

Inpatient Epilepsy Monitoring Unit (EMU) using Video-Electro-Encephalography (Video-EEG)

[For the list of services and procedures that need preauthorization, please refer to www.mcs.com.pr, go to “Proveedores” and click “Políticas Médicas”.]

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This policy applies to products subscribed by the following corporations, MCS Life Insurance Company (Commercial), and MCS Advantage, Inc. (Classicare) and Medical Card System, Inc., provider’s contract; unless specific contract limitations, exclusions or exceptions apply. Please refer to the member’s benefit certification language for benefit availability. Managed care guidelines related to referral authorization, and precertification of inpatient hospitalization, home health, home infusion and hospice services apply subject to the aforementioned exceptions.

DESCRIPTION

An **Epilepsy Monitoring Unit (EMU)** is an inpatient unit directed by specialists in epilepsy. These centers provide in-depth diagnostic and treatment services for people with difficult to diagnose or treat seizures or epilepsy. EMUs are typically part of a specialized epilepsy center that provides both outpatient and inpatient services to people with epilepsy and their families. Patients are admitted to the EMU when their condition requires prolonged EEG monitoring. Patients in the EMU receive Continuous Electro-Encephalography (EEG) and Video-EEG Monitoring.

Video Electro-Encephalography (EEG) monitoring is the synchronous recording and display of EEG patterns and video-recorded clinical behavior. Short recordings of several hours can be performed as an outpatient in an EEG laboratory, while longer recordings of 24 hours or more, are generally done in a hospital inpatient setting (UpToDate®/ Hirsch et al.,2023). The EEG monitors electrical impulses from the nerve cells in the brain to record the brain’s activities. EEG wires are glued to the scalp and connected to a computer which stores the information. The EEG is recorded continuously 24 hours a day. In addition, the patient is monitored by video to characterize the way a seizure looks as well as to allow the nursing staff to tell when a patient requires assistance. Monitoring typically requires a two to five-day hospital stay, in order to properly assess the required necessity for epilepsy care.

The spectrum of Epilepsy Care can be divided into **four (4)** levels:

- i. **Level 1** of Epilepsy Care typically starts with an evaluation in an emergency room or a primary care physician’s office;
- ii. **Level 2** of Epilepsy Care consists of a consultation with a general neurologist or possibly, a specialized epilepsy center, if considered necessary, and is locally available. The National Association of Epilepsy Centers (NAEC) recommends that referral to a level 3 or 4 specialized epilepsy center should occur when a patient’s seizures are not fully controlled with the resources available to the general neurologist after 1 year of medical treatment;

- iii. **Level 3** of Epilepsy Care is comprised of a specialized epilepsy center, which should provide the basic range of medical, neuropsychological, and psychosocial diagnostic and treatment services needed to treat patients with refractory epilepsy;
- iv. **Level 4** of Epilepsy Care corresponds to centers that serve as regional or national referral facilities for intractable epilepsy patients. These centers should provide the more complex forms of intensive neurodiagnostic monitoring, as well as more extensive medical, neuropsychological, and psychosocial treatment. Level 4 centers also offer a complete evaluation for epilepsy surgery, including intracranial electrodes, and provide a broad range of surgical procedures for epilepsy.

This medical policy addresses the medical necessity for an Inpatient Epilepsy Monitoring Unit (EMU) through the use of Video-Electro-Encephalography (Video-EEG).

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate member certificate and subscriber agreement contract for applicable diagnostic imaging, DME, laboratory, machine tests, benefits and coverage.

INDICATIONS

For **Both** the Commercial and Classicare (Advantage) Lines of Business (LOB): Medical Card System, Inc., (MCS) will consider as **medically necessary** the inpatient admission of adult and pediatric patients to an Epilepsy Monitoring Unit for evaluation with Video when **Any** of the following clinical scenarios are met:

1. For patients with Intractable, Refractory or Drug Resistant Epilepsy [DRE] defined by **1a – 1b** below:
 - a. Patients have failed to become (and stay) **seizure free** with adequate trials of **two (2)** seizure medications (i.e., Anti-Epileptic Drugs [AEDs]*); **and**
 - b. Anti-Epileptic Drugs (AEDs)* must have been chosen appropriately for the patient's seizure type, tolerated by the patient, and tried alone or together with other seizure medications.
2. For patients when the diagnosis of epilepsy is in doubt, particularly when **All** of the following occur:
 - a. To distinguish whether episodic **spells**¹ are either epileptic or non-epileptic. Disorders that may be confused with epilepsy include: Psychogenic Seizures, Syncope, Cardiac

¹ **Spells** are periods of bodily or mental distress/disorder (MW, 2022). They are characterized with symptoms ranging from dizziness, light-headedness, and sensory alterations to focal mayor symptoms and alterations in consciousness (DVA – p. 36, 2018).

- Arrhythmias, Transient Ischemic Attacks (TIA), Narcolepsy, other Sleep Disturbances, and other Behavioral Disorders (not an All-Inclusive List); **and**
- b. When initial standard evaluation techniques fail to resolve this latter issue; **and**
 - c. The spells are frequent enough to be caught during the inpatient stay period.
3. For patients’ seizure classification, when **Both** Epileptic and Psychogenic Seizures are suspected, and in order to complete **All** of the following:
 - a. Separate the 2 types of seizures; **and**
 - b. Document their co-existence; **and**
 - c. Substantially influence the choice of Anti-Epileptic Drugs (AEDs)*; **and**
 - d. Adjusting anti-epileptic medication levels.
 4. For patients that are being considered for surgical treatment of epilepsy, in order to locate the brain seizure focus.
 5. For acutely ill patients with uncontrolled seizures, status epilepticus, or patients with **epileptic foci adjoining eloquent cortex**². These patients are in need of an immediate thorough evaluation and aggressive treatment.

***Note₁:** Anti-Epileptic Drugs (AEDs) are the designated medications, or **Standard Medical Treatment (SMT)**, for epilepsy, which is used according to seizure types (UpToDate®/Sirven, 2023). Please refer to **Table 1** below for details:

| Table 1: AEDs and Seizure Types | |
|---|---|
| Seizure Type | AED |
| Broad Spectrum: Treats a broad range of seizure types (both focal and generalized onset) | Brivaracetam, Clobazam, Felbamate, Lamotrigine, Levetiracetam, Perampanel, Rufinamide, Topiramate, Valproate, Zonisamide. |
| Narrow Spectrum (focal): focal-onset seizures (including focal evolving to bilateral convulsive seizures*) | Carbamazepine, Eslicarbazepine, Gabapentin, Lacosamide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Tiagabine, Vigabatrin, Cenobamate, Primidone, and Stiripentol. |
| Narrow Spectrum (absence): Absence seizures only (a type of generalized seizure) | Ethosuximide |

² **Epileptic Foci Adjoining Eloquent Cortex** refers to the seizure focus within the brain that is next to the anatomical area labeled as the eloquent cortex. The eloquent cortex represents distinctive cortical areas of the brain that are crucial for different functions. Examples of such areas are the: Primary Motor Cortex, Primary Somatosensory Cortex, Essential Speech Areas (Broca’s & Wernicke’s region), Primary Visual Areas, Angular Gyrus & Mesial Temporal Regions crucial for memory.

Note₂: Please refer to **Appendix A** and **Appendix B** at the end of this medical policy, when evaluating medical necessity for **All** patients.

LIMITATIONS FOR BOTH THE COMMERCIAL and CLASSICARE (ADVANTAGE) LOB:

1. **All** diagnostic tests must be ordered by the physician/ non-physician practitioner who is treating the patient, that is, the physician practitioner who furnishes a consultation or treats a patient for a specific medical problem and, who uses the results in the management of the patient's specific medical problem. Tests **not** ordered by the physician/ non-physician practitioner who is treating the patient are **not reasonable and necessary**, and therefore, **Not covered**.
2. The following indications are **Not covered**, as they are **Not considered medically reasonable and necessary**:
 - a. Study of neonates; or
 - b. Study of unattended, non-cooperative patients.
 - c. Localization of seizure focus/foci when the seizure symptoms and/or other EEG recordings indicate the presence of bilateral foci or rapid generalization.
 - d. Final evaluation of patients being considered as candidates for resective surgery.
3. When used for diagnostic purposes, it is anticipated that once the diagnosis has been established, Video-EEG Monitoring **will not be repeated**, nor will it be used in the monitoring of a therapeutic regimen. Again, this expectation **will not** be applied to patients readmitted for inpatient care of their seizure disorder, or characterization of seizure changes in any setting. It would not be expected to see more than three services (three of one or three of any combination of services) billed in most circumstances within a one-year period.
4. The following items represent the number of **24-hour segments** of recordings for testing:
 - a. For **Diagnostic Testing**: **2 - 3 days** is usually sufficient when looking for seizures or interictal activity; **and**
 - b. For **Pre-Surgical Evaluation**: **7 - 10 days** to capture **at least 3 or 4 seizures** may be required in order to be sure of seizure onset location reliability. For follow-up, **2 - 3 days** is usually sufficient.
5. **Documentation Requirements** must be available upon request, and contain **All** of the following:
 - a. The patient's medical record must contain documentation that supports medical necessity for the service(s) as indicated in this medical policy under the Indications and Limitations Section; **and**
 - b. Documentation includes, but is not limited to: relevant medical history, physical examination, results of pertinent diagnostic tests or procedures and every page of the

- record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]); **and**
- c. The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
 - d. Documentation supporting the medical necessity of the service(s), such as ICD-10-CM diagnosis code(s), must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary; **and**
 - e. Documentation supporting medical necessity should be legible and maintained in the patient's medical record.
 - f. Monitoring beyond 72 hours must be supported by written documentation for each additional 24 hours of monitoring.
 - g. Video EEG Tests may be monitored and addressed through post payment data analysis and subsequent medical review audits.
6. Electroencephalographic (EEG) video monitoring will be limited ONLY when the diagnosis cannot be made by neurological examination, standard EEG studies, and ambulatory EEG monitoring, and non-neurological causes of symptoms (e.g., syncope, cardiac arrhythmias) have been ruled out.
7. Video recording with EEG will be limited to be performed as an inpatient procedure. Inpatient setting is required when stopping medications for pre-surgical planning.

PROVIDER QUALIFICATIONS

A qualified physician for this service/procedure is defined as follows: A Physician who has a training and expertise that have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty in the United States or must reflect equivalent education, training, and expertise endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States.

The accuracy of non-invasive diagnostic studies depends on the knowledge, skill and experience of the technologist and the physician performing the supervision and/or interpretation of the study. Consequently, the technologist and the physician must maintain proof of training and experience.

All non-invasive diagnostic studies must be:

- (1) performed by a qualified physician, or
- (2) performed under the general supervision of a qualified physician in the office setting.

For EEG studies performed in an IDTF setting, the supervising physician must be a Board Certified (ABMS) Neurologist, and the technician qualification must include credentialing by ABRET

Neurodiagnostic Credentialing and Accreditation for Registered Electroencephalographic Technologist (R. EEG T.).

RATIONALE

MCS framework is designed to improve access, outcomes, and our enrollee’s experience of care and to ensure all enrollees achieve their best health. This policy acts as a guideline for nursing staff in the initial screening of service requests, meticulously upholding a hierarchy that prioritizes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) established by the Centers for Medicare & Medicaid Services (CMS), followed by our organization's medical policy, recognized medical association guidelines, and clinical decision-making processes. It is crafted to ensure that preliminary assessments are in harmony with these layers of guidance, underscoring that all final coverage determinations strictly adhere to the relevant LCDs and NCDs, while also considering the insights from recognized medical associations and the clinical judgment of healthcare professionals (MD’s and DMD’s) as necessary.

CODING INFORMATION FOR **BOTH** THE COMMERCIAL and CLASSICARE (ADVANTAGE) LOB: CPT® Codes (List may not be all inclusive)

| CPT® Codes | DESCRIPTION |
|------------|--|
| 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 |
| 95705 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12-hours; unmonitored |
| 95706 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance |
| 95707 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance |
| 95708 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored |
| 95709 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance |
| 95710 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance |
| 95711 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored |
| 95712 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance |
| 95713 | Electroencephalogram with video (VEEG), review of data, technical description by EEG |

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| | technologist, 2-12 hours; with continuous, real-time monitoring and maintenance |
| 95714 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored |
| 95715 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance |
| 95716 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance |
| 95718 | 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; with video (VEEG) |
| 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 | 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; with video (VEEG) |
| 95721 | Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video |
| 95722 | Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG) |
| 95723 | Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video |
| 95724 | Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG) |
| 95725 | Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video |
| 95726 | Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG) |

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| 95957 | Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) |
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Current Procedural Terminology (CPT®) 2023 American Medical Association: Chicago, IL.

ICD-10 Codes (List may not be all inclusive)

| ICD-10-Codes | DESCRIPTION |
|----------------|--|
| F44.4 | Conversion disorder with motor symptom or deficit |
| F44.5 | Conversion disorder with seizures or convulsions |
| F44.6 | Conversion disorder with sensory symptom or deficit |
| F44.7 | Conversion disorder with mixed symptom presentation |
| G40.001 | Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, with status epilepticus |
| G40.009 | Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus |
| G40.011 | Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus |
| G40.019 | Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus |
| G40.101 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus |
| G40.109 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus |
| G40.111 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus |
| G40.119 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus |
| G40.201 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus |
| G40.209 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus |
| G40.211 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus |
| G40.219 | Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus |
| G40.301 | Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus |
| G40.309 | Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus |
| G40.311 | Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus |
| G40.319 | Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus |

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| G40.A01 | Absence epileptic syndrome, not intractable, with status epilepticus |
| G40.A09 | Absence epileptic syndrome, not intractable, without status epilepticus |
| G40.A11 | Absence epileptic syndrome, intractable, with status epilepticus |
| G40.A19 | Absence epileptic syndrome, intractable, without status epilepticus |
| G40.B01 | Juvenile myoclonic epilepsy, not intractable, with status epilepticus |
| G40.B09 | Juvenile myoclonic epilepsy, not intractable, without status epilepticus |
| G40.B11 | Juvenile myoclonic epilepsy, intractable, with status epilepticus |
| G40.B19 | Juvenile myoclonic epilepsy, intractable, without status epilepticus |
| G40.42 | Cyclin-Dependent Kinase-Like 5 Deficiency Disorder |
| G40.501 | Epileptic seizures related to external causes, not intractable, with status epilepticus |
| G40.509 | Epileptic seizures related to external causes, not intractable, without status epilepticus |
| G40.801 | Other epilepsy, not intractable, with status epilepticus |
| G40.802 | Other epilepsy, not intractable, without status epilepticus |
| G40.803 | Other epilepsy, intractable, with status epilepticus |
| G40.804 | Other epilepsy, intractable, without status epilepticus |
| G40.811 | Lennox-Gastaut syndrome, not intractable, with status epilepticus |
| G40.812 | Lennox-Gastaut syndrome, not intractable, without status epilepticus |
| G40.813 | Lennox-Gastaut syndrome, intractable, with status epilepticus |
| G40.814 | Lennox-Gastaut syndrome, intractable, without status epilepticus |
| G40.821 | Epileptic spasms, not intractable, with status epilepticus |
| G40.822 | Epileptic spasms, not intractable, without status epilepticus |
| G40.823 | Epileptic spasms, intractable, with status epilepticus |
| G40.824 | Epileptic spasms, intractable, without status epilepticus |
| G40.833 | Dravet syndrome, intractable, with status epilepticus |
| G40.834 | Dravet syndrome, intractable, without status epilepticus |
| G40.89 | Other seizures |
| G40.901 | Epilepsy, unspecified, not intractable, with status epilepticus |
| G40.909 | Epilepsy, unspecified, not intractable, without status epilepticus |
| G40.911 | Epilepsy, unspecified, intractable, with status epilepticus |
| G40.919 | Epilepsy, unspecified, intractable, without status epilepticus |
| I45.9 | Conduction disorder, unspecified |
| I67.9 | Cerebrovascular disease, unspecified |
| R55 | Syncope and collapse |

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|--------------|-------------------------|
| R56.1 | Post traumatic seizures |
| R56.9 | Unspecified convulsions |

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22. U.S. Department of Veteran Affairs / VA Epilepsy Centers of Excellence (2018). Epilepsy Manual. Second Edition. Accessed August 30, 2022. Available at URL address: https://www.epilepsy.va.gov/Library/VA_Epilepsy_Manual_2Ed_508Comp_V2.pdf#

POLICY HISTORY

| DATE | ACTION | COMMENT |
|-------------------|-----------------------|--|
| November 5, 2009 | Origination of Policy | |
| November 5, 2010 | Revised | Added to the policy CPT Codes 95950,95953 and 95956 |
| November 5, 2011 | Revised | |
| November 5, 2012 | Revised | References updated. |
| December 17, 2013 | Revised | <ol style="list-style-type: none"> 1. Code section was reviewed and updated. 2. References updated. 3. New references were added to references section (References #2, 5, 7, 8, 10, 12, and 13). <p>Note: December 17, 2013 the checklist to evaluate the admission to an Epilepsy Monitoring Unit and the Monitoring Unit Questionnaire were reviewed and approved by Dra. Ibis Morales.</p> |
| February 21, 2014 | Revised | To the Coding section: A new ICD-10 Codes (Preview Draft) section was added to the policy. |
| May 12, 2015 | Revised | The MCS Medical Advisory Committee (MAC) revised and approved <u>all</u> 2015 update changes on May 12, 2015. |
| | | To the References Section: |

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| | | <ul style="list-style-type: none"> References updated. Deleted: Centers for Medicare & Medicaid Services (CMS). National Coverage Determination for Ambulatory EEG Monitoring (160.22). Version Number 1. Effective Date of this Version: June 12, 1984. Available at URL address: http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=215&ncdver=1&bc=AgAAQAAAAAAAAA%3d%3d& Deleted: ClinicalTrials.gov (2015). Evaluation and Treatment of Patients with Epilepsy. Sponsor: National Institute of Neurological Disorders and Stroke (NINDS). ClinicalTrials.gov Identifier: NCT00013845. First received: March 30, 2001. Last updated: January 15, 2015. Study Status: This study is currently recruiting participants. ClinicalTrials.gov processed this record on February 16, 2015. Available at URL address: http://www.clinicaltrials.gov/ct/show/NCT00013845?order=1 Deleted: ECRI Institute. In-Home Video electroencephalography for Monitoring Epileptic Seizures. Published: 6/22/2012. Available at URL address: https://www.ecri.org/components/Hotline/Pages/13037.aspx Deleted: ECRI Institute. Video electroencephalography (Video-EEG) Monitoring of Seizures. Published 10/31/2005. Deleted: National Institute for Health and Care Excellence (NICE) (2004). The epilepsies: The diagnosis and management of the epilepsies in adults in primary and secondary care. NICE guidelines [CG20]. Published Date: October 2004. This guideline has been updated and replaced by NICE Clinical Guideline 137. Available at URL address: http://www.nice.org.uk/guidance/cg20/resources/guidance-the-epilepsies-the-diagnosis-and-management-of-the-epilepsies-in-adults-and-children-in-primary-and-secondary-care-pdf Added new references, numbers 1-2, 4, 7-8, 10-15, 18-20, 22-24. <p>To Heading of medical policy:</p> <ul style="list-style-type: none"> Modified medical policy title to read as follows: Inpatient Epilepsy Monitoring Unit (EMU) using Video-Electro-Encephalography (Video-EEG). <p>To the Description Section:</p> <ul style="list-style-type: none"> Deleted: For some patients the treatment of seizure disorders requires more than the right choice of an antiepileptic medication, or even the ability to perform epilepsy surgery. Seizures and their treatment affect many aspects of health and the ability to function in modern society. These needs have been recognized by the formation of specialized epilepsy centers. A specialized epilepsy center is defined as a program that provides comprehensive diagnostic and treatment services primarily or exclusively to people with intractable epilepsy. Physicians, psychologists, nurses, technologists, and other personnel with special training and experience in the treatment of epilepsy should staff this program. It includes facilities and equipment necessary to provide appropriate care or has well established patterns of access to necessary facilities. An established administrative system assures that these services are delivered appropriately and efficiently. Deleted: Epilepsy care can be divided into four levels: I. First level care is provided by the primary care physician. II. Second level care is provided by a general neurologist. Most patients with epilepsy are adequately treated at these levels. Patients with persisting seizures or side effects have failed standard treatment and should be referred to a third or fourth level |
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| | | <p>specialty epilepsy center. III. A third level epilepsy center should provide the basic range of medical, neuropsychological, and psychosocial services needed to treat patients with refractory epilepsy. Third level medical centers provide basic neurodiagnostic evaluation, as well as basic medical, neuropsychological, and psychosocial services. These centers do not perform resective epilepsy surgery, although some may implant vagus nerve stimulators. Third level medical – surgical centers provide basic diagnostic and treatment services. In addition, these centers offer noninvasive evaluation for epilepsy surgery, straightforward resective epilepsy surgery, and implantation of the vagus nerve stimulators. These centers do not perform intracranial evaluations or other more complex resective epilepsy surgery. Knowledge and experience with epilepsy surgery has become sufficiently widespread that straightforward surgical interventions at the third level are now reasonable. However, third level centers that offer such surgery should meet additional requirements. It is important that physicians making health care decisions at such centers be fully knowledgeable regarding all surgical options available and establish appropriate referral arrangements with fourth level centers. If surgery is required, the best surgical procedure for the particular situation must be recommended, and this may not necessarily be the procedure that can be provided locally. Third level centers will typically be found at many universities and some large community hospitals. IV.A fourth level epilepsy center serves as a regional or national referral facility. This center should provide the more complex forms of intensive neurodiagnostic monitoring, as well as more extensive medical, neuropsychological, and psychosocial treatment. Fourth level centers also offer a complete evaluation for epilepsy, surgery, including intracranial electrodes, and provide a broad range of surgical procedures for epilepsy.</p> <ul style="list-style-type: none"> Deleted: The Epilepsy Monitoring Unit (EMU) is a specialized unit designed to evaluate, diagnose, and treat seizures in patients with intractable epilepsy who need to be hospitalized. Patients are admitted to the unit when their condition requires prolonged electroencephalogram (EEG) monitoring or when they are being evaluated for epilepsy surgery. Such extensive monitoring helps epileptologists characterize the seizure type, localize the area where the seizure begins and exclude non epileptic seizures from the diagnosis. The primary goal is to achieve complete control or at least a reduction in the frequency of seizures and/or medical side effects experienced by epileptic patients. Therefore, video-EEG monitoring is the essential diagnostic tool used in Level 3 and 4 epilepsy centers. Added: An Epilepsy Monitoring Unit (EMU) is an inpatient unit directed by specialists in epilepsy. These centers provide in-depth diagnostic and treatment services for people with difficult to diagnose or treat seizures or epilepsy. EMUs are typically part of a specialized epilepsy center that provides both outpatient and inpatient services to people with epilepsy and their families (AES, 2015). Patients are admitted to the EMU when their condition requires prolonged EEG monitoring. Patients in the EMU receive Continuous Electro-Encephalography (EEG) and Video-EEG Monitoring (NPER, 2015). Video Electro-Encephalography (EEG) monitoring is the synchronous recording and display of EEG patterns and video-recorded clinical behavior. Short recordings of several hours can be performed as an outpatient in an EEG laboratory, while longer recordings of 24 hours or more are generally done in a hospital inpatient setting (UpToDate®, 2015). The EEG monitors |
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| | | <p>electrical impulses from the nerve cells in the brain to record the brain's activities. EEG wires are glued to the scalp and connected to a computer which stores the information. The EEG is recorded continuously 24 hours a day. In addition, the patient is monitored by video to characterize the way a seizure looks as well as to allow the nursing staff to tell when a patient requires assistance. Monitoring typically requires a two to five-day hospital stay (NPER, 2015).</p> <ul style="list-style-type: none"> • To phrase: 'Epilepsy Care can be divided into four (4) levels', added before it, the following: 'The spectrum of'. • Added: i. Level 1 of Epilepsy Care typically starts with an evaluation in an emergency room or a primary care physician's office; ii. Level 2 of Epilepsy Care consists of a consultation with a general neurologist or possibly, a specialized epilepsy center, if considered necessary, and is locally available. The National Association of Epilepsy Centers (NAEC) recommends that referral to a level 3 or 4 specialized epilepsy center should occur when a patient's seizures are not fully controlled with the resources available to the general neurologist after 1 year of medical treatment; iii. Level 3 of Epilepsy Care is comprised of a specialized epilepsy center, which should provide the basic range of medical, neuropsychological, and psychosocial diagnostic and treatment services needed to treat patients with refractory epilepsy; iv. Level 4 of Epilepsy Care corresponds to centers that serve as regional or national referral facilities for intractable epilepsy patients. These centers should provide the more complex forms of intensive neuro-diagnostic monitoring, as well as more extensive medical, neuropsychological, and psychosocial treatment. Level 4 centers also offer a complete evaluation for epilepsy surgery, including intracranial electrodes, and provide a broad range of surgical procedures for epilepsy (NAEC, 10/26/10). • Revised the following sentence, previously in medical policy: This policy addresses the medical necessity for Epilepsy Monitoring Unit (EMU), and the use of Video-Electro-Encephalography (Video-EEG); and modified it to read as it follows: This medical policy addresses the medical necessity for an Inpatient Epilepsy Monitoring Unit (EMU) through the use of Video-Electro-Encephalography (Video-EEG). <p>To the Indications Section:</p> <ul style="list-style-type: none"> • Deleted Coverage Statement: Medical Card System, Inc., (MCS) will consider medically necessary the admission to an Epilepsy Monitoring Unit for patients who need inpatient Electroencephalographic (EEG) Video Monitoring that meet One of the following criteria. • Deleted: 1. Patients with refractory epilepsy: a) Presenting inadequate seizure control for one year despite using potentially effective antiepileptic drugs. B) Failed two (2) or more antiepileptic drugs (AED) treatment after a year, at maximum tolerable levels. • Deleted Note 1: Uncontrolled Seizures is defined as - one or more convulsions in a month; or an unacceptable numbers of convulsions taking in consideration the nature of the patient's occupation or circumstances. • Deleted: 2. Patients who are being considered for seizure surgery, for monitoring to identify the location in the brain the seizures begin. • Deleted: 3. When the diagnosis cannot be made by neurological examination, standard EEG studies, and ambulatory cassette EEG monitoring, and non-neurological causes of symptoms have |
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| | | <p>been ruled out: a) To differentiate epileptic events from non-epileptic events, such as suspected transient ischemic attacks and psychogenic seizures; or b) To classify seizure types with unknown patterns, where such classification is medically necessary to select the most appropriate therapeutic regimen.</p> <ul style="list-style-type: none"> • Deleted Note 2: The duration of ambulatory EEG monitoring that is considered medically necessary depends on the frequency of the person’s symptoms that are being investigated, and generally can be completed in 3 to 5 days. • Added: For Both the Commercial & Classicare (Advantage) Lines of Business (LOB): Medical Card System, Inc., (MCS) will consider as medically necessary the inpatient admission of adult & pediatric patients to an Epilepsy Monitoring Unit for evaluation with Video-EEG (i.e., CPT® Code 95951), when Any of the following clinical scenarios are met: <ol style="list-style-type: none"> 1. For adult patients with Intractable, Refractory or Drug Resistant Epilepsy), defined by 1a – 1b below: a. Patients have failed to become (and stay) seizure free with adequate trials of two (2) seizure medications (i.e., AEDs or Anti-Epileptic Drugs); and b. AEDs* must have been chosen appropriately for the patient’s seizure type, tolerated by the patient, and tried alone or together with other seizure medications. 2. For patients when the diagnosis of epilepsy is in doubt, particularly when All of the following occur: a. To distinguish whether episodic spells are either epileptic or non-epileptic. Disorders that may be confused with Epilepsy Include: Psychogenic Seizures, Syncope, Cardiac Arrhythmias, Transient Ischemic Attacks (TIA), Narcolepsy, other Sleep Disturbances, and other Behavioral Disorders (not an All-Inclusive List); and b. When initial standard evaluation techniques fail to resolve this latter issue; and c. The spells are frequent enough to be caught during the inpatient stay period. Added Footnote 1: Spells are periods of bodily or mental distress/disorder (MW, 2015). They are characterized with symptoms ranging from dizziness, light-headedness, & sensory alterations to focal mayor symptoms & alterations in consciousness (DVA – Pg. 34, 2014). 3. For patients’ seizure classification, when Both Epileptic & Psychogenic Seizures are suspected, and in order to complete All of the following: a. Separate the 2 types of seizures; b. Document their co-existence; c. Substantially influence the choice of Anti-Epileptic Drugs (AEDs)*. 4. For patients’ those are being considered for surgical treatment of epilepsy, in order to locate the brain seizure focus. 5. For acutely ill patients with uncontrolled seizures, status epilepticus, or patients with epileptic foci adjoining eloquent cortex. These patients are in need of an immediate thorough evaluation and aggressive treatment. Added new Footnote 2: Epileptic Foci Adjoining Eloquent Cortex refers to the seizure focus within the brain that is next to the anatomical area labeled as the eloquent cortex. The eloquent cortex represents distinctive cortical areas of the brain that are crucial for different functions. Examples of such areas are the: Primary Motor Cortex, Primary Somatosensory Cortex, Essential Speech Areas (Broca’s & Wernicke’s region), Primary Visual Areas, Angular Gyrus & Mesial Temporal Regions crucial for memory (IH, 2008). • Added new *Note 1: Anti-Epileptic Drugs (AEDs) are the designated medications, or Standard Medical Treatment (SMT), |
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| | | <p>for epilepsy, which are used according to seizure types (UpToDate®/Sirven, 2015). Please refer to Table 1 for Details.</p> <ul style="list-style-type: none"> Added new **Note 2: Please refer to Appendix A & Appendix B at the end of this medical policy, when evaluating medical necessity for all patients. <p>To the Limitations Section for Both LOB:</p> <ul style="list-style-type: none"> Deleted: Video EEG Monitoring is considered NOT medically necessary when the cause of seizures and specific type of epilepsy has been established (e.g., for monitoring response to therapy or titrating medication dosages) and the case does not meet the above criteria. Added New Limitations 1-5. <p>To the Coding Information Section:</p> <ul style="list-style-type: none"> Clearly labeled section for Both The Commercial & Classicare (Advantage) LOB Deleted CPT® Codes: 95950, 95953, & 95956. Added the following new ICD-9-CM Codes: 300.11, 345.00, 345.10, 345.2, 345.3, 345.40, 345.50, 345.51, 345.70, 345.80, 345.90, 426.9, 437.9, 780.2, 780.33, and 780.39. Added the following new ICD-10 Codes: F44.4, F44.5, F44.6, F44.7, G40.309, G40.301, G40.311, G40.319, G40.201, G40.209, G40.001, G40.009, G40.101, G40.109, G40.011, G40.019, G40.111, G40.119, G40.501, G40.509, G40.801, G40.802, G40.812, G40.821, G40.822, G40.89, G40.A01, G40.A09, G40.B01, G40.B09, G40.901, G40.909, I45.9, I67.9, R55, R56.1, and R56.9. <p>To the Appendices Section:</p> <ul style="list-style-type: none"> Labeled previous documents and/or tables as Appendix A and Appendix B, respectively. Updated Appendix A according to the information within the Indications & Limitations Sections of this medical policy for the Both LOB. Revised content & structure of Appendix B. |
| <p>March 29, 2017</p> | <p>Revised</p> | <p>References updated. Added #3 & 18. Deleted # 10, 11, 16, 17, & 21.</p> <p>To the Description Section:</p> <ul style="list-style-type: none"> Updated AES and NPER citation years. <p>To the Indications Section:</p> <ul style="list-style-type: none"> To table 1: Added new anti-epileptic drugs brivaracetam and perampanel for broad spectrum seizures. To table 1: Deleted anti-epileptic drugs perampanel and primidone for narrow spectrum seizures. Added new note 3, which states: Ezogabine (retigabine) is being permanently discontinued by the manufacturer and will not be available commercially after June 2017. <p>To the Limitations Section:</p> <ul style="list-style-type: none"> To limitation #2 – Added limitation c: Localization of seizure focus/foci when the seizure symptoms and/or other EEG recordings indicate the presence of bilateral foci or rapid generalization. To limitation #2 – Added limitation d: Final evaluation of patients being considered as candidates for resective surgery. To limitation #5 – Added limitation e: Monitoring beyond 72 hours must be supported by written documentation for each additional 24 hours of monitoring. |

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| | | <p>To the Coding Section:</p> <ul style="list-style-type: none"> Deleted G40.411 and G40.419 <p>To Appendix A: Modified table heading to read as follows: For Both LOB, MCS will consider the inpatient admission to an EMU to be evaluated through Video-EEG (Code 95951) medically necessary when Any of the following clinical scenarios are met.</p> <p>To Appendix B:</p> <ul style="list-style-type: none"> Under Laboratories, question #2: replaced terms apply with applicable. Under Treatment Options Given to Patient: Replaced phrase started when with Include treatment duration with dates. Under Treatment Options Given to Patient: Replaced term doses with dosage. To endnote i: Removed word for. |
| October 24, 2018 | Revised | <p><u>To the Indications Section:</u></p> <ul style="list-style-type: none"> <u>To the table 1. AEDs and Seizure Types:</u> <ul style="list-style-type: none"> <u>To the Narrow Spectrum (focal):</u> Phrase “with or without alteration in consciousness or awareness and focal evolving to bilateral convulsive seizures” was deleted and substitute by the New Phrase “-onset seizures (including focal evolving to bilateral convulsive seizures*)” according to the Information contained in the “<u>Therapeutic spectrum of antiseizure drugs</u>” 2018. Drug “Ezogabine” was deleted from this Policy because was being permanently discontinued by the manufacturer and will not be available commercially after June 2017. <u>To the Narrow Spectrum (absence):</u> Information for Narrow Spectrum (absence) was deleted and Substitute by New information according to Therapeutic spectrum of antiseizure drugs 2018: Narrow Spectrum (absence): Absence seizures only (a type of generalized seizure) <u>Note3 was deleted from this Policy:</u> Note3: Ezogabine (retigabine) is being permanently discontinued by the manufacturer and will not be available commercially after June 2017. <p><u>To the Limitations Section:</u></p> <ul style="list-style-type: none"> New Limitations #6 and 7 were added to the Policy. <p><u>To the References Section:</u></p> <ul style="list-style-type: none"> New Reference #14 was added to the Policy. <u>The following References were deleted from this Policy:</u> #16, 18 and 19. |
| August 7, 2019 | Revised | <p><u>To the References Section:</u> <u>The following References were added to the Policy:</u> #16 and 18.</p> <p><u>The following References were deleted from this Policy:</u> #2.</p> |
| August 14, 2020 | Revised | <ul style="list-style-type: none"> <u>To the Indications Section:</u> <ol style="list-style-type: none"> CPT Code Example 95951 was deleted from the Coverage Statement from the Indications. New Point “D” was added the Indication #3. <u>Table of Drugs was actualized to 2020 document Table 1.</u> |

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| | | <p><u>New Drugs</u> was added to the Table: Cenobamate, Primidone, and Stiripentol.</p> <ul style="list-style-type: none"> <u>To the Limitations Section:</u> <ol style="list-style-type: none"> New Information was added to the Documentation Requirements Letter “b” - every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). New Letter “c” was added to the Documentation Requirements - The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient. New Letter “g” was added to the Documentation Requirements - Video EEG Tests may be monitored and addressed through post payment data analysis and subsequent medical review audits. <u>New Section “Provider Qualifications” was added to the Policy from LCD L34521.</u> <u>To the Coding Information Section:</u> <ul style="list-style-type: none"> <u>To the CPT Code Section:</u> <ol style="list-style-type: none"> CPT Code 95951 was deleted from this Policy according the information contained in the LCA A57667. <u>New CPT Codes were added to the Policy from the LCA A57667:</u> 95700, 95713, 95716, 95718, 95720, 95722, 95724, and 95726. <p><u>To the References Section:</u></p> <ul style="list-style-type: none"> The Following References were added to the Policy: #4, 18, and 22. |
| <p>August 25, 2021</p> | <p>Revised</p> | <p><u>To the Limitations Section for Both LOB:</u> Information for the Limitation of “3” services for be Perform per Year was added to the Limitations #3 from LCD L34521.</p> <p><u>To the Coding Information Section:</u></p> <ul style="list-style-type: none"> <u>To the CPT Codes Section:</u> <u>The following CPT Codes were added to the Policy:</u> 95711, 95712, 95714, and 95715. <u>To the ICD-10 Codes Section:</u> <u>The following ICD-10 Codes were added to the Policy:</u> G40.42, G40.833, and G40.834. <p><u>To the References Section:</u> <u>The Following Reference was deleted from this Policy: #4.</u></p> |
| <p>September 6, 2022</p> | <p>Revised</p> | <p>References updated. Deleted #15 Added new #15.</p> <p><u>To the Indications Section:</u></p> <ul style="list-style-type: none"> To Note 3: Updated citation date. To Table 1: Under Seizure Type Colum, 1st row (Broad Spectrum), Reworded to: “Treats a broad range of seizure types (both focal and generalized onset).” <p><u>To the Limitations Section:</u></p> <ul style="list-style-type: none"> To #1: Added term “non-physician”. <p><u>To the Coding Information Section:</u></p> <ul style="list-style-type: none"> Added new CPT Codes 95705, 95706, 95707, 95708, 95709, 95710, 95719, 95721, 95723, 95725, 95957. |

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| August 30, 2023 | Revised | <p>References updated.</p> <p><u>To the Coding Information Section:</u></p> <ul style="list-style-type: none"> <u>To the CPT Codes Section:</u> The following CPT Codes were deleted from this Policy: 95719. <p><u>To the References Section:</u> The Following Reference was deleted from this Policy: #3.</p> |
| April 11, 2024 | UMC Approval | |

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Medical Card System, Inc., (MCS) medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Medical Card System, Inc., (MCS) reserves the right to review and update its medical policies at its discretion. Medical Card System, Inc. (MCS) medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

APPENDIX A

MCS will use the following checklist to evaluate the admission to an Inpatient Epilepsy Monitoring Unit (EMU) using Video-Electro-Encephalography (Video-EEG):

| For Both LOB, MCS will consider the inpatient admission to an EMU to be evaluated through Video-EEG (Code 95951) medically necessary when Any of the following clinical scenarios are met: | Met | Not Met |
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| 1. For patients with Intractable, Refractory or Drug Resistant Epilepsy, defined by 1a – 1b below : | | |
| a. Patients have failed to become (and stay) seizure free with adequate trials of two (2) seizure medications (i.e., Anti-Epileptic Drugs [AEDs]*); and | | |
| b. AEDs must have been chosen appropriately for the patient’s seizure type, tolerated by the patient, and tried alone or together with other seizure medications. | | |
| 2. For patients when the diagnosis of epilepsy is in doubt, particularly when All of the following occur: | | |
| a. To distinguish whether episodic spells are either epileptic or non-epileptic. Disorders that may be confused with Epilepsy Include: Psychogenic Seizures, Syncope, Cardiac Arrhythmias, Transient Ischemic Attacks (TIA), Narcolepsy, other Sleep Disturbances, and other Behavioral Disorders (not an All-Inclusive List); and | | |
| b. When initial standard evaluation techniques fail to resolve this latter issue; and | | |
| c. The spells are frequent enough to be caught during the inpatient stay period. | | |
| 3. For adult patients’ seizure classification, when Both Epileptic and Psychogenic Seizures are suspected, and in order to complete All of the following: | | |
| a. Separate the 2 types of seizures; and | | |
| b. Document their co-existence; and | | |
| c. Substantially influence the choice of Anti-Epileptic Drugs (AEDs)*. | | |
| 4. For patients that are being considered for surgical treatment of epilepsy, in order to locate the brain seizure focus. | | |
| 5. For acutely ill patients with uncontrolled seizures, status epilepticus, or patients with epileptic foci adjoining eloquent cortex. These patients are in need of an immediate thorough evaluation and aggressive treatment. | | |
| LIMITATIONS – 1. All diagnostic tests must be ordered by the Physician practitioner who is treating the patient, that is, the Physician practitioner who furnishes a consultation or treats a patient for a specific medical problem and, who uses the results in the management of the patient’s specific medical problem. Tests Not ordered by the Physician practitioner who is treating the patient are Not reasonable and necessary, and therefore, Not covered . *Please refer to page 4 for the remainder of Limitations. | | |

APPENDIX B – CLINICAL CASE SUMMARY CHART

| Epilepsy Monitoring Unit (EMU) Questionnaire | |
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| Name: | Date: |
| Contract #: | Age: |
| Medical Information | |
| 1-When did seizures start? | |
| 2-Describe what seizures looked like? | |
| 3-What happened before seizures began? | |
| 4-Seizure's duration? | |
| 5-Number of seizures Per day ____? Per week ____? Per month ____? | |
| 6-Family history of seizures | |
| 7-History of other illness | |
| Comprehensive Physical Examination | |
| 1-General Exam | |
| 2-Neurological Exam | |
| Laboratories | |
| 1- Laboratories done | |
| 2- Medication blood levels (if applicable) | |
| Diagnostic Studies | |
| 1- Standard Electroencephalograph (EEG) Date Results | |
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| | |
| | |
| 2- Ambulatory cassette EEG monitoring Date Results | |
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| 3- Computed Tomography (CT) Magnetic Resonance Imaging (MRI) Positron Emission Tomography (PET) results | |
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| Treatment Options Given to Patient | | | |
|--|-----|----|-------------|
| 1- Anticonvulsant medications (Include treatment duration with dates, dosage, frequency, side effects). | | | |
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| 2- Other medications used (Include treatment duration with dates, dosage, frequency, side effects). | | | |
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| | | | |
| Other Treatment Options Given to Patient | Yes | No | Comment (s) |
| 1- Epilepsy surgery | | | |
| 2- *Vagus Nerve Stimulation (VNS) ⁱ | | | |
| 3- Other | | | |

ⁱ*Vagus Nerve Stimulator (VNS) (see MCS medical policy [MP-DME-04-10](#) is an adjunctive treatment for certain types of intractable epilepsy and major depression. VNS uses an implanted stimulator that sends electric impulses to the left vagus nerve in the neck via a lead wire implanted under the skin.