, 95953, 95956

DELETED

Code 95957 - Digital Analysis

This code cannot be used for running automated spike and seizure detection with the new codes. It can only be used for extra work performed such as dipole source localization.

NEW CPT CODES

Professional CPT Codes
For physician work only:
Creation of 10 Professional Component Codes

The new codes have been split into professional codes and technical codes. This is a big change because the four previous codes that are being eliminated were global codes that included the technical and professional components.

There are 10 professional codes that cover the physician work and 13 technical codes that do not include physician work.

Technical
No physician work included:
Creation of 13 Technical Component Codes

There were no changes to the LTM codes made for 2021. As of this writing (August 2021) the proposed CMS rule for 2022 does not include any changes to the Long-Term EEG Codes.

Technical Code Changes

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

95700 Setup Code

The new code 95700 is a significant change. This new code covers the supplies and work necessary to set up, maintain, and take down a patient. The specific supplies and activities that are included in this code will be outlined later.



The two hour or less routine EEG CPT codes remain unchanged

Recording Codes

A suite of 12 codes comprises the rest. There are two different durations of recording, from two to 12 hours and then from 12 to 26 hours. For each of these durations, there is a code with and without video in combination with EEG. Finally, there are different levels of vigilance that can be documented. Unmonitored is just that. There is no monitoring at all for the duration of the recording. The recording is initiated and then at the end of the recording period the data is uploaded, this would be analogous to a traditional ambulatory EEG. Intermittent monitoring is periodic vigilance and then finally continuous, where a recording is observed for the duration of the recording.



2 to 12 hours with a typical 8 hour duration

Studies < Two Hours Not Impacted

It is critical to understand that anything shorter than two hours in duration is not impacted by the CPT code changes. The short duration code set is unchanged and there is no change in the proposed payment. Note that you cannot bill the 95700 setup code for the shorter recordings.

The expectation is that a two to 12-hour study would be eight hours and that a 12 to 26-hour study would be 24 hours. This expectation is important, because the intent is that no one will be billing 12 hours and one minute routinely to achieve a higher reimbursement.



12 to 26 hours with a typical 24 hour duration

Monitoring Definitions

Continuous	Intermittent	Unmonitored
<ul style="list-style-type: none"> • Maximum of four patients • Location unspecified • Eyeballs on the recording 24/7 	<ul style="list-style-type: none"> • Maximum of 12 patients • Location unspecified • Five minutes per hour per patient. 	<ul style="list-style-type: none"> • 13 or more patients • No monitoring at all • Ambulatory study

The definitions of the monitoring are very important and will have a significant impact on the way in which facilities, offices and IDTFs staff their labs and business.

Continuous Monitoring

Continuous means just that, eyeballs on the recording 24/7 throughout the duration of the recording. However there is an important definition - at no time can the monitoring tech be viewing more than four concurrent patients or all the patients will be deemed to be intermittently monitored. This poses more questions: How can you prove that this ratio was not exceeded? How can you prove that the monitoring was continuous? What does that mean? Can a tech go to the bathroom? Can a tech look away from the screens? These ambiguities remain unresolved and will likely be addressed with future rules.



Intermittent Monitoring

The maximum patient to tech ratio is 12 for intermittent monitoring, with each patient observed or checked in on at least five minutes every hour or 10 minutes every two hours. The logic here is that the monitoring tech is rotating from screen to screen. Again, documenting this intermittent monitoring is not well defined.

The definitions of the monitoring are very important and will have a significant impact on the way in which facilities, offices and IDTFs staff their labs and business.



Definition – source AMA CPT Code Manual

EEG Technologist:

“An individual who is qualified by education, training, licensure/certification/ regulation in seizure recognition. An EEG tech 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).”

The definition of an EEG Technologist is critical. It is very important to note that it does not specify a Registered EEG Technologist (R. EEG T.) or a Certified Long Term Monitoring tech (CLTM). While those credentials are very important and would meet the definition, they are not specified.

It will be important for a facility or company to keep excellent records of credentials, training, and experience. A clear definition of “seizure recognition” needs to be defined. Is it the same definition for a hookup tech compared to a monitoring tech? The same people don’t all do the same work. A hookup tech may have documentation and training to support that they know how to recognize clinical seizures whereas a monitoring tech is trained to recognize electrographic seizures. The same would apply to a pruning/editing technologist.

Unmonitored:

“Services that have no real-time monitoring by an EEG tech during the continuous recording. If the criteria for intermittent or continuous monitoring are not met, then the study is an unmonitored study.”

Intermittent Monitoring (remote or on-site):

“Requires an EEG tech to perform and document real-time review of data at least every two hours during the entire recording period to assure the integrity and quality of the recording (ie., EEG, VEEG), identify the need for maintenance, and when necessary, notify the physician or other qualified health care professional of clinical issues. For intermittent monitoring, a single EEG technologist may monitor a max of 12 patients concurrently. If the number of intermittently monitored patients exceeds 12, then all of the studies are reported as unmonitored.”

Continuous Real-Time Monitoring (may be provided remotely):

“Requires all elements of intermittent monitoring. In addition, the EEG technologist performs and documents real-time concurrent monitoring of the EEG data and video (when performed) during the entire recording period. The EEG tech identifies when events occur and notifies, as instructed, the physician or other qualified healthcare professional.

For continuous monitoring, a single EEG tech may monitor a maximum of four patients concurrently. 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 an intermittent study. “

ASET position statement on the definition of a qualified neurodiagnostic technologist

Qualified Neurodiagnostic Technologists:

- Are credentialed
- Have met a minimum education and related educational and performance standards
- Meet continuing education requirements
- Perform within a code of ethics and defined scope of practice
- Perform under the direction of clinical leadership or a physician
- Are recognized by physicians, employers, the public, governmental agencies, payers and other health care professionals
- Form a national society whose activities include advocating for the profession, and
- Contribute to the advancement of knowledge in neuroscience.

-- Approved by the ASET Board of Trustees
May 27, 2020



Technical Codes – Implications and Response



Staffing & Patient Ratios

CPT code changes have had a significant impact on staffing. It is strongly advised that you conduct a detailed review of staffing ratios over the last two years to see how accurately staffing activity has been documented. Are you accomplishing the minimum requirements to provide the level of service that your standard of patient care requires? Many labs have found themselves understaffed and in need of additional personnel, or the assistance of third party contract monitoring services.



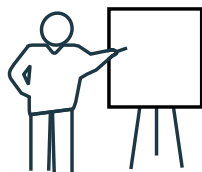
Billing and Reimbursement

It is important to understand how your facility bills and is reimbursed. If you are exclusively being reimbursed by DRG, then CPT codes may not be an impact. Many hospital EMUs that that are paid by DRG actually use CPT codes to keep track of completed work. These changes may successfully promote increased staffing levels. Many hospital outpatient departments bill using the APC code system. National pricing has been set and it will be discussed in another section. This may have a big impact on the services offered in outpatient departments.



Setup Time and Costs

Review your setup costs. Document how long it takes to conduct the activity and what supplies are actually used for a procedure. Determine if you can be more efficient in this work and the use of supplies.



Staff Training and Qualification

Determine how the training and qualification of your staff are documented. Ensure you have appropriate training records that would withstand external auditing to support the work you perform.

Physician Code Changes



The professional codes describe the work of the reading and interpreting physician. There are separate codes for EEG and video EEG.

There is a key differentiation between studies that are reported at the end of 12 or 24 hours and then studies that are reported at the end of a multi-day study. For the first 24 hours, it is clear which code should be used, either 95719 (EEG only) or 95720 (EEG and video).

For a 48-hour study, there are two options:

If the physician had access to the data throughout the study and generated a daily summary and a final report then they would bill 95719 or 95720 twice, once for each day.

If they did not have daily access and simply generate a final report at the end of the two days they would bill 95721 or 95722. The same applies to three and four-day studies. The code used is determined if there is daily access and reporting, or retrospective reporting.

There were no changes to the physicians professional codes made for 2021. As of this writing (August 2021) the proposed CMS rule for 2022 does not include any changes to the Long-Term EEG professional codes.



Physician Code Implications



Physician Access to Data

- Location is not specified
- How much data processing and annotation required for physician acceptance?
- Documentation of access and report?

Impacts all recording locations

- What is meant by physician access throughout recording?
- The 24-hour codes are used for the post hoc review of one-day AEEG studies.

The physician can be anywhere to access data and the code does not specify a location. If the physician has the technological capability to access the EEG from anywhere, that is acceptable.

However, how will physicians/facilities document and verify that the access and reporting took place? Is it acceptable for the physician to make notes in the EMR system rather than a full daily report? How soon after the period of recording can the report be made? These are all unanswered questions that will likely evolve in time. The recommendation is that each facility writes procedures and work orders to cover their own definitions.

The definition of “physician access throughout the recording” is important to consider. The implication is that a physician must have the capability to access the data throughout the recording, but it does not specify how often, or even if the data is accessed. This is another undefined area that needs clarification.

2020 CMS Physicians' Fee Schedule

- Published November 1, 2019
- 2475 pages EEG codes start on page 738 to 784 with charts page 823

There were no changes in 2021 and the proposed ruling for 2022 also does not include any changes.

[To access the Physicians' Fee Schedule click here.](#)

2020 CMS Physicians' Fee Schedule (continued)



Here is a brief review of pertinent notes and comments made in the final ruling:

Notes from the Final Rule

Page 745 as it relates to the EEG setup code:

- *“Provide education/obtain consent” (CA011) activity from 13 minutes to seven minutes*
- *We also proposed to refine the quantity of the non-sterile gloves (SB022) supply from three to two for CPT code 95700.*

It is clear that CMS takes this very seriously and worked diligently to get the valuation for the work performed accurately. For example, when considering the activity of educating the patient and obtaining consent for the procedure, they are able to look at a database of similar activities for other procedures and determine that this should take seven minutes. For an in-home video EEG where there is significant patient compliance information to share, this may not be enough time, however, this is the methodology used. Similarly, CMS feels that only two pairs of rubber gloves would be used.

CMS used this level of analysis and detail to assess every activity and every supply used:

Due to the nature of the continuous EEG taking place, we agree that the survey median clinical labor times of 12 minutes for the “Prepare room, equipment and supplies” (CA013) activity, 45 minutes for the “Prepare, set-up and start IV, initial positioning and monitoring of patient” (CA016) activity, and 22 minutes for the “Clean room/equipment by clinical staff” (CA024) activity would be typical for this procedure.

That is an example where CMS clearly got it wrong; at no time would an EEG technologist prepare and set up an IV as part of the EEG procedure. This exposes flaws in this detailed method of assessment when it is clear that the procedure being measured is not well understood.

Revenue implications of CPT Coding Changes

These are the proposed payment rates for professional codes. The final ruling increased these slightly.

National Pricing Final Rule Professional Fees

There is a difference for non-facility and facility practice expense, due to expenses incurred by a private practice vs the increased costs a hospital-based physician may incur. This represents an approximate 30-35 percent reduction in physician professional compensation for reviewing and reporting long-duration EEG.

CPT Code	Work RVUs ²	Non Facility PE RVUs ²	Facility PE RVUs ²	Mal-practice RVUs ²	Total Non Facility RVUs ²	Total Facility RVUs ²	2020 RVU Value	Total Professional Reimbursement	
95717	EEG Review & Report 2-12 hr w/o video	2.00	0.82	0.78	0.12	2.94	2.90	36.09	\$106.10
95718	EEG Review & Report 2-12 hr w/VEEG	2.50	1.19	1.13	0.18	3.87	3.81	36.09	\$139.67
95719	EEG 12-24hr ea incr w/o video	3.00	1.34	1.29	0.21	4.55	4.50	36.09	\$164.21
95720	EEG 12-24hr ea incr w/VEEG	3.86	1.85	1.76	0.28	5.99	5.90	36.09	\$216.18
95721	EEG phy/qhp>36<60 hr w/o video	3.86	1.90	1.78	0.28	6.04	5.92	36.09	\$217.98
95722	EEG phy/qhp>36<60 hr w/VEEG	4.70	2.28	2.15	0.35	7.33	7.20	36.09	\$264.54
95723	EEG phy/qhp>60<84 hr w/o video	4.75	2.37	2.21	0.37	7.49	7.33	36.09	\$270.31
95724	EEG phy/qhp>60<84 hr w/VEEG	6.00	2.92	2.74	0.44	9.36	9.18	36.09	\$337.90
95725	EEG phy/qhp>84 hr w/o video	5.40	2.73	2.52	0.42	8.55	8.34	36.09	\$308.57
95726	EEG phy/qhp>84 hr w/VEEG	7.58	3.69	3.46	0.56	11.83	11.60	36.09	\$426.94

Source AMA CPT 2020 Code Guide

Case Studies

Case Study #1

A 40-year-old female with intractable epilepsy is admitted to the epilepsy monitoring unit for presurgical evaluation to localize the seizure focus. Long-term Video EEG (VEEG) recording is started. Antiepileptic medications are tapered to provoke seizures. Five typical seizures are captured over the course of four days of VEEG recording and the patient is discharged on preadmission anti-epileptic medication in the afternoon of day five.

Case 1: Four day EMU Workup

2019 CPT	2019 Work Value	2020 CPT Code	2020 Work Value
95951-26 x 4	5.99 wRVU x 4 = 23.96 \$864.72	95720 x 4	3.86 wRVU x 4 = 14.00 \$557.23

- 36 percent drop (proposed 42 percent) drop in physician reimbursement
- What work will physicians need to be completed before they report?
- Report produced and documented daily
- No more than four patients monitored by one tech at any time point



Case Studies

Case Study #2

A 67-year-old male with a history of coronary artery disease, diabetes, and hypertension began having falls with loss of consciousness provoked with exertion. His cardiac evaluation was unremarkable, and he was then referred to a neurology clinic. An ambulatory EEG was ordered. A week after his clinic visit, the patient presented to the clinic where the EEG was connected by an EEG technologist. After four days of recording, he returned the equipment to the clinic and the study was uploaded for review by the neurologist. The neurologist generated a single report for this 96-hour recording.

Case 2: Four-day AEEG without video

2019 CPT	2019 Work Value	2020 CPT Code	2020 Work Value
95953 x 4	3.08 wRVU (PC) 7.88 PE RVU (TC) 10.96 x 4 = 43.84 \$1,582.19	97525 x 1 (PC) 95700 x 1 (setup) 995708 x 4 (TC)	5.40 (PC) Contractor (TC) \$Unknown

- Unknown drop in total reimbursement - proposed was 40 percent drop before the final rule
- What work will physicians need to be completed before they report?
- Is there less work in an AEEG on Jan 1 than on Dec 31st?
- Impacts hospital outpatients, IDTF and physicians



Case Studies

Case Study #3

Our same 67-year-old male with a history of coronary artery disease, diabetes, and hypertension began having falls with loss of consciousness provoked with exertion. His cardiac evaluation was unremarkable, and he was then referred to a neurology clinic. An in-home video EEG was ordered. A week after his clinic visit, a R. EEG T. arrived at the patient's home where EEG was connected and a camera was deployed. The patient was intermittently monitored via the internet for the duration. After four days of recording the tech returned and disconnected the equipment. The neurologist generated a single report for this 96-hour recording.

Case 3: Four-day in-home EEG with video

2019 CPT	2019 Work Value	2020 CPT Code	2020 Work Value
95951 x 4	12.00 RVU (PC) 33.33 RVU (TC) 44.33 x 4 = 177.34 \$6,400.00	95720 x 4 (PC) 95700 x 1 (setup) 95715 x 4 (TC)	15.44 (PC) Contractor (TC) Contractor(TC) \$Unknown

- 67 percent drop in total reimbursement per the proposed ruling
- Assumes daily report by a physician on an intermittently monitored study
- Physician payment lower if they report at the end
- Devalues the role of the technologist



Implications of the Final CMS Rule

What were some of the possible consequences of the new CMS final ruling?

- In-home video EEG service providers have had to adjust to market changes. There has been some consolidation of EEG service providers with companies being acquired and merging. Services are expanding to provide supplemental monitoring for hospitals.
- Staffing ratios will impact employment for EEG technologists. The application of new staffing ratios has created employment opportunities. However the impact of the pandemic in 2020 lessened the upside impact as many hospitals were forced to reduce or stop EEG services in the early months of the pandemic.
- Hospitals will need to adapt operations if more patients end up on waiting lists for inpatient testing and EMU admissions. This scenario will see CMS accruing more costs as more studies are paid under DRG.
- Patients in more rural areas may lack access to in-home testing and not have the resources or time to wait for inpatient testing at major medical centers.

EEG Activism

Considerable action was taken by many groups, consortia and individuals to impact the final ruling from CMS, including significant activism on Capitol Hill. The long-duration EEG codes benefited from a bipartisan letter signed by more than 70 congressional lawmakers. In addition, there were more than 1,000 comments filed on the ruling to CMS, which is unprecedented for such a small part of the rule. Everyone that contributed to this effort deserves many thanks.

Pricing Variability

There is considerable variation in the contractor negotiated prices between the CMS MACs. As a result there are active efforts to work with different MACs to try and eliminate these discrepancies. Variances create instability and have a great deal of impact in patient access to care.

How to Prepare for 2020 CPT Coding Changes



**CHANGE
AHEAD**

Not everyone prepared for the 2020 changes and still today I get questions about basic strategies for adopting the new codes. How does your current situation stack up against the steps needed to be successful?

There are several questions to ask to determine your preparedness:

Can you meet the staffing demands to achieve the required monitoring levels?

- Asses the staffing needs to achieve the level of services that you intend to offer. This may mean hiring new staff or using outside service providers to get you the manpower that you need.

Can you meet the technical demands?

- Does your current hardware and software solution meet the technical demands of providing 24/7 access to data from anywhere? Will your technology limit what you can accomplish and what you can bill? This should be assessed now to identify risks.

Can you handle a big swing in patient demand?

- What do you think is going to happen to patient demand in your setting? Will you see a significant swing in referrals? Will you see a significant change in the type of referrals? If physicians are going to be paid significantly less for their work will their patterns of referral change? Does your software review make it easier for physicians to access and rapidly review from any location to offset losses in pay for reading studies?

HIPAA, Regulatory and Security Concerns

When you change procedures, or the way in which data is accessed, or who has access to protected data, then it is necessary to consider regulatory and security concerns. Ask yourself these important questions.

- Will this change who has access to ePHI?
- Will this change how people access ePHI?
- New SOPs and department work instructions?
- Are your staff up-to-date in security training?

HIPAA

Update all your agreements

- Vendor service level agreements
 - Service availability and uptime
- Business Associate Agreements
 - Accountable for securing your ePHI

If you are going to use an outside vendor for technical or monitoring services you need to understand their commitments to uptime and availability. Most importantly you need to ensure that you have an appropriate Business Associates Agreement in place.

Thriving in 2020 and Beyond

Where there is a significant change, opportunities are created for those willing to think outside the box and try different things. The way in which outpatient EEG is performed in the home, from physicians' offices, and inside hospital EEG departments will evolve. Here are some suggestions for keeping up-to-date on the changing environment, as well as anticipating what the future may bring.

Actions to Take Now



Pay close attention to the negotiated rates set by the MACs. Stay informed by subscribing to the [Lifelines Neuro mailing list](#) and news provided by ASET, AES, ACNS and other respected national organizations.



Communicate with your payors and establish requirements for pre-approval of procedures - this is very important as we enter 2020.



Perform a thorough cost analysis of the supplies and work needed to achieve the requirements for each of the new CPT codes. The highest reimbursing codes may not be most financially viable as they require a significant incremental investment in resources. For example, non-monitored EEG only, in an ambulatory setting, will have significantly less overhead than a fully monitored video EEG.



Identify the codes that will provide your patients with the best possible care at the best value. It is highly likely that you will use a suite of codes depending on the intensity of vigilance needed for each patient.



Update all standard operating procedures (SOPs) and document that the staff has received training in the new SOPs.



What Could the Future Bring?



A greater focus on 24 hour EEG studies rather than long multi-day procedures.



Outpatient day monitoring services will be offered in hospital and clinic outpatient departments providing 8-hour observation of video EEG.



Freestanding 4-bed monitoring units, rather like a typical brick and mortar sleep lab, will start to develop as an alternative to in-home procedures.



Significantly more long-duration ambulatory EEG studies could be performed, the overhead is very low and the burden on the patient is greatly reduced.



Hospitals will need third party assistance to meet the monitoring needs of their patients.



Freelance EEG technologists will provide routine EEG and ambulatory EEG services to physicians in private practice.

Helpful Resources

[AAN Resources on Billing and Coding](#)

[ACNS Advocacy, Policies, Priorities \(members only\)](#)

[NAEC Updates/Resources](#)

[AES Summary of 2020 Medicare Rules - Long Term EEG Code Provisions](#)

[ASET CPT Coding Resource Center](#)

[CMS Final Rule CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies](#)

Coding Quick Reference Guide

Professional Codes

Code	Duration	Recording Type: EEG Video	Work	Notes
95717	2-12 hours		Review and Summary Report	May be billed once for a long-duration study to cover partial day at the start or end of a study
95718	2-12 hours			
95719	12-24 hours		Daily access to data, daily report and final summary report	Multiply this code by the number of days this work is performed. Daily access to data is required.
95720	12-24 hours			
95721	36-60 hours		Post hoc data review and report generated one time at the end of the recording	
95722	36-60 hours			
95723	60-84 hours			
95724	60-84 hours			
95725	84 hours plus			
95726	84 hours plus			



For detailed descriptions of the codes please refer to the AMA CPT 2020 publications.

Coding Quick Reference Guide

Technical Codes

Recording Type	Duration	Unmonitored	Intermittent	Continuous	Notes
 Setup	Setup, takedown and maintenance	95700	95700	95700	Billed one time for each recording
 EEG	 2-12hrs	95705	95706	95707	May be added at the start or end of a long-duration recording to make up for a partial day.
 EEG with Video	 2-12hrs	95711	95712	95713	
 EEG	 12-26hrs	95708	95709	95710	Additional units for each day of recording performed
 EEG with Video	 12-26hrs	95714	95715	95716	

For detailed descriptions of the codes please refer to the AMA CPT 2020 publications.

EEG CPT Codes, A Guide to Surviving and Thriving in the New EEG Economy has been created by Lifelines Neuro as an informational guide, based on information taken from AMA's CPT® 2020 Professional Edition. The information is created as a guide only and not intended to replace any information provided by the AMA and CMS.

Our goal is to provide information, as well as thoughtful insights, so you can make the best decisions to maintain a thriving business to enable providing critical care to patients.

About Lifelines Neuro Company:

Inspired by our users, Lifelines Neuro creates EEG products and solutions that help our customers perform at their best every day, to provide the highest quality patient care. Our platform anticipates users' needs and emerging industry trends to create intuitive products that enable our customers to imagine EEG anywhere.

Our Rendr Platform cloud software connects patients to physicians in real-time, all the time, on any device. Lifelines Neuro Trackit EEG amplifiers and systems are known globally for their exceptional engineering and durability.

For more information please contact

Simon Griffin

Founder, Lifelines Neuro

[ASET Foundation Board Member](#)

[BioLOGIC Foundation Board Member](#)

Simon.Griffin@lifelinesneuro.com



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