Health Policy Opinion

Declining Value of Work of Interventional Pain Physicians

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The year 2013 was a challenging year for Interventional pain physicians with national coverage determination threats for facets, epidurals, and spinal cord stimulation (1); certified registered nurse anesthetists (CRNAs) entering the full arena of interventional pain management (2-4); Center for Disease control supported single-dose vial policy being created without products to reasonably support it (5); Food and Drug Administration (FDA) regulating procedural standards of interventional techniques; Noridian led local coverage determinations (LCDs) prepared by Multi-Specialty Pain Workgroup (MPW) (6-8); threatened cuts of cervical epidural injections and facet joint interventions in Tennessee (9,10); empowered insurers limiting interventional pain management (IPM) services (11); usual sustained growth rate (SGR) cut fiasco (12,13); and finally the Thanksgiving gift of draconian cuts for epidural injections amounting to 33% for cervical epidural when in a facility and 56% when performed in a physicians office, and 19% for lumbar interlaminar epidural injection in a facility setting for physician fee and 49% when performed in a physicians office (14). Thus, CMS determined the work value of highly trained and skilled IPM physicians to be a whopping $42 to assess a patient preoperatively, to perform a high risk procedure of cervical epidural injection, and follow post-operatively for next 24 hours.

There were successes to match these challenges. Facet joints are not on a national coverage determination (NCD) list. We provided our opinions to the FDA and they are considering them on performance of interventional procedures; the Government Accountability Office (GAO) has started a study to assess if, in fact, CRNAs are qualified to perform interventional techniques (15,16); creation of a group purchasing organization (GPO) with Henry Schein (17); published evidence-based guidelines for interventional techniques listed on Agency for Healthcare Research and Quality's (AHRQ) National Guideline Clearinghouse (NGC) website (18); reversal of noncoverage decision on cervical epidurals and facet joint interventions in Tennessee (19,20); continuing negotiations with Cigna with evidence submission signed by 684 physicians (21); progress in negotiations with Noridian to revise LCDs based on evidence and reasonable and medically necessary; and finally with a 3 month fix for proposed 24% SGR cut (22).

The above referenced challenges have led some to enter 2014 with lackluster enthusiasm, frustration, and dismay. Issues continue, most importantly draconian cuts proposed by the Centers for Medicare and Medicaid Services (CMS) for lumbar and cervical interlaminar epidural injections CPT 62310 and CPT 62311 with a physician payment of $42 for preoperative assessment, performance of the procedure intraoperatively, and post operative management.

It is true a physician's work is valued at $42 or 1.18 or 1.17 physician relative value units (RVUs) by CMS. A national rate of physician reimbursement is $72.72 when performed for each procedure in a facility setting and $108.90 for cervical epidural and $110.69 for lumbar epidural when performed in an office setting. Using simple arithmetic, the reimbursement has dropped to $36 for

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cervical epidural injection and $20 for lumbar epidural for the office facility portion. This is a significant reduction from $252 and $212 in 2013. There is a separate payment for fluoroscopy of $31 for physicians in any setting and $54 when it is performed in an office as a facility fee.

Mixed news is that the SGR is fixed, but, only for 3 months. If that 3 month fix is reversed there will be an additional 24% in cuts. Table 1 shows relative values of some of the most commonly utilized interventional techniques. Table 2 shows the reimbursement rates of commonly performed interventional techniques.

This is in contrast $370 reimbursed in an ambulatory surgery center (ASC) as a facility fee and $670 paid to a hospital. While ASCs follow certain regulations, hospitals are not bound by any such regulations. They can perform these procedures in any room or a radiology suite, outpatient surgery, outpatient department,

Table 1. *Relative values of some of the most commonly performed interventional techniques.*

CPT	Description	Facility Total RVUs for Physician Payment						Non-Facility Total RVUs for Physician and Office Facility Payment					
		RVUs			Percentage of Change			RVUs			Percentage of Change		
		2013	2014P	2014F	2014P to 2013	2014F to 2013	2014F to 2014P	2013	2014P	2014F	2014P to 2013	2014F to 2013	2014F to 2014P
27096	(G0260) Injection procedure for sacroiliac joint, arthrography	2.52	2.46	2.43	-2.4%	-3.6%	-1.2%	5.00	4.66	4.61	-6.8%	-7.8%	-1.1%
64490	Cervical and thoracic facet joint injections, 1st level	3.24	3.15	3.12	-2.8%	-3.7%	-1.0%	5.94	5.55	5.48	-6.6%	-7.7%	-1.3%
64491	Cervical and thoracic facet joint injections, 2nd level	1.80	1.78	1.76	-1.1%	-2.2%	-1.1%	2.87	2.71	2.69	-5.6%	-6.3%	-0.7%
64492	Cervical and thoracic facet joint injections, 3rd level	1.82	1.80	1.78	-1.1%	-2.2%	-1.1%	2.88	2.72	2.71	-5.6%	-5.9%	-0.4%
64493	Paravertebral facet joint or facet joint nerve; lumbar/ sacral, 1st level	2.74	2.67	2.64	-2.6%	-3.6%	-1.1%	5.37	5.00	4.95	-6.9%	-7.8%	-1.0%
64494	Paravertebral facet joint or facet joint nerve; lumbar/ sacral, 2nd level	1.53	1.52	1.50	-0.7%	-2.0%	-1.3%	2.63	2.48	2.47	-5.7%	-6.1%	-0.4%
64495	Paravertebral facet joint or facet joint nerve; lumbar/ sacral, 3rd level	1.56	1.54	1.52	-1.3%	-2.6%	-1.3%	2.64	2.49	2.48	-5.7%	-6.1%	-0.4%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	10.50	10.19	10.07	-3.0%	-4.1%	-1.2%	21.24	19.79	19.57	-6.8%	-7.9%	-1.1%
62264	Percutaneous epidural adhesiolysis – 1 day	7.09	6.92	6.86	-2.4%	-3.2%	-0.9%	12.94	12.10	11.98	-6.5%	-7.4%	-1.0%
62310	Cervical epidural	3.24	3.17	2.07	-2.2%	-36.1%	-34.7%	7.40	6.90	3.09	-6.8%	-58.2%	-55.2%
62311	Lumbar epidural	2.64	2.58	2.03	-2.3%	-23.1%	-21.3%	6.23	5.80	3.04	-6.9%	-51.2%	-47.6%
62318	Epidural or subarachnoid, catheterization, C/T	2.94	2.88	2.22	-2.0%	-24.5%	-22.9%	7.06	6.57	3.11	-6.9%	-55.9%	-52.7%
62319	Catheterization, epidural, L/S	2.85	2.78	2.27	-2.5%	-20.4%	-18.3%	5.10	4.79	3.21	-6.1%	-37.1%	-33.0%

Table 1 (cont). *Relative values of some of the most commonly performed interventional techniques.*

CPT	Description	Facility Total RVUs for Physician Payment						Non-Facility Total RVUs for Physician and Office Facility Payment					
		RVUs			Percentage of Change			RVUs			Percentage of Change		
		2013	2014P	2014F	2014P to 2013	2014F to 2013	2014F to 2014P	2013	2014P	2014F	2014P to 2013	2014F to 2013	2014F to 2014P
64479	Cervical transforaminal epidural injections	4.01	3.92	3.89	-2.2%	-3.0%	-0.8%	7.30	6.88	6.82	-5.8%	-6.6%	-0.9%
64480	Cervical transforaminal epidural injections add-on	1.93	1.92	1.89	-0.5%	-2.1%	-1.6%	3.46	3.31	3.27	-4.3%	-5.5%	-1.2%
64483	Lumbar/sacral transforaminal epidural injections	3.38	3.28	3.25	-3.0%	-3.8%	-0.9%	6.83	6.36	6.29	-6.9%	-7.9%	-1.1%
64484	Lumbar/sacral transforaminal epidural injections add-on	1.55	1.53	1.51	-1.3%	-2.6%	-1.3%	2.67	2.52	2.50	-5.6%	-6.4%	-0.8%
77003	Fluoroscopic guidance for spine injection	NA	NA	NA	NA	NA	NA	2.8	2.56	2.54	-8.6%	-9.3%	-0.8%
77003-26	Fluoroscopic guidance and localization of needle or catheter tip for spine or therapeutic injection procedure	0.88	0.87	0.86	-1.1%	-2.3%	-1.1%	0.88	0.87	0.86	-1.1%	-2.3%	-1.1%
77003-TC	Fluoroscopic guidance and localization of needle or catheter tip for spine or therapeutic injection procedure	NA	NA	NA	NA	NA	NA	1.92	1.69	1.68	-12.0%	-12.5%	-0.6%
99201	Office/outpatient visit new	0.76	0.75	0.74	-1.3%	-2.6%	-1.3%	1.29	1.23	1.21	-4.7%	-6.2%	-1.6%
99202	Office/outpatient visit new	1.44	1.43	1.41	-0.7%	-2.1%	-1.4%	2.19	2.1	2.08	-4.1%	-5.0%	-1.0%
99203	Office/outpatient visit new	2.2	2.18	2.15	-0.9%	-2.3%	-1.4%	3.17	3.04	3.02	-4.1%	-4.7%	-0.7%
99204	Office/outpatient visit new	3.76	3.7	3.68	-1.6%	-2.1%	-0.5%	4.84	4.66	4.64	-3.7%	-4.1%	-0.4%
99205	Office/outpatient visit new	4.83	4.76	4.75	-1.4%	-1.7%	-0.2%	5.99	5.8	5.78	-3.2%	-3.5%	-0.3%
99211	Office/outpatient visit established	0.26	0.26	0.26	0.0%	0.0%	0.0%	0.6	0.57	0.56	-5.0%	-6.7%	-1.8%
99212	Office/outpatient visit established	0.72	0.71	0.71	-1.4%	-1.4%	0.0%	1.29	1.22	1.22	-5.4%	-5.4%	0.0%
99213	Office/outpatient visit established	1.46	1.45	1.44	-0.7%	-1.4%	-0.7%	2.13	2.04	2.04	-4.2%	-4.2%	0.0%
99214	Office/outpatient visit established	2.25	2.22	2.21	-1.3%	-1.8%	-0.5%	3.13	3.01	3.01	-3.8%	-3.8%	0.0%
99215	Office/outpatient visit established	3.17	3.13	3.11	-1.3%	-1.9%	-0.6%	4.2	4.05	4.03	-3.6%	-4.0%	-0.5%

Facility Total RVUs = Work RVUs + Facility Practice Expenses RVUs + Mal-Practice RVUs
Non-Facility Total RVUs = Work RVUs + Non-facility Practice Expenses RVUs + Mal-Practice RVUs

Table 2. *Comparison of physician payment rates for select interventional pain management services without SGR reduction and 0.5% update.*

CPT	Description	2013 (CF=$34.0230)		2014 Prposed (CF=$34.0230)* WITHOUT SGR CUT				2014 Final (CF=$35.8228) WITHOUT SGR CUT			
		Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	% of change from 2013		Non-Facility (Office)	Facility (ASC/ Hospital)	% of change from 2013	
						Non-Facility	Facility			Non-Facility	Facility
27096	(G0260) Injection procedure for sacroiliac joint, arthrography	$170.12	$85.74	$158.55	$83.70	-6.8%	-2.4%	$165.14	$87.05	-2.9%	1.5%
64490	Cervical and thoracic facet joint injections, 1st level	$202.10	$110.23	$188.83	$107.17	-6.6%	-2.8%	$196.31	$111.77	-2.9%	1.4%
64491	Cervical and thoracic facet joint injections, 2nd level	$97.65	$61.24	$92.20	$60.56	-5.6%	-1.1%	$96.36	$63.05	-1.3%	3.0%
64492	Cervical and thoracic facet joint injections, 3rd level	$97.99	$61.92	$92.54	$61.24	-5.6%	-1.1%	$97.08	$63.76	-0.9%	3.0%
64493	Paravertebral facet joint or facet joint nerve; lumbar/sacral, 1st level	$182.70	$93.22	$170.12	$90.84	-6.9%	-2.6%	$177.32	$94.57	-2.9%	1.4%
64494	Paravertebral facet joint or facet joint nerve; lumbar/sacral, 2nd level	$89.48	$52.06	$84.38	$51.72	-5.7%	-0.7%	$88.48	$53.73	-1.1%	3.2%
64495	Paravertebral facet joint or facet joint nerve; lumbar/sacral, 3rd level	$89.82	$53.08	$84.72	$52.40	-5.7%	-1.3%	$88.84	$54.45	-1.1%	2.6%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$722.65	$357.24	$673.32	$346.69	-6.8%	-3.0%	$701.05	$360.74	-3.0%	1.0%
62264	Percutaneous epidural adhesiolysis – 1 day	$440.26	$241.22	$411.68	$235.44	-6.5%	-2.4%	$429.16	$245.74	-2.5%	1.9%
62310	Cervical epidural	$251.77	$110.23	$234.76	$107.85	-6.8%	-2.2%	$110.69	$74.15	-56.0%	-32.7%
62311	Lumbar epidural	$211.96	$89.82	$197.33	$87.78	-6.9%	-2.3%	$108.90	$72.72	-48.6%	-19.0%
62318	Epidural or subarachnoid, catheterization, C/T	$240.20	$100.03	$223.53	$97.99	-6.9%	-2.0%	$111.41	$79.53	-53.6%	-20.5%
62319	Catheterization, epidural, L/S	$173.52	$96.97	$162.97	$94.58	-6.1%	-2.5%	$114.99	$81.32	-33.7%	-16.1%
64479	Cervical transforaminal epidural injections	$248.37	$136.43	$234.08	$133.37	-5.8%	-2.2%	$244.31	$139.35	-1.6%	2.1%
64480	Cervical transforaminal epidural injections add-on	$117.72	$65.66	$112.62	$65.32	-4.3%	-0.5%	$117.14	$67.71	-0.5%	3.1%
64483	Lumbar/sacral transforaminal epidural injections	$232.38	$115.00	$216.39	$111.60	-6.9%	-3.0%	$225.33	$116.42	-3.0%	1.2%
64484	Lumbar/sacral transforaminal epidural injections add-on	$90.84	$52.74	$85.74	$52.06	-5.6%	-1.3%	$89.56	$54.09	-1.4%	2.6%

Table 2 (cont.). *Comparison of physician payment rates for select interventional pain management services without SGR reduction and 0.5% update.*

CPT	Description	2013 (CF=$34.0230)		2014 Prposed (CF=$34.0230)* WITHOUT SGR CUT				2014 Final (CF=$35.8228) WITHOUT SGR CUT			
		Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	% of change from 2013		Non-Facility (Office)	Facility (ASC/ Hospital)	% of change from 2013	
						Non-Facility	Facility			Non-Facility	Facility
77003	Fluoroscopic guidance for spine injection	$95.26		$87.10		-8.6%		$90.99	-	--4.5%	-
77003-26	Fluoroscopic guidance and localization of needle or catheter tip for spine or therapeutic injection procedure	$29.94	$29.94	$29.60	$29.60	-1.1%	-1.1%	$30.81	$30.81	2.9%	2.9%
77003-TC	Fluoroscopic guidance and localization of needle or catheter tip for spine or therapeutic injection procedure	$65.32		$57.50		-12.0%		$60.18		-7.9%	-
99201	Office/outpatient visit new	$43.89	$25.86	$41.85	$25.52	-4.7%	-1.3%	$43.35	$26.51	-1.2%	2.5%
99202	Office/outpatient visit new	$74.51	$48.99	$71.45	$48.65	-4.1%	-0.7%	$74.51	$50.51	0.0%	3.1%
99203	Office/outpatient visit new	$107.85	$74.85	$103.43	$74.17	-4.1%	-0.9%	$108.18	$77.02	0.3%	2.9%
99204	Office/outpatient visit new	$164.67	$127.93	$158.55	$125.89	-3.7%	-1.6%	$166.22	$131.83	0.9%	3.0%
99205	Office/outpatient visit new	$203.80	$164.33	$197.33	$161.95	-3.2%	-1.4%	$207.06	$170.16	1.6%	3.5%
99211	Office/outpatient visit established	$20.41	$8.85	$19.39	$8.85	-5.0%	0.0%	$20.06	$9.31	-1.7%	5.2%
99212	Office/outpatient visit established	$43.89	$24.50	$41.51	$24.16	-5.4%	-1.4%	$43.70	$25.43	-0.4%	3.8%
99213	Office/outpatient visit established	$72.47	$49.67	$69.41	$49.33	-4.2%	-0.7%	$73.08	$51.58	0.8%	3.8%
99214	Office/outpatient visit established	$106.49	$76.55	$102.41	$75.53	-3.8%	-1.3%	$107.83	$79.17	1.3%	3.4%
99215	Office/outpatient visit established	$142.90	$107.85	$137.79	$106.49	-3.6%	-1.3%	$144.37	$111.41	1.0%	3.3%

or even emergency room. Further, they can purchase any physician office and bill them as a hospital outpatient department (HOPD). There can be 4 times more reimbursement for the same procedure performed in the same setting, just based on ownership.

The process that took place in arriving at these draconian cuts is worth reviewing.

Let's rewind to November 27, 2013. CMS posted the CY 2014 final rule for physician payments, hospital outpatient and ASC payments on its website with the new rates effective January 1, 2014, just hours before the start of the Thanksgiving holiday (3,14). These policies are covered in large volumes with a minimum of 600 pages of proposed rules and then 600 pages or so in the proposed rule and final rule governing Medicare payment policies for 2014 (3,13,14,23).

When the proposed rule and the final rule were released there was no positive news on SGR cuts; now we have the news the SGR cut has been delayed for 3 months (22). Congress continues to work on a perma-

nent fix for SGR (24-26). The proposed physician payment rule, without the SGR cut showed similar rates for epidural injections in 2013 (3,13). However, to everyone's surprise the final rule showed significant arguably devastating cuts of 19% and 33% for physician payment and 56% and 49% for in-office procedures for cervical and lumbar epidural injections.

Basically this translated to a $42 payment for a physician for preoperative assessment, intraoperative procedure performance, and post-operative follow-up with approximately $30 payment for practice overhead expense. $30 might very well not cover the overhead expenses considering that it represented 60% of previous payments. Practice expenses have been increasing at a rapid pace compared to increases in fee schedule payments.

These cuts were not mentioned in the proposed rule. CMS stated that they were based on Relative Value Update (RUC) survey, however, the RUC had recommended no reduction in fees even though they established that physician work time was reduced. CMS agreed with RUCs methodology; however, they disagreed with the work RVUs of 1.68 and 1.54 for CPT 62310 and CPT 62311, as recommended by RUC and reduced it to 1.18 and 1.17. Tables 3 and 4 show the magnitude of cuts and discrepancies between RUC recommendations and CMS rulings.

If the reader wonders why there is such a large discrepancy between the same procedures performed in different settings one need only look at formulas. Hospitals are calculated on a different formula, ASCs are calculated as a proportion of HOPD based on budget neutrality, whereas physician office expenses and physical work values are calculated based on RUC recommended values.

However, the authors of this review wish to underscore that office based practices are increasingly being purchased by hospitals and in this well documented circumstance, the ownership has the potential to change the payment dramatically. Thus for procedures which dictates payment of $670 in an office setting owned by a hospital, it is reduced to $33 and $35 plus $57 for fluoroscopy with a total of either $90 or $92 in the same office setting which is not owned by a hospital.

CMS did not accept the RUCs recommended work RVUs with the only stated reason being that the reduction from the current work RVU was not comparable to the reduction in time being recommended by the American Medical Association (AMA) RUC (14). CMS arrived at the lower work RVUs for both the codes plus catheterization codes by adopting the survey low for codes CPT 62318 and CPT 62319, which were outliers at the extremes of survey results, and then using those values to derive the values for CPT codes 62310 and CPT 62311. This is also important to note that 62318 and 62319 are rarely performed in interventional pain management. The expenses are much lower for these codes since these are not performed under fluoroscopy and contrast is not injected. Various other drugs are also injected for pro-

Table 3. *Relative values of epidural injections 2013 versus 2014.*

CPT Code	CY 2013 Work RVUs	AMA RUC Recommended Work RVUs	CY 2014 Work RVUs	Percent Change in Work RVUs from 2013 to 2014
62310	1.91	1.68	1.18	-38.2%
62311	1.54	1.54	1.17	-24.0%
62318	2.04	2.04	1.54	-24.5%
62319	1.87	1.87	1.50	-19.8%

Table 4. *Magnitude of reductions of epidural injections.*

	Physician Work RVUs			Non-Facility PE RVUs (Including office overhead payments)			Malpractice RVUs			Total Non-facility RVUs (Including office overhead and physician payments)		
CPT	2013	2014	% of change from 2013	2013	2014F	% of change from 2013	2013	2014F	% of change from 2013	2013	2014f	% of change from 2013
62310	1.91	1.18	-38.2%	5.33	1.81	-66.0%	0.16	0.10	-37.5%	7.40	3.09	-58.2%
62311	1.54	1.17	-24.0%	4.57	1.78	-61.1%	0.12	0.09	-25.0%	6.23	3.04	-51.2%
62318	2.04	1.54	-24.5%	4.86	1.46	-70.0%	0.16	0.11	-31.3%	7.06	3.11	-55.9%
62319	1.87	1.50	-19.8%	3.07	1.59	-48.2%	0.16	0.12	-25.0%	5.10	3.21	-37.1%

Table 5. *Comparison of epidural procedures payments in various settings*

CPT	Physician	Overhead / Facility payments					Office Overhead to	
		Office			ASC	HOPD		
		Overhead	77003-TC	Overhead total			ASC	HOPD
62310	$74.15	$36.54	$60.18	$96.72	$370.07	$669.91	26%	14%
62311	$72.72	$36.18	$60.18	$96.36	$370.07	$669.91	26%	14%
62318	$79.53	$31.88	$60.18	$92.06	$370.07	$669.91	25%	14%
62319	$81.32	$33.67	$60.18	$93.85	$370.07	$669.91	25%	14%

cedures covered by CPT 62310 and CPT 62311, which are not used in 62318 and 62319.

Above all, the results were available around October 2012 to CMS, yet CMS has not utilized them in the proposed rule. Chapter 1 of the Medicare Program Integrity Manual states with respect to improper payments that CMS should be measuring, correcting, and preventing overpayments as well as underpayments (27).

During the same period, due to elimination of payments for additional codes, payments for HOPDs as well as ASCs have increased approximately 18.4% for these particular codes. The differences between multiple settings are shown in Table 5 which shows comparison of epidural procedures payments in multiple settings with out an SGR cut.

Ultimately, the result will be that approximately 40% of pain physicians who focus their practices mainly in an office setting (28) will be seriously affected and transfer their practices to an ASC or more likely, to a hospital setting, stop offering interventional techniques or completely stop seeing patients. If all the patients are moved to a hospital setting this may cost Medicare in excess of $150 million in additional reimbursements.

Thus, we welcome 2014, with issues related to SGR (24-26), multiple regulatory burdens of the Affordable Care Act (29), the expected International Classification of Disease (ICD) transition (30,31), exploding Medicaid managed care, expanded Health Insurance Portability and Accountability Act (HIPAA) compliance (32), reimbursement tied to Physician Quality Reporting System (PQRS) and outcomes (14,33), multiple LCD issues, meaningful use of electronic medical records (EMRs) (34,35), and highly limited coverage policies from Affordable Care enrollees and private insurers (11,36).

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Conflict of Interest

Dr. Benyamin is a consultant and lecturer for Boston Scientific and Kimberly Clark.

Dr. Falco is a consultant for St. Jude Medical Inc. and Joimax Inc.

Dr. Kaye is a speaker for Depomed, Inc.

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