NATIONAL ASSOCIATION OF EPILEPSY CENTERS
NAEC

PRESIDENT'S REPORT – 2009

The debate over comprehensive health reform has dominated activity in Washington this year, as Congress and the Obama administration have been working on legislation to cover the millions of Americans who are uninsured while lowering health care costs and improving the quality of health care. Media accounts and the public debate have focused on contentious issues such as whether there should be a public, government-run insurance option, whether individuals and employers should be mandated to buy insurance, and how revenues should be raised to finance health reforms. However, there are also many issues on which the various health bills and even the political parties agree. These issues include reforms to the private insurance market, expanding Medicaid, and the creation of exchanges through which people can compare insurance plans and if eligible, receive tax credits to enable them to purchase insurance. To slow the growth in Medicare spending and help finance the costs of other reforms, significant reductions to various Medicare providers are included in the health reform bills. Medicare's managed care program (Medicare Advantage), home health program, imaging services, and drug payments are taking the biggest hits in the bills, but hospitals and other non-physician providers will also see reductions in their annual updates. There is a great deal of consensus around developing and testing new payment and delivery system models such as Accountable Care Organizations and patient-centered medical homes and enhancing quality performance programs for all Medicare providers. Finally, the bills invest in public health improvements with an increased focus on disease prevention and wellness and maintaining a diverse and competent workforce.

Reforming the flawed formula that determines the annual update in Medicare payments for physician services continues to be a major debate in Congress. Whether Congress has the votes to repeal the current formula known as the sustainable growth rate (SGR) is still unclear. The repeal is estimated to cost $210 billion over 10 years. Since action is needed before January 1, 2010 or a 21% reduction in fees will occur, Congress will likely enact a one year or shorter term extension of current payments. This would not preclude eliminating the SGR as part of health reform or in separate legislation in 2010.

NAEC will continue to closely follow the development of health reform and other Medicare and health legislation and work with other organizations including the American Academy of Neurology and the Epilepsy Foundation to see that the unique needs of individuals with epilepsy are addressed. This report outlines NAEC's activities for the past year and lays out an agenda for 2010. 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 2009

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.

Revisions to NAEC Guidelines

Over the past year NAEC has focused its efforts on revising its "Guidelines for Essential Services, Personnel, and Facilities in Specialized Epilepsy Centers." A committee chaired by David Labiner, MD and composed of Drs. Nathan Fountain, Susan Herman, Ted Walczak, and Anto Bagic was established to spearhead this effort. 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 an inter-disciplinary team approach. The draft guidelines will be presented to the membership at its 2009 annual meeting and should be finalized in 2010.

Quality Measures in Epilepsy under Development

For the past year, NAEC has joined the American Academy of Neurology and the American Epilepsy Society in developing quality measures for epilepsy care. NAEC Board Members, Drs. Nathan Fountain and Paul Van Ness, are chairing the committee overseeing this effort. The measures are being developed using the American Medical Association's Physician Consortium for Performance Improvement model. Once approved by the Centers for Medicare and Medicaid Services (CMS), the measures will be included in the Medicare Physician Quality Reporting Initiative (PQRI), which provides physicians bonus payments when they report quality measures. NAEC will disseminate the quality measures once they are approved by CMS.

The AAN/NAEC/AES committee recommended eight evidence-based measures which are currently under consideration:

- Documentation of Etiology of Seizure Type(s) and Current Seizure Frequency(ies);
- Documentation of Epilepsy Etiology or Epilepsy Syndrome;
- Electroencephalogram (EEG) Ordered, Reviewed or Requested;
- Magnetic Resonance Imaging/Computed Tomography Scan (MRI/CT Scan) Ordered, Reviewed, or Requested;
- Querying and Counseling about Anti-Epileptic Drug (AED) Side Effects;
- Surgical Therapy Referral Consideration for Intractable Epilepsy;
- Counseling About Epilepsy Specific Safety Issues;

- Counseling for Women of Childbearing Potential with Epilepsy.

ICD-9-CM and ICD-10-CM Diagnosis Coding/Terminology Revisions

In response to NAEC and AAN's request, CMS and the Centers for Disease Control and Prevention (CDC) added several terms to ICD-9-CM to describe intractability in order to assist coders on when to use the fifth digit for intractability. The terms, pharmacoresistant (pharmacologically resistant), treatment resistant, refractory (medically) and poorly controlled, were included in the manual as of October 1, 2009.

Also, NAEC, in tandem with AAN, provided comments to CMS and CDC on the epilepsy and recurrent seizures section of the current draft of ICD-10-CM which will take effect in 2013. These recommendations dealt with appropriate coding for specific types of epilepsy syndromes. A major change in diagnoses coding in ICD-10-CM will be the addition of a fifth digit for status epilepticus.

Ambulatory EEG Monitoring Codes (95950, 95953, 95956) Revised and Revalued

In 2009, CMS identified services with a growth in utilization exceeding 10% over the past three years and asked the AMA Relative Value Update Committee (RUC) to determine whether these services should be revalued. CPT Code 95956 – EEG monitoring with cable or radio for 24 hours – was included on this list. In an effort to not have the codes resurveyed, NAEC and AAN submitted comments to CMS 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 in a coma that may be caused by seizures. In the comments NAEC and AAN raised concerns that some of the growth in Medicare claims could be due to the inappropriate reporting of Code 95956 when in actuality Code 95953 is being performed.

Because CMS had identified 95956 as a high growth code and it had not been valued by the RUC before the Committee asked that the three ambulatory EEG monitoring codes – 95950, 95953, 95956 - be surveyed and presented at its Fall meeting in 2010. Thanks goes to the many NAEC member physicians for completing the surveys used to set values for the new codes. Marianna Spanaki, MD with the Henry Ford Hospital Comprehensive Epilepsy Center and Susan Herman, MD with BIDMC Comprehensive Epilepsy Program presented the codes to the RUC. While the RUC has voted on the new values, they will not be made public until the final Medicare Physician Fee Schedule Rule is published and will take effect as of January 1, 2010.

In addition the AAN has recommended that the terminology for CPT Codes 95953 and 95956 be revised to specify that 95953 is an unattended code and 95956 is attended by a technologist or nurse. AAN was also asked by the CPT Editorial Panel to revise the explanation in the CPT manual for codes that specify 24 hours of recording. Working in consultation with NAEC, AAN submitted the following recommendations:

- **Codes 95950 – 95953 and 95956** use codes without a modifier for monitoring for more than 12 hours.
- **Codes 95951 and 95956** use modifier 52 with the codes for 6 – 12 hours and use Code 95813 for less than 6 hours.
- **Codes 95950 and 95953** use 95999 for monitoring for less than 12 hours.

These terminology changes will be included in the 2011 CPT manual. In addition, a CPT Assistant article will be published shortly discussing the appropriate uses of CPT Codes 95953 and 95956.

United Healthcare Request for Information

At the invitation of the AAN, NAEC President, Robert J. Gumnit, MD, attended a meeting with representatives of United Healthcare to discuss several neurological conditions (including seizures and epilepsy) that represented high hospital admissions, readmissions and length of hospital stay. The United representatives also voiced concerns heard from their regional medical officers that video EEG monitoring is being overused. United 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. Drs. Andres Kanner and Bill Theodore with the AAN epilepsy section and several NAEC board members will identify existing published materials and develop new guidance to be responsive to United's concerns.

2009 *US News and World Report's* America's Best Hospitals Ranking Released

On July 16, 2009, the *US News and World Report* released its 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/health/best-hospitals/neurology-and-neurosurgery-hospital-rankings/. Since 2004, the NAEC guidelines for adult Level 4 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 health reform bills including the Medicare physician fee update options under discussion by the Congress is attached to this document and can be found on the NAEC website.

Update on Medicare Regulations and Federal Epilepsy Programs

2010 Medicare Final Rule on Hospital Inpatient Prospective Payment System (IPPS)

In late July 2009, CMS issued a final rule changing the payment rates and policies for inpatient services in acute care hospitals for the fiscal year beginning October 1, 2009. Overall, hospitals are receiving 2.1% higher payments per case in FY 2010 as compared with FY 2009. For the last few years, hospitals have been required to report on a number of quality measures to receive the full update in payment. If they do not successfully report on these quality measures, they sustain a 2 percent reduction in payment. According to CMS, 97% percent of participating hospitals received the full update last year.

There are two DRGs for non-surgical admissions for seizure patients: DRG 100, Seizures with Major Complications or Comorbidities (MCC) and DRG 101, Seizures without MCC. The relative weights for the DRGs, which determine payment levels, are decreasing slightly in 2010. CMS reports that in 2008 there were 19,464 admissions with an average length of stay of 6.1 days for DRG 100 and 56,938 admissions with an average length of stay of 3.6 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.

2010 Medicare Final Rule on Hospital Outpatient Prospective Payment System (HOPPS)

On October 30th, CMS posted the final hospital outpatient prospective payment system (HOPPS) rule for 2010. Most hospitals will receive an inflationary update of 2.1 percent in their payment rates for services furnished in outpatient departments. As required by Medicare law, CMS will reduce the update by 2.0 percentage points for hospitals that in 2009 did not participate in quality data reporting for outpatient services or did not report the quality data successfully, resulting in a 0.1 percent update for those hospitals.

The APC payment rates for procedures provided by epilepsy centers in the hospital outpatient department are proposed to increase slightly in 2010. Attached to this report are charts comparing 2009 and 2010 payment rates.

2010 Medicare Final Rule on the Physician Fee Schedule (PFS)

On October 30, 2009, CMS posted the Medicare Physician Fee Schedule Final Rule for CY 2010. In the absence of Congressional action, physicians will experience a negative update of 21.2 percent resulting in a 2010 conversion factor (CF) of $28.3769 effective

January 1, 2010. Negative updates have been scheduled every year since 2002 and have always been averted. It is likely that Congressional action will prevent a negative update for 2010 as well.

Neurologists are anticipated to experience an overall positive 1% impact as a result of the 2010 final regulations. This estimated impact does not take into account the scheduled negative CF update.

Attached to this report are charts providing the 2010 payment rates for epilepsy-related medical and neurosurgical services and Evaluation and Management (E&M) services. A .5% increase in the conversion factor was used to calculate the payment, which is a proposal currently being considered by Congress.

While numerous changes are proposed under the rule, proposals of significant interest to epilepsy centers are:

- The rule eliminates consultation codes other than for telehealth consultation services. Providers should report existing E&M services in lieu of consultation codes. CMS redistributed the associated relative value units (RVUs) from the eliminated codes to existing E&M codes which as a result, will increase their payments. CMS has also adjusted the payment for the surgical global period to reflect the higher value of the office visits furnished during the global period.

- In 2010, CMS will begin to use a new survey on physicians' practice costs to establish the practice expense (PE) RVUs. CMS will phase in the use of the Physician Practice Information Survey, which is designed and conducted by the American Medical Association, over a four year period. This new data includes updated data for neurologists.

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. Although all of the contracts have been awarded several are under protest or evaluation so this list is subject to change.

A/B MAC Award List				
MAC	**States Covered**	**Award Date**	**Status**	**Awardee**
1	American Samoa, California, Guam, Hawaii, Nevada & Northern Mariana Islands	10/25/2007	Awarded	Palmetto GBA
2	Alaska, Idaho, Oregon & Washington	5/5/2008	Under evaluation	National Heritage Insurance Corporation (NHIC)
3	Arizona, Montana, North Dakota, South Dakota, Utah & Wyoming	7/31/2006	Awarded	Noridian
4	Colorado, New Mexico, Oklahoma & Texas	8/03/07	Awarded	TrailBlazer
5	Iowa, Kansas, Missouri & Nebraska	9/5/07	Awarded	WSP
6	Illinois, Minnesota & Wisconsin	1/7/09	Under evaluation	Noridian
7	Arkansas, Louisiana & Mississippi	7/10/09	Under protest	Trailblazer
8	Indiana & Michigan	1/7/09	Under evaluation	National Government Services (NGS)
9	Florida, Puerto Rico & US Virgin Islands	9/12/08	Awarded	First Coast Services Options
10	Alabama, Georgia & Tennessee	1/7/09	Awarded	Cahaba Government Benefit Administrators, LLC
11	Northern Carolina, South Carolina, Virginia & West Virginia	1/7/09	Under evaluation	Palmetto Government Benefits Administrators, LLC
12	Delaware, District of Columbia, Maryland, New Jersey & Pennsylvania	10/24/2007	Awarded	Highmark
13	Connecticut & New York	3/8/08	Awarded	National Government Services
14	Maine, Massachusetts, New Hampshire, Rhode Island & Vermont	11/08	Awarded	NHIC
15	Kentucky & Ohio	1/7/09	Under evaluation	Highmark Medicare Services (HMS)

Medicare RAC Program Goes National

Medicare providers across the country are beginning to prepare for the national roll-out of the permanent Medicare Recovery Audit Contractor (RAC) program. Initially established as a demonstration project, the RAC program is scheduled to become a permanent national program in 2010. Through a claims audit process, RACs identify improper Medicare payments - both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of both the overpayments and underpayments they collect from and for providers. The original demonstration project identified approximately $900 million in overpayments and $38 million in underpayments.

RACs review claims on a post payment basis using the same Medicare policies as carriers, fiscal intermediaries and MACs. RACs will conduct two types of reviews: automated (no medical record needed) and complex (medical record required). For the permanent RAC program, 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. All four RACs have posted their first set of approved issues. These issues will be updated periodically.

RACs are required to employ staff consisting of nurses, therapists, certified coders and a physician medical director. If an improper payment is identified, a demand letter will be issued by the RAC. The RAC will offer an opportunity for the provider to discuss the improper payments determination with the RAC that is outside of the normal appeals process. RACs are only authorized to look-back at claims beginning October 1, 2007. CMS has placed a limit on the number of records a RAC can request during an audit.

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 2010

In 2010, 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.

NATIONAL ASSOCIATION OF EPILEPSY CENTERS

NAEC

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.

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. **The code 780.39 – other convulsions should 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.

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Health Reform Policies, Process, and Outlook

Congress has devoted much of 2009 to the enactment of comprehensive health reform legislation. While the process has taken several twists and turns over the past year, significant steps have recently occurred to move towards the passage of a final bill. The House of Representatives has passed its version of health reform, HR 3962, the Affordable Health Care for America Act and the Senate is currently debating its health reform bill, HR 3590, the Patient Protection and Affordable Care Act.

Below is a brief summary of some of the key provisions included in the bills, which have many similarities. A summary of the health reform process to date with an outlook for passage follows.

Expansions of Coverage and Private Insurance Reforms

Both bills would expand coverage to millions of Americans who are currently uninsured and create an exchange offering private insurance plans and a public insurance option to facilitate access to insurance coverage. In the House bill, the Secretary of Health and Human Services will administer the public option, which will negotiate payment rates with providers and would be available to individuals lacking health insurance in all states. The Senate bill as currently drafted also calls for the Secretary to negotiate payment rates, but would allow states to opt-out of the public option. This contentious provision could be changed as the bill is amended during the Senate floor debate.

Both bills would require most individuals to purchase health insurance, and would provide premium subsidies to help them do so. Each bill has a sliding scale of tax credits for up to 400% of the federal poverty level (FPL) (about $88,000 for a family of 4), but they differ slightly on the percentage of income a person or family can be expected to spend on health insurance premiums. People who do not purchase insurance will be subject to a tax.

In terms of public programs, the bills would expand Medicaid eligibility to 133% FPL in the Senate bill and to 150% FPL in the House bill. They would also offer enhanced federal support to states for both Medicaid and the Children's Health Insurance Program (CHIP). Also, both bills would extend COBRA subsidies which were originally enacted in the 2009 stimulus package. The stimulus included federal payment of 65 percent of a worker's COBRA health insurance extension for up to nine months, but unemployed workers who started receiving the subsidies in March lose the benefit this month.

The bills also reform the private insurance market to end discriminatory insurance practices. These include: the elimination of lifetime limits on coverage, the elimination of pre-existing conditions exclusions and the implementation of modified community rating to preclude insurers from rating based on health status. The bills would also extend dependent coverage, through age 26 in the House bill and through age 25 in the Senate bill. One key difference between the bills relates to implementation timelines and the types of plans which will be reformed. In the Senate bill, all "existing" plans –

plans in which a person is enrolled at the time that President Obama signs the law, as well as their renewals – are grandfathered and exempt from the reforms indefinitely.

Medicare and Medicaid Payment Reforms

Both bills make significant payment and policy changes to the Medicare and Medicaid programs. In Medicaid, prescription drug rebates would be increased from 15.1% to 22.1% in the House bill and 23.1% in the Senate bill, with exceptions for clotting factor and pediatric drugs in the Senate bill. Disproportionate share hospital (DSH) allotments under Medicaid will also decrease. The bills implement several demonstration programs and pilot projects to test new payment and delivery system models.

To slow the growth in Medicare spending and help finance the costs of other reforms, significant reductions to various Medicare providers are included in the health reform bills. In addition to limiting the annual updates to hospitals and other institutional providers, Medicare's managed care program (Medicare Advantage), imaging services, and drug payments are taking the biggest hits in the bills. Also, the bills significantly expand quality measure reporting in all areas of Medicare and create a new Center for Medicare and Medicaid Innovation which will develop and expand new payment and delivery system models, such as Accountable Care Organizations, patient-centered medical homes for individuals with chronic disease, bundling, and others. The Senate bill would also create an independent Medicare Advisory Board to present Congress with proposals to reduce costs and improve quality for Medicare beneficiaries.

Other Key Provisions

Both bills include investments in the nation's public health infrastructure to increase focus on prevention and wellness and create healthier communities. There are also several provisions to improve health workforce training, recruitment and retention. Both bills create a regulatory pathway for the U.S. Food and Drug Administration (FDA) to approve biosimilars. Both create the infrastructure for federally-supported comparative effectiveness research, to compare treatment options.

Paying for Health Reform

Both bills are fully paid for and would not increase the deficit. HR 3962, the House bill, is estimated to cost $1.05 trillion and the Senate bill is estimated to cost $849 billion. Both bills are primarily financed through a series of taxes and cost-saving reforms to Medicare and Medicaid. For example, under both bills, most employers would be required to offer health insurance to their employees or else pay a tax. The bills also tax various health sector industries. The Senate bill imposes fees on pharmaceutical and medical device companies and on health insurers and the House bill would also tax medical device companies.

There are some key differences between the financing of the bills, however. The House bill includes a tax on high-earning individuals making more than $1 million for married

taxpayers filing a joint return or $500,000 for single filers. The Senate bill is primarily funded through a 40% tax on high-cost employer-sponsored health coverage, so-called "Cadillac" plans with annual premiums above a threshold of $8,500 for individuals and $23,000 for family coverage.

Process and Outlook for Passage

The U.S. House of Representatives passed their bill on November 7, 2009. While there were several controversial issues related to funding for abortion and undocumented immigrants, which threatened to delay passage of the bill, H.R. 3962 passed 220-215 on a primarily party-line vote, with 39 Democrats voting against the bill and one Republican voting for it.

The Senate bill has already passed a key procedural vote allowing the debate to begin, but several Democratic Senators have expressed concerns with the content of the legislation. There will be several weeks of debate and amendments. Sixty votes will be required to end the debate and allow a vote on the final bill. As of today, it appears that it will be difficult for the Senate leadership to garner the 60 votes required. Once the Senate moves to a final vote on the legislation, only 51 votes are required for final passage.

Once the Senate passes its legislation, the bill will be combined with the House-passed legislation in a conference committee. It will be difficult to combine the two bills, since they differ on key issues, such as financing and the public option. One final bill will be voted on by each chamber and then sent to President Obama for his signature or veto. President Obama has requested a final bill on his desk for signature by the end of the year, but it is very unlikely that Congress will be able to meet this timeline.

2010 Final Hospital Outpatient Prospective Payment System (HOPPS) Epilepsy APCs					
HCPCS Code	**Short Descriptor**	**2009 APC Rate**	**2010 APC Rate**	**Change 2010 vs. 2009**	
APC 0209 – Level II Extended EEG, Sleep & Cardiovascular Studies		$754.41	$770.55	$16.64	2.14%
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, Sleep & Cardiovascular Studies		$153.05	$162.06	$9.01	5.89%
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		$176.06	$180.86	$4.80	2.73%
92584	Electrocochleography				
95961	Electrode stimulation, brain				
95962	Electrode stim, brain add-on				
APC 0218 – Level II Nerve and Muscle Tests		$78.30	$80.65	$2.35	3.00%
95954	EEG monitoring/giving drugs				
95970	Analyze neurostim, no prog				

2010 Final Hospital Outpatient Prospective Payment System (HOPPS) Epilepsy APCs					
HCPCS Code	**Short Descriptor**	**2009 APC Rate**	**2010 APC Rate**	**Change 2010 vs. 2009**	
	APC 0692 – Level III Electronic Analysis of Devices	$109.24	$107.85	-$1.39	-1.27%
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	Io ga n-stim subsq w/reprog				
	APC 0065 – Level I Stereotactic Radiosurgery, MRgFUS, and MEG	$952.38	$962.61	$10.23	1.07%
95966	Meg, evoked, single				
95967	Meg, evoked, each add				
G0251	Linear acc based stero radio				
	APC 0067 – Level III Stereotactic Radiosurgery, MRgFUS, and MEG	$3,803.23	$3,571.78	-$231.45	-6.09%
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				

2010 Final Hospital Outpatient Prospective Payment System (HOPPS) Epilepsy Surgery APCs					
HCPCS Code	**Short Descriptor**	**2009 APC Rate**	**2010 APC Rate**	**Change 2010 vs. 2009**	
APC 0221 – Level II Nerve Procedures		$2,375.49	$2,512.94	$137.45	5.79%
61720	Incise skull/brain surgery				
61770	Incise skull for treatment				
APC 0220 – Level I Nerve Procedures		$1,222.81	$1,261.84	$39.03	3.19%
61790	Treat trigeminal nerve				
APC 0203 – Level IV Nerve Injections		$949.39	$892.72	-$56.67	-5.97%
61791	Treat trigeminal tract				
APC 0687 – Revision/Removal of Neurostimulator Electrodes		$1,297.25	$1,323.73	$26.48	2.04%
61880	Revise/remove neuroelectrode				
APC 0039 – Level I Implantation of Neurostimulator Generator		$12,545.18	$13,892.45	$1,347.27	10.74%
61885	Insrt/redo neurostim 1 array				
APC 0315 – Level II Implantation of Neurostimulator Generator		$18,313.46	$18,519.10	$205.64	1.12%
61886	Implant neurostim arrays				
APC 0688 – Revision/Removal of Neurostimulator Pulse Generator Receiver		$1,951.81	$1,932.10	-$19.71	-1.01%
61888	Revise/remove neuroreceiver				

2010 Final Physician Fee Schedule (CMS 1413-FC)						
Payment Rates for Medicare Physician Services - Epilepsy						
* The 2010 CF assumes a 0.5% update from 2009. This is a proposal currently being considered in Congress.						
CPT Code	**Mod**	**Descriptor**	**2007 Frequency**	**2009 CF= $36.0666**	**2010* CF = $36.4309**	**% CHANGE 2009-2010**
95812		EEG, 41-60 minutes	7,230	$ 235.15	$ 263.15	11.91%
95812	TC	EEG, 41-60 minutes	678	$ 181.41	$ 209.51	15.48%
95812	26	EEG, 41-60 minutes	12,720	$ 53.74	$ 53.65	-0.17%
95813		EEG, over 1 hour	4,395	$ 288.17	$ 314.99	9.30%
95813	TC	EEG, over 1 hour	312	$ 202.69	$ 229.08	13.02%
95813	26	EEG, over 1 hour	6,847	$ 85.48	$ 85.91	0.50%
95816		EEG, awake and drowsy	54,148	$ 215.68	$ 241.40	11.93%
95816	TC	EEG, awake and drowsy	2,603	$ 161.94	$ 187.40	15.72%
95816	26	EEG, awake and drowsy	217,824	$ 53.74	$ 54.01	0.50%
95819		EEG, awake and asleep	49,775	$ 231.55	$ 264.60	14.28%
95819	TC	EEG, awake and asleep	2,153	$ 177.81	$ 210.96	18.64%
95819	26	EEG, awake and asleep	273,733	$ 53.74	$ 53.65	-0.17%
95822		EEG, coma or sleep only	843	$ 230.83	$ 254.45	10.24%
95822	TC	EEG, coma or sleep only	19	$ 177.09	$ 200.81	13.40%
95822	26	EEG, coma or sleep only	14,939	$ 53.74	$ 53.65	-0.17%
95824	26	EEG, cerebral death only	400	$ 36.79	$ 37.70	2.47%
95827		EEG, all night recording	8	$ 372.57	$ 450.19	20.83%
95827	TC	EEG, all night recording	1	$ 319.55	$ 396.54	24.09%
95827	26	EEG, all night recording	323	$ 53.02	$ 53.65	1.18%
95829		Surgery electrocorticogram		$ 1,197.41	$ 1,291.11	7.83%
95829	TC	Surgery electrocorticogram		$ 883.99	$ 984.10	11.32%
95829	26	Surgery electrocorticogram	300	$ 313.42	$ 307.01	-2.04%
95830	Hospital*	Insert electrodes for EEG	129	$ 84.76	$ 85.91	1.36%
95830	Office	Insert electrodes for EEG	75	$ 174.20	$ 183.41	5.29%
95950		Ambulatory eeg monitoring	258	$ 237.32	$ 246.12	3.71%
95950	TC	Ambulatory eeg monitoring	2	$ 162.30	$ 171.09	5.41%
95950	26	Ambulatory eeg monitoring	1,215	$ 75.02	$ 75.03	0.02%
95951	26	EEG monitoring/videorecord	38,185	$ 298.27	$ 305.56	2.44%
95953		EEG monitoring/computer	8,032	$ 398.90	$ 417.56	4.68%
95953	TC	EEG monitoring/computer	345	$ 235.88	$ 253.00	7.26%
95953	26	EEG monitoring/computer	5,977	$ 163.02	$ 164.56	0.94%
95954		EEG monitoring/giving drugs	888	$ 243.45	$ 263.15	8.09%
95954	TC	EEG monitoring/giving drugs		$ 130.20	$ 150.06	15.25%
95954	26	EEG monitoring/giving drugs	5,112	$ 113.25	$ 113.09	-0.14%
95955		EEG during surgery	471	$ 136.69	$ 143.18	4.74%
95955	TC	EEG during surgery	5	$ 87.28	$ 93.52	7.14%
95955	26	EEG during surgery	9,739	$ 49.41	$ 49.66	0.50%
95956		EEG monitoring, cable/radio	3,102	$ 700.41	$ 723.49	3.29%
95956	TC	EEG monitoring, cable/radio	1,990	$ 547.13	$ 570.16	4.21%
95956	26	EEG monitoring, cable/radio	3,080	$ 153.28	$ 153.32	0.03%
95957		EEG digital analysis	26,904	$ 256.43	$ 284.90	11.10%
95957	TC	EEG digital analysis	2,704	$ 157.61	$ 185.95	17.98%
95957	26	EEG digital analysis	30,955	$ 98.82	$ 98.95	0.13%
95958		EEG monitoring/function test	12	$ 377.62	$ 403.79	6.93%
95958	TC	EEG monitoring/function test		$ 166.63	$ 192.11	15.29%

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95958	26	EEG monitoring/function test	221	$ 210.99	$ 211.68	0.33%
95961		Electrode stimulation, brain	130	$ 231.55	$ 229.44	-0.91%
95961	TC	Electrode stimulation, brain	1	$ 70.33	$ 79.38	12.87%
95961	26	Electrode stimulation, brain	1,145	$ 161.22	$ 150.06	-6.92%
95962		Electrode stim, brain add-on	11	$ 212.43	$ 212.04	-0.18%
95962	TC	Electrode stim, brain add-on		$ 47.25	$ 51.47	8.94%
95962	26	Electrode stim, brain add-on	1,700	$ 165.19	$ 160.57	-2.79%
95965	26	MEG, spontaneous	53	$ 407.91	$ 414.30	1.57%
95966	26	MEG, evoked, single	47	$ 202.69	$ 207.33	2.29%
95967	26	MEG, evoked, each addÏl	34	$ 173.48	$ 178.33	2.80%
95970	Hospital*	Analyze neurostim, no prog	2,473	$ 22.00	$ 22.47	2.15%
95970	Office	Analyze neurostim, no prog	8,616	$ 49.05	$ 52.56	7.15%
95971	Hospital*	Analyze neurostim, simple	3,689	$ 40.03	$ 39.87	-0.41%
95971	Office	Analyze neurostim, simple	16,537	$ 56.62	$ 56.18	-0.78%
95972	Hospital*	Analyze neurostim, complex	12,731	$ 76.10	$ 76.48	0.50%
95972	Office	Analyze neurostim, complex	19,350	$ 100.99	$ 102.58	1.58%
95973	Hospital*	Analyze neurostim, complex	437	$ 45.08	$ 46.03	2.11%
95973	Office	Analyze neurostim, complex	613	$ 55.18	$ 56.91	3.13%
95974	Hospital*	Cranial neurostim, complex	3,267	$ 147.87	$ 151.51	2.46%
95974	Office	Cranial neurostim, complex	17,304	$ 168.79	$ 176.16	4.37%
95975	Hospital*	Cranial neurostim, complex	111	$ 85.48	$ 86.27	0.92%
95975	Office	Cranial neurostim, complex	787	$ 93.77	$ 95.69	2.05%

2010 Final Physician Fee Schedule (CMS 1413-FC)						
Payment Rates for Medicare Physician Services - Neurosurgery						
* The 2010 CF assumes a 0.5% update from 2009. This is a proposal currently being considered in Congress.						
CPT Code	**Mod**	**Descriptor**	**2007 Frequency**	**2009 CF= $36.0666**	**2010* CF = $36.4309**	**% CHANGE 2009-2010**
61531		Implant brain electrodes	39	$ 1,096.42	$ 1,143.95	4.33%
61537		Removal of brain tissue	153	$ 2,180.23	$ 2,324.51	6.62%
61538		Removal of brain tissue	75	$ 2,331.35	$ 2,507.20	7.54%
61539		Removal of brain tissue	12	$ 2,161.47	$ 2,234.62	3.38%
61540		Removal of brain tissue	32	$ 2,034.16	$ 2,073.69	1.94%
61541		Incision of brain tissue	17	$ 1,936.06	$ 2,034.90	5.11%
61542		Removal of brain tissue	1	$ 2,110.98	$ 2,177.71	3.16%
61543		Removal of brain tissue	7	$ 1,972.48	$ 2,044.33	3.64%
61566		Removal of brain tissue	29	$ 2,043.53	$ 2,142.55	4.85%
61567		Incision of brain tissue	4	$ 2,283.74	$ 2,445.22	7.07%
61720		Incise skull/brain surgery	85	$ 1,056.75	$ 1,160.99	9.86%
61735		Incise skull/brain surgery	13	$ 1,289.38	$ 1,451.69	12.59%
61750		Incise skull/brain biopsy	709	$ 1,282.89	$ 1,328.45	3.55%
61751		Brain biopsy w/ct/mr guide	1,624	$ 1,250.07	$ 1,292.20	3.37%
61760		Implant brain electrodes	93	$ 1,414.17	$ 1,471.26	4.04%
61770		Incise skull for treatment	259	$ 1,374.50	$ 1,499.90	9.12%
61790		Treat trigeminal nerve	754	$ 776.51	$ 805.77	3.77%
61791		Treat trigeminal tract	94	$ 1,002.29	$ 1,037.39	3.50%
61793		Focus radiation beam	12,311	NA	NA	NA
61795		Brain surgery using computer	18,219	$ 233.35	$ 236.69	1.43%
61867		Implant neuroelectrode	1,777	$ 2,010.35	$ 2,171.55	8.02%
61868		Implant neuroelectrde, add'l	616	$ 601.59	$ 487.52	-18.96%
61870		Implant neuroelectrodes	3	$ 1,080.56	$ 1,119.67	3.62%
61875		Implant neuroelectrodes	1	$ 1,042.69	$ 962.36	-7.70%
61880		Revise/remove neuroelectrode	329	$ 496.64	$ 519.42	4.59%
61885		Insrt/redo neurostim 1 array	4,282	$ 570.93	$ 606.41	6.21%
61886		Implant neurostim arrays	800	$ 719.53	$ 768.07	6.75%
61888		Revise/remove neuroreceiver	831	$ 364.27	$ 368.99	1.30%
64573		Implant neuroelectrodes	951	$ 543.16	$ 567.63	4.50%

2010 Final Physician Fee Schedule (CMS 1413-FC)

Payment Rates for Medicare Physician Services - Evaluation & Management Services

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** In 2010 CMS eliminates the use of all consultation codes by increasing work RVUs for the new and established office visits, initial hospital visits and initial nursing facility visits. Providers will bill initial visit codes in lieu of the consultation codes.

CPT Code	Mod	Descriptor	2007	NON-FACILITY (OFFICE)			FACILITY (HOSPITAL)		
				2009	2010*	%	2009	2010*	%
			Frequency	CF= $36.0666	CF = $36.2469	CHANGE 2009-2010	CF= $36.0666	CF = $36.2469	CHANGE 2009-2010
Evaluation and Management Services									
99201		Office/outpatient visit, new	354,658	$ 36.79	$ 39.15	6.41%	$ 23.44	$ 25.01	6.68%
99202		Office/outpatient visit, new	2,432,664	$ 63.48	$ 67.78	6.78%	$ 45.08	$ 48.57	7.74%
99203		Office/outpatient visit, new	5,175,289	$ 91.97	$ 98.23	6.81%	$ 68.17	$ 73.22	7.41%
99204		Office/outpatient visit, new	3,232,644	$141.74	$152.24	7.40%	$113.97	$123.60	8.45%
99205		Office/outpatient visit, new	1,040,042	$178.89	$191.38	6.98%	$148.23	$160.21	8.08%
99211		Office/outpatient visit, est	9,345,985	$ 18.75	$ 19.21	2.43%	$ 8.66	$ 9.06	4.69%
99212		Office/outpatient visit, est	21,647,315	$ 37.15	$ 39.15	5.38%	$ 23.08	$ 24.65	6.78%
99213		Office/outpatient visit, est	104,328,942	$ 61.31	$ 65.97	7.59%	$ 44.72	$ 48.57	8.60%
99214		Office/outpatient visit, est	65,511,137	$ 92.33	$ 98.95	7.17%	$ 69.25	$ 75.03	8.35%
99215		Office/outpatient visit, est	8,060,246	$124.79	$133.39	6.89%	$ 98.46	$105.84	7.49%
99221		Initial hospital care	425,845	NA	NA	NA	$ 89.81	$ 94.60	5.34%
99222		Initial hospital care	3,035,525	NA	NA	NA	$122.63	$127.95	4.34%
99223		Initial hospital care	5,631,298	NA	NA	NA	$180.33	$187.76	4.12%
99231		Subsequent hospital care	16,329,791	NA	NA	NA	$ 37.15	$ 38.42	3.43%
99232		Subsequent hospital care	51,080,310	NA	NA	NA	$ 66.72	$ 69.23	3.76%
99233		Subsequent hospital care	19,596,436	NA	NA	NA	$ 95.58	$ 99.32	3.91%
99241		Office consultation**	336,281	$ 48.69	$ 48.93	0.50%	$ 33.18	$ 33.71	1.59%
99242		Office consultation**	1,503,724	$ 90.89	$ 92.07	1.30%	$ 69.97	$ 70.68	1.02%
99243		Office consultation**	4,951,902	$124.79	$125.78	0.79%	$ 97.38	$ 98.59	1.24%
99244		Office consultation**	6,025,404	$184.30	$186.31	1.09%	$154.00	$156.59	1.68%
99245		Office consultation**	2,256,828	$226.50	$227.63	0.50%	$192.23	$194.28	1.07%
99251		Initial inpatient consult**	267,653	NA	NA	NA	$ 48.69	$ 49.66	1.99%
99252		Initial inpatient consult**	929,556	NA	NA	NA	$ 75.74	$ 76.48	0.98%
99253		Initial inpatient consult**	3,093,064	NA	NA	NA	$114.69	$116.72	1.76%
99254		Initial inpatient consult**	5,692,509	NA	NA	NA	$165.55	$168.55	1.81%
99255		Initial inpatient consult**	2,832,048	NA	NA	NA	$201.97	$203.71	0.86%
99291		Critical care, first hour	3,799,317	$253.91	$259.53	2.21%	$212.07	$217.12	2.38%
99292		Critical care, add'l 30 min	376,489	$114.69	$117.08	2.08%	$106.04	$108.38	2.21%
99471		Ped critical care, initial	65	$777.96	NA	NA	$777.96	$780.76	0.36%
99472		Ped critical care, subseq	198	$384.11	NA	NA	$384.11	$390.74	1.73%