

PRESIDENT'S REPORT – 2008

Reforming the current US health care system is a priority issue in the coming year. With the troubled economy and two wars, comprehensive change will not be immediate, but it is likely that the Democratic-led Congress and the new President will begin the process of moving health reform legislation early in the year. Unlike the early '90s when President Clinton's healthcare reform plan was rejected, the business community, health insurers, and providers are in agreement that something must be done to provide health coverage to all Americans and that the government is best equipped to do it. A single-payer system is clearly off the table. There is consensus behind a mixed approach utilizing the current employer-based health insurance system, expanding safety net programs for the poor, and providing subsidized insurance and other insurance mechanisms to the uninsured. There is agreement that any expansions in healthcare coverage will be combined with measures to bring down costs and improve quality. There is likely to be significant focus on drug costs, tying physician payment to quality measures, and utilizing health information technology to eliminate duplication and improve efficiency in the delivery of healthcare services. An increased emphasis on prevention is also anticipated, possibly resulting in universal coverage of vaccines, screenings and other preventive measures as the first step in the move toward comprehensive reform.

NAEC will closely follow the development of health reform legislation and work with other organizations to see that the unique needs of individuals with chronic diseases such as epilepsy are addressed. It is also likely that Medicare reforms will occur next year, including a change in the formula that updates physician fees. NAEC will keep its members apprised of legislative proposals and will seek your participation in advocacy efforts.

This report outlines NAEC's activities for the past year and lays out a broad agenda for 2009. Your involvement in these efforts is critical to the long term viability of specialized epilepsy centers and high quality care for patients with intractable epilepsy.

Summary of NAEC Activities for 2008

NAEC has maintained its focus on identifying opportunities to promote the comprehensive specialized services provided by epilepsy centers and to improve coding, 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 Administrative Contractors (MACs), carriers and fiscal intermediaries on specialized epilepsy services and assists member centers with problems that may arise within their hospitals and with local insurers. NAEC has developed several educational

tools that can assist centers in working with payers of epilepsy services. These materials can be found on the NAEC website – www.naec-epilepsy.org.

NAEC Creates Coding and Reimbursement Listserv

This year the Association created a listserv for epilepsy center administrative staff and hospital coders specifically to address coding and reimbursement problems that are occurring in many centers. NAEC sends its responses to reimbursement questions that occur throughout the year to the listserv and the listserv also functions as a forum for discussion on specific issues. Individuals can be added to the listserv at any time by sending an e-mail to info@naec-epilepsy.org.

NAEC Guidelines Being Revised

Work has begun on the third revision of NAEC's Guidelines for Essential Services, Personnel and Facilities in Specialized Epilepsy Centers in the US. NAEC has established a committee, which includes Drs. Nathan Fountain, Susan Herman and Ted Walczak and is chaired by David Labiner, MD, to revise the Guidelines with planned publication before the next annual meeting. Last updated in 2001, the Guidelines have served as the model for designating levels III and IV epilepsy centers. New to this version will be guidance on quality/outcome measures, safety, and a multi-disciplinary team approach.

Quality Measures in Epilepsy under Development

This year NAEC joined the American Academy of Neurology and the American Epilepsy Society in the development of quality measures in epilepsy. Drs. Nathan Fountain and Paul Van Ness are chairing the AAN committee spearheading this effort. In 2007, Medicare began its Physician Quality Reporting Initiative (PQRI), which allowed physicians to report quality measures and receive a bonus payment. The AAN/NAEC /AES committee has identified several evidence-based measures to present to the AMA and National Quality Forum for approval in 2009 and possible implementation in 2010.

Separate DRG for Intractable Epilepsy Patients with vEEG

NAEC continued to pursue the establishment of a separate DRG for hospital admissions of patients with intractable epilepsy having video EEG (vEEG) monitoring. In FY 2008 CMS initiated significant changes to the DRG system to better recognize patient severity. Two DRGs for seizures were established, one with major comorbidities and complications (MCCs) and one without MCCs. NAEC requested in comments submitted to CMS on the FY 2008 proposed rule that a separate DRG be established for patients with epilepsy (345.0 - 345.9) having vEEG monitoring. CMS did not agree to create a new DRG, but asked for additional data. Earlier this year, NAEC presented the requested data to CMS and refined its request asking for a separate DRG just for patients with intractable epilepsy (345.01 – 345.91) having vEEG.

Unfortunately, CMS did not agree to establish a separate DRG in FY 2009 for patients with intractable epilepsy when vEEG is provided. CMS stated that the Medicare data for the intractable epilepsy cases do not meet the criteria that it uses to establish a new DRG. While the intractable epilepsy cases did meet the CMS' criterion related to higher costs, they did not meet the criteria that the number of cases in the subgroup should be at least 5% of the total cases (there were only 879 cases out of a total of 54,000 cases in DRG 101).

It is clear from the Medicare data that most epilepsy centers are not reporting the ICD-9 codes for intractability or 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 and assuring that the fifth digit for intractability is coded on patients will improve the cost data for epilepsy center admissions and make a more compelling case for separate DRGs in the future.

ICD-9-CM Diagnosis Coding/Terminology Revisions

NAEC Vice President Greg Barkley, MD accompanied by AAN ICD-9-CM representative Laura Powers, MD made a presentation at the CMS/CDC ICD-9-CM meeting in September on coding for seizures and epilepsy. Barkley addressed questions regarding coding for a single seizure, repetitive vs. recurrent seizures, non-epileptic and psychogenic seizures. NAEC and AAN requested the addition of several terms to describe intractability in order to assist coders on when to use the fifth digit for intractability. They are: pharmacoresistant (pharmacologically resistant), treatment resistant, refractory (medically) and poorly controlled. At the next meeting NAEC/AAN will present a request for a new code for post traumatic seizures (780.3X). This would not include post traumatic epilepsy, which would be coded under 345.XX.

Resurveying Ambulatory EEG Monitoring Codes (95950, 95953, 95956)

In its proposed regulation on the Medicare physician fee schedule for 2009, CMS identified services with a growth in utilization exceeding 10% over the past three years. CPT Code 95956 – EEG monitoring with cable or radio for 24 hours – was included on this list. The growth in claims for the global, professional component and technical component of the code was greater than 10% annually, but the total volume of the service (approximately 3100 claims for the global and pc services) is very low.

Working with the AAN, NAEC drafted comments to the AMA Relative Value Update Committee (RUC) explaining that some of this growth is to be expected especially in hospital settings where the service is increasingly being utilized in the hospital ICU to assess elderly patients with multiple medical problems (diabetes, renal failure, cardiac rhythm disturbances, etc.) in a coma that may be caused by seizures. We did express some concerns that some of the growth in Medicare claims may be due to the inappropriate reporting of Code 95956 when in actuality Code 95953 is being performed.

While AAN, ACNS, and NAEC recommended that a CPT Assistant article be developed to clarify the appropriate use of 95956 and 95953 in the physician office and free-standing facilities, the RUC asked that the family of EEG monitoring codes be surveyed and placed on the agenda of an upcoming meeting for reevaluation. NAEC will be asking its members to take part in the survey process early next year.

US News and World Report

On July 10th 2008, *U.S. News and World Report* released its 2008 "Best Hospitals" issue, which included 170 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 2008, go here: http://www.usnews.com/directories/hospitals/index_html/specialty+IHQNEUR/.

Update on Legislation of Interest to Epilepsy Centers

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

On July 15, 2008 both the House and Senate overrode the President's veto of legislation preventing a 10.6% reduction in Medicare physician payment for the remainder of 2008 and provided a 1.1% increase for calendar year 2009. Several additional provisions included in the legislation benefit epilepsy centers and the patients that they treat.

Improvements for Patients

- Provides Medicare Part D coverage of benzodiazepines and barbiturates when used in the treatment of epilepsy beginning January 1, 2013.
- Places in the Medicare law the Secretary of HHS' authority to designate classes of drugs where all of the drugs in the class must be covered (AEDs are currently designated).
- Reduces Medicare beneficiaries' 50% copayment for mental health services to a 20% copayment as is the case for outpatient medical services, phasing the reduction in over 6 years.

Improvements for Providers

- Requires that the budget neutrality adjuster that CMS currently applies to the work RVUs for physician services be applied to the conversion factor. This should provide a slight increase in payments for Evaluation and Management services and the professional components of epilepsy procedural services.

- Extends the physician quality reporting initiative through 2010 and provides a 2% bonus payment to reporting physicians in 2009 and 2010.
- Provides a bonus payment for using qualified e-prescribing systems in 2009 – 2013 and requires e-prescribing in 2011 and beyond. Starting in 2012 a payment reduction of 2% will be applied to providers that do not e-prescribe.

Veterans' Mental Health and Other Care Improvements Act of 2008

The Veterans' Mental Health and Other Care Improvements Act of 2008 (PL 110-387), enacted on October 10, 2008 establishes up to six Epilepsy Centers of Excellence within the VA Medical system. These Centers would develop evidence-based methodology for treatment of epilepsy, coordinate care for veterans with epilepsy, develop a national referral system for veterans with epilepsy, expand telehealth technology for treatment of veterans with epilepsy and disseminate educational materials on the diagnosis and treatment of epilepsy. Additionally, the legislation authorizes the Secretary of the VA to designate an individual in the Veterans Health Administration (VHA) as a national coordinator for VHA epilepsy programs.

ADA Amendments Act of 2008

The Americans with Disabilities (ADA) Amendments Act of 2008 (signed into law on September 25, 2008) restores original Congressional intent. The ADA Amendments Act of 1990 was intended to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities. However, four Supreme Court decisions narrowed the definition of disability so much that people with serious conditions including epilepsy have been determined to not meet the definition. The new law rejects strict interpretation of the definition of disability, and makes it clear that the ADA is intended to provide broad coverage to protect anyone who faces discrimination on the basis of disability. For instance, the law prohibits the consideration of mitigating measures such as medication, prosthetics, and assistive technology, in determining whether an individual has a disability and covers people who experience discrimination based on a perception of impairment regardless of whether the individual experiences disability.

Update on Medicare Regulations and Federal Epilepsy Programs

2009 Medicare Final Rule on Hospital Inpatient Prospective Payment System (IPPS)

On July 31, 2008 CMS posted the final acute care inpatient prospective payment rule (IPPS). The final IPPS rule updates payment policies and rates for more than 3,500 hospitals that are paid under Medicare's DRG payment system. Overall, the final rule is estimated to increase Medicare payments to acute care hospitals by nearly \$4.75 billion. With a few exceptions, the rule took effect on October 1, 2008.

Overall hospitals are projected to receive a 4.1% increase in per case payments in FY 2009. The increase reflects the hospital inflationary update of 3.0%, a budget neutrality adjustment, and other minor changes. Slightly higher average increases are expected for large urban hospitals and teaching hospitals. Payment of the full update is dependent upon hospitals reporting a set of quality measures. Failure to successfully report the quality measures will result in a 2% penalty.

A summary of the rule can be found on the NAEC website.

2009 Medicare Final Rule on Hospital Outpatient Prospective Payment System (HOPPS)

On October 30, CMS issued the final rule updating payments for hospital outpatient department services. The rule can be found on the CMS webpage. CMS projects that total payments under the HOPPS will be about \$30.1 billion in 2009 compared with about \$28.5 billion in 2008. This reflects a 3.9% increase in payments to hospitals

In general the epilepsy-related APC rates (payment for the hospital's facility fee) will increase in 2009. The APCs that include EEG services are increasing by nearly 5%. The APC for VNS services and some of the MEG codes will decrease by 7% and 10% respectively.

2009 Medicare Final Rule on the Physician Fee Schedule (PFS)

The 2009 Final Medicare Physician Fee Schedule was published in the Federal Register on November 19, 2008. The final rule can be found in its entirety on the CMS website. Most of the provisions of this final rule are effective January 1, 2009.

On July 15, 2008, after the release of the 2009 proposed PFS rule, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Many of the provisions in MIPPA addressed similar issues that were raised in the proposed rule. The 2009 final rule is a combination of finalized proposals from the proposed rule, requests for further comments on proposals from the proposed rule, and discussion of implementation of provisions from MIPPA.

The conversion factor for CY 2009 will be \$36.07. This reflects a 1.1% increase mandated by Congress (averting a scheduled 15.1% cut), as well as an adjustment for budget neutrality, which for 2009 will be applied to the conversion factor rather than the physician work relative values. Because the budget neutrality adjuster is being applied to the conversion factor in 2009, payment rates for evaluation and management services and the professional component of most EEG services are increasing, while the opposite occurs for the global bills for office-based procedures.

Medicare Contractor Reform

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) allowed 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 or MACs. By 2011, a total of 15 new MACs will cover every state and the District of Columbia.

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	5/2008	N/A	National Heritage Insurance Corporation (NHIC)
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming	7/31/2006	March 07	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	Arkansas, Louisiana, and Mississippi	6/08	N/A	Pinnacle Business Solutions Inc.
8	Indiana and Michigan			
9	Florida, Puerto Rico, and US Virgin Islands	9/08	No later than March 2009	First Coast Services Options
10	Alabama, Georgia, and Tennessee			
11	Northern Carolina, South Carolina, Virginia and West Virginia			
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania	10/24/2007	No later than September 2008	Highmark
13	Connecticut and New York	3/08	No later than November 2008	National Government Services
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	11/08	No later than March 2009	NHIC
15	Kentucky and Ohio			

CDC Epilepsy Program

The CDC's Epilepsy Program, with an annual budget of about \$8 million, continues 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 Epilepsy Program Activities: http://www.cdc.gov/Epilepsy/program_activities.htm

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

In addition, on August 7th, 2008, CDC released a multi-state study on epilepsy. The study, which examined the prevalence of epilepsy and seizure disorders in 19 states, collected data on more than 120,000 adults. The study found that about one out of 100 adults have active epilepsy and that more than one out of three adults who have had recent seizures had not seen a neurologist or epileptologist in the past year.

The study can be found on the CDC website:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5706a1.htm>

Objectives for 2009

In 2009, NAEC will continue 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 and assist member centers in working with their local insurers to ensure that adequate coverage for epilepsy services is maintained. NAEC will also continue its efforts to:

- Further the Association's efforts to promote quality care for patients with epilepsy by revising NAEC's Guidelines for Epilepsy Centers and participating in epilepsy quality measure development.
- Improve coding and terminology for epilepsy diagnoses and procedural services
- Provide its 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.