



### **PRESIDENT'S REPORT 2005**

The President's Report is delivered each December during the NAEC Annual meeting held concurrent to the Annual AES meeting. For more information, please contact the NAEC at (952) 525-4526 or by e-mail at [info@naec-epilepsy.org](mailto:info@naec-epilepsy.org).

### **NAEC Assists Centers in Addressing Local Insurance Policies Limiting Coverage for EEG with Video Monitoring**

Of significant concern to comprehensive epilepsy centers is the increase in public and private insurance policies limiting the number of days EEG with video monitoring (95951) is covered. NAEC brought to the attention of its member centers in North Carolina, Maryland and Virginia a move by their Medicare carriers to limit coverage to three days. In the case of MD and VA, the limitation would apply for an entire year. In all of these states, additional days of monitoring could be reviewed for medical necessity requiring significant documentation on the part of providers. The Medicare Carrier Medical Director in New Jersey sought the assistance of Dr. Orrin Devinsky, Medical Director of the NYU Comprehensive Epilepsy Center, who contacted NAEC to assist him in responding to the Carrier's request.

This appears to be a trend that could very well increase in the coming years. Typically, insurers set coverage limitations when they see an increase in the volume of a service and in the case of EEG with video, aggressive marketing directly to patients. Our sense is that CPT Code 95951 is being billed much more frequently for services provided on an outpatient basis not only in the hospital, but in physician offices and patients' homes. Unfortunately, this is jeopardizing coverage for EEG with video during the intensive medical and surgical inpatient evaluation. The key to combating these policies is educating insurers about the services provided by comprehensive epilepsy centers in the diagnosis and treatment of patients with intractable epilepsy.

NAEC stands ready to assist its member centers in addressing these policies. NAEC has drafted suggested guidance to insurers related to coverage policy for EEG with video and a document detailing the major services provided by epilepsy centers. While the Association tries to monitor local insurance changes effecting epilepsy centers, it is key for each center to notify NAEC when it is alerted to changes in insurance policies. In the case of North Carolina, NAEC found out about the policy change after it had been finalized and the local insurer

was not willing to incorporate NAEC's recommendations into its policy. Because the policy for MD and VA was still in draft form and open for comment, NAEC and the centers in MD and VA are working together on comment letters and have scheduled a meeting with the Carrier Medical Director.

### **Pay for Performance/Value-Based Purchasing**

On the national front, both Congress and the Administration are developing policies linking Medicare payments for providers (hospitals, physicians, homecare and skilled nursing facilities) to services that result in good patient outcomes. Legislation has passed the Senate and has been introduced in the House, directing CMS to institute a pay for performance system which would link a portion of Medicare payments to services that conform to evidence-based practice measures. How such a system would work is still unclear, but CMS has decided to take a first step in 2006 by initiating a voluntary reporting program for physicians. CMS has identified 36 evidence-based quality measures endorsed by physician specialty societies and quality care experts for physicians to report to CMS by submitting newly created codes on Medicare claim forms. There will be no additional payment for reporting these measures next year, but participating physicians will be given feedback on how they compare to other physicians reporting on the same measures. There are no neurological measures included on the current CMS list. Measures related to heart disease, diabetes, end stage renal disease and several preventative measures (vaccinations) make up the bulk of the voluntary program's list. A fact sheet on CMS's Physician Voluntary Reporting Program can be found at:

<http://www.cms.hhs.gov/providers/p4p/>

### **Summary of NAEC Activities for 2005**

NAEC has maintained its focus on identifying opportunities to promote the comprehensive specialized services provided by epilepsy centers and to improve coverage and payment for these services by both public and private insurers. 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), the Health Resources and Services Administration and the National Institutes of Health (NIH). In addition, NAEC has reached out to private insurers and local Medicare carriers to educate these organizations about the specialized services provided by centers. NAEC continues to work closely with the American Academy of Neurology (AAN) and the American Association of Neurological Surgeons (AANS) on coding and the development of relative values and with the Epilepsy Foundation on Medicare and public health issues of importance to people living

with epilepsy. With the development and expansion of NAEC's website and more frequent mailings, the Association is providing its members greater access to important information on a timely basis.

## **US News and World Report**

NAEC once again provided *US News and World Report*, the results from its survey of level 4 epilepsy centers for its "Best Hospitals 2005" edition published on July 18, 2005. This is the second year *US News* has included Level 4 epilepsy centers as a key component in ranking hospitals with superior neurology and neurosurgery departments. Sixty-seven NAEC centers were included in this year's ranking. In addition to an epilepsy center, the other elements used to rank neurology/neurosurgery departments included number of patients discharged, mortality rates, R.N. to patient ratio, specialized technologies and patient services and trauma centers. The ranking of hospitals with superior neurology and neurosurgery departments can be found at:

[http://www.usnews.com/usnews/health/best-hospitals/rankings/specihqneur\\_nf.htm](http://www.usnews.com/usnews/health/best-hospitals/rankings/specihqneur_nf.htm)

## **JCAHO**

The NAEC Board has continued to hold discussions with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) about developing a disease-specific certification program for epilepsy centers. The Board believes that center certification would recognize the quality standards of the Association's centers and provide a competitive advantage in the eyes of health plans, employers and potential patients. The JCAHO certification program evaluates disease management and chronic care services provided by hospitals, health plans and disease management services by assessing:

1. Compliance with relevant quality standards;
2. Effective use of clinical practice guidelines to manage and optimize care;
3. Use of outcomes measurement leading to performance improvement.

NAEC would work in collaboration with JCAHO to develop this program, which would occur over a two to three year period.

## **ICD-9-CM Diagnosis Codes**

NAEC proposed several epilepsy diagnoses coding changes that have been accepted for inclusion in the ICD-9-CM edition for 2007 by the Centers for Disease Control and the Centers for Medicare and Medicaid Services. With the support of the American Academy of Neurology, the Child Neurology Society, and the American Epilepsy Society, NAEC requested that the 345-section title be revised and called “Epilepsy and Recurrent Seizures” and that the term recurrent seizures be added to codes 345.8 and 345.9. In addition, NAEC proposed editorial changes to the partial epilepsy codes to reflect more current terminology. These coding changes will take effect in October 2006. NAEC Board Members, Robert J. Gumnit, David Labiner and Greg Barkley were actively involved in this effort.

## **Coding Vignettes**

Earlier this year, NAEC distributed to all of the Medicare carriers and intermediaries a complete package of information on the services provided in comprehensive epilepsy centers. This included a document that provides a definition and clinical vignette on the CPT Codes for services typically provided in an epilepsy center, as well as, background information on intractable epilepsy and the guidelines for comprehensive epilepsy centers that were published in *Epilepsia*. This information was also distributed to all NAEC members. This document can be used by members in working with insurers locally and for other educational purposes. In addition, NAEC plans to distribute the document to Medical Directors of the national private insurance companies. A similar document with vignettes for the major epilepsy surgical services is being drafted and will be distributed next year. NAEC greatly appreciates the review and comments made on the vignette document, without remuneration, by Dr. Satya-Murti, a neurologist and former Medicare Carrier Medical Director for Kansas.

## **2006 Medicare Physician Fee Schedule**

On November 21, the Centers for Medicare and Medicaid Services (CMS) published the final physician fee schedule for 2006. The complete rule can be found at:

<http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-22160.pdf>.

Although the relative value units (RVUs) for EEG and epilepsy-related services are remaining stable, payments to physicians will likely decrease an average of 4% next year due to an anticipated change to the conversion factor. Based on the update formula, the conversion factor for 2006 will be reduced to \$36.18 from the 2005 level of \$37.90. Congress is currently considering legislation that would

provide a 1% increase or a freeze to the conversion factor, but without Congressional action the reduction in payment will occur. Attached is a table that shows the changes in payment and RVUs for EEG and epilepsy-related services.

Fortunately, CMS decided not to change the methodology for calculating practice expense (PE) in 2006. In the proposed physician fee schedule rule, CMS planned to reduce the practice expense values for neurology services by 4% over the next 4 years. CMS decided not to make this change due to concerns that the change in methodology would have led to substantial redistribution of payments between specialties. CMS will be holding meetings with specialty societies next year and plans to develop a strategy for funding and fielding multi-specialty indirect practice expense surveys.

### **2006 Medicare Hospital Outpatient Prospective Payment System**

On November 10, the Centers for Medicare and Medicaid Services (CMS) published the final rule on the Hospital Outpatient Prospective Payment System (HOPPS) for 2006. The complete rule can be found at:

<http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-22136.pdf>

Under HOPPS, hospitals are reimbursed a facility fee for all outpatient services. Payments are made by categories of services known as ambulatory payment classifications (APCs), which group services by clinical and resource cost similarities. All services in an APC are reimbursed at the same rate. The physician bills separately for the professional component of each service provided.

Under the rule, all APCs received a 3.7 percent inflation payment update. However, the actual payments for individual procedures may be substantially more or less than this increase. This is because the APC rates are based on median hospital costs derived from hospital charges which fluctuate greatly from year to year.

Payment for the Extended EEG APC 209, which includes 95951-EEG with video and the other 24-hour EEG codes, will increase 1.5% in 2006. Payment for APC 213 and APC 214, which includes the other EEG codes, are both decreasing largely due to the move of EEG codes 95816, 95819, and 95822 from APC 213 to APC 214. Payments for the three MEG APCs also are slated for reductions in 2006. Attached is a comparison of the 2006 APC payment levels to the 2005 APC rates for EEG and epilepsy-related services.

### **CDC Epilepsy Program**

The Centers for Disease Control's Epilepsy Program, with an annual budget of about \$8 million, is continuing its efforts to improve care and treatment, communications, self-management, epidemiologic and prevention research, and increasing public awareness and knowledge about epilepsy. The links below provide an updated overview of the activities and research funded by the CDC Epilepsy Program.

CDC's Epilepsy Program Activities:

[http://www.cdc.gov/Epilepsy/program\\_activities.htm](http://www.cdc.gov/Epilepsy/program_activities.htm)

CDC's Epilepsy Research Grants:

[http://www.cdc.gov/Epilepsy/research\\_projects.htm](http://www.cdc.gov/Epilepsy/research_projects.htm)

### **Health Resources and Services Administration (HRSA) – Second Phase Begins for Access to Epilepsy Care Grants**

A grant program sponsored by HRSA, aimed at improving access to epilepsy care for children in medically underserved areas, recently completed its first year of implementation. The grants which were awarded in the Fall of 2004, are broken down into three categories:

1. Statewide demonstration project grants were awarded to the Medical College of Wisconsin, Children's Hospital of Los Angeles, University of West Virginia, District of Columbia Department of Health, Easter Seals of Oregon and the Epilepsy Foundation to improve access to health care in medically underserved areas.
2. A grant was awarded to the National Initiative for Children's Healthcare Quality (NICHQ) to identify and implement quality measures in epilepsy care in support of the statewide demonstration projects.
3. A grant was awarded to the Epilepsy Foundation to develop a national public education and awareness campaign directed toward racial and ethnic populations to improve access to care.

NAEC has contributed significant support to the HRSA program by serving in an advisory capacity to the epilepsy program staff and to NICHQ. Earlier this year, NAEC, worked with Dr. Nathan B. Fountain, Medical Director of the University of Virginia's FE Dreifuss Comprehensive Epilepsy Program, to provide HRSA and NICHQ staff with a full-day site visit to the center. Dr. Fountain and his staff provided an extensive overview of the comprehensive services provided by a specialized epilepsy center and the complexities in diagnosing and treating patients with intractable epilepsy. The day was extremely educational and greatly appreciated by the HRSA and NICHQ staff.

NICHQ has completed the first phase of its grant by assessing the strengths in and barriers to epilepsy care and determining what changes need to be made in

order to improve the quality of care provided to patients with epilepsy. NICHQ has created what it calls a “change package,” which provides quality improvement strategies in treating patients with epilepsy. This “change package” is now being pilot-tested by the state awardees. Once this current phase is completed in 2006, NICHQ will then disseminate the findings more broadly. NAEC President, Robert J. Gumnit, MD serves as an advisor to NICHQ in these efforts.

### **Objectives for 2006**

In 2006, priority will be placed on further exploring the certification of epilepsy centers by JCAHO and assisting member centers in working with their local insurers to assure that adequate coverage for epilepsy services is maintained. NAEC will also continue its efforts to:

- Aggressively advocate for improved Medicare and private insurance reimbursement for epilepsy services, including physician services, hospital outpatient department payments and improved coverage for inpatient hospital care and new technologies.
- Provide membership with coding and reimbursement information as well as other legislative and regulatory information affecting comprehensive epilepsy care.
- Work with the Health Resources and Services Administration and its grantees to carry out statewide demonstration projects to improve access to epilepsy services for medically underserved children, by taking part in the development of quality measures and facilitating individual epilepsy center participation in the statewide projects.
- Participate in activities carried out by CDC’s Epilepsy Program, including 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.