



PRESIDENT'S REPORT – 2010

On March 23, 2010, President Obama signed sweeping healthcare reform legislation into law following more than a year of contentious debate in the House of Representatives and Senate over its development and passage. The bill was crafted and passed by members of the Democratic party with only a single Republican vote. While the poor economy was at the heart of this election the partisan approach to healthcare reform added to a massive change in the face of the new Congress. Republicans picked up 60 seats, the biggest gain for a party since the Great Depression, and will become the majority in the House in January. While the Senate will remain under Democratic control the Republicans added 6 new seats, significantly narrowing the majority's margin.

With the new Congress in place, there is a great deal of speculation on whether the healthcare reform law will be repealed, substantially changed, or stagnated due to limited funding for implementation. A full repeal is unlikely, but since many of the provisions reforming private insurance and providing federally subsidized health insurance to an additional 35 million Americans does not take effect until 2014, significant revisions can occur. In addition, states are split in their support of the Medicaid expansions in the law, even with federal funding for newly eligible individuals. Clearly, the sections of the law dealing with insurance coverage expansion are in the greatest jeopardy in the coming year.

What will likely not change much are the provisions in the law dealing with the Medicare program. The law reduced spending in Medicare by more than \$350 billion over 10 years by reducing the annual updates in payments for hospitals and most institutional providers and by significantly reducing spending in Medicare's managed care program known as Medicare Advantage. More importantly, the law set in motion a myriad of new payment concepts and the development of integrated systems of care called Accountable Care Organizations (ACOs). The Centers for Medicare and Medicaid Services (CMS) was provided \$10 billion to fund innovative payment and delivery mechanisms to improve quality and lower costs. Policymakers have directed CMS to explore bundling payments for episodes of care and multiple providers, to pilot patient-centered medical homes to provide primary care physicians additional payment for care coordination, and other demonstrations focused on meeting quality standards and promoting efficiencies.

With the uncertainty of the future of public insurance programs, the immediate challenges faced by epilepsy centers in dealing with private insurance remains. We have heard from many of you this year regarding denials of EMU admissions, limitations on length of stay, a new-found interest in observation beds and the utilization of ambulatory EEG and video EEG. Based on the increased instances of insurance denials, NAEC will be drafting a white paper to lay out criteria for admission to an epilepsy monitoring unit for a comprehensive epilepsy evaluation. This document will be shared with all NAEC members and the Association will reach out to the major private insurers with this information.

The following report outlines NAEC's accomplishments during the past year and its agenda for 2011. Successes of 2010 include the publication of the third iteration of NAEC's Guidelines for Essential Services, Personnel and Facilities in Specialized Epilepsy Centers, taking a

leadership role in crafting quality measures in epilepsy which will be integrated into the American Board of Psychiatry and Neurology's Maintenance of Certification program, and a fruitful discussion with United Healthcare to assure that brand as well as generic formulations of anti-epileptic drugs will be covered under its commercial insurance plans.

In 2011, NAEC will continue to closely follow the implementation of the health reform law as well as Medicare and other health legislation and regulations that could impact epilepsy centers. NAEC will also work with the American Academy of Neurology, American Epilepsy Society, Epilepsy Foundation and other organizations to see that the unique needs of individuals with epilepsy are addressed. 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 2010

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. In addition, NAEC works closely with its sister epilepsy organizations to promote access to quality epilepsy care.

NAEC Guidelines Finalized and Published

In January 2010, the Board of NAEC finalized the third version of its "Guidelines for Essential Services, Personnel, and Facilities in Specialized Epilepsy Centers," which were published in *Epilepsia* in June. (Labiner, D. M., Bagic, A. I., Herman, S. T., Fountain, N. B., Walczak, T. S., Gumnit, R. J. and for the National Association of Epilepsy Centers (2010), Essential services, personnel, and facilities in specialized epilepsy centers—Revised 2010 guidelines. *Epilepsia*, 51: 2322–2333. doi: 10.1111/j.1528-1167.2010.02648.)

Following the NAEC annual meeting, at the request of several centers in rural states a change was made to the guidelines to allow centers in isolated geographic areas to have one rather than two board certified neurologists with expertise in epilepsy to qualify as a level III center as long as all other standards are met.

The Guidelines, first established in 1989 and last updated in 2001, have served as the model for designating levels III and IV epilepsy centers in the US. New to this version is guidance on quality/outcome measures, safety, and an inter-disciplinary team approach. The Guidelines have been endorsed by the American Epilepsy Society.

United Healthcare Request for Information

United Healthcare, a major private insurer in the US, reached out to NAEC this year for information on the use of brand and generic anti-epileptic drugs (AEDs), specifically for divalproex sodium extended release (Depakote® ER), levetiracetam (Keppra®), lamotrigine (Lamictal®), and topiramate (Topamax®), for epilepsy indications. United was reviewing its pharmacy benefit policy for these pharmaceuticals and considering limiting coverage to the

generic equivalents of these medications or requiring that a trial of the generic occur before coverage for the brand would be allowed. NAEC President, Robert J. Gumnit, MD and Vice President, David Labiner, MD met with United officials to discuss the potential for problems when different manufacturer's formulations of generic equivalents are provided to patients with seizure disorders. NAEC provided United current peer-reviewed literature on this topic and responded to United's specific questions. Following these discussions, United Healthcare announced that effective January 1, 2011 for its commercial health plans that it will cover brand as well as generic AEDs when prescribed for seizure disorders. For non-epilepsy indications, United is requiring that a generic be tried first before a brand formulation will be covered. United Healthcare's letter to NAEC and Benefit Plan Information on select AEDs are attached to this report (attachment 1).

United is also interested in better understanding hospital admissions, readmissions and the length of hospital stay for patients with epilepsy and has asked the AAN and NAEC to provide them with evidenced-based practice standards and voluntary guidance to assist them in reviewing hospitalizations and use of technologies such as video EEG. NAEC will continue to provide United information and advocate for adequate coverage and payment for services provided in epilepsy centers.

Institute of Medicine Undertakes Study on Epilepsy

At the request of the Department of Health and Human Services and with the financial support of 11 epilepsy affiliated organizations including NAEC, the Institute of Medicine (IOM) will undertake a study on the public health dimensions of the epilepsies. IOM will convene an ad hoc committee to recommend priorities in public health, healthcare and human services, and health literacy and public awareness for epilepsy and to propose strategies to address these priorities. Importantly, IOM will be looking at what constitutes quality care and what gaps and needs for improvement exists. More information on the study can be found at: <http://www.iom.edu/Activities/Disease/Epilepsy.aspx>

The committee will begin its deliberations in January 2011 and a final report is scheduled to be released in March of 2012. There will be opportunities for NAEC to present testimony to the IOM committee and the Association has offered a site visit so that the panel can better understand the work of specialized centers.

Quality Measures in Epilepsy under Development

For the past several years, NAEC has worked with the AAN and the AES to develop quality measures for epilepsy care. NAEC Board Members, Drs. Nathan Fountain and Paul Van Ness, are chairing the committee overseeing this effort. The measures have been approved by the AAN and the American Medical Association's Physician Consortium for Performance Improvement. They are currently being reviewed by the National Quality Forum (NQF). If approved by NQF the measures will be submitted to the Centers for Medicare and Medicaid Services (CMS) for possible inclusion in the Medicare Physician Quality Reporting Initiative (PQRI), which provides physicians bonus payments when they report quality measures. Importantly, the measures will be integrated into the American Board of Psychiatry and Neurology's Maintenance of Certification program as a module that neurologists can complete to fulfill the requirements of the Board. Participation in the Maintenance of Certification program will be another avenue for neurologists to participate in Medicare's PQRI program and receive bonus payments.

There are eight evidence-based measures under consideration that require documentation:

At an initial visit -

- Electroencephalogram (EEG) Ordered, Reviewed or Requested
- Magnetic Resonance Imaging/Computed Tomography Scan (MRI/CT Scan) Ordered, Reviewed, or Requested

At each visit -

- Documentation of Current Seizure Frequency(ies) of each current seizure type
- Documentation of Epilepsy Etiology or Epilepsy Syndrome
- Querying and Counseling about Anti-Epileptic Drug (AED) Side Effects

At least annually -

- Counseling About Epilepsy Specific Safety Issues
- Counseling for Women of Childbearing Potential with Epilepsy

At least every 3 years-

- Surgical Therapy Referral Consideration for Intractable Epilepsy

2010 US News and World Report's America's Best Hospitals Ranking Released

This summer, the *US News and World Report* released its 2010 rankings of the best hospitals in America. Many NAEC member centers are included among the top neurology and neurosurgical centers. View the rankings on the *US News* website: <http://health.usnews.com/best-hospitals/rankings/neurology-and-neurosurgery>. Since 2004, the NAEC guidelines for adult Level IV epilepsy centers have been part of *US News*' criteria in ranking neurology and neurosurgery departments in U.S. hospitals. This raises national exposure for specialized epilepsy care and also offers many of our members an opportunity to rank among the top 50 neurology and neurosurgery centers in America.

Update on Legislation of Interest to Epilepsy Centers

A summary of the major components of the Patient Protection and Affordable Care Act, (healthcare reform law) can be found on the NAEC website - <http://naec-epilepsy.org/members/documents/NAEChealthreformsummary.pdf>

Update on Medicare Regulations and Federal Epilepsy Programs

2011 Medicare Final Rule on Hospital Inpatient Prospective Payment System (IPPS)

The Centers for Medicare & Medicaid Services (CMS) final Hospital Inpatient Prospective Payment System (IPPS) rule for fiscal year (FY) 2011 has taken effect for discharges occurring on or after October 1, 2010. The update in payment for FY 2011 will be 2.35 percent reflecting an inflation update of 2.6 percent less a 0.25 percent reduction as required by the Affordable Care Act (ACA - the healthcare reform law). An additional adjustment of -2.9% will be applied as a budget neutrality adjustment due to the move from DRGs to MS-DRGs.

There are two DRGs for non-surgical admissions for seizure patients. There is no significant change in the relative weights of DRG 100, Seizures with Major Complications or Comorbidities (MCC) and DRG 101, Seizures without MCC. CMS reports that in 2009 the average length of stay for DRG 100 was 6.0 days and 3.4 days for DRG 101.

NAEC continues to advocate for a separate DRG for patients with intractable epilepsy admitted for video EEG monitoring. To date, the Medicare data for these patients has not shown a

sufficient cost differential to convince CMS to create a new DRG. NAEC continues to urge centers to code for intractability and video EEG monitoring when it applies to patients admitted to the hospital. NAEC's coding guidance for inpatient hospital admissions is attached to this report (attachment 2).

2011 Medicare Final Rule on Hospital Outpatient Prospective Payment System (HOPPS)

On November 24, 2010, the Hospital Outpatient Prospective Payment System (HOPPS) final rule for 2011 was published in the Federal Register. The text of the rule can be found at: <http://edocket.access.gpo.gov/2010/pdf/2010-27926.pdf>. A summary of the rule can be found on the NAEC website. The rule updates payments to hospitals for their facility fees in providing services in the hospital outpatient setting. Payments are made for categories of services known as ambulatory payment classifications (APCs). The update and the other provisions of the rule are effective January 1, 2011.

The HOPPS payment update for 2011 will be 2.35 percent. This reflects a 2.6 percent inflationary increase reduced by 0.25 percent as mandated by the ACA. The full 2.35 percent update only applies to hospitals which successfully reported CMS designated quality measures in 2010. If a hospital did not successfully report these quality measures, the update will be 0.15 percent. A comparison of HOPPS 2010 to 2011 payments for services of interest to epilepsy centers is attached (attachment 3). The APC payments for the hospital's facility fee for almost all epilepsy-related services will increase slightly in 2011.

2011 Medicare Final Rule on the Physician Fee Schedule (PFS)

On November 29, 2010, the Medicare Physician Fee Schedule (PFS) final rule for 2011 was published in the Federal Register. The final rule can be found at: <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>. A complete summary of the final rule can be found on the NAEC website. The rule includes the standard annual fee schedule update, as well as implementation of provisions included in the ACA. Most of the provisions of the rule become effective on January 1, 2011.

At the time of the writing of this report, Congress has passed legislation extending the current conversion factor (CF) of \$36.87 until the end of the year and is working on a bill to prevent the 23% reduction from occurring on January 1, 2011. Even if Congress extends the current CF by preventing the reduction caused by the Sustainable Growth Rate formula, the final rule calls for a rescaling of the relative value unit (RVU) weights (-8.2 %) and a positive budget neutrality adjustment (+ 0.5%) caused by RVU changes, which will reduce the CF in 2011. Both the Administration and the Congress seem supportive of taking action to prevent the SGR-driven reductions from occurring. Assuming that the SGR reductions are prevented by legislation, but the other adjustments in the rule occur, the 2011 CF will be approximately \$34.00. Without congressional action, the CF \$25.52 on January 1, 2011, due to the SGR formula.

Attachment 4 includes several charts providing the 2011 and 2013 RVUs and payment rates for epilepsy-related medical and neurosurgical services and Evaluation and Management (E&M) services. The charts include data on 2013 to show the final year of the phase-in of changes being made to the practice expense components of all CPT codes. These changes are having a positive impact on most services provided in epilepsy centers. A \$34 conversion factor was used to calculate the payment in both 2011 and 2013.

Across the board the RVUs and payment for most neurology and neurosurgery services provided in epilepsy centers are increasing in both 2011 and 2013. Most of the professional component values for neurology services are increasing by approximately 8% in 2011 and by 9 - 11% in 2013. The RVUs for the professional component for EEG with video are increasing by 8.4% in 2011 and by 11.3% in 2013. The RVUs for almost all epilepsy surgery codes are increasing by 12 - 13% in 2011 and on average by 14 - 17% in 2013. The RVUs for the Evaluation and Management codes provided in the hospital setting are increasing by 7 - 8% in 2011 and by another 9 - 12% in 2013.

Medicare Contractor Reform

As required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS is replacing its current claims payment contractors - fiscal intermediaries and carriers - with new contract entities called Medicare Administrative Contractors (MACs). CMS plans to award a total of 19 MAC contracts through three procurement cycles. Fifteen of these contracts will be with entities that will cover the majority of Part A and Part B services. Even though CMS awarded 15 A/B MAC contracts, five contracts still have yet to be finalized. In the jurisdictions listed below as "under evaluation" the local Medicare carrier is still responsible for processing claims and setting local policies.

Status of Transition to MACs (updated November 8, 2010)

The chart below provides an update on the status of the transition to A/B MACs.

A/B MAC Transition Timeline				
MAC	States Covered	Award Date	Status of Transition	Awardee
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands	10/25/2007	Completed	Palmetto GBA
2	Alaska, Idaho, Oregon and Washington	7/21/10	CMS posted a notice cancelling the solicitation	Current FI and carriers will continue services
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming	7/31/2006	Completed	Noridian
4	Colorado, New Mexico, Oklahoma, and Texas	8/03/07	Completed	TrailBlazer
5	Iowa, Kansas, Missouri, and Nebraska	9/5/07	Completed	WSP
6	Illinois, Minnesota, and Wisconsin	1/7/09	Under evaluation	Noridian
7	Arkansas, Louisiana, and Mississippi	7/10/09	Under evaluation	Trailblazer
8	Indiana and Michigan	1/7/09	Under evaluation	National Government Services (NGS)

MAC	States Covered	Award Date	Status of Transition	Awardee
9	Florida, Puerto Rico, and US Virgin Islands	9/12/08	Completed	First Coast Services Options
10	Alabama, Georgia, and Tennessee	1/7/09	Completed	Cahaba Government Benefit Administrators, LLC
11	Northern Carolina, South Carolina, Virginia and West Virginia	5/21/10	Completed	Palmetto Government Benefits Administrators, LLC
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania	10/24/07	Completed	Highmark
13	Connecticut and New York	3/8/08	Completed	National Government Services
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	11/08	Completed	NHIC
15	Kentucky and Ohio	7/8/10	Under evaluation	CIGNA Government Services (CGS)

For additional information, please see:
http://www.cms.gov/MedicareContractingReform/07_PartAandPartBMedicareAdministrativeContractor.aspx#TopOfPage

Recovery Audit Contractors (RAC)

The Recovery Audit Contractor (RAC) program is fully operational in all 50 states and is responsible for identifying overpayments and underpayments for Medicare services. CMS has hired four contractors each responsible for a separate geographic area: Diversified Collection Services, CGI, Connolly Consulting, and Health Data Insights. While potentially anyone who files a claim with Medicare can be audited by a RAC, the RACs will identify specific issues they wish to pursue. These issues must be approved by CMS and posted on the RAC's website before they may proceed with a widespread review. Each of the RACs are currently reviewing hospital admissions under the Seizure DRGs. A chart showing the RAC audits is attached to this document (attachment 5).

On October 1, 2010, CMS issued a [letter](#) to State Medicaid Directors providing guidance on section 6411 of the ACA which expands the Recovery Audit Contractor (RAC) program to Medicaid. States are required to establish contracts with one or more RACs by December 31, 2010 to review services provided under Medicaid plans. Fully implemented Medicaid RAC programs must be complete by April 1, 2011. More information on RACs can be found at: http://www.cms.gov/RAC/03_RecentUpdates.asp#TopOfPage

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

Objectives for 2011

In 2011, 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 actively participate in the IOM study on the Public Health Dimensions of the Epilepsies to see that it addresses issues related to access to specialized services. NAEC will continue to educate United Healthcare and other private insurers regarding admissions to Epilepsy Monitoring Units and the services provided by specialized epilepsy services.

NAEC will also continue its efforts to:

- 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.

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November 11, 2010

PO Box 1327 Johnstown PA 15907-1327

Robert J. Gumnit, M.D.
 President
 National Association of Epilepsy Centers
 5775 Wayzata Boulevard
 Suite 200
 Minneapolis, MN 55416

RE: Changes in coverage for antiepileptic drugs when prescribed for non-seizure indications

Dear Dr. Gumnit:

We had previously written to the National Association of Epilepsy Centers on July 2, 2010 to offer the opportunity to comment on the proposed coverage strategies for the brand antiepileptic agents - divalproex sodium extended-release (Depakote ER[®]), levetiracetam (Keppra[®]), lamotrigine (Lamictal[®]) and topiramate (Topamax[®]). We met with you as well as some of your expert members on April 14th and again on August 30 to discuss our strategy for the four brand antiepileptic agents. We appreciate the written response received and excellent insight and feedback provided during our meetings on the evidence available for brand antiepileptic medications.

Effective January 1, 2011, we will implement a coverage review program for the brand antiepileptics – divalproex sodium extended-release (Depakote ER), levetiracetam (Keppra), lamotrigine (Lamictal) and topiramate (Topamax), and a step therapy type program (Progression Rx) when physicians prescribe these medications for non-epilepsy indications. Our pharmacy benefit designs include step therapy programs that require a member to try a more cost-effective medication before coverage is provided for the higher-cost medication. UnitedHealthcare members with a diagnosis of epilepsy will not be required to participate in a step therapy program; however, we will require a coverage review to establish the diagnosis. We will communicate with physicians prescribing the brands of these medications to inform them about this program and have included a copy of the letter.

We appreciate the opportunity to provide information on our programs and to continue to work with the National Association of Epilepsy Centers as we are developing our clinical pharmacy strategies. If you have any questions, please contact Susan Maddux, via email at susan_v_maddux@uhc.com or by phone at 314-592-7531.

Sincerely,

Susan Maddux, Pharm.D.
 Chief Pharmacy Officer

Richard A. Justman, M.D.
 Chair, National Pharmacy & Therapeutics
 Committee

Doc #: UHC0622b

Please do not reply to this return address. This P.O. Box is used for outbound mail only and we are not able to respond to messages sent to this address. Questions or Comments? Write to us at: UnitedHealthcare, MN012-N108, P.O. Box 1459, Minneapolis, MN 55440-1459.



Benefit Plan Information for Select Medications: Depakote ER, Keppra, Lamictal and Topamax

Program Overview

Effective January 1, 2011, we will implement a coverage review program for brand antiepileptics - Depakote[®] ER (divalproex sodium extended-release), Keppra[®] (levetiracetam), Lamictal[®] (lamotrigine), and Topamax[®] (topiramate), and a step therapy type program (Progression Rx) when physicians prescribe these medications for non-epilepsy indications. This program requires a trial of the generic formulation before obtaining coverage of the brand for non-seizure indications.

Why we are doing this

This "step therapy" program facilitates our ability to offer our customers cost effective access to these important medications while encouraging the use of the U.S. Food and Drug Administration (FDA) approved generic products for these four medications when they are used for non-epilepsy indications. Our National Pharmacy and Therapeutics Committee (P&T Committee) reviewed the list of medications and criteria, including the clinical evidence supporting the use of selected anticonvulsants for non-seizure indications. The P & T Committee concluded that patients may be successfully treated with the generic equivalents of these medications when used for non-seizure indications.

Are generics as good as brand name medications?¹

Many brand medications have generic equivalents available. Generics contain the same active ingredients as brand medications and must meet the same quality standards as brand name medications.

Then why are the brand name products being covered for patients being treated for seizure disorders without a trial of the generic equivalent?

Before implementing this program, we consulted with subject matter experts in the treatment of epilepsy. One of their concerns is the potential for inconsistency in providing the same manufacturer's formulation of the generic product. Therefore, we determined that coverage will be provided for either the brand or generic formulations for the treatment of seizure disorder patients. The treating physician still decides which medication to prescribe.

Are there tiering differences between the four brand and generic medications?

Yes, all four generic medications are Tier 1 medications. All four brand medications are Tier 3 medications. Tier 1 contains the lowest cost tier option for patients while Tier 3 contains the highest cost tier medications.

How does the program work?

If, after an initial treatment trial with the generic, you prescribe the corresponding brand name product your prescription will process without any additional action on your part. Our system will look for a claim for the generic medication within the past six months and, if present, the brand product will be covered.

Brand name products will be covered for patients being treated for seizure disorders without an earlier trial of generic medications. A coverage review will be required to document the epilepsy diagnosis.

¹ Information from <http://www.fda.org>

I am prescribing a brand name product for a seizure disorder. What is the coverage review process?

When a prescription requires a coverage review, the pharmacist will receive an online message with a phone number for the Coverage Review Unit.

The pharmacist will provide this toll-free number to the member and/or the prescribing physician or his/her office. The member, pharmacist, or the physician or his/her office staff can contact the Coverage Review Unit to initiate a coverage review. However, only the physician or his/her office staff can complete the coverage review. If all necessary information is available, the Coverage Review Unit will provide a coverage decision during the call. Brand name medications will be approved when being used for treatment of a seizure disorder. If coverage is approved, the authorization will be entered. A confirmation letter of approval or denial will be sent to both the physician and the member. If the coverage is denied, an explanation of the appeal process will be provided.

If my patient has already received authorization for a brand name medication, do I have to go through this process every time a new prescription is written?

No. An authorization is effective for up to 10 years.

Is there a phone number I can call to request an override?

Yes. You or your office staff can contact the Coverage Review Unit at 1-800-417-1764 to initiate a review. You will be able to provide the information during the call or a fax form with pertinent questions will be sent to your office for completion. If a prescription is needed after your office is closed and your patient is out of the medication, the pharmacy is able to obtain an emergency override by following a standard process.

Are impacted members notified of this program?

Yes. Affected members will be notified of this program information approximately 30 days prior to the effective date.

Does this impact all UnitedHealthcare members?

No, the protocol applies only to UnitedHealthcare commercial members and some affiliated commercial businesses. It does not apply to members in commercial benefit plans insured or administered by PacifiCare or Prescription Solutions. The protocol does not apply to members in Medicare benefit plans administered by SecureHorizons® and Medicare Advantage or Medicaid benefit plans administered by AmeriChoice®.

GUIDANCE FOR ICD-9 CODING FOR HOSPITAL INPATIENT ADMISSIONS

Proper coding is essential to the management of the patient as well as the DRG assignment and eventual payment to the hospital. Hospital Coders follow specific conventions in assigning codes that are based on the documentation in the patient's medical record. The more specific the documentation the better the coder can code for the admission. In addition, proper coding is a data tool that can be used to define patients seen in epilepsy centers and the corresponding high costs of their care. NAEC can use this coding data in making a case for a higher paying DRG for epilepsy center admissions.

Documentation and Coding Guidance –

As of October 1, 2007 there are two epilepsy-related DRGs (Diagnostic Related Groupings), DRG 100 - Seizures with Major Comorbidities and Complications (MCCs) and DRG 101-Seizures without MCCs. MCCs are secondary diagnoses such as ESRD, pneumonia, HIV/AIDs, which result in a much more costly hospital admission. Most admissions for a comprehensive epilepsy evaluation are admitted to DRG 101.

The ICD-9-CM diagnoses codes for Epilepsy and Recurrent Seizures are the series of codes – 345.0X – 345.9X. Except for 345.2 – petite mal seizure and 345.3 – grand mal seizure, the epilepsy codes are subclassified with a fifth digit, which is either 0 indicating the absence of intractability and 1 indicating with intractability. **The fifth digit code always should be used with the 345 epilepsy series of codes. Therefore the physician should always document that the patient's epilepsy is intractable or non-intractable.**

When the type of epilepsy is not clear the code 345.8X - other forms of epilepsy and recurrent seizures code can be used. Documentation for this code can be recurrent seizures, seizure disorder, or epilepsy NEC.

Many centers have raised concerns about coding for patients with psychogenic or non-epileptic seizures. Many coders use the code 300.11 – conversion disorder for these patients, which results in a psychiatric DRG assignment. The coders for the Penn Epilepsy Center sought guidance from the American Hospital Association Coding Clinic (which is designated the official publication for coding guidance) on this issue. **Coding Clinic recommended that the codes 780.39 – other convulsions and 306.8 – other specified psychophysiological malfunction be used when the terms Seizure, Psychogenic or non-epileptic seizures (or spells) are documented.** This will result in the admission being assigned to one of the seizure DRGs (100 or 101).

Few centers are using or are even aware that there are ICD-9-CM codes for the EEG with video procedure (89.19) and Wada test (89.10). These codes currently do not effect DRG assignment, which may be why the hospital coders do not report them. **NAEC recommends that epilepsy centers document when vEEG and Wada are performed and that these services be coded – 89.19 for vEEG and 89.10 for Wada.** While this will not have an immediate impact on payment it will provide NAEC with additional data on the high cost of care provided in an epilepsy center.

**2011 Final Hospital Outpatient Prospective Payment System (HOPPS) Regulations -
Epilepsy-Related APCs**

2011 Final APC	HCPCS	Descriptor	2010 Final Payment Rate	2011 Final Payment Rate	% Change
0209		Level II Extended EEG, Sleep, and Cardiovascular Studies	\$770.55	\$780.77	1.33%
	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			
0213		Level I Extended EEG, Sleep, and Cardiovascular Studies	\$162.06	\$166.64	2.83%
	95800	Slp stdy unattended			
	95801	Slp stdy unatnd w/anal			
	95806	Sleep study unatt&resp efft			
	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			
0216		Level III Nerve and Muscle Tests	\$180.86	\$186.17	2.94%
	92584	Electrocochleography			
	95961	Electrode stimulation, brain			
	95962	Electrode stim, brain add-on			
0218		Level II Nerve and Muscle Tests	\$80.65	\$80.78	0.16%
	95954	EEG monitoring/giving drugs			
	95970	Analyze neurostim, no prog			
0692		Level II Electronic Analysis of Devices	\$107.85	\$110.95	2.87%
	93271	Ecg/monitoring and analysis			
	95971	Analyze neurostim, simple			
	95972	Analyze neurostim, complex			
	95973	Analyze neurostim, complex			
	95974	Cranial neurostim, complex			
	95975	Cranial neurostim, complex			
	95978	Analyze neurostim brain/1h			
	95979	Analyz neurostim brain addon			
	95982	lo ga n-stim subsq w/reprog			
0065		Level I Stereotactic Radiosurgery, MRgFUS, and MEG	\$962.61	\$977.12	1.51%
	95966	Meg, evoked, single			
	95967	Meg, evoked, each addl			
	G0251	Linear acc based stero radio			

**2011 Final Hospital Outpatient Prospective Payment System (HOPPS) Regulations -
Epilepsy-Related APCs**

2011 Final APC	HCPCS	Descriptor	2010 Final Payment Rate	2011 Final Payment Rate	% Change
0067		Level III Stereotactic Radiosurgery, MRgFUS, and MEG	\$3,571.78	\$3,408.69	-4.57%
	0071T	U/s leiomyomata ablate <200			
	0072T	U/s leiomyomata ablate >200			
	95965	Meg, spontaneous			
	G0173	Linear acc stereo radsur com			
	G0339	Robot lin-radsurg com, first			
0039		Level I Implantation of Neurostimulator Generator	\$13,892.45	\$14,743.58	6.13%
	61885	Insrt/redo neurostim 1 array			
0220		Level I Nerve Procedures	\$1,261.84	\$1,317.77	4.43%
	61790	Treat trigeminal nerve			
0221		Level II Nerve Procedures	\$2,512.94	\$2,567.33	2.16%
	61720	Incise skull/brain surgery			
	61770	Incise skull for treatment			
0203		Level IV Nerve Injection	\$892.72	\$881.28	-1.28%
	61791	Treat trigeminal tract			
0315		Level II Implantation of Neurostimulator Generator	\$18,519.10	\$18,850.77	1.79%
	61886	Implant neurostim arrays			
0687		Revision/Removal of Neurostimulator Electrodes	\$1,323.73	\$1,496.15	13.03%
	61880	Revise/remove neuroelectrode			
0688		Revision/Removal of Neurostimulator Pulse Generator Receiver	\$1,932.10	\$2,003.33	3.69%
	61888	Revise/remove neuroreceiver			

2011 Final Physician Fee Schedule (CMS 1503-FC)
 Payment Rates for Medicare Physician Services - Epilepsy

CPT Code	Mod	Descriptor	2010		2011		2013		CHANGE		2010		2011		%		CHANGE	
			Total RVU	% CHANGE 2010-2011	Total RVU	% CHANGE 2010-2011	Total RVU	% CHANGE 2010-2013	2010	2013	2010	2013	2010	2013	2010	2013	2010	2013
*** These codes use the Facility RVU																		
95812		EEG, 41-60 minutes	7.23	28.77%	9.31	28.77%	10.94	51.31%	\$266.57	\$316.54	18.75%	CF= \$36.87	CF = \$34	\$371.96	39.54%			
95812	TC	EEG, 41-60 minutes	5.75	34.09%	7.71	34.09%	9.30	61.74%	\$212.00	\$262.14	23.65%			\$316.20	49.15%			
95812	26	EEG, 41-60 minutes	1.48	8.11%	1.6	8.11%	1.64	10.81%	\$54.57	\$54.40	-0.31%			\$55.76	2.19%			
95813		EEG, over 1 hour	8.67	20.88%	10.48	20.88%	11.63	34.14%	\$319.66	\$356.32	11.47%			\$395.42	23.70%			
95813	TC	EEG, over 1 hour	6.30	26.03%	7.94	26.03%	9.03	43.33%	\$232.28	\$269.96	16.22%			\$307.02	32.18%			
95813	26	EEG, over 1 hour	2.37	7.17%	2.54	7.17%	2.60	9.70%	\$87.38	\$86.36	-1.17%			\$88.40	1.17%			
95816		EEG, awake and drowsy	6.64	29.82%	8.62	29.82%	10.18	53.31%	\$244.82	\$293.08	19.71%			\$346.12	41.38%			
95816	TC	EEG, awake and drowsy	5.15	36.12%	7.01	36.12%	8.53	65.63%	\$189.88	\$238.34	25.52%			\$290.02	52.74%			
95816	26	EEG, awake and drowsy	1.49	8.05%	1.61	8.05%	1.65	10.74%	\$54.94	\$54.74	-0.36%			\$56.10	2.12%			
95819		EEG, awake and asleep	7.26	32.51%	9.62	32.51%	11.64	60.33%	\$267.68	\$327.08	22.19%			\$395.76	47.85%			
95819	TC	EEG, awake and asleep	5.78	38.75%	8.02	38.75%	10.00	73.01%	\$213.11	\$272.68	27.95%			\$340.00	59.54%			
95819	26	EEG, awake and asleep	1.48	8.11%	1.6	8.11%	1.64	10.81%	\$54.57	\$54.40	-0.31%			\$55.76	2.19%			
95822		EEG, coma or sleep only	7.00	28.43%	8.99	28.43%	10.46	49.43%	\$258.09	\$305.66	18.43%			\$355.64	37.80%			
95822	TC	EEG, coma or sleep only	5.52	33.88%	7.39	33.88%	8.82	59.78%	\$203.52	\$251.26	23.46%			\$299.88	47.34%			
95822	26	EEG, coma or sleep only	1.48	8.11%	1.6	8.11%	1.64	10.81%	\$54.57	\$54.40	-0.31%			\$55.76	2.19%			
95824		EEG, cerebral death only	1.04	7.69%	1.12	7.69%	1.14	9.62%	\$38.34	\$38.08	-0.69%			\$38.76	1.08%			
95827		EEG, all night recording	12.36	33.66%	16.52	33.66%	20.57	66.42%	\$455.71	\$561.68	23.25%			\$699.38	53.47%			
95827	TC	EEG, all night recording	10.87	37.26%	14.92	37.26%	18.91	73.97%	\$400.78	\$507.28	26.57%			\$642.94	60.42%			
95827	26	EEG, all night recording	1.49	7.38%	1.6	7.38%	1.66	11.41%	\$54.94	\$54.40	-0.98%			\$56.44	2.74%			
95829		Surgery electrocorticogram	35.53	24.18%	44.12	24.18%	49.07	38.11%	\$1,309.99	\$1,500.08	14.51%			\$1,668.38	27.36%			
95829	TC	Surgery electrocorticogram	27.05	29.43%	35.01	29.43%	39.70	46.77%	\$997.33	\$1,190.34	19.35%			\$1,349.80	35.34%			
95829	26	Surgery electrocorticogram	8.48	7.43%	9.11	7.43%	9.37	10.50%	\$312.66	\$309.74	-0.93%			\$318.58	1.89%			
95830	Hospital***	Insert electrodes for EEG	2.37	7.59%	2.55	7.59%	2.59	9.28%	\$87.38	\$86.70	-0.78%			\$88.06	0.78%			
95830	Office	Insert electrodes for EEG	5.05	11.49%	5.63	11.49%	5.71	13.07%	\$186.19	\$191.42	2.81%			\$194.14	4.27%			
95950		Ambulatory eeg monitoring	6.78	17.85%	7.99	17.85%	8.74	28.91%	\$249.98	\$271.66	8.67%			\$297.16	18.87%			
95950	TC	Ambulatory eeg monitoring	4.70	22.13%	5.74	22.13%	6.43	36.81%	\$173.29	\$195.16	12.62%			\$218.62	26.16%			
95950	26	Ambulatory eeg monitoring	2.08	8.17%	2.25	8.17%	2.31	11.06%	\$76.69	\$76.50	-0.25%			\$78.54	2.41%			
95951		EEG monitoring/videorecord	8.43	8.42%	9.14	8.42%	9.38	11.27%	\$310.81	\$310.76	-0.02%			\$318.92	2.61%			
95953		EEG monitoring/computer	11.50	6.00%	12.19	6.00%	12.31	7.04%	\$424.01	\$414.46	-2.25%			\$418.54	-1.29%			
95953	TC	EEG monitoring/computer	6.95	8.78%	7.56	8.78%	7.58	9.06%	\$256.25	\$257.04	0.31%			\$257.72	0.58%			
95953	26	EEG monitoring/computer	4.55	1.76%	4.63	1.76%	4.73	3.96%	\$167.76	\$157.42	-6.16%			\$160.82	-4.14%			
95954		EEG monitoring/giving drugs	7.23	26.56%	9.15	26.56%	10.60	46.61%	\$266.57	\$311.10	16.70%			\$360.40	35.20%			

CPT Code	Mod	Descriptor	2010		2011		% CHANGE		2013		CHANGE		2010-2013	
			Total RVU	Total RVU	Total RVU	Total RVU	2010-2011	2011-2013	Total RVU	Total RVU	2010-2011	2011-2013	2010-2011	2011-2013
95954	TC	EEG monitoring/giving drugs	4.11	5.8	41.12%	7.15	73.97%	CF = \$36.87	\$151.54	\$197.20	30.13%	\$243.10	60.42%	
95954	26	EEG monitoring/giving drugs	3.12	3.35	7.37%	3.45	10.58%		\$115.03	\$113.90	-0.99%	\$117.30	1.97%	
95955		EEG during surgery	3.94	4.96	25.89%	5.69	44.42%		\$145.27	\$168.64	16.09%	\$193.46	33.17%	
95955	TC	EEG during surgery	2.57	3.48	35.41%	4.16	61.87%		\$94.76	\$118.32	24.87%	\$141.44	49.27%	
95955	26	EEG during surgery	1.37	1.48	8.03%	1.53	11.68%		\$50.51	\$50.32	-0.38%	\$52.02	2.99%	
95956		EEG monitoring, cable/radio	19.89	29.82	49.92%	36.13	81.65%		\$733.34	\$1,013.88	38.25%	\$1,228.42	67.51%	
95956	TC	EEG monitoring, cable/radio	15.65	24.6	57.19%	30.70	96.17%		\$577.02	\$836.40	44.95%	\$1,043.80	80.90%	
95956	26	EEG monitoring, cable/radio	4.24	5.22	23.11%	5.43	28.07%		\$156.33	\$177.48	13.53%	\$184.62	18.10%	
95957		EEG digital analysis	7.84	10.01	27.68%	11.84	51.02%		\$289.06	\$340.34	17.74%	\$402.56	39.26%	
95957	TC	EEG digital analysis	5.10	7.05	38.24%	8.81	72.75%		\$188.04	\$239.70	27.47%	\$299.54	59.30%	
95957	26	EEG digital analysis	2.74	2.96	8.03%	3.03	10.58%		\$101.02	\$100.64	-0.38%	\$103.02	1.98%	
95958		EEG monitoring/function test	11.14	13.39	20.20%	14.98	34.47%		\$410.73	\$455.26	10.84%	\$509.32	24.00%	
95958	TC	EEG monitoring/function test	5.27	7.08	34.35%	8.55	62.24%		\$194.30	\$240.72	23.89%	\$290.70	49.61%	
95958	26	EEG monitoring/function test	5.87	6.31	7.50%	6.43	9.54%		\$216.43	\$214.54	-0.87%	\$218.62	1.01%	
95961		Electrode stimulation, brain	6.34	7.41	16.88%	8.12	28.08%		\$233.76	\$251.94	7.78%	\$276.08	18.11%	
95961	TC	Electrode stimulation, brain	2.19	2.93	33.79%	3.53	61.19%		\$80.75	\$99.62	23.38%	\$120.02	48.64%	
95961	26	Electrode stimulation, brain	4.15	4.48	7.95%	4.59	10.60%		\$153.01	\$152.32	-0.45%	\$156.06	1.99%	
95962		Electrode stim, brain add-on	5.84	6.67	14.21%	7.14	22.26%		\$215.32	\$226.78	5.32%	\$242.76	12.74%	
95962	TC	Electrode stim, brain add-on	1.41	1.88	33.33%	2.21	56.74%		\$51.99	\$63.92	22.95%	\$75.14	44.54%	
95962	26	Electrode stim, brain add-on	4.43	4.79	8.13%	4.93	11.29%		\$163.33	\$162.86	-0.29%	\$167.62	2.62%	
95965	26	MEG, spontaneous	11.44	12.34	7.87%	12.53	9.53%		\$421.79	\$419.56	-0.53%	\$426.02	1.00%	
95966	26	MEG, evoked, single	5.72	6.16	7.69%	6.25	9.27%		\$210.90	\$209.44	-0.69%	\$212.50	0.76%	
95967	26	MEG, evoked, each addl	4.93	5.34	8.32%	5.48	11.16%		\$181.77	\$181.56	-0.12%	\$186.32	2.50%	
95970	Hospital****	Analyze neurostim, no prog	0.62	0.68	9.68%	0.70	12.90%		\$22.86	\$23.12	1.14%	\$23.80	4.11%	
95970	Office	Analyze neurostim, no prog	1.45	1.74	20.00%	1.90	31.03%		\$53.46	\$59.16	10.66%	\$64.60	20.83%	
95971	Hospital****	Analyze neurostim, simple	1.10	1.18	7.27%	1.19	8.18%		\$40.56	\$40.12	-1.08%	\$40.46	-0.24%	
95971	Office	Analyze neurostim, simple	1.55	1.7	9.68%	1.67	7.74%		\$57.15	\$57.80	1.14%	\$56.78	-0.64%	
95972	Hospital****	Analyze neurostim, complex	2.10	2.28	8.57%	2.34	11.43%		\$77.43	\$77.52	0.12%	\$79.56	2.75%	
95972	Office	Analyze neurostim, complex	2.81	3.13	11.39%	3.20	13.88%		\$103.60	\$106.42	2.72%	\$108.80	5.01%	
95973	Hospital****	Analyze neurostim, complex	1.27	1.39	9.45%	1.46	14.96%		\$46.82	\$47.26	0.93%	\$49.64	6.01%	
95973	Office	Analyze neurostim, complex	1.57	1.76	12.10%	1.86	18.47%		\$57.89	\$59.84	3.38%	\$63.24	9.25%	
95974	Hospital****	Cranial neurostim, complex	4.19	4.55	8.59%	4.67	11.46%		\$154.49	\$154.70	0.14%	\$158.78	2.78%	
95974	Office	Cranial neurostim, complex	4.86	5.45	12.14%	5.76	18.52%		\$179.19	\$185.30	3.41%	\$195.84	9.29%	
95975	Hospital****	Cranial neurostim, complex	2.38	2.57	7.98%	2.65	11.34%		\$87.75	\$87.38	-0.42%	\$90.10	2.68%	
95975	Office	Cranial neurostim, complex	2.64	2.94	11.36%	3.10	17.42%		\$97.34	\$99.96	2.69%	\$105.40	8.28%	

2011 Final Physician Fee Schedule (CMS 1503-FC)

Payment Rates for Medicare Physician Services - Epilepsy Surgery

CPT Code	Descriptor	2010		2011		% CHANGE 2010-2011		2013		% CHANGE 2010-2013		2010		2011		% CHANGE 2010-2011		2013		% CHANGE 2010-2013	
		Total RVU		Total RVU		%	CF=	Total RVU		%	CF=	Total RVU		%	CF=	Total RVU		%	CF=	Total RVU	
61531	Implant brain electrodes	31.62		35.75	13.06%	36.48	15.37%	\$1,165.83	\$1,215.50	4.26%	\$1,240.32	6.39%	\$36.87	\$1,165.83	\$1,215.50	4.26%	\$1,240.32	6.39%	\$1,240.32	\$1,240.32	6.39%
61537	Removal of brain tissue	64.25		72.32	12.56%	74.05	15.25%	\$2,368.90	\$2,458.88	3.80%	\$2,517.70	6.28%	\$2,368.90	\$2,458.88	3.80%	\$2,517.70	6.28%	\$2,517.70	\$2,517.70	6.28%	
61538	Removal of brain tissue	69.31		78.23	12.87%	80.24	15.77%	\$2,555.46	\$2,659.82	4.08%	\$2,728.16	6.76%	\$2,555.46	\$2,659.82	4.08%	\$2,728.16	6.76%	\$2,728.16	\$2,728.16	6.76%	
61539	Removal of brain tissue	61.77		69.46	12.45%	70.85	14.70%	\$2,277.46	\$2,361.64	3.70%	\$2,408.90	5.77%	\$2,277.46	\$2,361.64	3.70%	\$2,408.90	5.77%	\$2,408.90	\$2,408.90	5.77%	
61540	Removal of brain tissue	57.33		64.42	12.37%	65.48	14.22%	\$2,113.76	\$2,190.28	3.62%	\$2,226.32	5.33%	\$2,113.76	\$2,190.28	3.62%	\$2,226.32	5.33%	\$2,226.32	\$2,226.32	5.33%	
61541	Incision of brain tissue	56.25		63.25	12.44%	64.44	14.56%	\$2,073.94	\$2,150.50	3.69%	\$2,190.96	5.64%	\$2,073.94	\$2,150.50	3.69%	\$2,190.96	5.64%	\$2,190.96	\$2,190.96	5.64%	
61542	Removal of brain tissue	60.19		66	9.65%	65.51	8.84%	\$2,219.21	\$2,244.00	1.12%	\$2,227.34	0.37%	\$2,219.21	\$2,244.00	1.12%	\$2,227.34	0.37%	\$2,227.34	\$2,227.34	0.37%	
61543	Removal of brain tissue	56.51		63.65	12.63%	65.14	15.27%	\$2,083.52	\$2,164.10	3.87%	\$2,214.76	6.30%	\$2,083.52	\$2,164.10	3.87%	\$2,214.76	6.30%	\$2,214.76	\$2,214.76	6.30%	
61566	Removal of brain tissue	59.21		66.45	12.23%	67.42	13.87%	\$2,183.07	\$2,259.30	3.49%	\$2,292.28	5.00%	\$2,183.07	\$2,259.30	3.49%	\$2,292.28	5.00%	\$2,292.28	\$2,292.28	5.00%	
61567	Incision of brain tissue	67.60		75.86	12.22%	76.90	13.76%	\$2,492.41	\$2,579.24	3.48%	\$2,614.60	4.90%	\$2,492.41	\$2,579.24	3.48%	\$2,614.60	4.90%	\$2,614.60	\$2,614.60	4.90%	
61720	Incise skull/brain surgery	32.10		36.51	13.74%	37.98	18.32%	\$1,183.53	\$1,241.34	4.88%	\$1,291.32	9.11%	\$1,183.53	\$1,241.34	4.88%	\$1,291.32	9.11%	\$1,291.32	\$1,291.32	9.11%	
61735	Incise skull/brain surgery	40.12		44.51	10.94%	45.36	13.06%	\$1,479.22	\$1,513.34	2.31%	\$1,542.24	4.26%	\$1,479.22	\$1,513.34	2.31%	\$1,542.24	4.26%	\$1,542.24	\$1,542.24	4.26%	
61750	Incise skull/brain biopsy	36.71		41.32	12.56%	42.08	14.63%	\$1,353.50	\$1,404.88	3.80%	\$1,430.72	5.71%	\$1,353.50	\$1,404.88	3.80%	\$1,430.72	5.71%	\$1,430.72	\$1,430.72	5.71%	
61751	Brain biopsy w/ct/mr guide	35.73		40.31	12.82%	41.04	14.86%	\$1,317.37	\$1,370.54	4.04%	\$1,395.36	5.92%	\$1,317.37	\$1,370.54	4.04%	\$1,395.36	5.92%	\$1,395.36	\$1,395.36	5.92%	
61760	Implant brain electrodes	40.68		45.99	13.05%	47.33	16.35%	\$1,499.87	\$1,563.66	4.25%	\$1,609.22	7.29%	\$1,499.87	\$1,563.66	4.25%	\$1,609.22	7.29%	\$1,609.22	\$1,609.22	7.29%	
61770	Incise skull for treatment	41.46		47.03	13.43%	48.54	17.08%	\$1,528.63	\$1,599.02	4.60%	\$1,650.36	7.96%	\$1,528.63	\$1,599.02	4.60%	\$1,650.36	7.96%	\$1,650.36	\$1,650.36	7.96%	
61790	Treat trigeminal nerve	22.28		25.32	13.64%	26.10	17.15%	\$821.46	\$860.88	4.80%	\$887.40	8.03%	\$821.46	\$860.88	4.80%	\$887.40	8.03%	\$887.40	\$887.40	8.03%	
61791	Treat trigeminal tract	28.68		32.53	13.42%	33.27	16.00%	\$1,057.43	\$1,106.02	4.59%	\$1,131.18	6.97%	\$1,057.43	\$1,106.02	4.59%	\$1,131.18	6.97%	\$1,131.18	\$1,131.18	6.97%	
61795	Brain surgery using computer	6.55	Discontinued		NA	NA	NA	\$241.50	NA	NA	NA	NA	\$241.50	NA	NA	NA	NA	NA	NA	NA	NA
61796	Srs, cranial lesion simple	24.82		28.49	14.79%	29.95	20.67%	\$915.11	\$968.66	5.85%	\$1,018.30	11.28%	\$915.11	\$968.66	5.85%	\$1,018.30	11.28%	\$1,018.30	\$1,018.30	11.28%	
61797	Srs, cran les simple, addl	5.74		6.43	12.02%	6.57	14.46%	\$211.63	\$218.62	3.30%	\$223.38	5.55%	\$211.63	\$218.62	3.30%	\$223.38	5.55%	\$223.38	\$223.38	5.55%	
61798	Srs, cranial lesion complex	32.86		38.05	15.79%	41.13	25.17%	\$1,211.55	\$1,293.70	6.78%	\$1,398.42	15.42%	\$1,211.55	\$1,293.70	6.78%	\$1,398.42	15.42%	\$1,398.42	\$1,398.42	15.42%	
61799	Srs, cran les complex, addl	7.93		8.88	11.98%	9.08	14.50%	\$292.38	\$301.92	3.26%	\$308.72	5.59%	\$292.38	\$301.92	3.26%	\$308.72	5.59%	\$308.72	\$308.72	5.59%	
61800	Apply srs headframe add-on	3.95		4.46	12.91%	4.56	15.44%	\$145.64	\$151.64	4.12%	\$155.04	6.46%	\$145.64	\$151.64	4.12%	\$155.04	6.46%	\$155.04	\$155.04	6.46%	
61867	Implant neuroelectrode	60.01		67.37	12.26%	68.45	14.06%	\$2,212.57	\$2,290.58	3.53%	\$2,327.30	5.19%	\$2,212.57	\$2,290.58	3.53%	\$2,327.30	5.19%	\$2,327.30	\$2,327.30	5.19%	
61868	Implant neuroelectrde, add'l	13.48		15.01	11.35%	15.16	12.46%	\$497.01	\$510.34	2.68%	\$515.44	3.71%	\$497.01	\$510.34	2.68%	\$515.44	3.71%	\$515.44	\$515.44	3.71%	
61870	Implant neuroelectrodes	30.95		34.85	12.60%	35.38	14.31%	\$1,141.13	\$1,184.90	3.84%	\$1,202.92	5.42%	\$1,141.13	\$1,184.90	3.84%	\$1,202.92	5.42%	\$1,202.92	\$1,202.92	5.42%	
61875	Implant neuroelectrodes	26.57		30.17	13.55%	30.88	16.22%	\$979.64	\$1,025.78	4.71%	\$1,049.92	7.17%	\$979.64	\$1,025.78	4.71%	\$1,049.92	7.17%	\$1,049.92	\$1,049.92	7.17%	
61880	Revise/remove neuroelectrode	14.34		16.36	14.09%	16.85	17.50%	\$528.72	\$556.24	5.21%	\$572.90	8.36%	\$528.72	\$556.24	5.21%	\$572.90	8.36%	\$572.90	\$572.90	8.36%	
61885	Insrt/redo neurostim 1 array	16.78		15.93	-5.07%	15.33	-8.64%	\$618.68	\$541.62	-12.46%	\$521.22	-15.75%	\$618.68	\$541.62	-12.46%	\$521.22	-15.75%	\$521.22	\$521.22	-15.75%	
61886	Implant neurostim arrays	21.26		24.33	14.44%	25.04	17.78%	\$783.86	\$827.22	5.53%	\$851.36	8.61%	\$783.86	\$827.22	5.53%	\$851.36	8.61%	\$851.36	\$851.36	8.61%	
61888	Revise/remove neuroreceiver	10.19		11.48	12.66%	11.62	14.03%	\$375.71	\$390.32	3.89%	\$395.08	5.16%	\$375.71	\$390.32	3.89%	\$395.08	5.16%	\$395.08	\$395.08	5.16%	
63620	Srs, spinal lesion	27.09		31.11	14.84%	32.96	21.67%	\$998.81	\$1,057.74	5.90%	\$1,120.64	12.20%	\$998.81	\$1,057.74	5.90%	\$1,120.64	12.20%	\$1,120.64	\$1,120.64	12.20%	

2011 Final Physician Fee Schedule (CMS 1503-FC)

Payment Rates for Medicare Physician Services - Evaluation & Management Services - Facility

CPT Code	Descriptor	2010		2011		% CHANGE 2010-2011		2013		2010		2011		% CHANGE 2010-2011		2013		% CHANGE 2010-2013	
		Total Facility RVU	% CHANGE 2010-2011	Total Facility RVU	% CHANGE 2010-2011	Total Facility RVU	% CHANGE 2010-2013	CF=	% CHANGE 2010-2011	Total Facility RVU	% CHANGE 2010-2013	CF=	% CHANGE 2010-2011	Total Facility RVU	% CHANGE 2010-2013	CF = \$34	% CHANGE 2010-2011		Total Facility RVU
<i>Evaluation and Management Services</i>																			
99201	Office/outpatient visit, new	0.69	9.21%	0.76	9.21%	0.78	13.04%	\$25.51	1.28%	\$25.84	\$36.87	\$25.84	1.28%	\$26.52	3.96%	\$26.52	3.96%	\$26.52	3.96%
99202	Office/outpatient visit, new	1.33	7.64%	1.44	7.64%	1.49	12.03%	\$49.17	-0.43%	\$48.96	\$36.87	\$48.96	-0.43%	\$50.66	3.03%	\$50.66	3.03%	\$50.66	3.03%
99203	Office/outpatient visit, new	2.02	8.18%	2.2	8.18%	2.28	12.87%	\$74.68	0.16%	\$74.80	\$36.87	\$74.80	0.16%	\$77.52	3.80%	\$77.52	3.80%	\$77.52	3.80%
99204	Office/outpatient visit, new	3.42	8.06%	3.72	8.06%	3.87	13.16%	\$126.44	0.03%	\$126.48	\$36.87	\$126.48	0.03%	\$131.58	4.07%	\$131.58	4.07%	\$131.58	4.07%
99205	Office/outpatient visit, new	4.41	7.74%	4.78	7.74%	4.94	12.02%	\$163.04	-0.32%	\$162.52	\$36.87	\$162.52	-0.32%	\$167.96	3.02%	\$167.96	3.02%	\$167.96	3.02%
99211	Office/outpatient visit, est	0.25	7.41%	0.27	7.41%	0.27	8.00%	\$9.24	-0.68%	\$9.18	\$36.87	\$9.18	-0.68%	\$9.18	-0.68%	\$9.18	-0.68%	\$9.18	-0.68%
99212	Office/outpatient visit, est	0.68	8.11%	0.74	8.11%	0.76	11.76%	\$25.14	0.08%	\$25.16	\$36.87	\$25.16	0.08%	\$25.84	2.79%	\$25.84	2.79%	\$25.84	2.79%
99213	Office/outpatient visit, est	1.34	8.22%	1.46	8.22%	1.51	12.69%	\$49.54	0.20%	\$49.64	\$36.87	\$49.64	0.20%	\$51.34	3.63%	\$51.34	3.63%	\$51.34	3.63%
99214	Office/outpatient visit, est	2.06	7.62%	2.23	7.62%	2.31	12.14%	\$76.16	-0.45%	\$75.82	\$36.87	\$75.82	-0.45%	\$78.54	3.13%	\$78.54	3.13%	\$78.54	3.13%
99215	Office/outpatient visit, est	2.91	7.62%	3.15	7.62%	3.25	11.68%	\$107.58	-0.45%	\$107.10	\$36.87	\$107.10	-0.45%	\$110.50	2.71%	\$110.50	2.71%	\$110.50	2.71%
99221	Initial hospital care	2.64	7.69%	2.86	7.69%	2.96	12.12%	\$97.60	-0.37%	\$97.24	\$36.87	\$97.24	-0.37%	\$100.64	3.11%	\$100.64	3.11%	\$100.64	3.11%
99222	Initial hospital care	3.58	7.97%	3.89	7.97%	4.04	12.85%	\$132.35	-0.07%	\$132.26	\$36.87	\$132.26	-0.07%	\$137.36	3.78%	\$137.36	3.78%	\$137.36	3.78%
99223	Initial hospital care	5.27	7.71%	5.71	7.71%	5.93	12.52%	\$194.83	-0.36%	\$194.14	\$36.87	\$194.14	-0.36%	\$201.62	3.48%	\$201.62	3.48%	\$201.62	3.48%
99231	Subsequent hospital care	1.05	7.08%	1.13	7.08%	1.15	9.52%	\$38.82	-1.04%	\$38.42	\$36.87	\$38.42	-1.04%	\$39.10	0.73%	\$39.10	0.73%	\$39.10	0.73%
99232	Subsequent hospital care	1.90	7.32%	2.05	7.32%	2.11	11.05%	\$70.24	-0.78%	\$69.70	\$36.87	\$69.70	-0.78%	\$71.74	2.13%	\$71.74	2.13%	\$71.74	2.13%
99233	Subsequent hospital care	2.73	7.14%	2.94	7.14%	3.02	10.62%	\$100.93	-0.97%	\$99.96	\$36.87	\$99.96	-0.97%	\$102.68	1.74%	\$102.68	1.74%	\$102.68	1.74%
99291	Critical care, first hour	5.99	6.41%	6.4	6.41%	6.52	8.85%	\$221.45	-1.77%	\$217.60	\$36.87	\$217.60	-1.77%	\$221.68	0.10%	\$221.68	0.10%	\$221.68	0.10%
99292	Critical care, add'l 30 min	3.00	6.54%	3.21	6.54%	3.27	9.00%	\$110.91	-1.62%	\$109.14	\$36.87	\$109.14	-1.62%	\$111.18	0.24%	\$111.18	0.24%	\$111.18	0.24%
99471	Ped critical care, initial	21.37	6.35%	22.82	6.35%	23.27	8.89%	\$790.05	-1.83%	\$775.88	\$36.87	\$775.88	-1.83%	\$791.18	0.14%	\$791.18	0.14%	\$791.18	0.14%
99472	Ped critical care, subseq	10.72	6.62%	11.48	6.62%	11.76	9.70%	\$396.32	-1.54%	\$390.32	\$36.87	\$390.32	-1.54%	\$399.84	0.89%	\$399.84	0.89%	\$399.84	0.89%

NEUROLOGY-RELATED APPROVED ISSUES FOR THE MEDICARE RECOVERY AUDIT CONTRACTORS (RAC) PROGRAM

Contractor/Region	Issue	Issue Description	Type of Review	States Affected	Providers Affected	Dates of Services
DCS/Region A	MS-DRG Validation for Seizures (At this time, medical necessity is excluded from review)	MS-DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS-DRGs 100, 101; principal diagnosis, secondary diagnosis and procedures that affect or can potentially affect the MS-DRG.	DRG Validation	CT, DC, DE, MA, ME, NH, NJ, NY, PA, RI, VT	Inpatient Hospitals	October 1, 2007 - Present
CGI/Region B	Nervous System Disorders MS-DRG 052, 053, 054, 055, 056, 057, 058, 059, 060, 061, 062, 063, 067, 068, 069, 070, 071, 072, 073, 074, 077, 078, 079, 080, 081, 082, 083, 084, 085, 086, 088, 089, 090, 091, 092, 093, 097, 098, 099, 101, 102 (Medical Necessity Excluded except for MS-DRG 056, 057 and 069)	MS-DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded on the hospital claim, matches both the attending physician description and the information contained in the medical record. Reviewers will validate MS-DRGs 052, 053, 054, 055, 056, 057, 058, 059, 060, 061, 062, 063, 067, 068, 069, 070, 071, 072, 073, 074, 077, 078, 079, 080, 081, 082, 083, 084, 085, 086, 088, 089, 090, 091, 092, 093, 097, 098, 099, 101 and 102 for diagnoses and procedures affecting the MS-DRG assignment.	Overpayment and Underpayment	IL, IN, KY, MI, MN, OH, WI	Inpatient	October 1, 2007 - Present
CGI/Region B	Seizures MS-DRGs 100, 101 (At this time, Medical Necessity is excluded from review)	The purpose of MS-DRG Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as CCs and MCCs are actually present, correctly sequenced, and coded. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnosis identified should represent all (MCC/CC) present during the admission that impact the stay. The POA indicator for all diagnoses reported must be coded correctly. Reviewers will validate for MS-DRG 100, 101 principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.	Overpayment and Underpayment	IL, IN, KY, MI, MN, OH, WI		October 1, 2007 - Present
Connolly/ Region C	Seizures MS-DRG 100 & 101 (At this time, Medical Necessity is excluded from review)	DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.		AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VI, VA, WV	Inpatient	October 1, 2007 - Present
Connolly/ Region C	Medical Necessity: Acute Inpatient Admission Neurological Disorders	RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly.		AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VI, VA, WV	Inpatient	October 1, 2007 - Present
HDI/Region D	DRG Validation-Nervous System Disorders	DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 052 thru 074, 077 thru 086, 088 thru 093 and 097 thru 103, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs. (Effective August 16, 2010, Medical Necessity Review may be performed for MS DRG #s 056, 057 and 069 only.)		AB MACs Fls	Inpatient	October 1, 2007 - Present