



PRESIDENT'S REPORT – 2003

Status of 95951 – Video/EEG Monitoring

As most of you remember, NAEC was forced to take quick action last December to resolve the disastrous move by the Centers for Medicare and Medicaid Services (CMS) to reduce payment for office-based video/EEG by over 80%. The final rule for the 2003 Medicare Physician Fee Schedule set a rate for the technical component of 95951 at .39 Relative Value Units (RVUs), reducing the global payment to \$318 from the 2002 rate of \$1629. While this reduction did not affect services provided in a hospital, NAEC was very concerned about the impact this reduction could have on private insurance since many plans use the Medicare fee schedule to set reimbursement rates.

NAEC became aware of this move by CMS prior to the publication of the final rule and contacted staff to alert them to the error and to voice strong opposition. Recognizing that a serious error had occurred, CMS staff agreed to eliminate the severe reduction, but felt that they had inadequate data to set a different national payment rate. For this reason, CMS decided that the global and technical components of 95951 should be priced by local Medicare carriers rather than in the national fee schedule.

On behalf of its centers, NAEC's President contacted several Medicare carriers and worked closely with the Kansas Medical Director, who is a neurologist, asking that local carriers use the 2002 Medicare payment rate for the technical component of 95951 in 2003. By March 2003, the carriers in IL, KS, MI, MN, and WI had agreed to this request. Our understanding is that carriers throughout the country followed suit. Any centers having problems with their local carriers regarding this service should contact NAEC.

Next Steps: NAEC plans to initiate a proactive effort to educate local Medicare carriers about the specialized services provided in epilepsy centers. Earlier this year in discussions with the Carrier Medicare Directors regarding payment for video/EEG (95951), several Directors raised questions on the appropriate use of other epilepsy related CPT codes. Unlike most CPT codes, the databases used by the carriers currently do not include clinical vignettes on most epilepsy codes. In order to provide the carriers with more information, NAEC member Paul Van Ness drafted clinical vignettes for the epilepsy CPT codes which are being finalized and will be sent to all of the Medicare carriers and the neurology carrier

advisors early next year. We will provide the membership with this document, which can be used with private insurers as well as the Medicare carriers.

NAEC is also in discussions with American Academy of Neurology (AAN) about whether to seek a new CPT code for video/EEG provided for less than 24 hours. At this time the only CPT code where video is included is 95951. NAEC surveys reveal that centers are doing more outpatient and shorter video/EEG studies and that there may be a need for a new code. If the decision is made to seek a new code for a shorter service NAEC, working with AAN, would make the request of the American Medical Association's CPT Editorial Panel. If accepted, a new code would not take effect until 2006.

Washington Update

The most extensive and expensive changes to the Medicare program since its creation in the 1960's will begin in 2004 with the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003. In addition to establishing of a prescription drug benefit, the bill calls for major changes to the structure of the Medicare program including means-testing the premium paid for all outpatient and physician services and beneficiary choice in whether to participate in traditional Medicare or private health plans. The bill provides payment increases to hospitals and physicians, especially those in rural areas, and provides coverage for diabetes and cardiovascular screening tests as well as an initial physical exam for new beneficiaries.

The hospital and physician payment increases will take effect in 2004, the drug benefit in 2006 and access to private health plans not until 2010. The long timeline for implementation will likely result in multiple revisions and the \$400 billion cost of the legislation will easily balloon. The political fallout remains uncertain. AARP supported the bill, but whether its members support the cost-sharing requirements of the drug benefit and the gap in coverage from \$2200 to \$3600 in out-of-pocket costs is uncertain.

The new drug benefit may be problematic for epilepsy centers. While the number of Medicare beneficiaries with drug coverage will increase dramatically concerns that epilepsy centers have had with existing drug plans, especially state Medicaid programs could easily occur. A movement to formularies or other means to restrict access to brand name drugs will have to be monitored closely.

On a positive note, Congress continues to push for Medicare coverage of comprehensive services to treat beneficiaries with one or more chronic diseases. The Medicare reform bill furthers CMS's disease management pilot projects by establishing chronic care improvement programs throughout the country. CMS will contract with disease management organizations (companies, hospital, physician or other groups who must meet certain standards) to provide coverage for a broad array of services. At the outset, Congress is focusing this effort on

patients with congestive heart failure, diabetes, COPD and stroke, but the Secretary of HHS may include other diseases in the program. While CMS's interest in chronic disease management is closely tied to improved outcomes and cost savings, Congress and CMS are recognizing that the needs of patients with chronic disease are often not met in the current program with its acute care focus.

Summary of NAEC Activities for 2003

NAEC has focused its efforts this year on coding, reimbursement and public health strategies of importance to comprehensive epilepsy centers. The Association worked directly with the Department of Health and Human Services and its agencies such as the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), as well as Congress. In addition, as coding and the development of relative value units have become increasingly important to determining payment levels, NAEC has worked closely with the American Academy of Neurology (AAN) and the American Association of Neurological Surgeons (AANS) on coding issues of importance to epilepsy centers. NAEC continues to collaborate with the Epilepsy Foundation and American Epilepsy Society on public health issues of importance to people living with epilepsy.

ICD – 10 Diagnostic Codes

Earlier this year the NAEC Board contacted the National Center for Health Statistics seeking long-needed revisions to the epilepsy section of the ICD diagnosis codes. The NAEC Board was concerned that terminology used in ICD-9-CM did not reflect current medical knowledge of epilepsy and seizures and sought several changes to the existing codes as part of the ICD-10-CM update. Working with the National Center for Health Statistics (NCHS) staff, NAEC suggested several changes that have been incorporated into the current draft of the ICD-10-CM, which can be found on-line at <http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm>. The major changes recommended were: renaming the section "seizures and epilepsy," adding the terms grand mal and petite mal to the code for generalized idiopathic epilepsy, and adding separate fifth and sixth digit codes for intractability and non-intractability with and without status epilepticus for all subcategories of the epilepsy codes. A summary of the changes made to the epilepsy and seizure section is found in attachment 1 of this report. Prior to its implementation, NCHS plans to pilot test the draft ICD-10-CM next year.

Neurosurgical CPT Codes

Following the creation of new CPT epilepsy surgery codes, the American Association of Neurological Surgeons sought NAEC's assistance in surveying neurosurgeons practicing within epilepsy centers to develop the physician work

relative values used in determining reimbursement by both public and private insurers. The new codes and Medicare payment levels that take effect on January 1, 2004 are included in this report as attachment 2.

2004 Medicare Physician Fee Schedule

Minimal changes were made to the relative values for the professional components of the epilepsy CPT codes in the 2004 physician fee schedule rule. For services provided in a physician office or free-standing center, the technical fees (TCs) were decreased substantially for certain EEG codes - 95812, 95813, 95816, 95819, 95822, and 95950. Some of this decrease can be attributed to a repricing of the supplies used for the services, but the reason for the magnitude of the reductions is not clear.

In Medicare legislation passed in November, Congress overrode the scheduled 4.2% reduction in the conversion factor and mandated a 1.5% increase in 2004 and 2005. The conversion factor as of January 1, 2004 is \$37.34. Attachment 3 is a chart showing the payment rates for EEG and epilepsy services and evaluation and management services for 2003 and 2004.

2004 Medicare Hospital Outpatient Prospective Payment System

For most epilepsy hospital outpatient services, Medicare reimbursement under the Hospital Outpatient Prospective Payment System (HOPPS) will increase in 2004. Under HOPPS, hospital procedures are grouped by clinical and resource cost similarities into ambulatory payment classifications (APCs), which are similar to DRGs. The APC payment is made to the hospital for the facility fee associated with a particular procedure. Physicians continue to bill the professional component of the service separately.

Effective January 1, 2004, payment for the two major epilepsy APCs 0209 and 0214 will increase at a rate slightly greater than the average inflationary increase for all APCs. Hospital payment for APC 0213 (95812, 95813, 95950, 95955, 95958) will decrease by more than 6%. A substantial increase will occur for the New Technology APC that includes MEG (95965), which will be paid at \$5250, a doubling of the current rate. The one APC that is being decreased substantially is APC 692, which provides hospital payment for vagus nerve stimulation analysis (CPT codes: 95970 – 95975). Payment will drop from the 2003 rate of \$326.44 to \$60.33 in 2004. A chart showing the CPT codes and payment rates for the epilepsy-related APCs is included at attachment 4.

HIPAA Privacy and Coding Standards

On April 14, 2003 the privacy standards for individually identifiable health information took effect. All centers should have privacy policies that are made available to patients. Hospital-based centers will likely follow their hospital's privacy practices. NAEC prepared a summary of the privacy regulation that was distributed to the membership earlier this year.

HIPAA also requires that all claims for health care services be submitted electronically in a standard format. Due to a delay in the publication of the regulation implementing the code standards, CMS recognized that most physicians would not be able to meet the new standard by the implementation date of October 16, 2003. CMS decided to allow providers who have made a good faith effort to comply with the new standards to submit non-compliant claims to CMS intermediaries for a period of time. Several non-Medicare insurers including Blue Cross/Blue Shield, CIGNA, and AETNA have also agreed to follow procedures similar to CMS to ensure that payments will continue to flow smoothly after the deadline passes. CMS is yet to set a firm deadline for the coding standards.

CMS released a guidance document available at www.cms.hhs.gov/HIPAA/HIPAA2/guidance-final.pdf to help physicians comply with the coding standards. Additional information can also be found at the HIPAA website – www.cms.hhs.gov/HIPAA/HIPAA2/default.asp.

CDC Epilepsy Program

Living Well with Epilepsy II Conference

On July 30 – 31, NAEC joined the Epilepsy Foundation (EF), the American Epilepsy Society (AES), the Association of State and Territorial Chronic Disease Program Directors, and the Centers for Disease Control and Prevention in sponsoring the second Living Well with Epilepsy Conference. The purpose of the conference was to further the development of a public health agenda for epilepsy. Participants took part in working groups that made recommendations in four areas: recognition, diagnosis and treatment; epidemiology and surveillance; self-management and quality of life. These recommendations will be used to guide future activities of CDC's epilepsy program and collaborative efforts of EF, AES, and NAEC. A formal report on the Conference is being prepared and a congressional briefing was held in early December. Once completed the report will be available from NAEC.

Epilepsy Managed Care Specifications

NAEC continued to work with CDC to further promote standards for epilepsy care provided in Medicaid HMOs and private managed care plans. In 2002, CDC awarded a grant to the George Washington University Center for Health Services Research to bring together an expert panel to develop specifications for state

Medicaid programs to utilize in contracting with managed care organizations for epilepsy services. The specifications were based on the goal of “No Seizures, No Side Effects.” They include a recommendation that if a patient reports a seizure or treatment related side effect within three months of the implementation of a treatment plan, the treating physician must revise the plan or refer the patient to a more specialized level of epilepsy care. This policy would remain in effect until the patient does not experience seizures or side effects. This call for early referral would significantly improve access to appropriate care for patients with intractable epilepsy.

This year at NAEC’s request, CDC agreed to have a consumer guide drafted that could be used by epilepsy chapters and individual patients to advocate for the specifications with state Medicaid programs and private HMOs. The guide also provides information on how Medicaid works and how to be effective in improving care within the managed care system. NAEC will continue to work with CDC to further the dissemination of the epilepsy specifications and will provide centers with materials for their own use with managed care organizations.

Agency for Healthcare Research and Quality

At the request of CDC and the Social Security Administration, AHRQ commissioned an Evidence Report on the Management of Treatment-Resistant Epilepsy. The report is an evaluation and synthesis of the published literature on the diagnosis of and medical and nonmedical interventions for treatment-resistant epilepsy. Unfortunately, the quality and quantity of published literature was insufficient to permit an evidence-based evaluation in many areas. However, this review of peer-reviewed studies can help us identify gaps and potential areas of future research. The report can be found on the AHRQ website at www.ahrq.gov.

Objectives for 2004

NAEC will continue its efforts to:

- Aggressively advocate for improved reimbursement for epilepsy services, including physician services, hospital outpatient department payments and improved coverage for inpatient hospital care and new technologies.
- Participate in activities carried out by CDC’s epilepsy program, including further advocacy of the epilepsy specifications for Medicaid managed care contracts and follow-up efforts to the “Living Well with Epilepsy II” conference.
- Identify areas and projects of mutual interest to pursue in collaboration with other epilepsy organizations.

- Advocate for increased Federal support for epilepsy programs and health care policies benefiting people with epilepsy.
- Provide membership with coding and reimbursement information as well as other legislative and regulatory information affecting comprehensive epilepsy care.