Long-term EEG Monitoring FAQs

This resource was developed in collaboration with the American Academy of Neurology, American Clinical Neurophysiology Society (ACNS), and American Epilepsy Society (AES).

Billing / Coverage Questions	
Can I report 95718 or 95720 for an ambulatory VEEG if I receive a download of the VEEG data every 24 hours instead of a single download at the end of the ambulatory study?	No, it would not be appropriate to report either code for ambulatory studies > 24 hours. 95717 – 95720 are intended for long term EEG monitoring services where the physician has access to the EEG data throughout the duration of the recording and generates daily report for each 24-hour segment of the recording with a summary report at the conclusion of the multi-day studies. If these requirements are not met the correct code for the professional component would be chosen from 95721 – 95726.
Am I correct that a 72-hour VEEG could be billed 2 ways: 95720 x 3 with a report each date OR bill 95724 with a summary report?	This is correct: If the physician has continuous access to the data during the recording AND generates a daily report during the study (as is typical for inpatient studies) you would bill 3 units of 95720. If the physician does NOT have continuous access to the data during the recording or generates a single report at the conclusion of the recording (as is typical for ambulatory studies), you would bill 1 unit of 95724. The code selection is differentiated by the medical necessity for the data to be available continuously.
If a day time monitoring in office study is 3 hours can I still bill the 2-12-hour code?	Yes, you would report either 95717 (2-12 hour recording without video) or 95718 (2-12 hour recording **with** video) for the physician services.
We currently perform ambulatory EEG in the office and report 95953. what code I should be using now? For hospital inpatients we	There is not a direct one to one crosswalk from the exiting codes to the new codes as we are going from 4 to 23 codes, and the

used 95951-26, what CPT I should be using now?	new code set is differentiated by professional component (PC) and technical component (TC) codes. The PC codes are differentiated by the duration of recording, with or without video, and the timing of physician report generation and whether they have access to the data during the study. The TC codes are differentiated by length of recording, with or without video and the level of monitoring. A full description of the code set is available on the NAEC Long Term EEG VEEG Coding Changes Pocket Guide.
Will the private payer follow these changes as well?	Private payers generally follow Medicare guidelines for coverage, though they have their own internal review process to determine overall coverage of a procedure/ code/device. It is recommended that members review the payers updated policies to determine coverage. Many payers have coverage policies available via their websites.
Are the PC codes billed on the day the study is initiated or the day it ends?	While the CPT code book does not specify the date of service that must be reported for a multi-day study, a good coding practice is to use date the procedure starts. We recommend looking to any policies or workflow you have established in your center; the key is to be consistent among physicians and coders. (If an alternate procedure date is used, we recommend retaining a process document on file for audit or compliance purposes.)
NAEC does not have the technical codes payment rates posted online, where can I find that?	Medicare did not assign national payment rates for the TC codes, rather made them "contractor priced" which means that rates will be set by each regional Medicare Administrative Contractor (MAC) for their geographic jurisdiction. Each MAC will be responsible for posting their fee schedule and coverage policies. Contact NAEC if you need guidance on how to identify the MAC for your region, locate and review a coverage policy.

Are codes 95816 & 95819 still valid in 2020?	Yes. None of the routine EEG codes (95812, 95813, 95816, 95819, 95822, 95830) have changed, except for 95827 (all night recording) which has been deleted.
For a 72-hour ambulatory EEG with video should we use code 95724 in 2020 instead of 95951? What if the study is done on an inpatient?	Yes, if the physician does not have access to the data during the recording, and only generates a single report at the conclusion of the recording, then yes 95724 is the correct code for the physician work. If the physician has access to the data during the recording AND generates a daily report, then you would report 95720 daily for 3 days.
We employ our own EEG technologist, and in the past, we billed both the technical and professional component. Can we still do the same or are we not able to bill the TC anymore?	Yes, you will still be able to bill the technical component, however the way you report it will be different as now there are separate codes for the professional and technical services. Historically the same numeric CPT code was used to report the technical and professional components, which were differentiated by a 26 or TC modifier. You can review the full code descriptions and definitions, which specify which code to use depending on the duration of the recording, etc. on the NAEC website.
Where can I find CPT descriptions for all codes 95700 through 95726?	CPT code descriptions and definitions can be found on the NAEC Coding Resources page
Can professional code 95718 VEEG, 2-12 hours be billed at either the beginning or ending of a multiple day study if it is used only once? This would be when there are daily reports, but the first report falls within the 2-12-hour period.	No, 95718 should only be reported at the conclusion of a study. Count time continuously from the start of recording. For a multi-day study, the first 24-hour period of 95720 will end during the second calendar day. If the final day includes more than 2 hours beyond a 24-hour period, then use 95718 for that final recording day spanning between 2-12 hours.

Are both Professional and Technical components new codes effective January 2020?	Yes. All new long-term EEG monitoring codes 95700, 95706 - 95726 are effective January 1, 2020.
When billing 95957 in cases where manual dipole modelling is performed, should 95957 only be billed once for the entire VEEG recording, or for each day's data that is analyzed?	95957 is reported once per recording session, not once per each 24 hours of recording.
Have the RVUs been established? How do the payments for EEGs in 2020 translate in comparison to current Medicare rates?	Medicare has assigned RVUs for the professional component (PC) services which are available in NAEC's summary of the Medicare rule. Given the changes in code structure there is not a direct "one to one" crosswalk from the old to the new codes, however based on case studies we anticipate an approximate 30% reduction to the professional services in 2020.
Using the 95718 codes once works fine when recording starts during "normal hours", but not as much if studies start in the night-time hours. What are recommendations if a study starts at a late hour (6 pm thru early morning)?	The parenthetical language following code 95718 states that (*95717, 95718 may be reported a maximum of once for an entire long-term EEG service to capture either the entire time of service or the final 2-12 hour increment of a service extending beyond 24 hours).* In the scenario you describe you would not bill separately for the recording time between 6 pm and the following 24-hour recording period the next date of service. Rather count time continuously from the start of recording. For a multi-day study, the first 24-hour period of 95720 will end during the second calendar day. If the final recording period is between 2 – 12 hours, report 95718 for the final recording period.
Will there be a delay in claims processing by Medicare since there are no national values for the new technical codes?	Unfortunately, we can't say with certainly how quickly Medicare and private insurers will process claims submitted with the new codes. It is safe to assume there may be delays as several Medicare Administrative Contractors (MACs) have indicated they will

	not update their coverage policies until after January 1 when they begin to see claims.
If a video EEG is started during the EEG hook up and the patient were to have an event during the hook up but before the full array of electrodes are on, does that still count for the start of the VEEG?	For reporting purposes, the start is when the EEG recording is started, not when the electrodes are applied. The same applies for the end time, the end time is when the actual EEG recording concludes, not when the electrodes are removed.
Is there any plan to augment CPT for surgical (intracranial) EEG	There are no new codes specific to intracranial EEG for 2020, though the NAEC and the other societies have identified this as a coding gap.
What are the correct PC codes to bill for the following scenario: an at home video ambulatory study started at 11:00 am Monday, concluded at 3:00 pm the following day (Tuesday) and was reviewed on Wednesday by physician.	This is a challenge for studies lasting greater than 36 hours and a potential coding gap. It would be correct to report 1 unit each of 95720 and 95718 in this case as there is not a separate code for a 24-hour ambulatory study.
If a study lasts 26-28 hours what would you bill?	For a 26 - 36-hour study you would report 1 unit of each 95719 and 95717 (without video) OR 1 unit of each 95720 and 95718 (with video) for the professional services.
Do we need to have technologists watching the EEG 24/7 for the professional component codes?	The physician services are NOT defined by the level of technologist monitoring. When selecting the correct PC code, one should consider: the duration of the recording; if there is video or not; daily report generation by the physician; and whether the physician has access to the data during the recording.
Case specific / timing questions	
What would you bill for a patient connected from 10 AM Monday to 2 PM Wednesday? 10 AM-midnight Monday 95720, MN-MN Tuesday 95720, MN-2 PM Wednesday 95720? or 10 AM M - 10 AM T 95720, 10 AM T-10 AM W 95720, and 10 AM W - 2 PM W	We have created a case study to assist with this response: A 32-year-old patient is admitted to the epilepsy monitoring unit for presurgical evaluation with recording starting at 10 am Monday and recording ending at 2 pm Wednesday for a total of 52 hours of video

95718? Or is it based on when the report is written?	recording. In the admission, progress, and discharge notes, a brief summary of EEG findings is mentioned. At discharge, a report summarizing each day's findings is generated. How would you code for the EEG LTM reports? Since a formal report is generated retrospectively, then 1 unit of 95722 would be reported. A "professional" report would need to have been generated daily to bill 95720 x 2 and 95718 x 1. In the same scenario as above, in addition to the admission, progress, and discharge notes, a formal EEG report is generated each day of the admission. How would you code for the EEG LTM reports? As a professional report is generated daily, it would be coded in addition to the E/M codes as 95720 x 2 (Monday 10 am to Wednesday 10 am) and 95718 (Wednesday 10 am to 2 pm).
We do daily reports at 7 A.M. That means that a study that started at 11 A.M. The first day would be from 11 until 7 A.M. the next day. When the study concludes at two then the last session will be from 7 A.M. until 2 P.M. on the final day. Is that true?	Time is continuous from the start of recording. The 7AM times do not affect the overall duration. A total recording time of 27 hours would be reported as PC codes 95720 (x 1) and 95718 (x 1) – (assuming the physician has access during the duration of the recording and is generating daily reports.)
We do reports midnight to midnight. Can we continue to do this and use the 95718 for the start of the study?	The parenthetical language following code 95718 states that (95717, 95718 may be reported a maximum of once for an entire long-term EEG service to capture either the entire time of service or the **final 2-12 hour increment** of a service extending beyond 24 hours). Therefore, you could report 95718 for the time at the conclusion of the study if less than 12 hours on the final day of recording.

	Time is continuous for the start of recording. Midnights do not affect the overall duration.
Physician daily report / documentation questions	
What constitutes a daily report? What must be included for documentation?	The CPT code book does not define daily report however the medical societies recommend the daily report include: • Indications and patient history • Technical details • Day and time the recording started and stopped and the day and time of this daily report • Baseline findings • Interim findings during monitoring • Impressions • Clinical correlations
What is a "summary" report? Currently, we do not generate a "summary" report after a number of days of monitoring for a patient in the ICU. A discharge summary is generated for patients in the EMU, does this qualify as a "summary" report.	The CPT code book does not define summary report however the medical societies recommend the summary report include: • The collection of daily reports followed by a final impression and a Final Clinical Correlation section. • Day and time the EEG was started and stopped. The final or summary report of the VEEG or EEG procedure cannot be part of another report. It is very reasonable to include parts of the Summary Monitoring Report in the Discharge Summary, just like one does for other significant lab reports. But that does not replace the need for a separate VEEG/EEG Procedure Report in the procedures section of the chart. If a summary report is not generated in some Institutions, and there are no national guidelines, it is up to the institution to decide about the content and the granularity of the summary report.
Question regarding EMU billing: If our daily notes include brief EEG findings daily but then a final detailed summary report, how would this be billed?	• In order to bill 95719 or 95720, a physician interpretation and report is generated after each 24-hour period. A final summary report as you described can also be provided, but a separate code

	is not billed for the completion of the summary report.
Do the daily reports need to be entered separately into the medical record, or is 1 report, broken down by date, sufficient?	In order to report 95717 - 95720 a separate daily report must be documented for each 24-hour recording period (in addition to the physician reviewing the data during the recording.)
Does it matter if the code is put into the system (Epic) daily? Or can the codes be added at the end of the study if daily reports are prepared?	The reporting time and billing time may not necessarily align in the new coding structure. This will vary among institutions, depending on how each billing workflow is set up.
TC Questions	
Does the EEG technologist and monitoring technologist have to have the same qualifications?	Not necessarily; they may be persons with distinctly different skills, knowledge, ability, training and experience. Each should be competent for the job performed. The CPT description for 95700 states the service is administered in person by EEG technologist and is followed by the instructional language: For setup performed by non-EEG technologist or remotely supervised by an EEG technologist, use 95999. Each must fit the CPT definition: *An EEG technologist is 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).*
If the recording is continued but electrodes are bad, can we bill for the time when EEG leads are bad?	Sometimes one or more leads are poorly connected. As long as the remainder of the EEG is technically adequate for interpretation, then that period of time counts as monitored. Part of the

	responsibility of the technologist is to repair or replace poorly connected channels for time that it continuously or intermittently monitored. If most channels go bad or the whole EEG is disconnected, then that time does not count toward the recording time.
Can a study be considered as being continuously monitored if it was interrupted for two hours for an MRI but otherwise was monitored continuously ?	The CPT codebook does not specify a time limit if a patient must leave the EEG suite for diagnostic testing, etc. This requirement will likely be determined by MACs and other payers, however it is reasonable to use a 2-hour time frame for continuously monitored inpatients. The time off EEG monitoring should be deducted from the total monitoring time.
If a patient is on a long-term unmonitored study for 9 hours the first day, 13 the next day and 14 hours the next (for a total of 36 hours for all three days), would we bill 95711 and 95714 or 95711 and 95714 (X2)?	The CPT codebook guidelines state "If diagnostic EEG recording stops, timing stops until the diagnostic EEG is resumed." As the total time is 36 hours you would report 1 unit of 95711 and 1 unit of 95714."
Does my EEG technologist need to be licensed to report the TC codes? What are the required qualifications for the technologist?	The CPT definition of technologist is 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)*. The definition does not explicitly state the requirements rather defers to the criteria established by facility or state scope of practice.
What if the patient is in a non-networked room?	The technologist service would be considered unmonitored if the criteria for intermittent or continuous monitoring are not met.

Is the ratio of patients being monitored based per technologist or per lab?	The CPT definitions for level of monitoring are based on the ratio of EEG technologist to monitored patients.
Are modifiers required for any the TC codes?	No. As there are now separate codes for the professional and technical component a TC or 26 modifiers should not be appended to the new professional and technical codes.
If technician drives to a patient's home during the monitoring to fix an EEG lead, do I bill for this visit?	There is not a separate code to bill for this scenario, rather it is considered part of the maintenance as defined by CPT: *Performed by the EEG technologist(s) and involves ensuring the integrity and quality of the recording(s) (eg, camera position, electrode placement, and impedances).* The traveling expense is built into the reimbursement for the monitoring service.
Does pruning the study count for 95705?	Codes 95705 - 95716 describe monitoring, maintenance, review of data, and creating a summary technical description. However, only the total EEG recording time serves as a basis for choosing the codes. Pruning, marking, archiving and storing are considered a bundled part of the EEG monitoring technical service, and are not separately coded or billed. (*The EEG technologist(s)'s written documentation of the reviewed EEG/VEEG data, including technical interventions. The technical description is based on the EEG technologist(s)'s review of data and includes the following required elements: uploading and/or transferring EEG/VEEG data from EEG equipment to a server or storage device; reviewing raw EEG/VEEG data and events and automated detection, as well as patient activations; and* ***annotating, editing, and archiving EEG/VEEG data for review by the physician*** *or other qualified health care professional*)

For ambulatory EEG what specifically constitutes continuous EEG monitoring?	The CPT code book defines continuous real-time monitoring (which may be provided remotely) as follows: *Requires all elements of intermittent monitoring. In addition, the EEG technologist(s) performs and documents real-time concurrent monitoring of the EEG data and video (when performed) during the entire recording period. The EEG technologist(s) identifies when events occur and notifies, as instructed, the physician or other qualified health care professional. For continuous monitoring, a single EEG technologist 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.*
Are "unmonitored/13+ patients" technical codes going to be applicable mostly for ambulatory EEG in the home, or are there other situations where they would be used? I.e., how often would you expect to see unmonitored codes used, other than for home-based EEG?	We anticipate the unmonitored TC codes will most frequently be used for ambulatory / in home studies; however, in any scenario when the intermittent criteria are not met, you would need to report the unmonitored codes. If an EMU or ICU had 20 patients with one monitoring technologist, then the "unmonitored" codes would be reported for the technical services.
Do you need to keep a certificate for the technologist?	Not necessarily, as the CPT codebook definition of EEG technologist defers to scope of practice as allowed by law, regulation, and facility policy (when applicable) this decision lies with each facility providing the services.
What technical codes are reported for a 48-hour ambulatory? One set up and what additional codes?	One set up code (95700) is reported per recording session. Assuming the ambulatory study is unmonitored you would report 2 units of 95708 for a study without video or 2 units of 95714 for a study with video.

95700 Set up code questions	
Can you bill 95720 with code 95700?	95700 is the technical code, used by the technologist. 95720 is a professional code used by the physician. They are not coded by the same person.
I have a question about 95700. We are a Private Neurologist group and normally bill EEG under provider. Can we bill 95700 under a provider or is this for technologist only?	Yes, as the employer of the technologist, you can code for their work. Code 95700 is for a technologist's services, not a physician. Expect some confusion and denials at first, but please see that through appeals and discussions with the carriers.
Can 95700 be billed a second time for a study if there is an interrupting procedure on a different calendar date from the initial hook up?	No. The CPT guidelines state that 95700 can only be reported one time per recording session. If the patient's recording session ends and later in that hospitalization there arises another medical necessity to restart monitoring, then that is considered a new session. Code 95700 can be used for that second separate session later in the hospitalization. Sending the patient for an MRI or another procedure is not a basis for considering it a second separate monitoring session. That would be just a continuation of the same session after a break, and for that the code 95700 would not be used.