2025 AES ANNUAL MEETING

Guidance on Coding and Documentation for Epilepsy Services and EMU Admissions in 2026

Gregory L. Barkley, M.D.

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AMERICAN EPILEPSY SOCIETY

Learning Objectives: 2026 Update on Neurophysiology Coding and Payment Policy

- Apply the correct coding rules regarding Video EEG Monitoring to correctly report your claims and avoid coding errors
- Describe the changes in payment policy for neurophysiology procedures for 2026
- Analyze the effects of the 2026 Medicare Fee Schedule cuts on your practice and plan how you adapt to them in your daily work in 2026
- N.B, All coding must meet the definition of Medical Necessity
- CMS provides this specific definition of medical necessity under the Social Security Act (SSA): **"No Medicare payment** shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."
- Social Security Act §1862 (ssa.gov)

Coding References

- This talk uses CPT codes defined, updated, and published annually by the AMA. The 2026 edition:
  - Current Procedural Terminology 2026. American Medical Association, Chicago, September 2025
- The Billing and Coding guidelines discussed are applicable to patients with Medicare insurance. **Private insurance companies may make their own rules which may or may not be published.**
- Federal Register :: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Components of the CPT code

- Most CPT codes have two components, a Physician Component (PC) and a Technical Component (TC)
  - The 24-hour EEG codes are an exception to this.
- The Physician Component has three parts
  - The wRVU which is informed by the RUC survey process.
  - The Practice Expense of of the PC which is the expenses for the office expenses to cover the wRVU
  - Practice Liability Insurance which is the insurance cost of the PC
- The Technical Component
  - Paid to the office for an outpatient visit in most cases and determined by the RUC bottom up methodology

    Paid to the facility in a medical center that uses Facility-based billing using APCs

    Paid to the hospital for inpatients through the DRG

Three components of the Physician Component of the CPT code

- Physician Work – determined by time and intensity based upon surveys
- Practice Expense of the PC – can be thought of as the practice expenses necessary for the physician or QHP to perform the service and make the report
- Product Liability Insurance – this is actuarial data
  - Here is the PLI by specialty for 2026

1	CY 2026 Malpractice Risk Index and Premium Amounts by Specialty							
2	Specialty Code	Specialty Name	2026 Service Risk Group	2026 Risk Index	2026 Normalized Premium Rate	2025 Service Risk Group	2025 Risk Index	2025 Normalized Premium Rate
21	11	Internal medicine	All	0.79	$17,287	All	0.76	$16,387
22	12	Osteopathic manipulative medicine	All	0.59	$12,851	All	0.43	$9,388
23	13	Neurology	Non-surgery	0.97	$21,096	Non-surgery	0.94	$20,272
24	13	Neurology	Surgery	4.85	$105,572	Surgery	4.73	$102,296
25	14	Neurosurgery	All	4.85	$105,572	All	4.73	$102,296
26	15	Speech language pathology	All	0.01	$269	All	0.01	$230
27	16	Obstetrics/gynecology	Non-surgery	0.99	$21,606	Non-surgery	0.67	$14,485
28	16	Obstetrics/gynecology	OB	3.69	$80,320	OB	3.49	$75,445
29	16	Obstetrics/gynecology	Surgery	2.02	$43,959	Surgery	1.93	$41,677
30	17	Hospice and palliative care	All	0.78	$17,002	All	0.75	$16,167

Interim Report

CY2026 Medicare Physician Fee Schedule (PFS) Update to the Geographic Practice Cost Indices (GPCIs) and Malpractice (MP) Risk Index

Long-Term EEG Monitoring: PC Services (95717-95726)

- Reporting is based on the following elements:
  1. Duration of recording
  2. When the report is generated
  3. Performed with or without video
  4. Physician access to EEG and video data during recording or after testing is completed

PC (Professional Component) Services

Conceptual Framework of 10 New PC Codes		
With Video	**Duration/Time of Report**	**Without Video**
95718	2-12 Hours/Daily Report	95717
95720	>12-26 Hours/Daily Report	95719
95722	36-60 Hours/One Report at End	95721
95724	>60-84 Hours/One Report at End	95723
95726	>84 Hours/One Report at End	95725

PC Services: 95720 & 95719, Each Increment > 12 Hours, Up to 26 Hours EEG Codes

#●**95719** Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video

- #●**95720** with video (VEEG)

▶(95719, 95720 may be reported only once for a recording period greater than 12 hours up to 26 hours. For multiple-day studies, 95719, 95720 may be reported after each 24-hour period during the extended recording period. 95719, 95720 describe reporting for a 26-hour recording period, whether done as a single report or as multiple reports during the same time)◀

Tip: This code may be used every day for a long as the patient needs the service. There is no upper limit to how many times it may used during an admission. If a patient is monitored for three weeks and you make 21 separate daily reports, you could bill 95720 x 21 times.

PC Services: 2-12 Hour EEG Codes (95717 & 95718)

- #●**95717** Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video
- #●**95718** with video (VEEG)

▶(For recording greater than 12 hours, see 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726)◀

PC Services: *Special Instructions for 95718 and 95719*

Report 95717-95718 **ONCE** for an entire service:

- a complete EEG service that lasts only 2-12 hours; OR
- the final 2-12-hour increment of an EEG service that extends beyond 24 hours

▶(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 multiday studies, take care that the total number of days claimed equals the recording time, using this code for the final partial day.

CPT Assistant: Re: *When does the clock start?*

- **Question:** *For inpatients, how should you count the 24-hour periods in reporting long term EEGs/VEEGs?*

Answer: EEG Monitoring is coded per 24 hours from the start of the service. Typical EMU and ICU monitoring is reported each day. One physician codes for the service for each 24 hours with codes 95719 (no video) or 95720 (with video). If the final portion of a multi-day service is 2-12 hours, then the partial day codes 95717 (no video) or 95718 (with video) are used for that monitoring portion. The partial day codes are used only once if needed during a multi-day study.

TC (Technical Component) Services: Setup (95700)

- ►Long-term EEG Setup◄
- #●**95700** Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels
- ►(95700 should be reported once per recording period)◄
- ►(For EEG using patient-placed electrode sets, use 95999)◄
- ►(For setup performed by non-EEG technologist or remotely supervised by an EEG technologist, use 95999)◄
- ►***Setup:*** Performed in person by the EEG technologist(s) and includes preparing supplies and equipment and securing electrodes using the 10/20 system. Code 95700 is reported only once per recording period on the date the setup was performed. "In person" means that the EEG technologist(s) must be physically present with the patient.◄

TC Services: Monitoring (95705-95716)

- Time-based
- Includes:
  - Review of EEG/VEEG data
  - Written technical description of data and interventions
    - 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 unmonitored services, the EEG technologist(s) annotates the recording for review by the physician or other qualified health care professional and creates a single summary.

TC Services: Monitoring (95705-95716)

Reporting is based on the following elements:

1. Performed with or without video
2. Duration of recording
3. Type of monitoring
   - ➢ Unmonitored
   - ➢ Intermittent
   - ➢ Continuous, real-time

   For 2026, technical services for these codes will remain carrier priced in nonfacility and paid by APCs where facility-based billing is performed.

Technical Monitoring Defined

Monitoring		
Unmonitored	**Intermittent**	**Continuous Real-Time**
• Report if criteria for intermittent or continuous are not met	• Remote or on-site • Review and document data every 2 hours • Maximum of 12 patients concurrently • >12 patients is reported as unmonitored	• Remote or on-site • Same elements as intermittent, *Plus …* • Real-time concurrent monitoring of EEG data and video (when performed) • Maximum of 4 patients concurrently • >4 patients reported as unmonitored or intermittent • If there is a break in the monitoring, reported as intermittent study

TC Services: Monitoring (95705-957160)

Conceptual Framework of 12 New TC Codes		
With Video	**Duration/Intensity of Monitoring**	**Without Video**
	2-12 Hours	
95711	Unmonitored	95705
95712	Intermittent	95706
95713	Continuous Real-time	95707
	>12-26 Hours	
95714	Unmonitored	95708
95715	Intermittent	95709
95716	Continuous Real-time	95710

Related Revisions: *Do not use 95957 with new long term EEG codes except under special circumstances such as when the data are being used as part of surgical planning. Use one time per session*

Special EEG Tests

95957 Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

(Do not report 95957 for use of automated software. For use of automated spike and seizure detection and trending software when performed with long-term EEG, see 95700-95726)

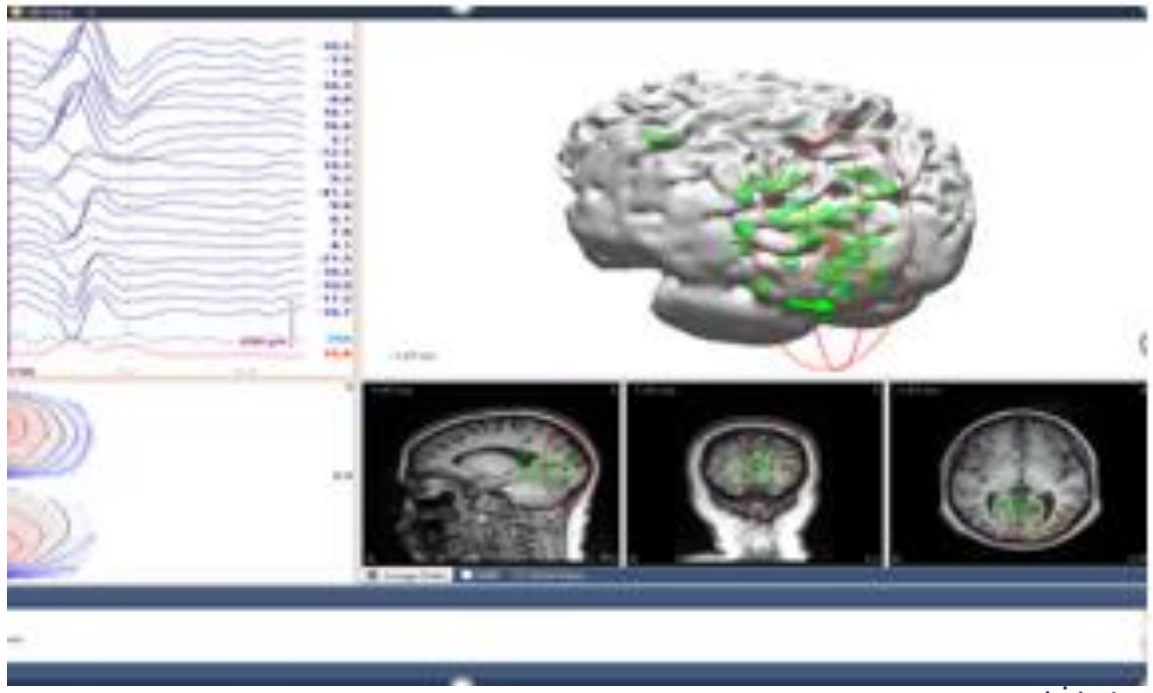
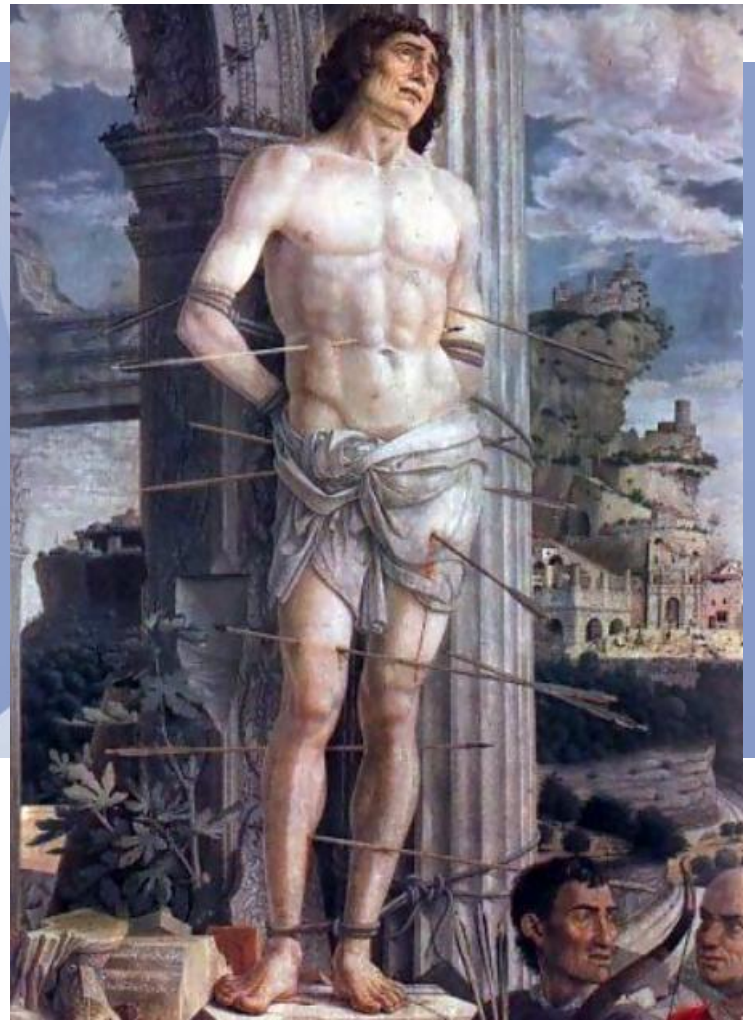


Image courtesy of Gregory L. Barkley, M.D.

St. Sebastian, by Andrea Mantegna, 1480, Musée du Louvre, Paris



Congressional reconciliation package – the "One Big Beautiful Bill Act" includes a temporary 2.5% physician payment increase in 2026

CMS Final Rule has two conversion factors for 2026, one for QPs (qualified participants) in Alternate Payment Models (APM) and another for all others

Medicare Conversion Factors			
	2025 Conversion Factors	2026 Conversion Factors	Percentage Change
APM QP	$32.3465	$33.5675	**3.77%**
Non-APM QP	$32.3465	$33.4009	**3.26%**
Anesthesia APM QP	$20.3178	$20.5998	**1.39%**
Anesthesia Non-APM QP	$20.3178	$20.4976	**0.88%**

2026 HOPPS (Hospital Outpatient Prospective Payment System)

- Used for outpatient technical payments for ambulatory procedures in many hospital centers
  - E.g., All short EEGs have the same APC
  - Will maintain 5 levels of Neurostimulator APCs for now but considering a sixth level
- CMS proposes many changes in HOPPS
  - “In order to ensure that GME accreditation for approved medical residency programs complies with applicable laws related to race-based admission policies and to improve the accreditation process, CMS is proposing that accreditors may not require as part of accreditation, or otherwise encourage institutions to put in place, diversity, equity, and inclusion programs that encourage unlawful discrimination on the basis of race or other violations of Federal law.”
  - 3-year phase out of inpatient only list
  - Reduction in the 340 B medication program
  - Expanded site neutral payment policy
  - Adopt a policy to make the relative weights under the inpatient prospective payment system (IPPS) using hospital reported data on negotiated charges with Medicare Advantage Organizations (MAO).

CMS Proposes changes to Practice Expense of the Professional Component I

- CMS is proposing significant updates to its PE methodology. It is proposing to recognize greater indirect costs for practitioners in office-based settings compared to facility settings.
- CMS is also proposing to utilize data from “auditable, routinely updated hospital data (i.e., from the Medicare Outpatient Prospective Payment System to set relative rates and inform [its] costs assumptions for some technical services paid under PFS.”
- **CMS proposes an arbitrary reduction in indirect practice expense RVUs for all services provided in the facility setting.**
- The mechanism for the reduction is highly technical as CMS would reduce the portion of facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.
- CMS cites AMA and MedPAC studies showing the growing number of employed physicians and physicians in hospital-owned practices and the shrinking number of private practices as its rationale for this proposal. CMS believes that physicians who provide services in the facility no longer maintain a separate office and receive “duplicative payments” under the MPFS and the facility fees under the outpatient or the ASC payment schedules.

CMS Proposes changes to Practice Expense of the Professional Component II

- **Facility-based payment to physicians will decrease overall by -7% while non-facility-based payment to physicians will increase by 4%. The results to individual physicians and specialties are proposed to be substantial.**

- Impact on Epilepsy Centers and Academic Neurology Departments:

CPT Code	Mod	Descriptor	2025 Work RVUs	2026 Work RVUs	% change	2025 Total RVUs	2026 Total RVUs	% change	2025 Payment CF=$32.3465	2026 Payment CF=$33.4009	% payment change 2025 to 2026
95718	Hospital	Eeg phys/qhp 2-12 hr w/veeg	2.50	2.44	-2.40%	3.97	3.34	-15.87%	$128.42	$111.56	-13.1%
95718	Office	Eeg phys/qhp 2-12 hr w/veeg	2.50	2.44	-2.40%	4.04	4.13	2.23%	$130.68	$137.95	5.6%
95719	Hospital	Eeg phys/qhp ea incr w/o vid	3.00	2.93	-2.33%	4.75	4.01	-15.58%	$153.65	$133.94	-12.8%
95719	Office	Eeg phys/qhp ea incr w/o vid	3.00	2.93	-2.33%	4.83	4.94	2.28%	$156.23	$165.00	5.6%
95720	Hospital	Eeg phy/qhp ea incr w/veeg	3.86	3.76	-2.59%	6.10	5.14	-15.74%	$197.31	$171.68	-13.0%
95720	Office	Eeg phy/qhp ea incr w/veeg	3.86	3.76	-2.59%	6.20	6.34	2.26%	$200.55	$211.76	5.6%

CMS Estimate of Effect of Impact on Each Specialty
p1191 of 1808 of proposed rule
Neurology facility charges -9%; NS facility – 7%

TABLE 92: CY 2026 PFS ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
ALLERGY/IMMUNOLOGY	*TOTAL*	$212	0%	7%	0%	7%
	Non-Facility	$204	0%	8%	0%	8%
	Facility	$8	0%	-11%	0%	-11%
	Facility	$653	0%	-9%	0%	-9%
NEUROLOGY	*TOTAL*	$1,312	0%	1%	0%	1%
	Non-Facility	$833	0%	6%	0%	6%
	Facility	$480	0%	-9%	0%	-9%
NEUROSURGERY	*TOTAL*	$682	-1%	-4%	0%	-5%
	Non-Facility	$115	0%	6%	0%	6%
	Facility	$567	-1%	-6%	0%	-7%

CY 2026 Proposed Rule | CMS

CMS proposes Efficiency Rule for non time-based codes, part I

- CMS says AMA RUC process is flawed because “only a small portion of the total codes are considered for revaluation annually, and CMS relies primarily on subjective information from surveys that have low response rates, with respondents who may have inherent conflicts of interest (since their responses are used in setting their payment rates). Research over time has demonstrated that the time assumptions built into the valuation of many PFS services are, as a result, very likely overinflated.[1]

- [1] Merrell, K., C. Schur, T. Oberlander, et al. 2014. Analysis of physician time use patterns under the Medicare fee schedule. Report prepared for the Assistant Secretary for Planning and Evaluation. Washington, DC: Social & Scientific Systems and the Urban Institute.

CMS proposes Efficiency Rule for non time-based codes, part II

- CMS proposes to apply an efficiency adjustment to the work RVU and corresponding intraservice portion of physician time of non-time-based services that CMS expects to accrue gains in efficiency over time.
  - This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM.

- CMS proposes to use a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage to calculate this efficiency adjustment.
- **CMS is proposing a look-back period of five years, which would result in a proposed efficiency adjustment of -2.5% for CY 2026.**
- Going forward, CMS may give preference to empiric studies of time to incorporate into service valuation, compared to low-response rate survey data, and solicit comment on the types of empiric data that CMS should consider. CMS expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically.

Coding Tip from the CPT Codebook for use of APPs

- “When advanced practice nurses or physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician. A “physician or other qualified health care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff”. A clinical staff member is a person who works under the supervision of a physician or other qualified health professional, and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service. Other policies may also affect who may report specific services.

- *CPT Coding Guidelines, Introduction, Instruction for the Use of the CPT Codebook*

Observation Status in the EMU

- Many patients are granted Observation Status by insurance companies for the start of an EMU stay
- Upon entering the hospital, with further discussion, transition to inpatient status can be negotiated.
  - It is helpful to have a good relationship with the liaison to the insurance company to facilitate these approvals to change to admitted status
- Many patients who are in Observation Status may have significantly higher copayments due for EEGs and other tests which would be bundled into the DRG if the patient were admitted.
- For video EEG monitoring, the technical codes are billed under APCs during Observation Status. .
- If the patient stays two days, the stay becomes an inpatient admission by the Two Midnight Rule.

Tips to facilitate Prior Authorization to Admission for EMU stays

- There are some “magic words” that should always be used when dealing with insurance authorization for EMU stays to increase the chances of approval for admission:

Pre-surgical Evaluation

Patient required close evaluation as inpatient due to stopping/reducing anti-seizure medication

Patient admitted for intracranial electrode evaluation

Patient has experienced a change in seizure pattern, type of seizure and duration of seizure requiring long-term EMU evaluation

Patient requires change in treatment during EMU stay

Patient has a history of status epilepticus, and/or seizures producing injury during medication changes

Impact on Clinical Care

- The Final Rule determines how epilepsy care will be reimbursed for 2026.
- For Epilepsy Centers, especially those where practice expenses are done by facility-based billing, both professional billing and technical billing are likely to be negatively impacted.
- For 2026, the Conversion Factor is increased by 2.5%
  - But there are reductions for those not practicing in Advanced Payment Model (APM) practices.
  - There are reductions in the Practice Expense of the Professional Component for non time-based CPT codes
  - The revision of technical payments for procedure codes will greatly decrease payment for epilepsy centers for the two most commonly used CPT codes: 95720 and 95718 and their technical accompaniments
  - Below is a highlight sheet of the changes in the Final Rule for 2026:
  - Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) | CMS
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Non time-based EEG/ECoG/MEG Codes subject to 2.5% cut

- 95816, EEG, including recording awake and drowsy
- 95819, EEG, including recording awake and asleep
- 95822, EEG, recording in coma or sleep only
  - (Do not use above in conjunction with 95700-95726)
- 95829, Electrocortigram at surgery (separate procedure)
- 95954, Pharmacological or physical activation requiring physician or other QHP attendance during EEG recording of activation phase (e.g. thiopental activation test)
- 95957, Digital analysis of EEG (e.g. for epileptic spike analysis)
- 95958, Wada activation test for hemispheric function, including EEG monitoring

- 95965, MEG recording and analysis, for spontaneous brain magnetic activity (e.g. epileptic cerebral cortex localization)
- 95966, MEG for evoked magnetic fields
- 95957, MEG for evoked magnetic fields, each additional modality (List separately in addition to code for primary procedure)

Non time-based EEG/ECoG/MEG Codes subject to 2.5% cut, II

- 95812, EEG, extended monitoring, 41-60 minutes
- 95813, EEG, extended monitoring, 61-119 minutes
- 95836, ECoG from an implanted brain neurostimulator pulse generator/pacemaker, including recording, with interpretation and written report, up to 30 days

- Neurostimulation codes being cut:
- 95976, with simple cranial nerve stimulator, programming by physician or QHP, **(one to three parameter changes)**
- 95977, with complex cranial nerve neurostimulator, programming by physician or QHP, **(four or more parameter changes)**

Time-based EEG/ECoG Codes not subject to 2.5% cut

- 95940, Intraoperative neurophysiology monitoring in OR, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
- 94941, Intraoperative neurophysiology monitoring from outside OR, (remote or nearby) for more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)
- 95983, Electronic analysis of implanted neurostimulator, with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other QHP (i.e. 8-22 minutes)
- 95984, Electronic analysis of implanted neurostimulator, with brain neurostimulator pulse generator/transmitter programming, each additional15 minutes face-to-face time with physician or other QHP (i.e. 23-37 minutes) (List separately in addition to code for primary procedure)

Neurostimulator programming codes not getting cut

- 95970, Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or QHP, without programming (Do not report with 95971, 95972, 95976, 95983, 95984
- 95971, with simple spinal cord or peripheral nerve (e.g. sacral nerve) neurostimulator by physician or QHP **(one to three parameter changes)**
- 95972, with complex spinal cord or peripheral nerve (e.g. sacral nerve) neurostimulator by physician or QHP **(four or more parameter changes)**

CMS Final Rule has two conversion factors for 2026, one for QPs (qualified participants) in Alternate Payment Models (APM) and another for all others

- For QPs in APMs, the update to the qualifying APM conversion factor for CY 2026 is +0.75 %
- The update to the nonqualifying APM conversion factor for CY 2026 is +0.25%.
- The changes to the PFS conversion factors for CY 2026 include these updates as required by statute, a one-year increase of +2.50 percent for CY 2026 stipulated by statute, and an estimated +0.55 percent adjustment necessary to account for proposed changes in work RVUs for some services.
- The proposed CY 2026 qualifying APM conversion factor of $33.59 represents a projected increase of $1.24 (+3.8%) from the current conversion factor of $32.35.
- The proposed CY 2026 nonqualifying APM conversion factor of $33.42 represents a projected increase of $1.07 (+3.3%) from the current conversion factor of $32.35.
- Per statutory requirements, CMS is also proposing updates to the geographic practice cost indices (GPCIs) and malpractice RVUs.

2025 AES ANNUAL MEETING

AES/NAEC Joint Session:
Optimizing Coding for Services in the Outpatient Epilepsy Clinic – Care Coordination

Susan T. Herman, MD
Vice Chair of Clinical Affairs
Barrow Neurological Institute

December 8, 2025

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AMERICAN EPILEPSY SOCIETY

Learning Objectives

- Implement neurophysiology and evaluation and management coding strategies for epileptologists and epilepsy centers to use for patients seen in both the outpatient and inpatient settings.
- **Recognize regulatory requirements included in the FY 2026 Medicare Physician Fee Schedule final rule.**
- Evaluate different epilepsy center strategies and approaches to common coding and policy questions.
- **Utilize new codes for coordination of care for epilepsy patients (serious chronic condition).**

Centers for Medicare and Medicaid Services (CMS) Final Rule for the 2026 Physician Fee Schedule (PFS)

- 2 conversion factors for 2026
  - 33.5675 for qualifying Alternative Payment Model (APM) participants
  - 33.4009 for non-APM participants
  - Mandated by the Medicare Access and CHIP Reauthorization Act (MACRA)

- -2.5% efficiency adjustment: applies to relative value units (RVUs) and corresponding intra-service portion of physician time for non-time-based services (does not apply to E/M, care coordination, telehealth)

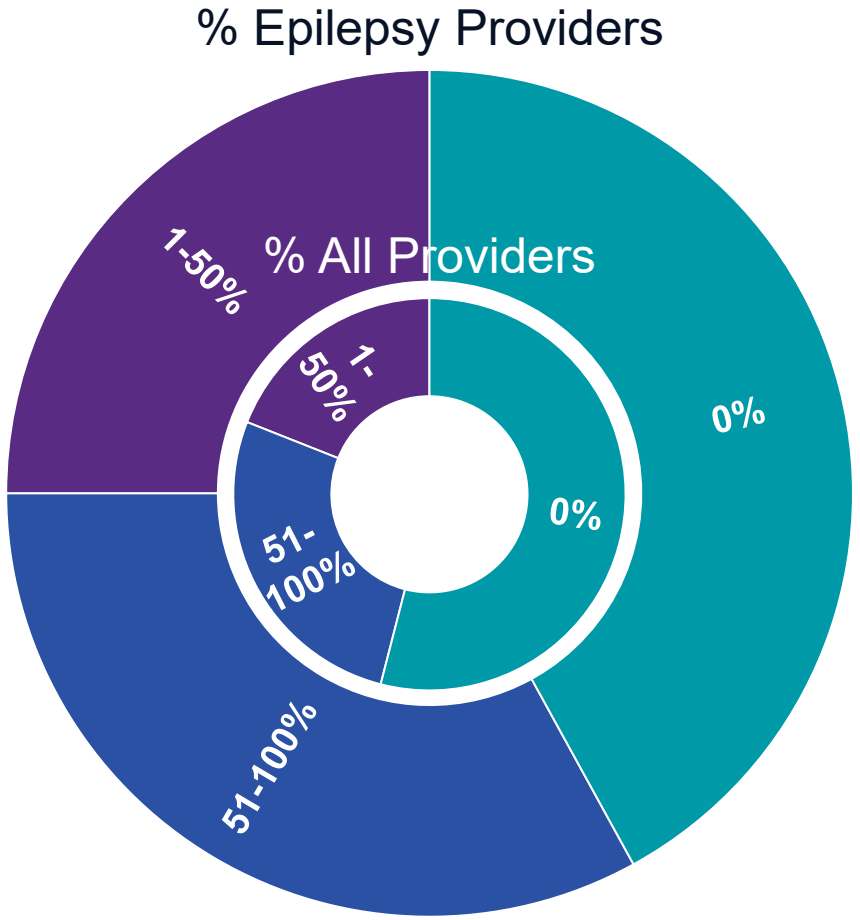
- 50% decrease in facility-based indirect practice expense
  - 7-10% decrease in RVUs for facility-based services
  - 4% increase in RVUs for non-facility-based

Trajectory of PFS

	PFS Final Rule	Congressional Fix	Final Cut	CF
CY 2020				$36.08
CY 2021	-10.2 %	6.9%	-3.3%	$34.09
CY 2022	-3.8%	3%	-0.8%	$34.60
CY 2023	-4.5%	2.5%	-2%	$33.88
CY 2024	-3.37%	1.68% (after 3/9)	-1.69% (after 3/9)	$33.28
CY 2025	-2.83%	0%	-2.83%	$32.34
CY 2026	+3.26%			$33.40

Use of G2211: Add-on Code for Medical Complexity

% Appts with G2211 Jan-June 2025	% of Providers (n = 100)	% of Epilepsy Providers (n = 12)
91-100%	4	
81-90%	4	
71-80%	8	
61-70%	7	8
51-60%	4	25
41-50%	5	8
31-40%	2	
21-30%	2	
11-20%	2	
1-10%	8	16
0%	54	42



Institutional data, unpublished

The Challenge of Epilepsy Management

- Chronic, complex condition with varied presentations and treatment responses
- High comorbidity burden (mental health, cognitive, etc.)
- Need for ongoing surveillance, medication management, and lifestyle adjustments
- Fragmented care often leads to suboptimal outcomes and increased costs (ED, hospitalizations)

- **The CMS Imperative: Value-Based Care & Care Coordination**
  - Shift from fee-for-service to value-based reimbursement
  - Emphasis on preventative care, chronic disease management, and patient-centered outcomes
    Care coordination as a cornerstone of improved quality and reduced costs

- **The Financial Imperative for Epilepsy Practices**
  - Maintaining financial viability in a challenging healthcare environment
  - Identifying revenue streams beyond traditional office visits
  - Leveraging existing resources and specialized staff to maximize efficiency and revenue

Care Coordination Services

- Team model

- Components
  - Collaboration with all medical and nonmedical providers
  - Patient and caregiver education
  - Medication management and adherence support
  - Risk stratification
  - Population management
  - Coordination of care
  - Care planning

- Shift care coordination to lower salaried employees
  - Care manager, case manager, care coordinator, patient navigator, community health worker
  - RNs, LPNs, medical assistants, other unlicensed trained personnel

Care Coordination Codes Most Relevant to Epilepsy

Chronic / Complex Chronic Care Management (high requirements)	Transitional Care Management (TCM)	Principal Care Management (PCM)
Remote Therapeutic Monitoring (RTM)	Community Health Integration (CHI)	Principal Illness Navigation (PIN)

Principal Care Management (PCM)

- Treatment of single chronic condition or multiple chronic conditions but focused on single high-risk condition
  - Expected to last 6 months – 1 year or until the patient's death
  - Chronic condition is expected to last between, at minimum, 3 months to lifelong
  - Chronic condition must place the patient at significant risk of death, acute exacerbation or decompensation, or a state of functional decline, and/or be associated with a recent hospitalization
- Typically billed by a specialist
- Patient written or verbal consent required
- Establishment or revision of an electronic disease-specific care plan
- Condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care

Principal Care Management (PCM)

CPT	Description	wRVU
99424	Principal care management services, **first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month**	1.45
99425	Principal care management services, **each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month**	1.00
99426	Principal care management services, **first 30 minutes of clinical staff time** directed by physician or other qualified health care professional, **per calendar month**	1.00
99427	Principal care management services, **each additional 30 minutes of clinical staff time** directed by a physician or other qualified health care professional **per calendar month** (List separately in addition to code for primary procedure)	0.71

Remote Therapeutic Monitoring (RTM)

- Use of a medical device (as defined by the FDA) to monitor a patient's health or response to treatment using non-physiological data
- Data around indicators such as therapy / medication adherence, therapy / medication response, and pain level
- 16 days of readings every 30 days
- Interactive communication per month (phone, telemedicine, maybe secure email / portal)

Remote Therapeutic Monitoring (RTM)

CPT	Description	wRVU
98975	Remote therapeutic monitoring, **initial set-up and patient education** on use of equipment	0.00 PE 0.58
~~98976~~ ~~-~~	~~Remote therapeutic monitoring; **device(s) supply** with scheduled recording(s) and/or programmed alert(s) transmission to monitor **respiratory**, 30 days~~	~~0.00~~ ~~PE 1.41~~
~~98977~~ ~~-~~	~~Remote therapeutic monitoring, **device(s) supply** with scheduled recording(s) and/or programmed alert(s) transmission to monitor **musculoskeletal**, each 30 days~~	~~0.00~~ ~~PE 1.41~~
98980	RTM treatment management services, time over a calendar month requiring at least **one interactive communication** with the patient/caregiver; **first 20 minutes** of E/M	0.62
98981	RTM treatment management services, time over a calendar month requiring at least **one interactive communication** with the patient/caregiver; **each additional 20 minutes** of E/M services	0.61

Designing a Care Coordination Program

- Overall program
  - Identify key staff roles, provide training
  - Define eligible patient populations
  - Determine how patients will be identified and enrolled (efficient at patient visits)
  - Streamline consent procedures
  - Create care plan templates
  - Develop a time logging system
  - Develop a monthly billing process
  - Create communication protocols: intra-practice and external
  - Create educational resources
  - Utilize technology: Optimize EHR, use FDA-approved devices
- Patient visits or interactive communications
  - Identify: evidence of provider involvement (order for service) and medical necessity
  - Enroll and obtain consent
  - Schedule monthly (phone or telemedicine)
  - Assess patient needs
  - Create or review individual disease-specific care plan
  - (Provide device education)
  - Document visit or communication and resources provided
  - Log visit time (start/stop, tasks performed)
  - Aggregate time per month for each service

Staff Able to Provide Care Coordination Services

- Billing Provider
  - Physician or qualified healthcare professional (NP, PA, CNM)
  - Reimbursement per unit time is lower than E/M
  - Order services, establish medical necessity, establish the care plan, oversee delivery
  - Perform medical assessments
  - Bill for services

Staff Able to Provide Care Coordination Services

- Other personnel
  - Clinical staff under the general supervision of the billing provider
  - Must work within professional scope of practice (license, certification, or training)
  - Dedicated care coordinator
  - RNs
  - LPNs, LVN
  - MAs
  - Social workers
  - Health educators
  - Care coordinators and patient navigators (scheduling, resource identification, communication)
- Provide training and competency assessment
  - Principles of care coordination, communication skills, resource identification
  - Documentation and time logging

Eligible Epilepsy Populations

- **General (new patients)**
  - Seizure types, tracking, and triggers
  - Seizure safety and first aid
  - Seizure action plan, rescue ASMs
  - ASM knowledge, adherence, barriers
  - Lifestyle modifications (sleep, diet, trigger avoidance)
  - Coping mechanisms

- Specific
  - **Known non-adherence**
  - **Recent ER visit or hospitalization**
  - **Intellectual / developmental disabilities**
  - **Drug-resistant epilepsy**
  - **EMU admission and discharge**
  - **Epilepsy surgery or device planning**
    - Admission and discharge
  - **Device management**
  - Ketogenic diet
  - Pregnancy
  - Social determinants of health needs
  - Comorbidity management (mood, cognition, sleep)

Care Plan Templates

- Indicate which topics are relevant to the patient
- Provide details for each topic
- Establish patient goals
- Example: Medication management
  - Current medications for seizures and epilepsy with patient friendly dosing information
  - Seizure rescue medications, including instructions for use
  - ASM knowledge assessment (names, doses, timing, rationale for use, side effects, interactions)
  - Current ASM efficacy
  - ASM adherence assessment
  - Barriers to adherence
  - ASM side effects
  - Planned adjustments in ASMs
  - Other relevant medications, indication, and patient friendly dosing information
- Don’t be afraid to use artificial intelligence to reformat visit notes

Demographics

Eval Date:	**Epilepsy Dx:**
Name:	**Dx Onset:**
ID:	**Hispanic:**
DOB:	**Race:**
Visit Age:	**Sex:**
Care Phase:	

Epilepsy Classification

First Seizure	Family Hx	Current Epilepsy Syndrome	Surgical Hx	Drug Resistant
? Uknown first seizure age (Duration: Missing dates)	?		?	?

Seizure Summary

*** No Seizure Data Entered ***

Medications

Daily	Week 1 (8/30 - 9/5)							Week 2 (9/6 - 9/12)							Week 3 (9/13 - 9/19)							Week 4 (9/20 - 9/26)						
Medication	Wed	T	F	S	S	M	T	Wed	T	F	S	S	M	T	Wed	T	F	S	S	M	T	Wed	T	F	S	S	M	T
*** No Daily Medications ***																												
*** NonDaily ***																												
Medication	Wed	T	F	S	S	M	T	Wed	T	F	S	S	M	T	Wed	T	F	S	S	M	T	Wed	T	F	S	S	M	T
*** No nonDaily Medications ***																												

Safety Assessment

Name	Rescue Meds / Reason	Comments
Fall Risk ()	N/A	N/A

PRO Dashboard

Standard Measures			Top Priorities	Other Domains		Last Seizure: 1 to 4 weeks ago
	2.9	QOLIE10	1 Daily Activities			Ed: HS Grad
		PROMIS-Physical	2 Mental activity			Work:
		PROMIS-Mental	3 Overall QOL	Rel Status:	Single	Ability:
	2	GAD	Internet via:	Unmeet Needs:		Need Help:
		NDDIE	Has Devices:	Transportation:		Ins:
	4	PHQ	#1 Med Barrier: No Barriers	Background:	Missing Info	Socialize:
	2	Good Days	Side Effects:			Stress:

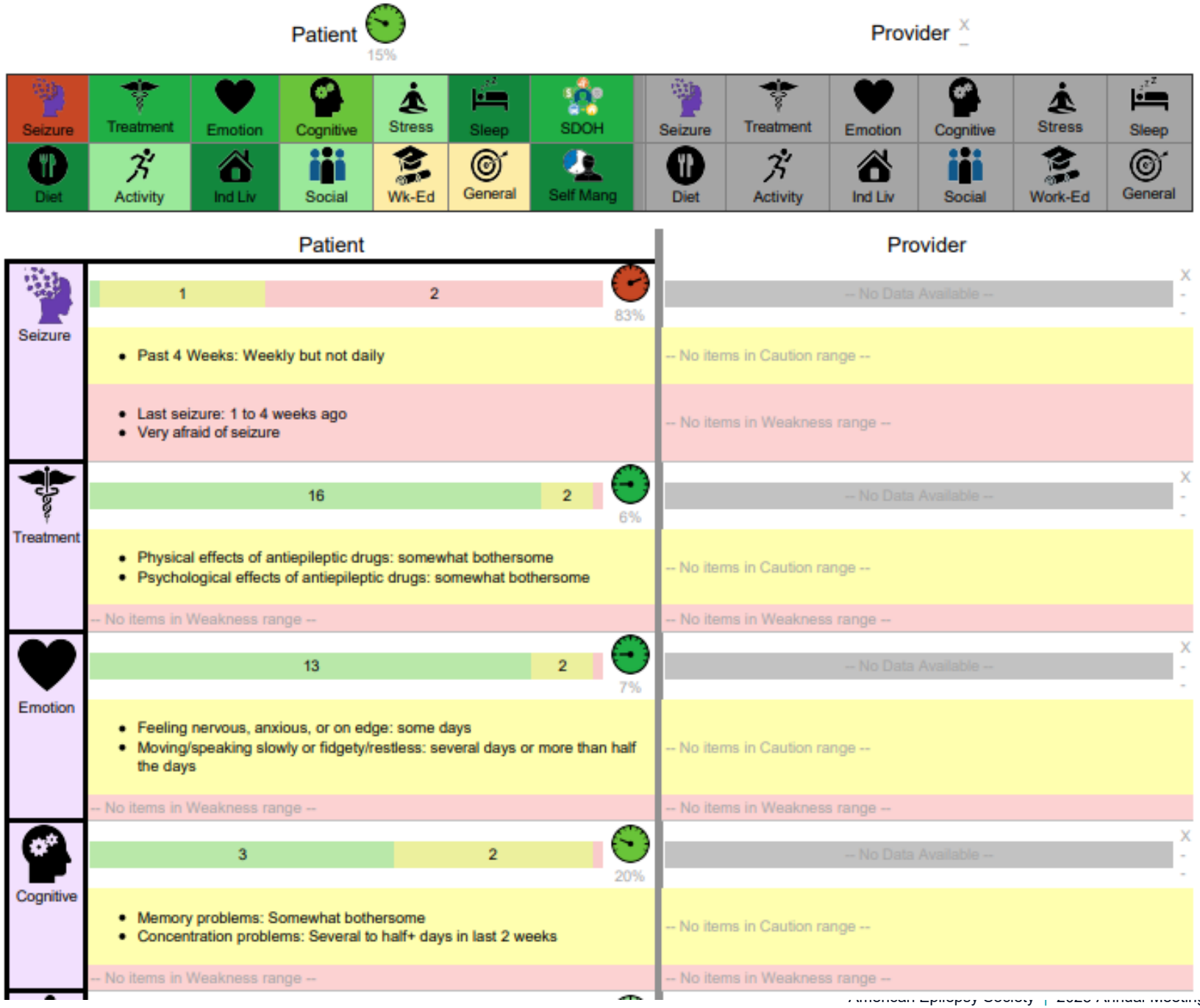
==========

Details Section Below

Instructions List

*** No anti-epileptic Medications Entered ***

PRO Details


Patient
15%
Provider
Seizure
Treatment
Emotion
Cognitive
Stress
Sleep
SDOH
Diet
Activity
Ind Liv
Social
Wk-Ed
General
Self Mang
Work-Ed
Patient
Provider
1
2
83%
-- No Data Available --
Past 4 Weeks: Weekly but not daily
Last seizure: 1 to 4 weeks ago
Very afraid of seizure
-- No items in Caution range --
-- No items in Weakness range --
16
2
6%
Physical effects of antiepileptic drugs: somewhat bothersome
Psychological effects of antiepileptic drugs: somewhat bothersome
13
2
7%
Feeling nervous, anxious, or on edge: some days
Moving/speaking slowly or fidgety/restless: several days or more than half the days
3
2
20%
Memory problems: Somewhat bothersome
Concentration problems: Several to half+ days in last 2 weeks

Reference ID: 1488288
Site: BNI

Created: 10/21/2025 4:26:54

Medication Summary - Now

Report Date: 10/21/2025

Daily	Week 1 (10/21 - 10/27)							Week 2 (10/28 - 11/3)							Week 3 (11/4 - 11/10)							Week 4 (11/11 - 11/17)						
Medication	Tue	W	T	F	S	S	M	Tue	W	T	F	S	S	M	Tue	W	T	F	S	S	M	Tue	W	T	F	S	S	M
Lamotrigine(mg)	400																											
Perampanel(mg)	3																											
*** NonDaily ***																												
Medication	Tue	W	T	F	S	S	M	Tue	W	T	F	S	S	M	Tue	W	T	F	S	S	M	Tue	W	T	F	S	S	M
Clonazepam(mg)	1																											

Medication Details

Week 1

Daily Medications

Time	Medication	Week of 10/21/25 to 10/27/25 Tue	Wed	Thr	Fri	Sat	Sun	Mon
8:00 AM	Lamotrigine 200mg	•	•	•	•	•	•	•
8:00 PM	Lamotrigine 200mg	•	•	•	•	•	•	•
8:00 AM	Perampanel 3mg	•	•	•	•	•	•	•

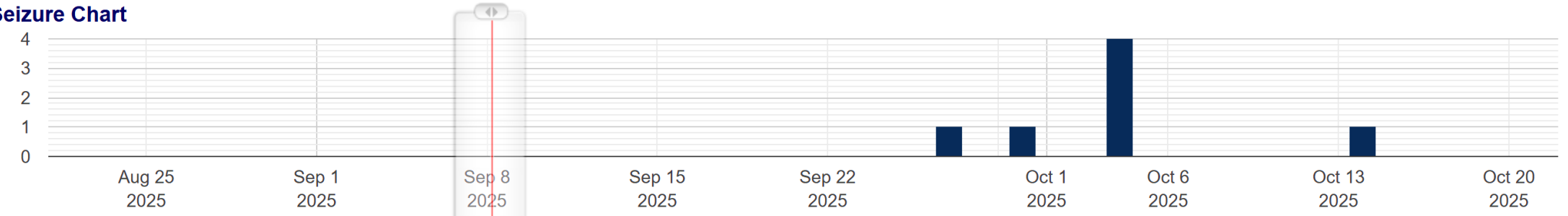
nonDaily Medications

Time	Medication	Week of 10/21/25 to 10/27/25 Tue	Wed	Thr	Fri	Sat	Sun	Mon
as needed, PRN	Clonazepam 1mg	〰	〰	〰	〰	〰	〰	〰

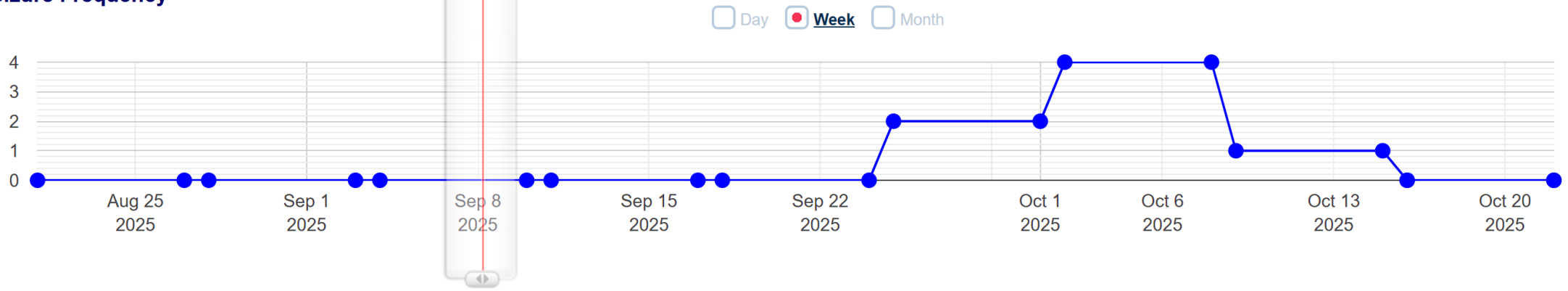
Details	Identifier	Enrolled	Seizures in past 30 days (1)	Avg /day	Seizures in past week (2)	Avg /day	Seizures yesterday	Date of last seizure	Sz type	Last took med	Date last viewed	Days W/O Data	Last login (ET)	Patient usage days this month	Minutes this month	Int. Comm.	Patient Dashboard
		04/02/25	7	0.23	1	0.14	0	10/14/25	Staring episodes Blackout	10/20/25	09/23/25	1	10/20/25 10:18	20	0		
		01/22/25	1	0.03	1	0.14	0	10/19/25	Sz-red	10/20/25	09/24/25	1	10/20/25 23:09	20	0		
		01/22/25	3	0.1	1	0.14	0	10/18/25	left temporal lobe	10/20/25	08/21/25	1	10/20/25 22:01	20	0		
		01/22/25	1	0.03	0	0	0	09/27/25	Staring spell	10/20/25	10/06/25	1	10/20/25 23:00	20	19:29		
		09/24/25	29	0.97	6	0.86	0	10/19/25	gran mal twitches Coughing a...	10/19/25	09/26/25	2	10/20/25 03:28	19	0		
		01/22/25	0	0	0	0	0	08/29/25	Seizure	10/20/25	10/17/25	1	10/20/25 15:46	19	01:34		
		01/22/25	0	0	0	0	0	08/22/25	Large Seizure Small Seizure	10/19/25	01/22/25	2	10/20/25 00:35	19	0		
		01/22/25	0	0	0	0	0	04/25/25	INCIDENT	10/19/25	01/22/25	2	10/20/25 01:52	19	0		

DATA VISUALIZATION

Seizure Chart



Seizure Frequency



Epilepsy

Days this month 20

Provider Time (h:m:s) 00:00:41

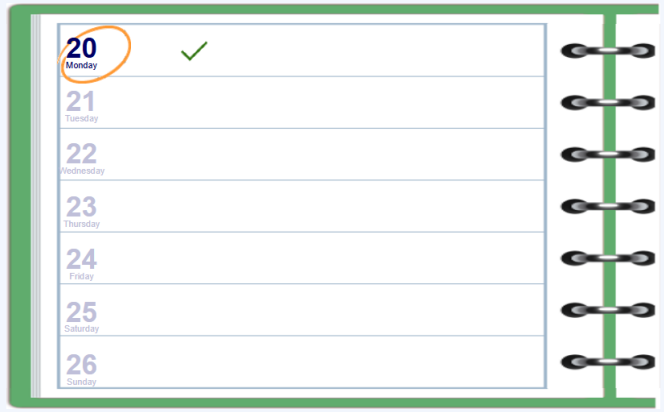
MEDICATIONS

All | Titration Plans

Lacosamide (Vimpat) 100mg

Edit Medications

PATIENT DIARY



View Diary

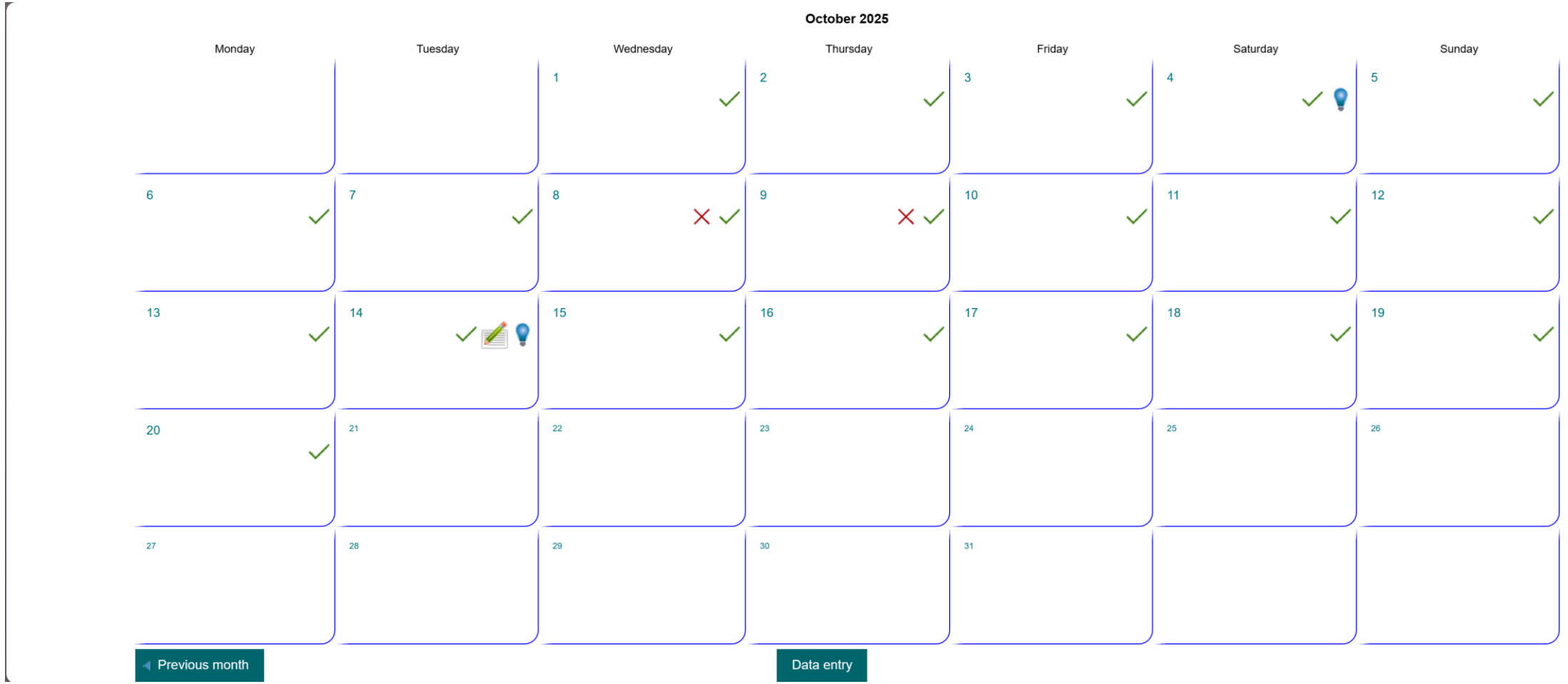
PATIENT ACTIONS

Patient Communication

Assessments

Exercising & Lifestyle

Progressive Muscle Relaxation


October 2025
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
Previous month
Data entry

Patient Assessments

Schedule a new assessment

Please select (multi-select)
Seizure Severity Questionnaire (SSQ)
PIES
NDDI-E
Pittsburgh Sleep Quality Index
A-B Neuropsychological Assessment Schedule (ABNAS)
Generalized Anxiety Disorder
Neurological Disorders Depression Inventory
Depression Scale (CES-D)
Quality of Life in Epilepsy (QOLIE-10-P)
Anti-epileptic Drug Adverse Event Profile (AEP)

Please select (multi select)
Before next visit
In 1 month
In 3 months
In 6 months
Every 3 months
Every month
Every week

Enter a specific date:

mm/dd/yyyy

Patient will be reminded starting two days before scheduled date and up to two days following, at this time in the day:

12:00 PM

Save

Fill an Assessment Now

For this patient

Please select one
Seizure Severity Questionnaire (SSQ)
PIES

Current Orders

#	Assessment	Scheduled

Past Assessments

#	Assessment	Date	Score	Reviewed

Patient Centered Care Plan

Name:

Plan Date: 08/05/2025

Goals Important To Patient

- [ ] Control blood pressure
- [ ] Control blood sugar
- [ ] Be seizure-free
- [ ] Reduce headaches frequency
- [ ] Reduce headaches intensity
- [ ] Have more energy
- [x] Increase quality of life
- [x] Better quality of sleep
- [ ] Less enxiety and stress

Potential Barriers

- [ ] Fear
- [ ] Social stigma
- [ ] Can't stop drinking alcohol
- [ ] Prescribed mesicines didn't stop seizures
- [ ] Prescribed medicines cause side effects

Problems / Symptoms To Reduce Or Prevent

Scope of this report: All Epilepsy Patients

Download Summary PDF Download Details PDF Print Summary Print Details

Billing Report For Period: October 1, 2025 - October 31, 2025 (31 days)

Created: October 20, 2025 Expand All Requirements for RTM billing codes

Name	Days	Pr.Time	Pt.Comm	CPT Code(s)
Miranda, Michael	15	00:37:31		*Billing 98980 requires pt. communication.*

id	Date	Provider	Description	Session time	Notes
13661	10/06 13:14		Patient selected	00:13:35	
13662	10/06 13:15		Set a fixed medicine (00:15)		
13664	10/06 13:16		Set a fixed medicine (00:13)		
13666	10/06 13:16		Medication titration (00:07)		
13668	10/06 13:16		Set a fixed medicine (00:16)		
13670	10/06 13:16		Set a fixed medicine (00:38)		
13672	10/06 13:17		Set a fixed medicine (10:25)		
13675	10/06 13:28		Explicit logout		
13677	10/06 13:55		Patient selected	00:07:03	Excluded: Set Manual Time (02:44)
13678	10/06 13:56		Issue app prescription (03:05)		
13683	10/06 14:05		Explicit logout		
13685	10/06 14:16		Patient selected	00:14:30	Excluded: Set Manual Time (03:12)
13686	10/06 14:16		Set a fixed medicine (07:31)		
13691	10/06 14:34		Explicit logout		
13706	10/14 11:28		Patient selected	00:00:23	
Manually reported					
42	10/06 11:02			00:01:00	Set up the EpiDiary app for Michael after calling him and setting a Zoom appointment. Called Michael at the appointment time to guide him through a Zoom login. Once on the login in a family member, Lorraine, tried to login using his phone without success. Advised her to try to load the app via the QR code and I will call her back once his is logged on.
43	10/06 11:31			00:01:00	Resumed call with Michael and Lorraine (wife) after they loaded the app onto his phone. We reviewed the app, icons, functionality of EpiDiary. All questions were answered and patient encouraged to contact me with any questions at the number and email provided to him. We discussed completion of the MINDSET survey as well to assist him and Dr Herman in managing his care. Advised I would call back and check in a few days. They acknowledge understanding.

Potential Barriers

- Require patient consent (must be documented - written or verbal)
- May require patient co-pay
- Mechanisms to aggregate time / track threshold over calendar month
- Development of care plans (may require new software)
- Difficult to calculate return on investment (ROI): Payer variations, payer mix
- Requires culture and practice change
- Need to develop new materials:
  - Educational modules
  - Templates for rapid documentation

Revenue Calculations

- Cost analysis: Staff time, technology, training
- Typical salary of care manager = $65,000 + 30% benefits = $84,500

- Volume of enhanced care coordination
  - 8 hours per day, 5 days per week, 48 weeks per year
  - 8 (30 minute) PCM encounters per day
  - 5 x 8 x 48 = 1920 x 61.34 = $117,772

- Not all payers will reimburse for all codes!
  - Medicare 30% of patients x 100% paid = 0.30
  - Medicaid 30% of patients x 40% paid = 0.12
  - Commercial 40% of patients x 80% paid = 0.32
- Reimbursement mix = 0.74 = $87,151

Benefits Beyond Direct Reimbursement

- Reduced emergency room visits and hospitalizations
- Improved patient satisfaction and retention
- Reduced call and portal message volumes
- Enhanced reputation and market differentiation
- Better patient outcomes
- Potential for future value-based care incentives

- Track performance metrics: Utilization, revenue, and patient outcomes to demonstrate value and drive continuous improvement

Impact on Clinical Care

- Be a champion for organizational change
- Not just about billing; fundamental to providing optimal comprehensive care in accredited center
- Can use both traditional and new CMS CPT codes for care coordination, quality improvement, and population health activities
- Many new codes introduced in past few years
- Reimbursement of codes varies across payer types (Medicare, Medicaid, commercial) and payers (e.g. each commercial payer or Medicaid by state)
- Focus on staff time for care coordination, not provider
- Include your business manager / financial officer in your planning!

2025 AES ANNUAL MEETING

2025 AES ANNUAL MEETING

Solutions to Common Epilepsy Center Coding and Insurance Questions

Deepti Zutshi, MD, FAES, FAAN, FACNS

December 8, 2025

AES®
AMERICAN EPILEPSY SOCIETY

Learning Objectives: Adventures in Coding

- Develop an epilepsy consultant practice on inpatient units outside of the EMU.
- Design and construct admission phrases for inpatient EMU admission approvals.
- Assemble tips and tricks to improve charge capture and billing codes.

Case 1: The EMU Admission: Inpatient vs Observation

- Clinical Scenario: As the epilepsy center director, the CFO reaches out to ask you about EMU admissions being denied inpatient status based on the documentation of the ordering physician. The current case that is being denied:

H&P: 36-year-old male started having passing out spells (2x year) for 6 years characterized as light headedness, syncope without TB/UI or AMS after regaining consciousness. No risk factors for epilepsy. He has migraines. He has depression/anxiety and a history of abuse in childhood. Cardiac work-up negative. MRI Brain is normal.

Meds: No home ASMs, trazadone 100mg qhs, buspirone 30 mg/d

Assessment and Plan:
34 yo male with no PMH, here for characterization and diagnosis of passing out spells.
-admit to EMU unit
-no home ASMs
-Continue home trazadone 100mg Qhs, buspirone 30 mg/d for anxiety
-Sleep deprivation and photic stimulation tonight

Question 2:

What could you add to documentation to approve this as an inpatient stay?

A. Report symptoms are not classic for seizures
B. Seizure etiology work-up is non-diagnostic
C. Report outpatient EEG is non-diagnostic and normal
D. Patient does not report alcohol or alcohol withdrawal prior to events
E. Patient does not report abuse of drugs within 48 hour of events
F. All of the above

F. All of the above.

- This patient has spells for 6 years but occurs twice a year. There is no strong evidence for seizures or epilepsy but diagnostic evaluation could be helpful with EMU and longer study.
- However, most inpatient criteria usually will allow inpatient status for one of the following.
  - Known seizure disorder with **all** of the following:
    - Recurrent refractory seizures despite treatment of 2 or more ASMs
    - No current seizure provoking medications
  - ASM withdrawal or adjustment during which there is specific risk for requiring immediate medical attention
  - Provocation maneuvers are required that warrant direct observation[2]
  - Epilepsy surgical localization of seizure focus prior to surgery or intracranial electrode implantation in patients with refractory seizures
  - Differentiating Epileptic vs. Non-epileptic when **ALL** of the following apply:
    - Recurrent symptoms not classic for seizures
    - History or lab results are non-diagnostic for seizure etiology
    - Routine EEG non-specific, (some require ambulatory EEG)
    - No cessation of alcohol within 48 hours of seizure or intoxication of drugs of abuse within 48 hours of seizure activity
  - If ASM withdrawal is deemed unsafe in the outpatient setting AND all of the criteria above are met
  - Outpatient video EEG LOS is usually < 48 hours and no longer than 72 hours of observation. If event is not in this timeframe, then inpatient video EEG may be authorized, i.e. Seizure not expected within an ambulatory EEG timeframe[2].

Sample Inpatient Criteria for video EEG monitoring admissions
(Each insurance company will have different criteria that may be conflicting and may differ by state)

- Inpatient criteria for video electroencephalography in a healthcare facility may be considered medically necessary if ONE of the following criteria is met:
  - Known seizure disorder with **all** of the following:
    - Recurrent refractory seizures despite treatment of 2 or more ASMs
    - No current seizure provoking medications
  - ASM withdrawal or adjustment during which there is specific risk for requiring immediate medical attention
  - Provocation maneuvers are required that warrant direct observation[2]
  - Epilepsy surgical localization of seizure focus prior to surgery or intracranial electrode implantation in patients with refractory seizures

Molina Healthcare Policy 133; United Healthcare 2025T0596N, Blue Cross Blue Shield (Kansas)

Inpatient Criteria for video EEG monitoring admissions (sampling of a few insurance companies, differs by state!)

- Differentiating Epileptic vs. Non-epileptic when **ALL** of the following apply:
  - Recurrent symptoms not classic for seizures
  - History or lab results are non-diagnostic for seizure etiology
  - Routine EEG non-specific, (some require ambulatory EEG)
  - No cessation of alcohol within 48 hours of seizure or intoxication of drugs of abuse within 48 hours of seizure activity
- If ASM withdrawal is deemed unsafe in the outpatient setting AND all of the criteria above are met
- Outpatient video EEG LOS is usually < 48 hours and no longer than 72 hours of observation. If event is not in this timeframe, then inpatient video EEG may be authorized, i.e. Seizure not expected within an ambulatory EEG timeframe[2].

Molina Healthcare Policy 133; United Healthcare 2025T0596N, Blue Cross Blue Shield (Kansas)

Case 1: The EMU Admission: Inpatient vs Observation

Sample Change in our own practice....

Add in criteria for admission into your EMR orders or into your daily EMU admissions.

We went from 18 denials in 3 months (6 bed emu) to 1 denial after implementation of these into our notes.

Daily Report

Name: <Last Name>, <First Name>
DOB: <Date of Birth>

Recording Start Date/Time: 00.00.00 at_____am/pm
Recording End Date/ Time: 00.00.00 at_____am/pm

REFERRING PHYSICIAN: <Ref. Phys.>

TECHNIQUE: 21 channels of EEG, 2 channels of EOG, and 1 channel of EKG were recorded utilizing the International 10/20 System, plus right and left zygomatic electrodes. The recording was performed in a digitized monopolar referential format and playback was reformatted into various referential and bipolar montages utilizing appropriate filter settings. Video was recorded during the study. Automatic seizure and spike detection programs were utilized throughout the recording.

Sphenoidal electrodes were placed on:

EMU DAY # X

CLINICAL DATA:

ICD 10 Diagnosis Code:

Daily Reason for inpatient EMU Admission:
[ ] Pre-surgical Evaluation
[ ] Patient required close evaluation as inpatient due to stopping/reducing anti-seizure medications
[ ] Patient admitted for intracranial electrode evaluation
[ ] Patient has experienced a change in seizure pattern, type of seizure and duration of seizure requiring long-term EMU evaluation
[ ] Patient requires change in treatment during EMU stay

ANTIEPILEPTIC MEDICATIONS:

ACTIVATION PROCEDURES: reduction of medications / sleep deprivation/ photic driving / hyperventilation

Case 2a: The epilepsy clinic visit - QuickPicks

- Clinical Scenario: You are a busy epilepsy specialist in a level 3 center. You see 16 patients a day in the outpatient clinic.

Case 1. A 7 year-old child comes for follow-up with 3 breakthrough seizures in the last 2 months. You adjust the ASM doses today, prescribe a rescue medication and review potential side-effects, and counsel regarding SUDEP. Follow-up in 2 months.

Question 3:

What would you bill this patient?

A. 99213
B. 99213 + G2211
C. 99214
D. 99214 + G2211
E. 99215
F. 99215 + G2211

Best answer: 99214 + G2211. Patient has an uncontrolled condition and meds are adjusted. It's an automatic 99214. There is a longitudinal follow-up for this chronic illness so you should also bill G2211. Bill it, even if you don't get paid usually. There are cases where it will get paid and can vary from state to state and payor to payor.

Case 2b: The epilepsy clinic visit - QuickPicks

- Clinical Scenario: You are a busy epilepsy specialist in a level 3 center. You see 16 patients a day in the outpatient clinic.

Case 2. A 34-year-old with right temporal lobe seizures and right mesial temporal sclerosis returns for follow-up. Despite 3 ASMs, she has had 4 seizures in the last 1 month of which one resulted in a fall dislocating her shoulder. You discuss the risks and benefits of a right temporal lobectomy with her. You adjust her medications today and make a referral to see the functional neurosurgeon. She is to follow-up in 4 weeks after a decision regarding surgery.

Question 4:

What would you bill this patient?

A. 99213
B. 99213 + G2211
C. 99214
D. 99214 + G2211
E. 99215
F. 99215 + G2211

Best answer: 99215 + G2211

- Patient has an uncontrolled condition which resulted in a bad fall and is refractory. This is high level complexity. The decision of surgery is there but YOU MUST include the procedures risk and benefits (descriptions) and document discussion. This could then be 99215.
- There is a longitudinal follow-up for this chronic illness so you should also bill G2211. Bill it, even if you don’t get paid usually. There are cases where it will get paid and can vary from state to state and payor to payor.

Case 2c: The epilepsy clinic visit - QuickPicks

- Clinical Scenario: You are a busy epilepsy specialist in a level 3 center. You see 16 patients a day in the outpatient clinic.

Case 3. A 25-year-old with controlled epilepsy for 5 years arrives for follow-up. You see the patient annually and refill same dose of ASMs. No new complaints. Counseling is given on driving, SUDEP, medication side-effects. Patient was asked to return for follow-up in one year.

Question 5:

What would you bill this patient?

A. 99213
B. 99213 + G2211
C. 99214
D. 99214 + G2211
E. 99215
F. 99215 + G2211

Answer: 99213 + G2211

Patient has CONTROLLED and stable chronic illness, Refills are given and there is low risk of morbidity from treatment as it's been the same.
There is a longitudinal follow-up for this chronic illness so you should also bill G2211. Bill it, even if you don't get paid usually. There are cases where it will get paid and can vary from state to state and payor to payor.

Case 2d: The epilepsy clinic visit - QuickPicks

- Clinical Scenario: You are a busy epilepsy specialist in a level 3 center. You see 16 patients a day in the outpatient clinic.

Case 4. A 31-year-old pregnant female comes in urgently for follow-up due to recent exacerbation of seizures. While in the office, she has 2 focal seizures in a cluster and returns to baseline. You decide to directly admit the patient to the inpatient neurology service for video EEG monitoring and ASM management. Total time spent that day was 39 minutes.

Question 6:

What would you bill this patient?

A. 99213
B. 99213 + G2211
C. 99214
D. 99214 + G2211
E. 99215
F. 99215 + G2211

Best answer: 99215 + G2211

Patient has exacerbation of the chronic illness and there is a threat to her and possibly maternal risk. Direct admissions to the hospital are considered 99215 or if she went above 40 minutes. If you sent her to the Emergency room, that would not count as 99215.
There is a longitudinal follow-up for this chronic illness so you should also bill G2211. Bill it, even if you don't get paid usually. There are cases where it will get paid and can vary from state to state and payor to payor.

Moderate Complexity Tips

- If a follow-up patient is being seen for a chronic condition that has not reached treatment goal(s) and you continue a prescription or start a prescription or even discuss medications but do not start, then it's an automatic 99214
  - Eg. Chronic epilepsy with breakthrough seizures requires continued levetiracetam prescription.

<u>As epileptologists in level 3 and 4 centers such scenarios may represent a majority of our patients.</u>

- In these situations, the only way to increase to 99215 is:
  - Documenting time you spent with the patient and with charting on the same day OR
  - Patient has a life-threatening condition AND either
    - You are referring the patient to have surgery AND describe risks and benefits OR
    - You have to admit the patient <u>to the hospital</u> emergently

G2211: Medical Complexity Add-on Code

- G2211: Visit complexity inherent to evaluation and management services associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition
  - Can be added to any outpatient (99201-99205, 99212-99215), annual wellness visit, vaccine or preventive service
  - Cannot be added with same day procedure code (25 modifier)
  - Medicare is the only insurance paying for it currently
  - Small wRVU value of 0.3 but can add up

Documentation example: "I am providing the patient longitudinal care requiring continued follow-up over time for this condition."
Documentation example of follow-up established will also be of help. "I last saw the patient on 06/01/2025. They initially established care in January 2020 with my colleague, Dr. M."

Practice Question 7

I provide epilepsy or status epilepticus consultations on the inpatient services, independent of general neurology or EEG interpretation services.

A. True
B. False
C. Not applicable

Case 3a: The Medical ICU

Clinical Scenario: You are the epileptologist on call for the LTVM EEGs.

- A patient with non-convulsive status continues to seize on day 4 despite 3 ASMs and 2 anesthetic agents. The general neurologist who has seen the patient on days 1-3 and the medical ICU doctor are requesting you to consult on the case to provide clinical management and treatment. You:
  - review the chart (history, labs, imaging)
  - come to the patient's bedside in the MICU to look at the patient,
  - speak to the MICU team for 10 minutes regarding management of ASMs and drug/renal monitoring, anesthetics, and further diagnostic work-up
  - speak to the patient's family members for another 25 minutes regarding patient's critical status
  - document a new consultation note for 20 minutes.
- The total time spent was 70 minutes.

Question 8:

According to the CPT coding manual, what is the best billing code for this consult?

A. 99232 (subsequent hospital day, mod complexity)
B. 99233 (subsequent hospital day, high complexity)
C. 99254 (Initial consult, mod complexity)
D. 99255 (Initial consult, high complexity)
E. 99291 (critical care, 30-74 minutes)
F. 99292 (critical care, each 30 minutes > 75 min)

Answer is E.

- Choices A and B are follow-up because the distractor is that there is a general neurologist who saw the patient on the first 3 days. However, epileptology has a new taxonomy code so can bill as a new consult so A and B are wrong.
- Choice C is incorrect as this is a higher complexity; by time, it has to be 60 minutes or more though.
- Choice D: could argue this as it is a high complexity patient due to acute illness posing a threat to life AND anesthetics, and drug therapy discussion were discussed.
- Choice F: It has to be at least 75 minutes or more so we cannot bill it this by time.
- Choice E: however, provides the best billing scenario than D as this person is critically ill and physician is working specifically on the status epilepticus and critical adjustments to medications, plan for anesthetics and discussion with team and family members.

Epilepsy Specialist: Taxonomy Code

- Epilepsy Specialist, New Taxonomy code, F6 (since July 1, 2024)

- To change specialty code, refer to PECOS application online or paper (CMS-8551).
- You cannot use this until you have formally received the new taxonomy designation

- Under this code, you can bill a new patient visit even if the patient was seen by a general neurologist prior your consultation.
  - Cannot bill a new visit for non-seizure related visits (headache, stroke, MS if you are on call and taking over from another general neurologist)

Neurocritical Care Specific Codes

- Defined critically ill and injured patients as *those who are experiencing one or more vital organ failure(s) and who have a high probability of life-threatening deterioration in their condition*
- Not limited to ICU floors, not for "boarders in the ICU"
- These codes are for total time spent in a 24-hour period and does not need to be face-to-face for all of it. However, it must occur on the unit and cannot be at home or in office.
  - < 30 minutes (use the regular inpatient codes)
  - 99291 (30 to 74 minutes)
  - 99292 (each additional 30 minutes)
- Beware of the political landscape of your work environment regarding consultations

CPT code	Descriptor	wRVU (2024)
99255	Initial consult	3.86
99291	Critical Care, 30-74 minutes	4.5
99292	Critical care, each add'l 30 minutes	2.25

AAN.com, Tools and Resources, Medicare 2024 Physician Fee Schedule

Critical Care Billing Attestation Sample

Attestation Example:

"I personally spent a total of 70 minutes in the care of this critically ill patient due to patient's presentation of acute onset non-convulsive status epilepticus.

Medical decision-making involved review and modification of antiseizure medications, management of anesthetics, drug level and renal monitoring, and workup for cause of new onset seizures.

The time noted above includes time spent performing the following interventions while on the unit where the patient resides: Life support management/intervention, lab review, brain imaging review, other data review & discussion with Intensive Care Unit Team and/or consultants . The time above includes time spent with family discussing history, diagnosis, and treatment decisions."

Case 3b continued

- **Clinical Scenario:**
- You return to the EEG lab, read and report on the LTRV of the same patient, and document a 24-hour video-LTRV report on the same date of service.
- Later that evening, while at home, the ICU attending calls and asks you about adjustments for the IV anesthetics and ASMs due to increasing GFR and creatinine. You spend 15 minutes on the phone with them. You agree to see the patient again the next day for follow-up.

Question 9:

According to the CPT coding manual, what would you bill for this patient for the entire day of services?

A. 99291, 95718
B. 99291, 99292 x 1, 95720
C. 99291 + 25, 95720
D. 99291 + 25 , 99292 x 1; 95720
E. 99291 + 25 + G2211, 99292 x 1, 95720

Key:
95718: 2-12 hour video EEG
95720: 12-26 hour video EEG
99291: 30-74 min critical care
99292: add'l 30 min, critical care
+ 25 modifier: procedure code
G2211: longitudinal care code

Answer is C.

- We spent an additional 15 minutes on the phone but that cannot count as you're not on the unit so still at 70 minutes billable time. Cannot add 99292 also due to the fact that it has to be a FULL 30 minutes of additional time past the 74 minutes of 99291.
- We also billed a 24 hour video –LTRV report so this is 95720. But this is a procedure on the same date of service. This requires a + 25 modifier added to the E/M code.
- The G2211 cannot be used on inpatient service codes and cannot be combined with a +25 modifier in the outpatient setting (such as with RNS, VNS programming in the outpatient clinic).

Same Day Procedure Code

- Modifier 25: indicates that there was a significant and separately identifiable evaluation and management service performed on the same date of service as a procedure by the same physician OR another physician in the same group.
  - This applies to inpatient and outpatient codes and includes procedures such as EEGs, EMGs, device programming (VNS, RNS, DBS), LPs, line, botulinum injections, etc.
  - Tricks: Cannot be used with G2211
  - Added to the E&M codes (NOT THE PROCEDURE CODES)

Modifier 25: example

In the Epilepsy Monitoring unit, I see the patient on admission with an H&P that is moderate complexity but also am on call to read the EEG for that date which is an 18-hour study.

Admission H&P would be a moderate complexity code: 99222 PLUS 25 modifier
EEG report would be an additional 95720 (12-26 hour video EEG).
I must have two separate notes for that day's encounters (E&M and EEG report).

References

- CPT Coding Handbook 2024 Edition. American Medical Association.
- Long-Term EEG Monitoring FAQs. American Academy of Neurology. 2020. <eeg-faq-on-aan-template-2.21.2020-revised>
- Molina Clinical Policy, Video EEG Monitoring Policy, Policy No. 133, Approval 2/14/2025. <Accessed 10.5.2025 https://www.molinahealthcare.com/providers/oh/medicaid/policies/-/media/Molina/PublicWebsite/PDF/Providers/oh/medicaid/policies/MCP-133-Video-EEG-Monitoring-0324.pdf >.
- United Healthcare, Video EEG Monitoring and Recording Policy 2025T0596N, May 1, 2025 <accessed 10.5.2025 https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/video-electroencephalographic-monitoring-recording.pdf >.
- Blue Cross Blue Shield of Kansas. Vide EEG Monitoring Policy; January 9, 2025 <accessed 10.5.2025 https://www.bcbsks.com/medical-policies/video-electroencephalogram-eeg-monitoring >.

Resources

American Academy of Neurology's Practice Section on Billing and Coding: https://www.aan.com/practice/cpt-and-coding-resources

National Association of Epilepsy Center's Center Resources Pages on Coding and Reimbursement:

https://naec-epilepsy.org/category/center-resources/coding-reimbursement

American Epilepsy Society's Clinical Care section on billing and coding:

https://www.aesnet.org/clinical-care/running-your-practice/billing-coding

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