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1.0 Description of the Procedure, Product, or Service

Stereotactic electroencephalography (SEEG) is a diagnostic test which measures the electrical activity of the brain (brain waves) using highly sensitive recording equipment. It is an invasive procedure. Long needlelike electrodes are implanted in specific brain areas through holes that are drilled into the skull (burr holes). SEEG is typically used to record from structures within the temporal lobe of the brain (the hippocampus or amygdala area). SEEG is used to locate the area of the brain where the seizure starts (seizure focus) in recipients who are candidates for surgery.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary **AND**

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Stereotactic electroencephalography is considered medically necessary and eligible for coverage when **ALL** of the following three conditions are met:

- a. The recipient's seizures cannot be corrected with medical therapy;
- b. Prior diagnostic studies suggest, but do not confirm, the presence of a localized seizure focus; **AND**
- c. The seizure focus is located in an area of the brain where surgical resection can be done.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Stereotactic electroencephalography is not covered when all of the medical criteria in **Subsection 3.2** are not met.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is not required for stereotactic electroencephalography.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
September 30, 2011	Throughout	Policy Date of Termination.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Code
61760

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.