

Resource Tool: UCH 24 Hour Video EEG Monitoring and Digital Analysis 95951, 95813, 95957

Generated on: 01/26/2018

Note: This is not a coding directive, but an informal coding guidance based on the date generated. These resource tools will not be regularly reviewed and updated. Please refer to the most recent references and resources available.

Per the "Principles of CPT Coding" 6th edition, 2010, and all other references, the time frame for EEG monitoring is the rolling 24 hour period, not per calendar date. Any time frame between 12 hours and up to 24 hours will be billed as a full 24 hour period with CPT 95951. Any time frame between 6 and 12 hours will be billed as 95951 with a 52 modifier. Any time frame less than 6 hours, but more than 61 minutes will be billed with CPT code 95813. For any time frame less than 61 minutes please see chart below.

Date of Service: The first day of billing should be classified as the day the service was initiated or began and not the first 24 hour period.

Status / Time w Video	< 20 min	20-40 Min	41-60 Min	61 Min- 6 Hrs	> 6 Hrs but < 12Hrs	> 12 hrs to 24 hrs
Sleep Only	Not Billable	95822	95812	95813	95951-52	95951
Coma	Not Billable	95822	95812	95813	95951-52	95951
Awake Only	Not Billable	95816	95812	95813	95951-52	95951
Aware and Drowsy	Not Billable	95816	95812	95813	95951-52	95951
Awake and Sleep	Not Billable	95819	95812	95813	95951-52	95951

Digital Spike Analysis with 24 Hour Video EEGs:

According to the University of Colorado Health (UCH) neurology providers, a digital spike analysis is always done with the 24 hour EEGs; this is due to a precursor that the patient MUST be off of all of their medication in order for the test to be performed. With no medication in their system, the patient will consistently be spiking.

UCH neurology providers will only include the Digital Spike Analysis note for patients that supports the medical necessary and the additional provider and technician time required for the CPT 95957, as shown in the following documentation example.

Resource Tool: UCH 24 Hour Video EEG Monitoring and Digital Analysis 95951, 95813, 95957

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Documentation Example:

Start date and time: November 7, 2017, at 12:26

End date and time: November 10, 2017, at 11:15

History: 43yo RH woman here for spell characterization of events since 2010. She has a history of MVC (8/2010-LOC for minutes) with resultant paresthesia, vomiting/vertigo and "feeling strange" thereafter. Several weeks thereafter developed visual hallucinations (colors coming together- possibly more like an illusion, and a stop sign "growing arms"). She also states that she has had "memory" problems where she seems to have difficulty attending. Staring spells have been noted by co-workers and other witnesses that last about 3 minutes, with headache thereafter. These are occurring a few times weekly. No noted automatisms or other changes other than staring during the events. She has no clear aura or other sensations that she has noted. No clear history of imagining, but the patient arrived with limited records.

Medications:

paxil 60mg daily

Trazodone 100mg qHS

HCTZ 25mg daily

(previous trial of ritalin)

Conditions:

This is a continuous video-EEG monitoring report. The EEG electrodes were placed using the standard International 10-20 system of electrode placement, with additional anterior temporal electrodes placed bilaterally. Hyperventilation and photic stimulation were used as activating maneuvers. XLTEK spike and seizure detection algorithms were used for digital EEG analysis throughout the monitoring period to screen the EEG and select potential electrographic seizures and interictal epileptiform discharges for review. Each of these electronic detections, as well as the raw EEG record, were reviewed and interpreted by the attending neurophysiologist. Digital EEG analysis was medically necessary for the aid in detection and evaluation of seizure patterns and long-term EEG trends in this patient.

Findings

Background EEG: On each day, the posterior dominant rhythm was well formed at approximately 10 Hz bilaterally. She had symmetric amplitude, with good organization and reactivity. There was a very mild degree of diffuse intermixed slowing noted throughout the recording. No focal slowing was appreciated. Her sleep was well formed and symmetric, and she displayed N2, slow-wave and REM sleep during the EMU visit. HOWEVER, the patient was noted to have frequent waking during her sleep, and occasional desaturations (especially while in slow-wave sleep) to the low 80s. Activating maneuvers in the forms of photic stimulation, hyperventilation and sleep deprivation were employed. There were no abnormalities noted with these maneuvers. There were no interictal epileptiform discharges.

Resource Tool: UCH 24 Hour Video EEG Monitoring and Digital Analysis 95951, 95813, 95957

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Events: There were no "push button" events or clinical/electrographic seizures noted throughout the recording, however, the patient did state she experienced her typical symptoms throughout the day on 11/9/17 with headache and confusion (especially when her children were present). She did not push the event button as these symptoms seemed to progress throughout the day. As was stated, there were no changes in the EEG background throughout the day on 11/9/17 to suggest seizure.

Impression: For this report, she was monitored for a total of four days. During this time, the EEG background was abnormal as described above, with a very mild amount of diffuse intermixed slowing. These findings are nonspecific as to etiology, however, are suggestive of a very mild degree of diffuse cortical dysfunction. The EEG recording was also abnormal secondary to the presence of frequent waking while sleeping, and oxygen desaturations while sleeping. Given the patient had a 'typical' event throughout the day on 11/9/17 of headache (present in AM and increased during the day) and confusion/inattention (without clearly impaired consciousness) without EEG changes, we do not believe that her current events represent seizures. This information was discussed with the patient. We strongly recommend that the patient has a formal polysomnograph done, as we have very high suspicion that the patient has sleep apnea (and, may require assistive devices such as CPAP). She will follow-up with her referring neurologist, Dr. Barbee.

How would this be coded?

Start/DOS	Stop	Total Time	CPT
11/7/2017 12:26	11/08/2017 12:25	24 hrs	95951, 95957
11/08/2017 12:26	11/09/2017 12:25	24 hrs	95951, 95957
11/9/2017 12:26	11/10/2017 11:15	22 hrs, 49 min	95951, 95957

Additional Coding Scenarios:
1. What happens if I do not have the required 12 hours to count for coding a 95951?

- If you have greater than 6 hours, but do not have a full 12 hour period for the encounter, you should bill 95951 with a modifier-52 to show that this is a reduced service.

Start date and time: 11/7/17 12:26

End date and time: 11/8/17 23:00

Start/DOS	Stop	Total Time	CPT
11/7/2017 12:26	11/08/2017 12:25	24 hrs	95951, 95957
11/08/2017 12:26	11/08/2017 23:00	10 hrs, 34 min	95951- 52, 95957

Note: Modifier 52 is only used with CPT 95951 not 95957. CPT 95957 is not a time based code.

Resource Tool: UCH 24 Hour Video EEG Monitoring and Digital Analysis 95951, 95813, 95957

Generated on: 01/26/2018

2. What happens if I have more than 61 minutes, but do not have a full 6 hours to count for coding a 95951?

- You should bill CPT 95813.

Start date and time: 1/17/18 10:25:54 am

Stop date and time: 1/18/18 11:57:45 am

Start/DOS	Stop	Total Time	CPT
1/17/2018 10:25	01/18/2017 10:24	24 hrs	95951, 95957
01/18/2018 10:25	01/18/2018 11:57	92 min	95813, 95957

3. How should the encounter be entered into the system when multiple dates apply?

- Each date of service for the Video EEG should be listed under one encounter in the TES system. It should not be broken up into days with a separate encounter for each date of service.
- Within each encounter, there will be separate line items to encompass the dates of service and CPT codes.