



NAEC Activities and Accomplishments – 2013

NAEC continued to grow in 2013 with a total membership of 198 specialized epilepsy centers as of December 1, 2013 with at least one center in every state except for AK, MT, ND, and SD. Twenty-one centers joined the Association for the first time this year.

Annual reports were completed by 190 centers, resulting in 153 centers being recognized as level 4 and 37 as level 3. NAEC reported the names of hospitals with level 4 epilepsy centers to *US News and World Report*, which recognizes level 4 epilepsy centers as a component of its national ranking of hospitals with top Neurology/Neurosurgery services.

Member Services and Association Management:

NAEC Annual Reports, Data Collection and Publications - NAEC computerized its annual report in 2012, which allowed for the pre-population of center information that typically doesn't change, such as center personnel and training information. This made the submission of data in 2013 less time consuming for members.

NAEC is creating a searchable electronic database of its historical paper reports. Aggregate data submitted from NAEC centers since 2004 will be available for research purposes next year. No center-specific data will be released. The NAEC Board is developing policies related to how and by whom the data can be accessed, released and published.

Analysis of Medicare Regulations/Policies and Member Education - NAEC provides its members with analysis of the major Medicare regulations on the physician fee schedule and the hospital inpatient and outpatient prospective payment systems annually. Due to the significant changes proposed in this year's Medicare rules, NAEC held two webinars on the rules in August, which were attended by over 70 NAEC members. Due to the high participation rates and positive feedback from participating members, NAEC plans to hold additional webinars in 2014 on reimbursement policies.

The publication of the final Medicare regulations was significantly delayed this year due to the government shutdown. An analysis of the 2014 Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment System regulations will be presented to NAEC members at the annual meeting and posted on the NAEC website.

Plans are underway to update NAEC's coding manual next year and to develop a crosswalk of the ICD-9-CM to ICD-10-CM diagnosis codes prior to the implementation of ICD-10 in October 2014. The manual will include updated information on the Medicare carriers (MACs) and Recovery Audit Contractors (RACs) as well as clinical vignettes on the major diagnostic and treatment services provided by epilepsy centers. NAEC members interested in working on the manual should contact NAEC at info@naec-epilepsy.org.

Throughout the year, NAEC has provided legislative and regulatory updates related to the implementation of the Affordable Care Act (the health reform legislation) and other issues of importance to epilepsy centers and NAEC staff responds to coding and reimbursement questions raised by member centers.

On-line Medical Education Series on Patient Safety – NAEC joined with the American Epilepsy Society (AES) in developing an online continuing medical education series “Safety in the Epilepsy Monitoring Unit.” The on-line program can be found at www.EMUCaring.org and is intended for all members of the epilepsy center team. The online program consists of seven modules addressing topics such as Seizure Observation, Environment and Activity, Managing Seizures and Comorbidities, and Preparing for Transition to Outpatient Care. For ease of learning, each module can be completed independently. The program is approved for physicians, nurses and EEG technologists to receive up to a maximum of 3.5 continuing education credits by the Accreditation Council for Continuing Medical Education (ACCME), EduPro Resources LLC (EDUPRO), and ASET – The Neurodiagnostic Society.

Policy and Program Activities and Accomplishments:

Evaluation and Analysis of Accreditation of Epilepsy Centers – NAEC continues to evaluate the Institute of Medicine (IOM) report *Epilepsy across the Spectrum: Promoting Health and Understanding* (March 23, 2012) recommendation calling for the accreditation of epilepsy centers and the establishment of an epilepsy care network of accredited centers to collaborate in professional education, data collection and research. The focus of the recommendation is on the importance of external review and validation by an independent body to ensure “excellence, consistency, clarity, and transparency in the provision of epilepsy care.” NAEC staff has completed an initial evaluation of several of the different models of accreditation that exist for similar centers, including the Joint Commission’s accreditation of stroke centers, the American College of Surgeons’ accreditation of transplant centers and cancer centers, ABRET’s accreditation of EEG labs and EMUs and the Residency Review Committee’s accreditation of specialty teaching programs.

The NAEC Board also contracted with Michelle Hanson, JD (the legal advisor for ABRET) to provide a legal and liability analysis of establishing an accreditation program for epilepsy centers. Ms. Hanson prepared a memorandum outlining the various issues that an organization should consider when determining whether to implement an accreditation program as well as steps an organization can take to limit its exposure to potential claims. A copy of this analysis will be provided to NAEC members upon request.

Patient-Centered Decision-Making Tool – NAEC has also taken a leadership role within the epilepsy community’s collaboration called Vision 20/20 in developing a web-based tool to help individuals with epilepsy, their families, and caregivers organize their concerns about their health and determine their need for more specialized epilepsy care. The tool will be launched at the AES meeting and can be found at www.MySeizuresKnowMore.com. The Vision 20/20 Working Group spearheading this effort included Nathan Fountain, MD, NAEC Vice President, Patty Shafer R.N.,

M.N., of Beth Israel Deaconess Medical Center's Comprehensive Epilepsy Program, Robert Moss, Founder of SeizureTracker.com and Ellen Riker, NAEC's Executive Director.

The tool includes 6 simple questions that are essential to epilepsy diagnosis and management, and provides information and resources on individual's psychological, social and behavioral concerns and other comorbidities that can impact health and quality of life. The tool allows individuals to print or email a report with their responses. Respondents are encouraged to share the report with their current health care providers to determine if a change in their treatment plan is needed or if a referral to an epilepsy specialist or center would be beneficial. Instructions on how to place the tool on your center's website are available at the NAEC booth in the AES exhibit hall.

The tool was developed based on another recommendation of the IOM Epilepsy report which focused on improving the early identification of epilepsy and its comorbid health conditions. The report called for the development and validation of screening tools for at-risk populations (people with developmental disabilities and mental health conditions) co-morbidities, and people with persistent seizures. The working group decided to develop a tool specifically for patients with active seizures that would benefit from referral to more specialized epilepsy care. In March, the IOM held a workshop on screening tools and other efforts to identify patients in need of specialized care in Washington, DC. Participants included the Vision 20/20 epilepsy organizations as well as participants from primary care societies and general neurology organizations.

Coding for EEG with video (CPT Code 95951) – For the past several years, the Centers for Medicare and Medicaid Services (CMS) has directed the AMA Relative Value Update Committee (RUC) to systematically reexamine the values assigned to all CPT Codes. Two of the criteria used to select services for review as potentially misvalued are whether the service has shown a growth in volume and/or if it has not been reviewed for a number of years. The Medicare utilization of Code 95951, vEEG has been growing steadily and increased by over 20 percent per year for the previous two years for which data is available. In light of this fact and because the value of Code 95951 has not been reexamined by CMS or the RUC since 1995, CPT Code 95951 could be subject to RUC review in the near future.

For this reason, NAEC established a working group in 2013 to discuss how best to prepare for a possible RUC review of vEEG. Members of the work group included NAEC Officers David Labiner, MD and Sue Herman, MD and Reimbursement Committee Chairs, Marc Nuwer, MD and Greg Barkley, MD. The working group met by phone and agreed that we would benefit from a better understanding of the current utilization of 95951 and the factors that might explain the growth in the utilization of this service. There was a discussion of the use of vEEG in the ICU setting and an interest in seeing if this was a cause for the growth in Medicare volume.

The work group sought an analysis of the Medicare claims data to get a better handle of the usage of Code 95951 for critical care patients. NAEC contracted with an independent researcher, who has done analysis for NAEC in the past to conduct this analysis. The analysis looked at 95951-26 billings in the inpatient setting, which represented about 86 percent of all Medicare billings for this code during an episode of inpatient care where a critical care service was also billed. (Please note that critical care codes can be rendered in a hospital outside of an ICU but the analysis assumes

that almost all of the critical care services billed with 95951 were rendered in the ICU.) The key finding is that in 2011, only 30.0% of inpatient 95951-26 bills occurred in inpatient episodes where at least one critical care hour appears on the bill for the same day as a billing for Code 95951- 26.

As a next step, the working group has developed and the NAEC Board has approved surveying NAEC members to help us better understand how 95951 is being used by epilepsy centers and whether there is any perceived difference in the work of interpreting an EEG video monitoring study in an ICU vs. an EMU. The survey will be distributed to the NAEC membership electronically after the annual meeting. NAEC will work closely with AAN and ACNS in determining if any coding changes for vEEG or any of the other EEG codes should be pursued at the RUC.

NAEC Comment Letters - NAEC also submitted several comment letters and statements on policies of note to epilepsy centers in 2013. These statements include:

FY 2014 Medicare Inpatient Proposed Rule (June 2013):

NAEC submitted comments on the FY 2014 Medicare Inpatient Proposed Rule supporting the request of NeuroPace for a new technology add-on payment. NAEC argued that this device meets the criteria for a new technology add-on payment and further that it is a critically important new tool for specialists to use to treat intractable epilepsy. NAEC's comment letter is available on the [NAEC website](#).

ACEP's Guidelines on Emergency Department Treatment of Seizures (June 2013)

NAEC submitted comments on the American College of Emergency Physicians' clinical practice guideline, "Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Department with Seizures."

CY2014 Medicare Hospital Outpatient Prospective Payment System (HOPPS) Proposed Rule (September 2013):

NAEC's comments on the Medicare HOPPS Proposed Rule focused on the proposed change in the packaging of diagnostic procedures and clinical lab tests under HOPPS and the proposed collapsing of clinic and emergency department visit codes. NAEC advocated for CMS to withdraw its proposal to collapse the current HOPPS five levels of evaluation and management (E/M) services for both new and established patients into a single APC for all clinic services with a payment rate of \$88.31 since it could lead to a deterioration of patient care. NAEC also advocated that CMS not finalize its proposal to package and no longer pay separately for a number of neurologic and other diagnostic tests, when billed on the same day with a surgical procedure, a significant procedure or a clinic or emergency department (ED) visit. We highlighted why these policies would harm epilepsy centers and the patients they serve. The comment letter can be found on the [NAEC website](#).

ILAE Epilepsy Definition (September 2013):

NAEC submitted this comment on ILAE's new epilepsy definition:

"In several sections of the definition the need to rely on the physician's discretion in determining risk of recurrence and accurate diagnosis is discussed. In the Imperfect Information section it even states, "Optimal application of this definition often requires specialized diagnostic and

interpretative skills...” but the article never mentions epileptologists or epilepsy centers as having the needed expertise to assess patient risk for recurrent seizures, diagnose syndromes and determine optimal treatment. Would it be appropriate to add information on epilepsy specialists and centers?”

NINDS 2014 Benchmarks for Epilepsy Research (October 2013):

In October, the National Institute for Neurological Diseases and Stroke (NINDS) released proposed Benchmarks for Epilepsy Research, which follow from the April 2013 Curing Epilepsy Conference and seek to reflect shared priorities across the epilepsy community for research toward clinically meaningful advances in understanding and treating the epilepsies. The draft 2014 Benchmarks for Epilepsy Research provide a framework for focusing research and benchmarking progress over the next five to ten years. NAEC submitted the following comments:

“The National Association of Epilepsy Centers (NAEC) appreciates the opportunity to comment on the proposed 2014 Benchmarks for Epilepsy Research. NAEC is an organization of over 190 specialized centers in the U.S. that diagnose and treat patients with complex and intractable epilepsy. We applaud NINDS for its commitment to research in epilepsy and appreciate the breadth of areas identified in the Benchmarks. Based on the direction of the Benchmarks, NAEC encourages NINDS to broaden its research portfolio in epilepsy by looking beyond basic science research to fund clinical and translational research studies. Investments in practical, prospective, rigorous research studies that answer straight-forward clinical questions will benefit people with epilepsy and improve their daily care. Examples of such studies include: whether to withdraw medications quickly or slowly to precipitate seizures in the EMU; a randomized, blinded, controlled trial of common AEDs as first line therapy for new onset seizures or in subpopulations of patients; and determining what clinical indicators provide evidence of quality care and improve outcomes. We recognize the challenging budget environment for NIH and that well-designed clinical research studies require significant funding, but these studies would provide desperately-needed evidence for clinical epilepsy practice.”

Collaborative Activities:

NAEC has been an active participant in the collaborative efforts of the Epilepsy community under the umbrella of Vision 20/20. This effort has been important to furthering the recommendations of the 2012 IOM Report on Epilepsy. NAEC was also a co-sponsor of NINDS’ Curing Epilepsy Conference in April 2013.

During the coming year, NAEC will be working closely with the AAN in reviewing and developing new quality measures in Epilepsy for inclusion in Medicare’s PQRS program. The AAN panel working on the measures will be chaired by NAEC members Nathan Fountain, MD and Paul Van Ness, MD.

NAEC has also supported the Epilepsy Foundation by supporting the Epilepsy Walk in 2013 and in June NAEC submitted a letter to the Department of Health and Human Services’ Health Resources and Services Administration in support of EF’s application to be funded as the Coordinating Center for Access to Services for Children and Youth with Epilepsy.