

Clinical Policy: Magnetoencephalography

Reference Number: TX.CP.MP.570

Last Review Date: 10/19

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Description

Magnetoencephalography (MEG) is a non-invasive method of measuring magnetic fields in the brain and is used to precisely localize both the essential functional cortex (i.e., the eloquent cortex) and abnormal epileptogenic brain activity as part of a pre-surgical evaluation. The origin of abnormal MEG brain activity can be precisely localized (source localization) and displayed as a map or image.

The following applies for MEG services:

- A. MEG services provided by providers in comprehensive level IV epilepsy centers or physiological laboratories.
- B. The MEG test must be ordered by an adult or pediatric neurologist, epileptologist, or neurosurgeon.
- C. MEG may assist in guiding the placement of intracranial electroencephalography (EEG) and, in some members, avoid an unnecessary intracranial EEG. In the case of pre-surgical mapping of members with operable lesions, MEG provides non-invasive localization of eloquent cortices (e.g., motor, sensory, language, auditory, or visual).

This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

Policy/Criteria

- I. It is the policy of Superior HealthPlan that magnetoencephalography is **medically necessary** for members meeting the following criteria:
 - A. Preoperative evaluation of individuals with intractable focal epilepsy to identify and localize area(s) of epileptiform activity when other techniques designed to localize a focus are indeterminate; or
 - B. Preoperative localization of eloquent cortex prior to surgical resection of brain tumor or vascular malformations in order to maximize preservation.
 - C. Documentation includes all of the following:
 1. Signature of the provider on a prescription or request form must be current, on or before the start date, and no older than 90 days before the actual date of service. To contain all of the following elements:
 - a. Member's name
 - b. Description of the item or items and codes
 - c. Pertinent diagnosis/conditions that relate to the need for MEG
 - d. The treating provider's signature
 - e. The date the treating provider signed the order

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II. It is the policy of Superior Health Plan the following magnetoencephalography services are **not** covered benefits:

- A. MEG when used as a stand-alone test for epilepsy.
- B. MEG when used as a first-line diagnostic screening.
- C. MEG when used for the evaluation of:
 - 1. Alzheimer’s disease
 - 2. Autism
 - 3. Cognitive and mental disorders
 - 4. Developmental dyslexia
 - 5. Learning disorders
 - 6. Migraines
 - 7. Multiple sclerosis
 - 8. Parkinson’s disease
 - 9. Schizophrenia
 - 10. Stroke rehabilitation
 - 11. Traumatic brain injury
- D. Magnetic Source Imaging (MSI) (procedure code S8035) is not a benefit of Texas Medicaid.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)
95966	For evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)
95967	For evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization)(List separately in addition to code for primary procedure)

HCPCS Codes	Description
N/A	



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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	12/15	12/15
Added STAR Kids to product type. Removed MRSA and CHIP RSA from product type. Grammatical edits. Updated references and signatories.	12/16	12/16
Updated references, revision date, and signatories.	11/17	11/17
Annual Review. Updated references, review date and signatories. Changed authorization Protocols to documentation requirements.	10/18	10/18
Updated to new template from TX.UM.70 (TX.CP.MP.570 nomenclature implementation 10/1/19). Updated references.	10/19	10/19

References

1. Texas Medical Provider Procedures Manual, 2019, 9.2.63 Magnetoencephalography (MEG)

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to



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applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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