September 2, 2014

Marilyn B. Tavenner
Administrator
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201 Phone: 202-690-6726 DC | 410-786-3151 Baltimore
Marilyn.Tavenner@cms.hhs.gov


Dear Honorable Administrator Tavenner:

The American Society of Interventional Pain Physicians (ASIPP) would like to thank you for the opportunity to comment on Proposed Rule 42 CFR Parts 403, 405, 410, 414, 425, and 498 [CMS-1612-P]. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B Proposed Rule for CY 2015.1

ASIPP is a not-for-profit professional organization composed of over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are over 8,500 well-trained and qualified physicians practicing interventional pain management in the United States.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain-related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment.2

Interventional pain management techniques are minimally invasive procedures, including percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps, and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain.3

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The subject of this letter is the draconian cuts which were unusually omitted in the proposed rule of 2014 and later published in the final rule of 2014. Since then many meetings have been held and congressional requests have been made to reverse these cuts, however, the reversal of the cuts has not occurred. Unfortunately the trend of misunderstandings continues.

Consequently, we once again write to you in reference to the proposal to prohibit the separate reporting of imaging guidance code in conjunction with CPT 62310 and 62311 pertaining to caudal and lumbar interlaminar, cervical and thoracic interlaminar epidural injections, and 62318 and 62319 pertaining to cervical and thoracic epidural with catheterization and lumbar and caudal epidural with catheterization.

Because of the multiple meetings and numerous comment letters as acknowledged by CMS proposed rule, we are pleased that CMS has acknowledged our concerns about the valuation of these services for 2014 and has presented a process to address them for 2015 and beyond. However, this process also appears to be without significant thought and has resulted in draconian cuts. CMS proposes to return to the 2013 work values and practice expense resources for 2015 and to gather data to determine how to most accurately value these important services. In essence, CMS is looking at how to utilize imaging guidance for future years. Further, CMS emphasizes that the recommendations published in the rule included the “removal of the radiographic – fluoroscopic room for 62310, 62311, and 62318 and portable C-arm for 62319.” However, in reality, this is not the case. It is not only the fluoro room (practice expense) which is removed which affects the office payments, but also it has eliminated physician payments for fluoroscopy completely. Thus, the devastating effects will continue.

Once again CMS is applying flawed formula and wrong data with epidural injections with catheterization. Epidural injections with catheterization are rarely performed in chronic pain settings and fluoroscopy is not utilized generally for these procedures. As shown in the proposed rule for 62310 fluoroscopy was utilized almost 80% of the time, whereas, for 62319 it was utilized 40% of the time. Similar results were found for facility setting also; however, it appears that in facility setting fluoroscopy is used less frequently indicating that these may be performed by non-physicians ineffectively and without following Medicare regulations as described in LCDs. As CMS would know, almost all LCDs have mandated fluoroscopy for 62310 and 62311. In either case, fluoroscopy requires additional time and effort for physicians as well as office practices. Thus, value of work, equipment, intensity, and risk has not been incorporated in these assessments. These are two separate codes and the value has been assessed by the RUC committee separately with recommendations for separate payment.

With the new formula being applied as shown in the enclosed table, essentially there is only 7% increase for CPT 62310 performing the injection in the cervical spine resulting in approximately $7 which is extremely high risk procedure, whereas, for 62311 lumbosacral epidural which is also high risk procedures, though, less risky than 62310, actually suffers a cut of $11 with an 11% decline compared to 2014 when fluoroscopy is bundles. Consequently, the cuts of 20% for 62310 and 23% for 62311 for 2015 compared to 2013 continue. The results are somewhat better for in-office procedures with a 21% increase from 2014 for 62310, but a 29% decrease compared to 2013; whereas the decreases continued at 27% compared to 2013 and with a small increase of 13% compared to 2015.

Epidural payments and payment in office settings.

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<tbody>
<tr>
<td>Facility</td>
<td>$110.23</td>
<td>$74.15</td>
<td>$112.13</td>
<td>$1.90 (1.72%)</td>
<td>$37.98 (35.1%)</td>
<td>$89.82</td>
<td>$72.72</td>
<td>$92.06</td>
<td>$2.24 (2.74%)</td>
<td>$19.34 (17.4%)</td>
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<tr>
<td>Fluoro</td>
<td>$29.94</td>
<td>$30.81</td>
<td>$0.00</td>
<td>(-$0.87 (-29.4%))</td>
<td>(-$10.81 (-100%))</td>
<td>$29.94</td>
<td>$30.81</td>
<td>$0.00</td>
<td>(-$0.87 (-29.4%))</td>
<td>(-$10.81 (-100%))</td>
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<tr>
<td>Total</td>
<td>$140.17</td>
<td>$104.96</td>
<td>$112.13</td>
<td>$1.90 (1.72%)</td>
<td>$37.98 (35.1%)</td>
<td>$119.76</td>
<td>$103.53</td>
<td>$92.06</td>
<td>$2.24 (2.74%)</td>
<td>$19.34 (17.4%)</td>
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<tr>
<td>Office</td>
<td>$251.77</td>
<td>$110.69</td>
<td>$244.67</td>
<td>$(-7.10 (-2.81%))</td>
<td>$(-103.66 (-42.8%))</td>
<td>$211.96</td>
<td>$108.90</td>
<td>$225.33</td>
<td>$13.37 (16%)</td>
<td>$116.43 (110.0%)</td>
</tr>
<tr>
<td>Fluoro</td>
<td>$95.26</td>
<td>$90.99</td>
<td>$0.00</td>
<td>$(-4.27 (-4.72%))</td>
<td>$(-90.99 (-100%))</td>
<td>$95.26</td>
<td>$90.99</td>
<td>$0.00</td>
<td>$(-4.27 (-4.72%))</td>
<td>$(-90.99 (-100%))</td>
</tr>
<tr>
<td>Total</td>
<td>$347.03</td>
<td>$201.68</td>
<td>$244.67</td>
<td>$(-145.35 (-53.3%))</td>
<td>$(-103.66 (-42.8%))</td>
<td>$307.22</td>
<td>$199.89</td>
<td>$225.33</td>
<td>$13.37 (16%)</td>
<td>$116.43 (110.0%)</td>
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This essentially will result in an underpayment for chronic pain procedure 62310 and 62311 and may encourage providers specifically non-physician providers to perform them without fluoroscopy. It may be considered by some that CMS is advocating these procedures be performed without fluoroscopy. As you well know the CPT codes still dictate with or without fluoroscopy. Thus, for any procedure specifically 62318 and 62319 where fluoroscopy is seldom used there will be overpayments with underpayments for chronic pain procedure 62310 and 62311.

Thus, if the proposed prohibition of reporting imaging guidance or bundling with primary procedure is troubling since CMS has utilized this without appropriate information. CMS also admits that it will be collecting data, yet, cuts are being implemented. Thus, separate reporting of imaging guidance should be permitted until new CPT codes are developed and new RUC valuations are provided. As shown in the proposed rule, CMS should follow the same philosophy as they have followed for facet joint injections, facet joint radiofrequency neurotomy, transforaminal epidural injections, and sacroiliac joint injections. This will be a cost saving measure as it will reduce the cost to the program by performing one interlaminar epidural than multiple transforaminal epidurals. At the same time, it will provide appropriate high-quality care. This process will also provide the information to the agency to accurately value these services in context of current practice with mandated imaging guidance. Once again we are requesting the same process the agency has used when considering the proper valuation of other procedures in the past.

In summary, we request that these deficiencies be corrected prior to the publication of the final rule and also retroactively permit reimbursement at 2013 levels, effective January 2014, as CMS now understands that it was an error.

Failure to act upon these issues could be a detriment to interventional pain management practices and the many chronic pain patients. If not reversed, these changes will force office based physicians to either close or move into the more expensive hospital setting. Either outcome will have a devastating effect on patient access to care. Further, without access to care, patients will have only one option for pain management; they will have to rely increasingly on opioids for pain relief. We fear the result will be an explosion in the already existing pill mill crisis.

Once again, thank you for your consideration which will maintain access to care for needy patients without increasing opioid usage and also without increasing fraud and abuse with provision of high quality services. If you have any questions please feel free to contact us.
Thank you,

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