NATIONAL ASSOCIATION OF EPILEPSY CENTERS
NAEC

PRESIDENT'S REPORT – 2007

Celebrating its 20th Anniversary, NAEC continues its mission to ensure the availability of and access to high quality specialized epilepsy care in the U.S. When founded in 1987, none of the existing epilepsy or neurology organizations were focused on or responding to the massive changes occurring within public and private health insurance programs. NAEC was established to fill this void and ensure that epilepsy centers would have a voice on the national level.

NAEC has been active in promoting and advocating for specialized epilepsy care over the past 20 years. One of the first activities of the Association was to publish guidelines for epilepsy centers. In 1989, *Guidelines for Essential Services, Personnel and Facilities in Specialized Epilepsy Centers in the United States* was published. It was updated in 2001 and plans are underway to develop a third revision this year. Coding, or a lack of codes to be precise, was a problem in the early years. NAEC was actively involved in developing CPT codes for the major epilepsy services. In the early days of the physician fee schedule, NAEC represented clinical neurophysiology in the development of relative values for many of the procedural neurology services. NAEC more recently spearheaded changes to the ICD-9-CM diagnoses codes for epilepsy, bringing coding terminology up to date and better defining the disorders of patients served by specialized centers.

Public and private insurance coverage and recognition of the high cost of specialized epilepsy services continues to be a high priority for the Association. In addition to the guidelines, NAEC has prepared several documents describing the comprehensive epilepsy evaluation and the needs of patients with intractable epilepsy. NAEC has been responsive in assisting centers with problems on the local level and proactively reaching out to insurers with model coverage policies.

NAEC was at the forefront of the public health campaign to educate people with epilepsy about the goal of controlling seizures without side effects. The establishment of the Epilepsy Program at the Centers for Disease Control and Prevention (CDC) was the result of NAEC's congressional advocacy efforts. NAEC continues to work with CDC, the Epilepsy Program at the Health Resources and Services Administration (HRSA) and the National Institute of Neurological Diseases and Stroke (NINDS), along with the Epilepsy Foundation and the American Epilepsy Society on research, education and outreach programs.

The work of NAEC continues on behalf of its 116 member centers. This report outlines the past year's activities and lays out a broad agenda for 2008. Your participation in these efforts is critical to the long term viability of specialized epilepsy centers and high quality care for patients with intractable epilepsy.

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Summary of NAEC Activities for 2007

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. Throughout the year, NAEC responds to inquiries from private insurers and local Medicare MACs, carriers and fiscal intermediaries on the specialized services provided by centers and assists member centers with problems that may arise with local insurers. NAEC has developed several educational tools that can assist centers in working with payers of epilepsy services.

The Association works directly with the Department of Health and Human Services and its agencies such as the Centers for Medicare and Medicaid Services (CMS), CDC, HRSA, and the National Institutes of Health (NIH). NAEC continues to work closely with the American Academy of Neurology (AAN) on coding and the development of relative values and with the Epilepsy Foundation and the American Epilepsy Society on research 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.

Insurers Look to NAEC for Guidance on Epilepsy and EEG Services

This year, NAEC was approached by United Healthcare requesting guidance on the appropriate use of vEEG. The attached document titled "Indications for EEG," drafted by Nathan Fountain, MD, a member of the NAEC Board, was sent to United Healthcare in response to their request for information. The document provides information on the methods, use, and indications for both routine and long term EEGs in diagnosing patients with seizures and epilepsy. Your epilepsy center will find this to be a useful tool in working with local insurers.

NAEC continues to monitor public and private insurance policies placing limitations on coverage for EEG with video monitoring (95951). At last year's annual meeting, we reported on restrictive Medicare policies established by TrailBlazer in the mid-Atlantic states and TX and by Blue Cross Blue Shield of Arkansas in effect in AR, LA, NM, OK, and RI. These policies are still in effect, but a similar restrictive policy in North Carolina has been retired. We recently received a request for information from CAHABA, the Medicare fiscal intermediary for AL, SD, and IA, but as of yet a draft coverage policy has not been posted.

Typically, insurers set coverage limitations when they see an increase in the volume of claims and payment for a service. 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 vEEG during the intensive medical and surgical inpatient evaluation.

NAEC stands ready to assist its member centers in addressing local insurance issues. While the Association tries to monitor local insurance changes affecting epilepsy centers, it is key for each center to notify NAEC when it is alerted to changes in insurance policies.

DRG Analysis – Improved Coding Needed to Make the Case for Separate DRG

As of October 1, 2008, Medicare revised its inpatient payment structure by adjusting the DRG classification system to account for patient severity. The new structure is referred to as Medicare Severity DRGs or MS-DRGs. The goal of the new system is to ensure that hospitals are paid more for treating sicker and more costly patients and less for patients who are less ill. With this change, the relative values of both of the seizure DRGs – DRG 100: Seizure with Major Complications and Comorbidities (MCC) and DRG 101: Seizure without MCC - are increasing for 2008.

The new severity based DRG structure presents the opportunity for NAEC to pursue a separate DRG for patients with epilepsy admitted for vEEG. To initiate this effort, NAEC contracted with an outside consultant to look at Medicare cost data for the proposed DRGs for 2008. Our premise has always been that patients seen in epilepsy centers for a comprehensive evaluation are more costly admissions with a longer length of stay than other patients assigned to the same DRGs. To see if this was the case, we analyzed the cost data for cases in both seizure DRGs with a primary diagnosis of epilepsy (345 series) or convulsions (780.39) and one of two ICD-9 procedure codes - vEEG (89.19) or Wada (89.10). This group of cases we identified as the target group. We also looked at the cost of those cases with a primary diagnosis of intractable epilepsy (345.0 – 345.9 with the fifth digit 1). We then compared both groups to all other admissions in the DRGs.

In 2006, there were 73,277 total cases in DRGs 100 and 101. Ninety-six percent (70,365) of these cases were not in the epilepsy/vEEG target group. There were 2,862 cases in the target group. The majority of target group cases (2,588 out of 2,862) were in DRG 101. The target group cases were 15% more costly in DRG 100 and 25% more costly in DRG 101. In DRG 101 the standard cost of cases when intractability is coded (only 781 cases) is even greater (45%). (See below)

	mean std cost/all	mean std cost/target	mean std cost/intractability coded
DRG 100	$7,933 (6.3 days)	$9,117 (7.1 days)	$9,398 (7.1 days)
DRG 101	$4,142 (3.7 days)	$5,118 (4.5 days)	$5,988 (5.4 days)

Based on this data, NAEC submitted comments on the proposed hospital inpatient rule asking that CMS subdivide DRGs 100 and 101 to break out the cases in the target group, resulting in four rather than two seizure DRGs. In the final rule, CMS did not agree to establish separate DRGs for patients in the target group, but the agency expressed a willingness to look more closely at the data we have collected. We plan to meet with CMS officials early in 2008 to pursue the establishment of a new DRG for

patients with an epilepsy or convulsions diagnosis when vEEG is provided. It will be difficult to achieve new DRGs based on the existing claims data. The volume of claims in the target group is small and the cost differential may not be significant enough for CMS to make the change. With an effort to improve coding, our hope is that we will have better data and a stronger case to make in 2009.

It is clear from the Medicare data that most epilepsy centers are not coding for vEEG. While the CPT code for vEEG, 95951-26, is reported for the physician service the hospital can also report the vEEG and Wada tests with ICD-9 codes. Many hospitals do not report the ICD-9 codes for vEEG (89.19) or Wada (89.10) because they currently do not affect payment. Coding for these services allows NAEC to analyze the cost data for epilepsy center admissions and make a more compelling case for separate DRGs in the future.

Improving coding for hospital admissions will be a primary goal for the Association in 2008. NAEC will provide each center with coding guidance for hospital coders as well as information to physicians on medical record documentation and its impact on coding. In addition, NAEC plans on creating an e-mail listserv for hospital administrative and medical records staff to discuss coding and reimbursement issues and provide coding information and advice. The 2007 annual meeting program is also dedicated to this topic.

US News and World Report

On July 16th 2007, *U.S. News and World Report* released its 2007 "Best Hospitals" issue, which included 173 hospitals in 16 specialties, including neurology and neurosurgery. The NAEC Guidelines for Level 4 epilepsy centers were part of the criteria for ranking neurology and neurosurgery departments in hospitals. In addition to having an epilepsy center, the other elements used to rank neurology departments include number of patients discharged, mortality rates, R.N. to patient ratio, the use of specialized technologies and patient services and the presence of trauma centers. To view the online rankings of the Best Neurology and Neurosurgery Hospitals for 2007, click here:

http://health.usnews.com/sections/health/best-hospitals

NAEC Website Launched

In August 2007, NAEC's new website was launched at www.naec-epilepsy.org. The new website includes updated information for patients and their families, as well as for NAEC members.

For patients and their families, the new website provides information about epilepsy, and the benefits of specialized epilepsy care. A searchable directory links consumers to the 116 epilepsy centers that retain membership with the NAEC. The directory can also be accessed at the Epilepsy Therapy Project website www.epilepsy.com, which receives over 200,000 hits per month.

Exclusively for its members, the NAEC site contains need-to-know information neatly organized in one location and updated regularly. Guidelines for epilepsy centers, government regulations and third party reimbursement information affecting epilepsy services can be found in the Members-Only section.

To access the Members-Only section of the NAEC website, please enter the following:

username: epilepsy
password: centers2007

Update on Medicare Regulations and Federal Epilepsy Programs

2008 Medicare Final Rules on Hospital Outpatient Prospective Payment Systems and the Physician Fee Schedule

The summaries of the rules and accompanying charts are attached to this report.

Medicare Contractor Reform

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) allowed the Centers for Medicare and Medicaid Services (CMS) to make significant changes to its administrative structure. Through Medicare Contracting Reform, CMS is integrating the administration of Medicare Parts A and B (carriers and fiscal intermediaries) into new entities called Medicare Administrative Contractors (MACs). By 2011, a total of 15 new Medicare contractors (MACs) will cover every state and the District of Columbia.

To date, there is one MAC, Noridian (AZ, MT, ND, SD, UT, WY), which is fully operational. TrailBlazer was awarded the MAC for CO, NM, OK, and TX and Wisconsin Physician Services (WPS) will be the MAC for IA, KS, MO, and NE. Both of these contractors have until September 2008 to assume full responsibility. Two additional MAC contracts were awarded in October, but protests have been filed against both of these contracts.

There is not a great deal of information available on the MAC implementation process. CMS has said that the MACs are obliged to meet with the outgoing contractors' medical director and medical review staff to discuss local coverage determinations (LCDs) and to retain LCDs and medical review edits until the new MACs assume full responsibility. In addition, the current carrier and fiscal intermediary (FI) must provide historical records for each LCD. There are other significant issues that remain unanswered, including whether there will be a single medical director for the entire region and what the impact of this new administrative structure will be on Carrier Advisory Committees (CACs).

The chart below summarizes the composition of each MAC jurisdiction, and the progress of the MACs that have already been awarded.

A/B MAC Transition Timeline

MAC	States Covered	Award Date	Assume Full Responsibility*	Awardee
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands	10/26/2007	No later than June 2008	Palmetto GBA
2	Alaska, Idaho, Oregon and Washington	9/07 (est)		
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming	7/31/2006	No later than March 2007	Noridian
4	Colorado, New Mexico, Oklahoma, and Texas	8/02/07	No later than Spring 2008	TrailBlazer
5	Iowa, Kansas, Missouri, and Nebraska	9/5/07	No later than Sept 9 2008	WPS
6	Illinois, Minnesota, and Wisconsin	7/08 (est)		
7	Arkansas, Louisiana, and Mississippi	9/07 (est)		
8	Indiana and Michigan	9/08		
9	Florida, Puerto Rico, and US Virgin Islands	9/08		
10	Alabama, Georgia, and Tennessee	9/08		
11	Northern Carolina, South Carolina, Virginia and West Virginia	7/08 (est)		
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania	10/24/2007	No later than September 2008	Highmark
13	Connecticut and New York	9/07 (est)		
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	7/08 (est)		
15	Kentucky and Ohio	7/08 (est)		

* The MAC will take over responsibility from the FI and carrier on an incremental basis

National Institutes of Health/National Institute of Neurological Disorders and Stroke (NINDS) —

On March 29 and 30, 2007, NAEC joined the other major epilepsy organizations and the NINDS in sponsoring the NIH conference, "Curing Epilepsy 2007: Translating Discoveries into Therapies." Similar to the conference held in 2000, the goal of the Curing Epilepsy conference was to lay out a blueprint for epilepsy research over the next five years. Research "benchmarks" were developed in three areas: I. Preventing

Epilepsy and its Progression, II. Curing Existing Epilepsy, and III. Preventing or Reversing Co-morbidities. More details on the research benchmarks can be found at: http://messageboards.ninds.nih.gov/default2.aspx

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 and increase public awareness and knowledge about epilepsy. Also, CDC has steadily built a research program in epilepsy. Opportunities exist for epilepsy centers to initiate and participate in studies on health outcomes, self-management and quality of life and epidemiologic and population studies. 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

CDC's Epilepsy Research Projects:
http://www.cdc.gov/Epilepsy/research_projects.htm

Health Resources and Services Administration (HRSA) – Project Access: Improving Care for Children with Epilepsy

HRSA recently awarded a second round of grants for state-wide demonstration projects aimed at improving access to care for medically-underserved children and youth with epilepsy through community-based services. Three-year grants were awarded to:

1. Children's Hospital Los Angeles: A regional epilepsy cooperative will focus on system change and training using distance learning technologies in Alaska, California, Nevada and Wyoming.

2. Washington State Department of Health: The Title V agency will focus on improving care in rural communities with significant Hispanic populations in Washington State.

3. Epilepsy Foundation: The Epilepsy Foundation will partner with local affiliates to improve the system of care for Hispanic and Haitian populations in Florida and Chinese and Caribbean immigrants in New York, as well as work with the Navaho Nation in Arizona and conduct outreach and education in Wyoming.

4. Trustee of Dartmouth College: The project will be working in New Hampshire and Maine to enhance the capacity of primary care physicians and pediatric neurologists to co-manage the care of children and youth with epilepsy.

A cooperative agreement was awarded to the Epilepsy Foundation to support a National Center to provide guidance to the HRSA/Maternal and Child Health Bureau Epilepsy

Program and work with funded states to develop public education and awareness campaigns; develop and disseminate resources on trends and issues related to access to care for children and youth with epilepsy; and provide forums to stimulate discussion about strategies to reduce the shortage of epilepsy providers. A grant was awarded to the National Initiative for Children's Healthcare Quality (NICHQ) to identify and implement quality measures in epilepsy care to support the statewide demonstration projects.

NAEC has continued to support the HRSA program by serving in an advisory capacity to the Epilepsy Program staff and to NICHQ.

Objectives for 2008

In 2008, priority will be placed on pursuing a separate DRG for patients admitted for long term video monitoring under the Medicare program. NAEC will continue to work with public and private insurers and assist 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.

- Participate in and provide support for federal research and public health programs in epilepsy funded by the NIH, CDC, and HRSA.

- Identify areas and projects of mutual interest to pursue in collaboration with other epilepsy organizations.

NATIONAL ASSOCIATION OF EPILEPSY CENTERS

NAEC

Hospital Outpatient Prospective Payment System for 2008

On November 1, 2007, CMS published the final Hospital Outpatient Prospective Payment System (HOPPS) rule for 2008. The rule can be found at **http://www.cms.hhs.gov/HospitalOutpatientPPS/downloads/cms1392fc.pdf**.

ISSUES OF SPECIFIC INTEREST TO NAEC

Update and Hospital Impact

For 2008, the inflationary update in the outpatient payment rates will be 3.3 percent. Due to other policy changes being made by the rule the average increase in outpatient payments for hospitals will be 3.8 percent, with urban hospitals seeing a slightly larger increase than rural hospitals. Teaching hospitals will see an average increase of about 3.8 percent.

Comparison of 2007 and 2008 Payment Rates

Attached are charts showing the 2007 and 2008 HOPPS rates for procedural services of interest to neurologists. Increases in payment are occurring for almost all of the neurology APCs.

Value Based Purchasing

CMS is moving toward a system of value-based purchasing under HOPPS and has set two goals – 1) To encourage the provision of high quality services leading to improved outcomes for Medicare beneficiaries through the quality data reporting program and 2) To initiate specific payment approaches to encourage the efficient delivery of services and control future growth of the volume of services.

With this in mind, hospitals must report seven outpatient specific quality measures in 2008 to receive the full APC payment update in 2009. If they do not report this data, payments to the hospitals will be reduced by 2.0 percentage points. These measures include five measures relating to the care of patients with acute myocardial infarctions in the ER and two measures aimed at improving the care of surgical patients. The two surgical quality measures relate to the perioperative care of surgical patients—the timing of antibiotic prophylaxis and the selection of the prophylactic antibiotic.

To encourage increased efficiency of outpatient care, CMS is expanding the "bundle" of services included within an APC payment. CMS believes increases in

packaging provide hospitals with the flexibility to manage their resources more efficiently. CMS established eight categories of procedural services, which will no longer be separately paid when part of a primary diagnostic or treatment procedure. These services are: guidance services, image processing services, intraoperative diagnostic services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents and observation services. Generally, the change in packaging is estimated to be budget neutral since the payment for the primary procedure is being increased to reflect the cost of the packaged services.

This will impact several neurological procedures - 95829, surgical electrocorticogram, 95920, Intra operative nerve test add on, 95955, EEG during surgery and 96020, fMRI – brain mapping. The hospital will not be able to bill a separate APC for these services when they are provided in the hospital outpatient department, but the physician will still be able to bill for the professional component of the service.

2008 Final Hospital Outpatient Prospective Payment System (HOPPS) Epilepsy APCs

HCPCS Code	Short Descriptor	2007 APC Rate	2008 APC Rate	Change 2008 vs. 2007	
	APC 0209--Level II Extended EEG and Sleep Studies	$691.29	$718.61	$27.32	3.95%
95805	Multiple sleep latency test				
95807	Sleep study, attended				
95808	Polysomnography, 1-3				
95810	Polysomnography, 4 or more				
95811	Polysomnography w/cpap				
95950	Ambulatory EEG monitoring				
95951	EEG monitoring/videorecord				
95953	EEG monitoring/computer				
95956	EEG monitoring, cable/radio				
	APC 0213--Level I Extended EEG and Sleep Studies	$139.87	$146.37	$6.50	4.65%
95806	Sleep study, unattended				
95812	EEG, 41-60 minutes				
95813	EEG, over 1 hour				
95816	EEG, awake and drowsy				
95819	EEG, awake and asleep				
95822	EEG, coma or sleep only				
95827	EEG, all night recording				
95958	EEG monitoring/function test				
	APC 0216--Level III Nerve and Muscle Tests	$167.19	$170.99	$3.80	2.27%
95824	**EEG, cerebral death only (moved from 0214)**				
95961	Electrode stimulation, brain				
95962	Electrode stim, brain add-on				
	APC 0218--Level II Nerve and Muscle Tests	$72.97	$73.57	$0.60	0.82%
95954	**EEG monitoring/giving drugs (moved from 0214)**				
95970	Analyze neurostim, no prog				
	APC 0692--Level II Electronic Analysis of Devices	$118.77	$117.04	-$1.73	-1.46%
0162T	*Anal program gast neurostim (new to 0692)*				
95971	Analyze neurostim, simple				
95975	Cranial neurostim, complex				
95978	Analyze neurostim brain/1h				

2008 Final Hospital Outpatient Prospective Payment System (HOPPS) Epilepsy APCs

HCPCS Code	Short Descriptor	2007 APC Rate	2008 APC Rate	Change 2008 vs. 2007	
	APC 0663--Level I Electronic Analysis of Devices	$68.03	$97.53	$29.50	43.36%
95972	**Analyze neurostim, complex (moved from 0692)**				
95973	Analyze neurostim, complex				
95974	**Cranial neurostim, complex (moved from 0692)**				
95979	Analyz neurostim brain addon				
	APC 0065--Level I Stereotactic Radiosurgery, MRgFUS, and MEG	$691.29*	$1,056.75	$365.46	52.87%
95966	**Meg, evoked, single (moved from 0209)**				
95967	**Meg, evoked, each add (moved from 0209)**				
G0251	Linear acc based stero radio				
	APC 0067--Level III Stereotactic Radiosurgery, MRgFUS, and MEG	$3,289.53*	$3,929.70	$640.17	19.46%
0071T	U/s leiomyomata ablate <200				
0072T	U/s leiomyomata ablate >200				
95965	**Meg, spontaneous (moved from 0038)**				
G0173	Linear acc stereo radsur com				
G0339	Robot lin-radsurg com, first				

* This is the 2007 payment level for the MEG codes, not for APCs 0065 and 0067.

NATIONAL ASSOCIATION OF EPILEPSY CENTERS

NAEC

CMS Releases 2008 Physician Fee Schedule

On November 1, 2007 the Centers for Medicare and Medicaid Services (CMS) issued the final physician fee schedule for 2008. The final rule, effective for services on or after January 1, 2008, will be published in the Federal Register on November 27, 2007. The rule can be found on the CMS website at: http://www.cms.hhs.gov/physician.asp. Highlights of the rule follow.

-10.1% Reduction in Payment Announced (2008 CF = $34.0682)

CMS announced a -10.1% reduction in the conversion factor. This reduced the conversion factor from the 2007 rate of $37.8975 to $34.0682. The negative update is the result of the application of the Sustainable Growth Rate (SGR) formula which requires a negative update when the actual rate of spending on physician services exceeds a set target rate. Congress has intervened every year since 2003 to prevent a negative update. It is anticipated that this will occur again in 2008.

11.94% Budget Neutrality Adjustment to be Implemented in 2008

Recent changes in work values due to the Five Year Review and increases in the work values for anesthesia services resulted in total changes in expenditures under the fee schedule of greater than $20 million. CMS is required by law to maintain budget neutrality when this threshold is met. In 2008 CMS will achieve budget neutrality by applying a separate budget neutrality (BN) adjustor to the work RVUs for all services. CMS will apply a work adjustor of 0.8806 or a reduction of 11.94% to all work RVUs. This represents an increase in the reduction of work RVUs from the previous year.

Physician Quality Reporting Initiative Continues in 2008

Legislation required the Secretary to implement a voluntary quality reporting system with a bonus payment in 2007. On July 1, 2007 CMS implemented the 2007 Physician Quality Reporting Program Initiative (PQRI). This program will continue in 2008. The rule requires that the final 2008 PQRI quality measures be determined and published by November 15, 2007.

2008 Medicare Payment Rates for Commonly Performed Services

Attached are charts showing the Medicare payment rates for neurology services under two different scenarios. Scenario A reflects a decrease of 10.1% from the 2007 conversion factor (CF) for 2008 as was announced in the final rule. Scenario B reflects a 0% update from the 2007 conversion factor (CF). This reflects one potential scenario that could occur with Congressional action.

2008 Final Physician Fee Schedule (CMS 1385-FC) 2008 Payment Rates for Epilepsy and Evaluation and Management (EM) Medicare Physician Services					
CPT Code	Mod	Descriptor	2007 CF= $37.8975	2008 Scenario A:* (CF= $34.0682)	2008 Scenario B: ** (CF= $37.8975)
95812		EEG, 41-60 minutes	$213.36	$207.13	$230.42
95812	26	EEG, 41-60 minutes	$54.95	$47.35	$52.68
95812	TC	EEG, 41-60 minutes	$158.41	$159.78	$177.74
95813		EEG, over 1 hour	$271.35	$254.83	$283.47
95813	26	EEG, over 1 hour	$87.16	$74.95	$83.37
95813	TC	EEG, over 1 hour	$184.18	$179.88	$200.10
95816		EEG, awake and drowsy	$198.20	$190.78	$212.23
95816	26	EEG, awake and drowsy	$54.95	$47.35	$52.68
95816	TC	EEG, awake and drowsy	$143.25	$143.43	$159.55
95819		EEG, awake and asleep	$185.32	$192.83	$214.50
95819	26	EEG, awake and asleep	$54.95	$47.35	$52.68
95819	TC	EEG, awake and asleep	$130.37	$145.47	$161.82
95822		EEG, coma or sleep only	$226.63	$210.88	$234.59
95822	26	EEG, coma or sleep only	$54.95	$47.35	$52.68
95822	TC	EEG, coma or sleep only	$171.68	$163.53	$181.91
95824	26	EEG, cerebral death only	$37.90	$32.36	$36.00
95827		EEG, all night recording	$229.28	$281.06	$312.65
95827	26	EEG, all night recording	$53.06	$45.99	$51.16
95827	TC	EEG, all night recording	$176.22	$235.07	$261.49
95829		Surgery electrocorticogram	$1,350.67	$1,152.53	$1,282.07
95829	26	Surgery electrocorticogram	$312.65	$271.86	$302.42
95829	TC	Surgery electrocorticogram	$1,038.01	$880.66	$979.65
95830	Office	Insert electrodes for EEG	$183.80	$161.48	$179.63
95830	Hospital	Insert electrodes for EEG	$87.16	$74.27	$82.62
95950		Ambulatory eeg monitoring	$229.28	$213.27	$237.24
95950	26	Ambulatory eeg monitoring	$76.93	$66.09	$73.52
95950	TC	Ambulatory eeg monitoring	$152.35	$147.17	$163.72
95951	26	EEG monitoring/videorecord	$305.07	$262.67	$292.19
95953		EEG monitoring/computer	$420.28	$372.37	$414.22
95953	26	EEG monitoring/computer	$164.85	$142.75	$158.79
95953	TC	EEG monitoring/computer	$255.43	$229.62	$255.43
95954		EEG monitoring/giving drugs	$256.57	$226.55	$252.02
95954	26	EEG monitoring/giving drugs	$122.79	$102.89	$114.45
95954	TC	EEG monitoring/giving drugs	$133.78	$123.67	$137.57
95955		EEG during surgery	$134.92	$124.35	$138.33
95955	26	EEG during surgery	$49.27	$42.93	$47.75
95955	TC	EEG during surgery	$85.65	$81.42	$90.58
95956		EEG monitoring, cable/radio	$713.61	$652.07	$725.36
95956	26	EEG monitoring, cable/radio	$156.52	$134.57	$149.70
95956	TC	EEG monitoring, cable/radio	$557.09	$517.50	$575.66
95957		EEG digital analysis	$203.89	$209.86	$233.45
95957	26	EEG digital analysis	$101.19	$86.87	$96.64
95957	TC	EEG digital analysis	$102.70	$122.99	$136.81

2008 Final Physician Fee Schedule (CMS 1385-FC) 2008 Payment Rates for Epilepsy and Evaluation and Management (EM) Medicare Physician Services					
CPT Code	Mod	Descriptor	2007 CF= $37.8975	2008 Scenario A:* (CF= $34.0682)	2008 Scenario B: ** (CF= $37.8975)
95958		EEG monitoring/function test	$318.34	$312.06	$347.14
95958	26	EEG monitoring/function test	$213.36	$184.99	$205.78
95958	TC	EEG monitoring/function test	$104.98	$127.07	$141.36
95961		Electrode stimulation, brain	$226.25	$204.41	$227.39
95961	26	Electrode stimulation, brain	$165.61	$142.75	$158.79
95961	TC	Electrode stimulation, brain	$60.64	$61.66	$68.59
95962		Electrode stim, brain add-on	$222.46	$193.17	$214.88
95962	26	Electrode stim, brain add-on	$170.16	$146.49	$162.96
95962	TC	Electrode stim, brain add-on	$52.30	$46.67	$51.92
95965	26	MEG, spontaneous	$408.91	$354.31	$394.13
95966	26	MEG, evoked, single	$202.75	$175.45	$195.17
95967	26	MEG, evoked, each addÏl	$167.89	$147.17	$163.72
95970	Office	Analyze neurostim, no prog	$48.89	$44.29	$49.27
95970	Hospital	Analyze neurostim, no prog	$21.60	$19.08	$21.22
95971	Office	Analyze neurostim, simple	$54.19	$47.35	$52.68
95971	Hospital	Analyze neurostim, simple	$37.52	$32.71	$36.38
95972	Office	Analyze neurostim, complex	$102.32	$89.94	$100.05
95972	Hospital	Analyze neurostim, complex	$74.66	$65.41	$72.76
95973	Office	Analyze neurostim, complex	$57.23	$48.72	$54.19
95973	Hospital	Analyze neurostim, complex	$46.23	$39.52	$43.96
95974	Office	Cranial neurostim, complex	$170.92	$148.88	$165.61
95974	Hospital	Cranial neurostim, complex	$153.48	$130.82	$145.53
95975	Office	Cranial neurostim, complex	$95.12	$82.79	$92.09
95975	Hospital	Cranial neurostim, complex	$87.92	$75.63	$84.13
* Scenario A reflects a decrease of 10.1% from the 2007 conversion factor (CF) for 2008.					
**Scenario B reflects an 0.0% update from the 2007 conversion factor (CF). This reflects one potential scenario that could occur with Congressional action.					

2008 Final Physician Fee Schedule (CMS 1385-FC)							
Final 2008 Payment Rates for Evaluation and Management (EM) Medicare							
		NON-FACILITY (OFFICE)			**FACILITY (HOSPITAL)**		
		2007	**2008**	**2008**	**2007**	**2008**	**2008**
CPT Code	**Descriptor**	CF= $37.8975	Scenario A:* (CF= $34.0682)	Scenario B: ** (CF= $37.8975	CF= $37.8975	Scenario A:* (CF= $34.0682	Scenario B: ** (CF= $37.8975)
99201	Office/outpatient visit, new	$35.62	$32.36	$36.00	$21.98	$19.76	$21.98
99202	Office/outpatient visit, new	$62.15	$55.53	$61.77	$43.58	$38.16	$42.45
99203	Office/outpatient visit, new	$92.09	$81.42	$90.58	$67.08	$58.60	$65.18
99204	Office/outpatient visit, new	$139.84	$124.01	$137.95	$109.90	$97.44	$108.39
99205	Office/outpatient visit, new	$175.47	$155.69	$173.19	$144.01	$126.73	$140.98
99211	Office/outpatient visit, est	$20.09	$17.72	$19.71	$8.34	$7.50	$8.34
99212	Office/outpatient visit, est	$36.76	$33.39	$37.14	$22.36	$19.76	$21.98
99213	Office/outpatient visit, est	$59.50	$53.15	$59.12	$42.07	$37.48	$41.69
99214	Office/outpatient visit, est	$90.20	$80.40	$89.44	$66.32	$58.60	$65.18
99215	Office/outpatient visit, est	$122.03	$108.68	$120.89	$95.50	$84.15	$93.61
99221	Initial hospital care	NA	NA	NA	$84.89	$75.97	$84.51
99222	Initial hospital care	NA	NA	NA	$119.00	$104.59	$116.35
99223	Initial hospital care	NA	NA	NA	$173.57	$153.65	$170.92
99231	Subsequent hospital care	NA	NA	NA	$35.62	$31.68	$35.24
99232	Subsequent hospital care	NA	NA	NA	$63.67	$56.55	$62.91
99233	Subsequent hospital care	NA	NA	NA	$90.95	$81.08	$90.20
99241	Office consultation	$48.51	$42.93	$47.75	$32.21	$28.28	$31.45
99242	Office consultation	$89.44	$79.72	$88.68	$67.46	$59.62	$66.32
99243	Office consultation	$122.41	$109.36	$121.65	$93.23	$83.13	$92.47
99244	Office consultation	$179.63	$160.12	$178.12	$145.91	$130.14	$144.77
99245	Office consultation	$222.84	$197.60	$219.81	$184.56	$163.53	$181.91
99251	Initial inpatient consult	NA	NA	NA	$45.86	$40.88	$45.48
99252	Initial inpatient consult	NA	NA	NA	$73.52	$64.73	$72.01
99253	Initial inpatient consult	NA	NA	NA	$108.77	$97.09	$108.01
99254	Initial inpatient consult	NA	NA	NA	$156.52	$140.02	$155.76
99255	Initial inpatient consult	NA	NA	NA	$195.17	$172.39	$191.76
99291	Critical care, first hour	NA	$224.17	$249.37	$208.82	$182.61	$203.13
99292	Critical care, addÏl 30 min	NA	$100.16	$111.42	$104.60	$91.64	$101.94
99293	Ped critical care, initial	NA	NA	NA	$756.81	$662.63	$737.11
99294	Ped critical care, subseq	NA	NA	NA	$374.43	$324.33	$360.78
* Scenario A reflects a decrease of 10.1% from the 2007 conversion factor (CF) for 2008.							
**Scenario B reflects an 0.0% update from the 2007 conversion factor (CF). This reflects one potential scenario that could occur with Congressional action.							