Priority Health	BILLING POLICY No. 078
MAGNETOENCEPHEPHALOGRAPHY (MEG)	
Date of origin: Mar. 18, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Magnetoencephalography (MEG) is a non-invasive medical test that uses a superconducting quantum interference device (SQUID) and a computer to measure neuromagnetic activity within the brain.

MEDICAL POLICY

- 91627 – Magnetoencephalography (MEG)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

The MEG services may be performed in combination with other studies such as EEG, evoked potential studies, computed tomography scans (CT), magnetic resonance imaging (MRI).

Service includes a cursory exam and associated discussions and shouldn't be coded as a separate E/M service on the same date.

E/M should only be reported if service is above and beyond what would be expected or associated with MEG and any associated testing. Modifier 25 guidelines must be adhered to.

CPT codes

- **95965**: Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)
- **95966**: Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)
- **95967**: Magnetoencephalography (MEG), recording and analysis; 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)

Revenue codes

- **860**: Magnetoencephalography (MEG) – General
- **861**: Magnetoencephalography (MEG) – MEG

Place of service
22 – Outpatient

Documentation requirements

- Extensive workup
- Orders
- Review of prior studies
- Identification of true spikes on the whole head or large array of MEG tracings
- Location of patient's epileptic events
- Interpretation of the source and postprocessed data, data maps and comparison of any relevant prior studies
- Report of the procedure must be prepared, reviewed and signed

Modifiers

- **26**: Professional component
- **TC**: Technical component

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made