



# American Society of Interventional Pain Physicians

81 Lakeview Drive | Paducah, KY 42001 |  
(P) 270-554-9412 | (F) 270-554-5394

[www.asipp.org](http://www.asipp.org)

## FACT SHEET

### **MEDICARE PAYMENT SCHEDULES FOR INTERVENTIONAL PAIN MANAGEMENT SERVICES FOR 2014**

CMS posted the CY2014 final rules for physician payments, hospital outpatient and ambulatory surgical center payments on its Website on November 27, 2013 with the new rates effective January 1, 2014, only hours before the start of the Thanksgiving holiday. Physician policies are covered in a more than 600–page proposed rule, now the final rule, to govern Medicare physician payment policy in 2014. The proposed rule was released on July 8 and published in the Federal Register on July 19. The final rule was released on the 27<sup>th</sup> and was expected to be published in the Federal Register on December 9.

The Proposed rule, without the SGR cut of 20.1% showed similar rates for epidural injections. However, the final rule showed significant rather devastating draconian cuts with 36% for physician payment in a facility setting and 58% for the procedures performed in an office setting (CPT 62310, 62311, 62318, 62319).

This is while the hospital outpatient rule also showed increased payment for lumbar epidural injections from \$565.75 to \$669.91 with an increase of 18.4%, at a much higher level than any other setting from 2013. While previously hospital payments were 3-4 times higher than the in-office reimbursement, now it is 21 to 26 times higher than in office setting with SGR cut and 19 to 21 times without SGR cuts.

- This may put 40% of pain physicians out of practice.
- Reducing access may increase Medicare expenses by \$187 million.

Comparison of epidural procedures payments  
**Without Cut (CF=\$34.0230)**

CPT	2013 (CF=\$34.0230)		2014 Proposed		2014 Final		2014 Proposed - % Of change from 2013		2014 Final - % Of change from 2013	
	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility	Facility	Non-Facility	Facility
62310 - Cervical epidural	\$251.77	\$110.23	246.09	113.06	\$105.13	\$70.43	-2.3%	2.6%	-58.2%	-36.1%
62311 - Lumbar epidural	\$211.96	\$89.82	206.89	92.02	\$103.43	\$69.07	-2.4%	2.4%	-51.2%	-23.1%
62318 - Epidural or sub-arachnoid, catheterization,C/T	\$240.20	\$100.03	234.32	102.72	\$105.81	\$75.53	-2.4%	2.7%	-55.9%	-24.5%
62319 - Catheterization, epidural, L/S	\$173.52	\$96.97	170.84	99.15	\$109.21	\$77.23	-1.5%	2.3%	-37.1%	-20.4%

Comparison of epidural procedures payments  
**With SGR Cut (CF=\$27.2006)**

CPT	2013 (CF=\$34.0230)		2014 Proposed		2014 Final		2014 Proposed - % Of change from 2013		2014 Final - % Of change from 2013	
	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility	Facility	Non-Facility	Facility
62310 - Cervical epidural	\$251.77	\$110.23	\$187.68	\$86.23	\$84.05	\$56.31	-25.5%	-21.8%	-66.6%	-48.9%
62311 - Lumbar epidural	\$211.96	\$89.82	\$157.76	\$70.18	\$82.69	\$55.22	-25.6%	-21.9%	-61.0%	-38.5%
62318 - Epidural or sub-arachnoid, catheterization,C/T	\$240.20	\$100.03	\$178.71	\$78.34	\$84.59	\$60.39	-25.6%	-21.7%	-64.8%	-39.6%
62319 - Catheterization, epidural, L/S	\$173.52	\$96.97	\$130.29	\$75.62	\$87.31	\$61.75	-24.9%	-22.0%	-49.7%	-36.3%

Comparison of epidural procedures payments - Office overhead vs HOPD

Description	Office Overhead (proposed)	HOPD –Facility (proposed)	% of over Office Overhead	Office Overhead (Final)	HOPD –Facility (Final)	% of over Office Overhead
62310 - Cervical epidural	\$133.03	\$680.00	511%	\$34.70	\$669.90	1931%
62311 - Lumbar epidural	\$114.87	\$680.00	592%	\$34.36	\$669.90	1950%
62318 - Epidural or sub-arachnoid,catheterization,C/T	\$131.6	\$680.00	517%	\$30.28	\$669.90	2212%
62319 - Catheterization, epidural, L/S	\$71.69	\$680.00	949%	\$31.98	\$669.90	2095%

Comparison of epidural procedures payments - Office overhead vs HOPD  
**WITH SGR CUT**

Description	Office Overhead (proposed)	HOPD –Facility (proposed)	% of over Office Overhead	Office Overhead (Final)	HOPD –Facility (Final)	% of over Office Overhead
62310 - Cervical epidural	\$101.45	\$680.00	670%	\$27.74	\$669.90	2415%
62311 - Lumbar epidural	\$87.58	\$680.00	776%	\$27.47	\$669.90	2439%
62318 - Epidural or sub-arachnoid,catheterization,C/T	\$100.37	\$680.00	677%	\$24.20	\$669.90	2768%
62319 - Catheterization, epidural, L/S	\$54.67	\$680.00	1244%	\$25.56	\$669.90	2621%

CMS also went against Medicare expense index which has been rising gradually. It has increased from 2001 almost 30% which represents practice costs as per Medicare (significantly less than actual expenses) compared to no increase in Medicare payments for these procedures.

This is also in contrast to Medicare Payment Advisory Commission (MedPAC) advice. MedPAC in essence discussed the equalizing pay rates across different care settings. MedPAC clearly noted that MedPAC was worried about physician payments and noted how it is expensive to do business with hospitals. No wonder hospitals are grabbing all physician practices and reaping the funds.

Please do not forget Medicaid, Champus, Tricare, and all private insurers will be rapidly following this trend and reducing the payments, essentially leaving us no other choice since Medicare has acted first.

In the June report, MedPAC discussed the possibility of equalizing pay rates across different care settings since hospital payments were much higher than any other setting. Further, MedPAC also expressed its concern in relation to physician payments and influence of SGR formula on quality of care.

Other cuts are related to spinal cord stimulators. When trials are performed in an office setting, starting January 1, 2014, there will also be a huge reduction in reimbursement approaching 60% for a single lead and 75% for a dual lead trial. While CMS will continue to reimburse under Medicare with CPT code 63650 and expected to be reported for each lead insertion procedure and trial, L8680 will no longer be reported for the device component. The new global payment in the office setting for 63650 has been reduced to \$1,281.65 nationally. A 50% modifier will still be applied for a second lead in a dual lead trial.

In the proposed rule, as well as in the final rule CMS also has erroneously considered percutaneous adhesiolysis (CPT 62644) similar to ambulatory surgery center (ASC) moving it from neurolytic blocks APC group to epidural and facet joint Ambulatory Payment Classification (APC) group reducing the payment to epidural levels in hospital as well as in ambulatory surgery center settings. For many hospitals this may be okay because these are performed in a small room, without all the expenses ASCs have to go through, but it continues to be devastating for offices and represents a significant disadvantage for ASCs.

#### **THE BASIS FOR MEDICARE CUTS**

AMA conducted a RUC survey in 2012 which was inconspicuous and many of the physicians were not aware of it. None of the ASIPP physicians remember this survey or its participation. Across the nation, among almost 10,000 physicians performing epidural injections, approximately 50 of them participated and provided their opinions. Based on this survey, physician time was reduced by approximately 50%. Despite this, the AMA RUC recommended no change in the work values for the RVUs of these codes. CMS decided on their own to reduce these work values.

CMS used this data which was generated back in 2012 and acted inappropriately by not providing a comment period despite obtaining the data over a year ago. The final rule fees were not posted in the proposed rule even when CMS injecting their own methodology beyond RUC. Medicare also removed the cost of fluoroscopy and significantly reduced cost of a tray for epidural injection to \$12.

Based on the available information, as of now:

- The RUC process did not involve all the physicians.

This data was available in 2012, yet the proposed schedule in July did not include the proposed cuts.

**Consequently, there was no comment period even though this is required by Medicare regulation.**

- Medicare has not taken into consideration Medicare Economic Index (MEI) which has been increasing substantially. Now the gap with the SGR cuts will be 90% and even without the SGR cuts will be 70% between expenses and revenue.
- Medicare has not taken into consideration MedPAC recommendation of widening gaps between hospital and physician payments. The difference between office and hospital payments was commented upon in 2013 when MedPAC made their recommendations and raised concerns about the widening gap and empowerment by hospitals. Now it is a whopping 2,315% to 2,668% difference between offices and the hospital site of service, it is unclear this is supposed to save money. Many doctors will not be able to provide this service at the proposed fee and will therefore shift care to a more expensive site of service (ACS or hospital) and this will cost CMS more money in the end.
- Hospitals have increased their payment by almost 20% for the same procedures, whereas in-office procedures are facing almost a 60% cut.
  - In fact, moving these procedures from in an office setting to hospital outpatient department (projected to move at least 80%), will increase the costs so substantially that the patient copay itself is 4 times higher than the entire payment in an office setting, and was equivalent to full payment with proposed rates.
  - In addition, the total costs of these procedures will increase based on 2011 statistics which showed 412,799 of 1,114,458 epidurals (only 2 codes 62310 and 62311) were performed in office setting in Medicare population. If 80% these procedures (330,239) were performed in HOPD setting, the cost of these 2 procedures increased over \$187 million per year considering the reimbursement in the proposed rule of \$85-\$105 per procedure.
    - This may even lead to with kickback as hospitals receiving much higher facility payments and offering physicians occasionally a portion of these revenues, which will lead to troubles at a later date.
- This change will also fuel pill mills with increasing deaths.

Click here for [2014 Final Physician Fee Schedule](#).

Based on these changes, we may see upwards of 40% of pain practices going out of business or they will not provide epidural injections in the treatment armamentarium. This is the most commonly performed procedure in interventional pain management. Considering 40% of the

physicians practice in an office setting and epidural injections constitute 50% of interventional pain management procedures, there is a risk of losing many high quality interventional pain management practices. Further, Medicare's estimated \$640 million continues to stay the same as an expenditure towards interventional pain management.

**Compounding Problems:**

Recently we have been bombarded with multiple problems to reduce utilization and basically provide no services. These include:

- Noridian-developed national coverage decisions, LCDs, and continued threat of national coverage determinations with severe restrictions.
- Multiple insurers following restrictive regulations imposed by the government.
- The usual saga of SGR cut of 20.1%
- All the expenses, threats, which really reduce physician input and make physician practice cookbook medicine based on regulation with unfunded mandates rather than evidence-based medicine with:
  1. ICD-10
  2. RACs
  3. OIG investigations
  4. EMRs
  5. Single-dose vials and infection control practice regulations
  6. Ever-expanding HIPAA regulation and many others

Consequently, we request Congress to act swiftly and decisively to request Medicare withdraw the proposed final rule for the family of codes 62310-62319 and allow the public time to comment, as required within the Medicare Integrity Manual, before implementing more reasonable changes in 2015.

If you have any further questions, please feel free to contact:

**Hans C. Hansen, MD**

President, ASIPP  
Medical Director  
The Pain Relief Centers, LLC  
224 Commerce St  
Conover, NC 28613  
Phone: (828) 261-0467  
Fax: (828) 261-7293  
[hhansen@painreliefcenters.com](mailto:hhansen@painreliefcenters.com)

**Laxmaiah Manchikanti, MD**

Chairman of the Board and Chief Executive Officer, ASIPP  
Medical Director, Pain Management Center of Paducah  
Clinical Professor, Anesthesiology and Perioperative Medicine  
University of Louisville, Kentucky  
2831 Lone Oak Road  
Paducah, KY 42003

Phone: 270-554-8373 ext. 101

Fax: 270-554-8987

[drm@asipp.org](mailto:drm@asipp.org)

**Tim Hutchinson**

Senior Advisor (US House 93-96; US Senate 97-02)

Dickstein Shapiro LLP

1825 Eye Street NW

Washington DC 20006

[HutchinsonT@dicksteinshapiro.com](mailto:HutchinsonT@dicksteinshapiro.com)

**Jeff Mortier**

Legislative Partner

Ryan, Mackinnon, Vasapoli and Berzok, LLP

1634 Eye Street NW, Suite 1200

Washington, DC 20006

[jmortier@rmvbllp.com](mailto:jmortier@rmvbllp.com)