Health Policy

Reframing Medicare Physician Payment Policy for 2019: A Look at Proposed Policy

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On July 12, 2018, the Centers for Medicare and Medicaid Services (CMS) released the proposed 2019 Medicare physician fee schedule and quality payment program, combining these 2 rules for the first time. This occurred in a milieu of changing regulations that have been challenging for interventional pain management specialists. The Affordable Care Act (ACA) continuous to be amended by multiple administrative changes. This July 12th rule proposes substantial payment changes for evaluation and management (E&M) services, with documentation requirements, and blending of Level II to V CPT codes for E&M into a single payment. In addition, various changes in the quality payment program with liberalization of some metrics have been published. Recognizing that there are differing impacts based on specialty and practice type, as a whole interventional pain management specialists would likely see favorable reimbursement trends for E&M services as a result of this proposal. Moreover, in comparison with recent CMS final ruling, this proposed rule has relatively limited changes in procedural reimbursement performed in a facility or in-office setting.

CMS, in the new rule, has proposed an overhaul of the E&M documentation and coding system ostensibly to reduce the amount of time physicians are required to spend inputting information into patients' records. The new proposed rule blends Level II to V codes for E&M services into a single payment of $93 for office outpatient visits for established patients and $135 for new patient visits. This will also have an effect with blended payments for services provided in hospital outpatients. CMS also has provided additional codes to increase the reimbursement when prolonged services are provided with total reimbursement coming to Level V payments. Interventional pain management-centered care has been identified as a specialty with complexity inherent to E&M associated with these services.

Among the procedural payments, there exist significant discrepancies for the services performed in hospitals, ambulatory surgery centers (ASCs), and offices. A particularly egregious example is peripheral neurolytic blocks, which is reimbursed at 1,800% higher in hospital outpatient department (HOPD) settings as compared with procedures done in the office. The majority of hospital based procedures have faced relatively small cuts as compared with office based practice. The only significant change noted is for spinal cord stimulator implant leads when performed in office setting with 19.2% increase. However, epidural codes, which have been initiated with a lower payment, continue to face small reductions for physician portion.

This review describes the effects of the proposed policy on interventional pain management reimbursement for E&M services, procedural services by physicians and procedures performed in office settings.

Key words: Physician payment policy, physician fee schedule, Medicare, Merit-Based Incentive Payment System, interventional pain management, regulatory tsunami, Medicare Access and CHIP Reauthorization Act of 2015

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The Centers for Medicare and Medicaid Services (CMS) released its proposed 2019 Medicare Physician Fee Schedule on July 12, 2018, with the comment period ending September 10, 2018 (1). As opposed to prior iterations, the 2019 Medicare physician fee schedule (MPFS) and quality payment program (QPP) proposed rule is the first year that the 2 rules have been combined. This rule also is accompanied by multiple fact sheets including ones on changes to the quality payment program and physician fee schedule proposals for 2019. In many ways, these changes reflect the philosophy of the Trump administration. This is in contrast to the 2017 proposed rule at which time the Obama administration had declared the success of the Patient Protection and Affordable Care Act (ACA) with significant progress towards solving longstanding challenges facing the US health care system related to access, affordability, and quality of care (2-8). As we have described in the past, reducing health care expenditures with increased access to affordable insurance coverage and improvement in quality have been the cornerstones of multiple legislative efforts and regulations including the ACA (4-18). Despite the fact that there are clear examples of program success, the effectiveness of ACA in achieving some of its primary goals has been questioned (5,8). There has been a net increase in the number of individuals with insurance; a portion of which is attributable to the expansion of Medicaid. Moreover there likely has been a reduction in costs; however, with diminished access for many who were previously insured and concerningly without corresponding improvement in the quality of care (4,5,8).

National health expenditures (NHEs) have grown with expenditures reaching $3.3 trillion in 2016, which is equivalent a 17.9% share of the gross domestic product (GDP) (19). Medicare spending also reached a historic $672.1 billion with a share of 20.36% of total NHEs, while Medicaid spending grew almost as high as Medicare to $565.5 billion in 2016, and a 17.1% share of total NHE (19). The Trump administration started with plans to repeal the ACA, which have not materialized even with multiple legislative attempts through Congress leaving it as the law of the land (20,21). The statistics showing expenditures in the United States reveal that the US spent $87.6 billion on back and neck pain with an additional $95.9 billion on musculoskeletal disorders in 2013 (22). Further, the same authors also showed that the major reason for the increase in expenditures was related to changes in service price and intensity, whereas changes in service utilization were not associated with a statistically significant change (23). The data also showed that changes in disease prevalence of instance were essentially associated with spending reductions of 2.4% or $28.2 billion (23). Even then, disability continues to escalate, along with opioid related deaths, which continue to increase at epidemic rates (24-26). It was also postulated that a nominal decrease in health care cost based on price reductions and cost calculation methodology of services with site-of-service differentials by Medicare and others, and multiple policy changes, may have led to the unintended consequences of limiting access to medically needed services (2-4,27,28).

In a press release from July 2018, in the form of a letter to physicians from CMS Administrator, Seema Verma, the administration understandings of the issues facing provider communities and Medicare were described (29). Administrator Verma highlighted the following:

- Years of eduction, training, and hard work, as well as the expertise of physicians, are not utilized appropriately, but instead, they are being forced to spend far too much of their time on burdensome and often mindless administrative tasks.
- Wasteful tasks imposed on physicians have been draining energy and taking time away from patients, from reporting on measures that demand that physicians follow complicated and redundant processes, to documenting lines of text that don't add value to patient's medical record, to hunting down records and faxes from other physicians and sifting through them.
- The systems have taken the most brilliant students and put them to work clicking through screens and copying and pasting, with 42% of physicians reporting burnout.
- Doctor/patient relationship has been deteriorating and patients are not being put first.
- Physicians should be able to deliver care to patients, not sitting at a computer screen.

Administrator Verma blamed Washington for many of the frustrations with the current system, as policies that have been put forth as solutions either have not worked or have moved health care in the opposite direction. In fact, she stated that electronic health records that should make it easier for physicians to record notes and achieve interoperability. Amazingly, the government spent $30 billion to encourage their uptake, turning this tool into a serious distraction from patient care due to the inability to exchange records between systems and the increasing requirements for information that must be documented. Administrator Verma promised that CMS is committed to turning the tide and has launched "Patients Over Paperwork" initiative, under which they have been working to reduce the burden of unnecessary rules and requirements. CMS indicates that is has thus proposed an overhaul of the evaluation and management (E&M) documentation and coding system ostensibly to dramatically reduce the amount of time physicians have to spend in putting unnecessary information into patient's records. Administrator Verma also described multiple other changes that are reflected in this proposed rule including a major reduction of the documentation burden for E&M office visit code, .new payments for physician services that are not part of a face-to-face office visit and some easements in the quality payment program

The proposed policy favorably affects interventional pain management's reimbursement for E&M services, procedural services by physicians and procedures performed in office settings.

Background

Medicare establishes a physician fee schedule for services furnished by physicians and other practitioners in all sites of services, including office visits, surgical procedures, diagnostic tests, therapy services, and multiple specified preventive services. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through application of a conversion factor. Payment rates are calculated to include an overall payment update specified by the statute.

The impact of the Medicare physician fee schedule is enormous for interventional pain physicians. The Medicare fee schedule affects not only fee-for-service Medicare, but also Medicare Advantage Plans, a large number of Medicaid plans, and a significant proportion of private payers. Since 2016, interventional pain management has suffered significant losses in multiple areas of payments, not only for physician payments, but also facility payments for in-office procedures and ambulatory surgery centers. Further, the opioid epidemic has also become a focus affecting interventional techniques in that interventional techniques might appropriately be considered in lieu of prescriptions opioids (24-26,30-40). Manchikanti et al (2) demonstrated significant declines in payment rates in 2017, which continued through 2018, despite multiple efforts by American Society of Interventional Pain Physicians (ASIPP) and others to avoid these reductions. This is likely resulting in reductions in utilization of interventional techniques as shown in Appendix Table 1 and Appendix Figs. 1-4 (33-39). Opioid prescriptions are down but deaths continue to increase concurrent with a decline in interventional techniques as shown in Appendix Figs. 5 and 6 (24-32).

Even prior to the proposed rule, interventional techniques have been facing a multitude of issues despite demonstration of clinical and cost effectiveness due to improper evidence synthesis (41-58). Based on the available data, CMS is proposing updated pricing recommendations for supply and equipment items currently used as direct practice expense (PE) inputs. These data were derived from market research resources and methodologies including field surveys, aggregate databases, vendor resources, market scans, market analysis, physician substantiation, and statistical analysis. CMS is proposing to update supply and equipment pricing over a 4-year phase-in.

Physician Payment Update

The proposed rule updates physician payment schedule conversion factor from $35.9996 to $36.0463, reflecting a statutory update of 0.25%, offset by a budget neutrality adjustment of -0.12%, resulting in a 0.13% update.

Evaluation and Management Services Payments

CMS proposed to collapse payment for office and outpatient visits to a single blended payment for office visits, Level 2 to 5 for new patients (CPT 99202-99205) with a single payment of $134.45 and for established patient office visits with a single payment for Levels 2-5 (CPT 99212-99215) into a single payment of $92 as shown in Table 1.

In addition, new codes would be created to provide additional payments to office visits of $5, $14 and $67, with multiple procedure adjustment with reduction when an E&M visit is furnished in combination with a procedure on the same day (Table 2). Physicians will be allowed to choose their method of documentation, among the following options:

- 1995 or 1997 E&M guidelines for history, physical examination, and medical decision making (current framework for decision making, which is the

Table 1. *Proposed blended payment schedule for office and outpatient based evaluation and management visits.*

	Physician Office Payments		Hospital Outpatient Payments					
Established Patients	**2018**	**2019 Proposed**	**2018**			**2019 Proposed**		
			Physician	**Facility**	**Total**	**Physician**	**Facility**	**Total**
Level 1 – CPT 99211	$21.96	$24.15	$9.36		$123.04	$9.73		$125.49
Level 2 – CPT 99212	$44.64		$25.92		$139.60			
Level 3 – CPT 99213	$74.16	$91.92	$52.20	$113.68	$165.88	$65.60	$115.76	$181.36
Level 4 – CPT 99214	$109.44		$79.92		$193.60			
Level 5 – CPT 99215	$147.60		$113.04		$226.72			
New Patients								
Level 1 – CPT 99201	$45.36	$43.26	$27.36		$141.04	$25.59		$141.35
Level 2 – CPT 99202	$76.32		$51.48		$165.16			
Level 3 – CPT 99203	$109.80	$134.45	$78.12	$113.68	$191.80	$102.37	$115.76	$218.13
Level 4 – CPT 99204	$167.40		$131.76		$245.44			
Level 5 – CPT 99205	$210.60		$172.08		$285.76			

Table 2. *Proposed additional payment codes in 2019 physician payment rule.*

• Proposing ~**$5 add-on payment** to recognize additional resources to address inherent complexity in E&M visits associated with primary care services.
• Proposing ~**$14 add-on payment** to recognize additional resources to address inherent visit complexity in E&M visits associated with certain non-procedural based care.
• Proposing ~**$67 add-on payment for a 30 minute prolonged E&M visit**.

current framework for documentation)

- Medical decision making only.
- Physician time spent face-to-face with patients.

It seems that some physicians will continue to document and report among the 5 levels of codes. CMS will only require documentation to support the medical necessity of the visit and to support a Level 2 CPT visit code. In order to report an established office visit to Medicare, physicians need to document medical necessity and then one of the following:

- Two of the 3 components:
  1) Problem-focused history that does not include a review of systems or a past, family or social history;
  2) A limited examination of the affected body area or organ system; and
  3) Straightforward medical decision making measured by minimal problems, review, and risk; or
- Time personally spent by billing practitioner face-to-face with the patient.

However, CMS is soliciting comments on what time should be required if this is the documentation selection with multiple options being considered. One option being 10 minutes (CPT defined typical time) or 16 minutes which is a weighted average of all established office visits.

An impact analysis with additional payment accuracy adjustments was performed by CMS as shown in Table 3. For 2019, multiple specialties may face a reduction. For some specialties, it is rather significant and it is thus easy to understand their concern. Obstetrics and gynecology will be the major beneficiary with overall 4% increase, followed by nurse practitioners of 3%. Interventional pain management will see less than 3% increases. Anesthesiology and physical medicine and rehabilitation specialties will see minimal changes to overall payments.

Song and Goodson (59) analyzed the CMS proposal to reform office visit payments. Overall they had a negative opinion about collapsing of the codes and also the resultant adverse consequences. As shown in Appendix Fig. 7, they postulated that these changes may benefit by removing physicians' incentive to spend time with patients who have complex needs. Thus, physicians who

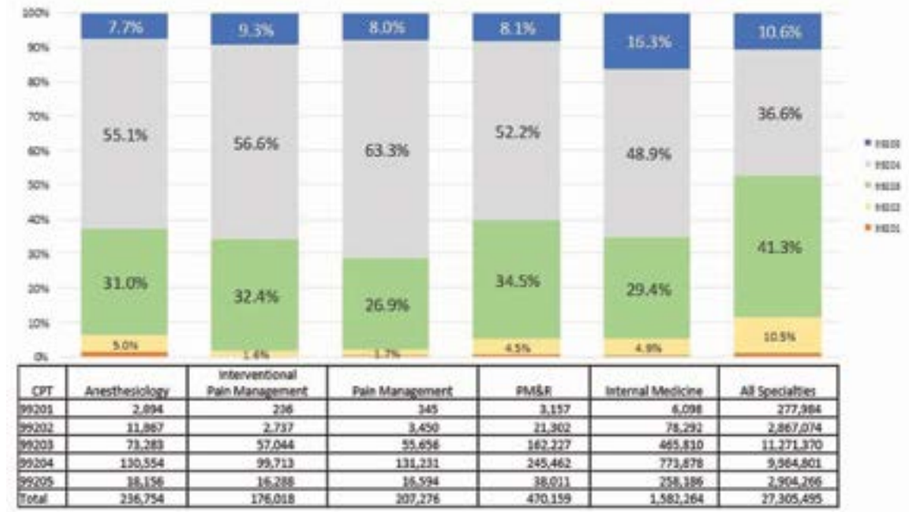
Table 3 *Specialty-specific impacts including payment accuracy adjustments.*

Specialty	Allowed Charges (in millions)	Estimated Potential Impact of Valuing Levels 2-5 Together, with Additional Adjustments
Obstetrics/Gynecology	$664	4%
Nurse Practitioner	$3,586	3%
Obstetrics/Gynecology	$664	Less than 3% estimated increase in overall payment
Nurse practitioner	$3,586	
Hand Surgery	$202	
Interventional Pain Management	$839	
Optometry	$1,276	
Physician Assistant	$2,253	
Psychiatry	$1,260	
Anesthesiology	$1,995	Minimal change to overall payment
Cardiac Surgery	$313	
Cardiology		
Chiropractor	$789	
Colon and Rectal Surgery	$168	
Critical Care	$334	
Emergency Medicine	$3,196	
Endocrinology	$482	
Family Practice	$6,382	
Gastroenterology	$1,807	
General Practice	$461	
General Surgery	$2,182	
Geriatrics	$214	
Infectious Disease	$663	
Internal Medicine	$11,173	
Interventional Radiology	$362	
Multispecialty Clinic/Other Physicians	$141	
Nephrology	$2,285	Minimal change to overall payment
Neurosurgery	$812	
Nuclear Medicine	$50	
Ophthalmology	$5,542	
Oral/Maxillofacial Surgery	$57	
Orthopedic Surgery	$3,815	
Other	$30	
Pathology	$1,151	
Pediatrics	$64	
Physical Medicine	$1,120	
Plastic Surgery	$387	
Radiology	$4,898	
Thoracic Surgery	$360	
Vascular Surgery	$1,132	
Allergy/Immunology	$240	Less than 3% estimated decrease in overall payment
Audiologist	$67	
Hematology/Oncology	$1,813	
Neurology	$1,565	
Otolaryngology	$1,220	
Pulmonary Disease	$1,767	
Radiation Oncology and Radiation Therapy Centers	$1,776	
Rheumatology	$559	-3%
Dermatology	$3,525	-4%
Podiatry	$2,022	-4%
TOTAL	$93,486	0%

disproportionately care for patients with complex needs would face a fee cut for Levels 4 and 5 visits, despite the add-on payment. Further, physicians in nonprocedural specialties whose revenue derives largely from these visits as shown in Appendix Fig. 7 could find this cut untenable. Figures 1 and 2 compare the interventional pain management, pain management, and parent specialties compared with internal medicine and overall specialties. As illustrated earlier, interventional pain management would see an increase with added benefit of reduced documentation, facilitating increased patient time.

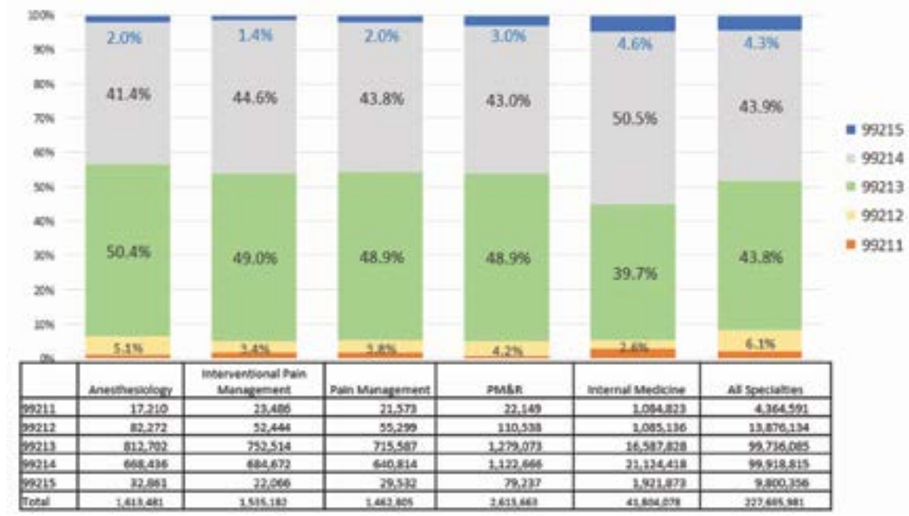
Other Evaluation and Management Proposals

1. When physicians report an E&M service and a procedure on the same date, CMS proposes to implement a 50% multiple procedure payment reduction to the lower paid of the 2 services. However, this policy is not consistent with current valuation of procedures commonly performed with office visits, as duplicative resources have already been removed from the underlying procedures. It appears CMS proposed this policy to offset payment increases to dermatology and other specialties that



CPT	Anesthesiology	Interventional Pain Management	Pain Management	PM&R	Internal Medicine	All Specialties
99201	2,094	236	345	3,157	6,098	277,384
99202	11,867	2,737	3,450	21,302	78,292	2,867,074
99203	73,283	57,044	55,656	162,227	465,810	11,271,370
99204	130,554	99,713	131,231	245,462	773,878	9,364,801
99205	18,156	16,288	16,594	38,011	258,186	2,904,266
Total	236,754	176,018	207,276	470,159	1,582,264	27,305,495

Fig. 1 *2016 Medicare E&M services by level of service – new patient visits.*



	Anesthesiology	Interventional Pain Management	Pain Management	PM&R	Internal Medicine	All Specialties
99211	17,210	23,486	21,573	22,149	1,084,823	4,364,591
99212	82,272	52,444	55,299	110,538	1,085,136	13,876,134
99213	812,702	752,514	715,587	1,279,073	16,587,828	99,736,085
99214	668,436	684,672	640,814	1,122,666	21,124,418	99,918,815
99215	82,861	22,066	29,532	79,237	1,921,873	9,800,356
Total	1,413,481	1,535,182	1,462,805	2,613,663	41,804,078	327,695,981

Fig. 2. *2016 Medicare E&M services by level of service – established patient visits.*

often report lower level office visit codes in conjunction with minor procedures.

2. In addition, CMS will add $5 to each office visit performed for primary care purposes via a new code GPC1X visit complexity inherent to E&M associated with primary medical care services. In addition, relevant to interventional pain management, CMS identified multiple specialties including interventional pain management that often report higher level office visits and noted that potential reduction in payment. To offset this loss, CMS proposes to add $14 to each office visits performed by the specialists in the following specialties via a new code GCGOX visit complexity inherent to E&M (Table 2). The following specialties have been identified:
   - Allergy/immunology
   - Cardiology
   - Endocrinology
   - Hematology/oncology
   - Interventional pain management-centered care
   - Neurology
   - Obstetrics/gynecology
   - Otolaryngology
   - Rheumatology
   - Urology

A new prolonged service code will be implemented to add on to any office visit lasting more than 30 minutes beyond the office visit (i.e., hour-long visits in total. It is reported by:

- Code GPR01, prolonged evaluation and management or psychotherapy services(s). with a payment rates of $67 (Table 2).

An interventional pain management physician currently reporting 99205 and spending more than 60 minutes with a patient would be paid $211. Under the proposed new method, the interventional pain physician would report 99202-99205, depending on their documentation selection ($134), plus GCG0X ($14), plus GPR01 ($67), for a combined payment of $215.

CMS will implement new codes and payment for remote monitoring and inter-professional consultations.

3. Medicare would pay physicians for their time when they reach out to beneficiaries via telephone or other telecommunication devices to decide whether an office visit or other service is needed. CMS also proposes to pay for the time it takes physicians to review a video or image sent by a patient seeking care or diagnosis for an ailment.

Practice Expense Relative Values

Based on the Protecting Access to Medicare Act of 2014 (PAMA), CMS initiated a market research to update the direct PE inputs for supply and equipment pricing for calendar year (CY) 2019.

Proposed Additional Calculation for Evaluation and Management Services

CMS determines the proportion of indirect PE allocated to a service by calculating a PE per hour based upon the mix of specialties that bill for a service. However, a wide range of specialties bill for E&M services and the change into one payment level will have an effect on PE per hour for many specialities. To address this issue, CMS is proposing to create a single PE per hour value for E&M visits of $136.34, based on an average of the PE per hour across all specialties that bill E&M codes, weighted by the volume of those specialties allowed charge for E&M services.

Creation of a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

Due to the available evidence suggesting that routine counseling, either associated with medication-assisted treatment (MAT) or on its own, can increase the effectiveness of treatment for substance use disorder, the federal guidelines for opioid treatment programs describe that MAT and wraparound psychological and support service can include the following services (60):

- Physical examination and assessment
- Psychological assessment
- Treatment planning
- Counseling
- Medication management
- Drug administration
- Comprehensive care management and supportive services
- Care coordination
- Management of care transition
- Individual and family support services
- Health promotion

CMS now believes that making a separate payment for a bundled episode of care for management and counseling for substance use disorders could be effective in preventing the need for more acute services (61). Medicare pays for one-third of opioid related hospital stays, and Medicare has seen the largest annual increase

in the number of these stays over the past 2 decades. CMS is requesting comments on whether the counseling portion and other MAT components could also be provided by qualified practitioners "incident" to the services of the billing physician who would administer or prescribe any necessary medications and manage the overall care, as well as supervise any other counselors participating in the treatment.

Professional Liability Insurance Relative Values

CMS is seeking specific comments on ways to improve how specialties in the state-level raw rate filings data are cross walked for categorization into CMS specialty codes in order to develop the specialty-level risk factors and the professional liability insurance (PLI) RVUs. At present CMS is proposing to add 28 codes identified as low-volume services to the list of codes for anticipated specialty assignment. These codes are reported with the -26 modifier and were submitted by the RUC. In the addendum for the CY2019 malpractice risk factors and premium amounts by specialty, CMS cross walked non-MD-DO specialties to the lowest MD-DO risk factor specialty, allergy immunology. The RUC also has consistently maintained that a risk factor linked to a physician specialty is too high for many of the non-physician health care professions.

In addition, cardiothoracic surgery and neurosurgery, specialties with high PLI costs, are proposed to receive positive impacts to payments related to their insurance costs for 2019.

Global Surgery Data Collection

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement a process to collect data on post-operative visits and use these data to assess the accuracy of global surgical package valuation.

CMS currently bundles payments for postoperative care within 10 or 90 days after many surgical procedures. Historically, CMS has not collected data on how many postoperative visits are actually performed during the global period. In the year 2017 FFS final rule, CMS adapted a policy to collect postoperative visit data (62). Consequently, CMS required practitioners in groups with 10 or more practitioners in 9 states including Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island to use the no pay CPT code 99024 for the postoperative follow-up visit, normally included in the surgical package, to indicate that an E&M service was performed during a postoperative period for reasons related to the original procedure to report postoperative visits. However, this has not affected practitioners who only practice with fewer than 10 practitioners. There have been multiple data reporting utilizing CPT 99024 in anesthesiology. The proportion of practitioners reporting CPT code 99024 in anesthesiology is 29%, pain management is 40%, and interventional pain management is 33%. Further, these were variable for 10-day and 90-day global period. In the future, CMS may add or increase physician payment work value based on this data.

2019 Potentially Misvalued Codes List

CMS continues to propose a list of potentially misvalued codes for review by the RUC and possible adjustment. Historically, the RUC and CMS has identified 2,086 services through 20 different screening criteria for further review by the RUC since 2006 (63-66). The RUCs efforts for 2009 to 2018 have resulted in $5 billion for redistribution within the Medicare Physician Payment Schedule.

Potentially misvalued codes are identified in the following categories:

- Codes that have experienced the fastest growth
- Codes that have experienced substantial changes in practice expense
- Codes that describe technologies or surveys within an appropriate time period (such as 3 years) after the relative values are initially established for such codes
- Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment
- Codes that have not been subject to review since implementation of the fee schedule
- Codes that account for the majority of spending under the fee-for-service (FFS)
- Codes for services that have experienced a substantial change in the hospital length of stay or procedure time
- Codes for which there may be a change in the typical site of service since the code was last valued
- Codes for which there is significant difference in payment for the same service between different sites of service
- Codes for which there may be anomalies in relative values within a family of codes
- Codes for services when there may be efficiencies when a service is furnished at the same time as other services
- Codes with higher intraservice work per unit of time
- Codes with high PE RVUs
- Codes with high cost supplies
- Codes as determined appropriate by the secretary

Apart from CMS identifying the misvalued codes, the public and stakeholders, including insurers, may nominate potentially misvalued codes for review by submitting the code with supporting documentation by February 10 of each year.

Payment for Interventional Pain Management Procedures

In the proposed rule, the physician payment schedule conversion factor is updated to $36.0463 from the previous factor of $35.9996. This is a reflection of the statutory update of 0.25%. However, this is offset by the budget neutrality adjustment of 0.12% and so the actual update result is only 0.13%

The physician payment schedule is mostly without significant changes in payment rates for procedures, without major changes for more commonly performed procedures, while some procedures have seen significant increases; consequently, it is a mixed bag. Table 4 shows the 2019 proposed physician payment rates comparing them to the 2018 final rates. The schedule shows the rates for facility and non-facility; facility rates when a physician performs the procedure in an ASC or hospital; whereas, non-facility rates include the facility expense portion of the office. An extended schedule is available on the ASIPP website under Physician Fee Schedules at http://www.asipp.org/Fee-Schedules.html.

Based on the available literature (28,33-39), an overwhelming majority of interventional techniques are performed in outpatient settings, either in physicians' offices, hospital outpatient departments (HOPDs), or ambulatory surgery centers (ASCs). In 2012, the Medicare Payment Advisory Commission (MedPAC) recommended that if the same service can be safely performed in different settings, a prudent purchaser should not pay more for that service in one setting than in another (27,67). The Office of Inspector General (OIG) also has expressed a similar approach (68); however, because of hospital acquisition of practices and increased levels of payments which is costing more for Medicare. More and more procedures are performed in an HOPD setting, essentially in an office setting which is most likely similar to offices utilized outside, but paid at 300% more than in-office procedures and over 80% more than in ASCs. Further, for some procedures there is such a dramatic difference that hospitals are paid at 2,000% as shown in Table 5 (1,68).Thus, the same procedures are provided in an office is reimbursed at a rate of $14-$20 with continued reductions in 2019, which were initiated in 2017. These rates are inadequate for these procedures which must be performed in sterile fashion following the guidance set by the Centers for Disease Control and Prevention (CDC).

With the continued decline in reimbursement initiated in 2017, percutaneous adhesiolysis (CPT 62263 and 62264) continue to be the subject of comments in the past and continue to face declines. Once again, the fee schedule shows a 0.9% to 2.4% reduction for non-facility settings and a reduction of 1.5% to 4.9% for facility setting. CPT 62263 involving multiple percutaneous epidural adhesiolysis sessions, 2 or 3 days, is performed very infrequently or rarely. However, CPT 62264 is commonly performed (38), though its utilization is declining rapidly as shown in Appendix Fig. 3. and Appendix Table 2. The reimbursement is reduced 0.9% in a non-facility setting and 1.5% in a facility setting. Even though there is no significant difference for the facility portion of the work involved to perform the procedure in a non-facility setting, there is a significant difference in reimbursement of $426.43 versus $597.65.

The saga related to epidural injections with and without fluoroscopy which started in 2017 continues. Overall, the reimbursement changed with an increase of 0.1% to 0.8% for non-facility services; whereas, it declined by 1.6% to 2.1% when the procedure is performed in a facility setting. The reimbursement rates continue to be inadequate with elimination of separate payment for fluoroscopy, leading potentially to a shift of procedures to the more highly reimbursed transforaminals rather than interlaminars. Interlaminars have declined significantly over the past few years though there are other confounding factors at play with regards to this migration (Appendix Fig. 2 and Appendix Table 3) (34,37). Ironically, there are meaningful increases for continuous epidural injections which are never performed in chronic pain management settings and carry different codes when they are performed in obstetric anesthesia.

There are significant reductions for electronic analysis of programmable pump (CPT 62367), electronic analysis of programmable pump with reprogramming (CPT 62368) with 8.1% and 6.8% reductions for non-facility performance, whereas, these reductions are 2.8% and 4% in a facility setting.

Table 4. *2019 proposed physician payment rates compared to 2018 rates.*

CPT	Description	2018 (CF=35.9996)		2019 Proposed (CF: 36.0463)		% of change from 2018	
		Non-Facility (Office)	Facility (ASC/ HOPD)	Non-Facility (Office)	Facility (ASC/ HOPD)	Non-Facility (Office)	Facility (ASC/ HOPD)
20526	Injection, therapeutic, carpal tunnel	$79.56	$59.76	$79.30	$59.84	-0.3%	0.1%
20550	tendon sheath, ligament injection	$54.36	$40.68	$53.35	$40.01	-1.9%	-1.6%
20551	Tendon origin/insertion	$62.28	$44.28	$53.71	$40.73	-13.8%	-8.0%
20552	Single or multiple trigger point(s), 1 or 2 muscle group(s)	$56.52	$39.24	$55.87	$38.57	-1.1%	-1.7%
20553	Single or multiple trigger point(s), 3 or more muscle groups	$65.16	$44.64	$64.88	$44.34	-0.4%	-0.7%
20600	Small joint injection	$49.32	$36.72	$47.58	$35.69	-3.5%	-2.8%
20605	Intermediate joint injection	$51.84	$38.88	$50.46	$37.85	-2.7%	-2.7%
20610	Major joint injection	$61.92	$47.88	$61.28	$47.94	-1.0%	0.1%
22510	Vertebroplasty (Thoracic)	$1,727.62	$453.24	$1,816.73	$454.90	5.2%	0.4%
22511	Vertebroplasty (Lumbar)	$1,705.66	$423.72	$1,797.27	$426.07	5.4%	0.6%
22512	Vertebroplasty - Additional	$978.47	$216.72	$933.24	$217.00	-4.6%	0.1%
22513	Percut kyphoplasty, thor	$7,328.08	$541.43	$7,090.67	$541.06	-3.2%	-0.1%
22514	Percut kyphoplasty, thor	$7,293.52	$503.99	$7,063.99	$503.57	-3.1%	-0.1%
22515	Percut kyphoplasty, Additional	$4,415.35	$233.64	$4,106.76	$234.30	-7.0%	0.3%
22534	Percut kyphoplasty, lumbar		$379.08		$382.45		0.9%
22869	Insj stablj dev w/o dcmprn		$551.81		$471.49		-14.6%
22870	Insj stablj dev w/o dcmprn add-on		$142.56		$128.32		-10.0%
27093	Injection procedure for HIP arthrography – without anesthesia	$191.88	$72.72	$207.99	$72.45	8.4%	-0.4%
27095	Injection procedure for HIP arthrography – with anesthesia	$252.00	$86.40	$277.20	$86.51	10.0%	0.1%
27096	Injection procedure for Sacroiliac joint, arthrography	$163.08	$86.40	$162.57	$85.07	-0.3%	-1.5%
27279	Arthrodesis sacroiliac joint		$725.61		$719.99		-0.8%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$612.35	$329.40	$597.65	$313.24	-2.4%	-4.9%
62264	Percutaneous epidural adhesiolysis – 1 day	$430.20	$245.88	$426.43	$242.23	-0.9%	-1.5%
62268	Percutaneous aspiration, spinal cord cyst or syrinx		$267.84		$266.38		-0.5%
62270	Spinal puncture, diagnostic	$162.36	$81.00	$153.92	$80.74	-5.2%	-0.3%
62272	Spinal puncture, therapeutic	$208.08	$86.76	$202.58	$87.23	-2.6%	0.5%
62273	Epidural, blood patch	$178.20	$117.36	$176.27	$116.07	-1.1%	-1.1%
62284	Injection procedure myelography	$194.76	$91.08	$203.66	$91.56	4.6%	0.5%
62287	Disc decompression		$595.43		$592.24		-0.5%
62290	Diskography each level: lumbar	$334.08	$175.32	$344.60	$172.30	3.2%	-1.7%
62291	Diskography each level: C/T	$331.92	$173.52	$330.91	$165.45	-0.3%	-4.6%
62320	Cervical or Thoracic interlaminar epidural; without fluoro	$170.28	$103.32	$165.45	$100.93	-2.8%	-2.3%
62321	Cervical or Thoracic interlaminar epidural; with fluoro	$253.80	$110.88	$254.13	$108.50	0.1%	-2.1%
62322	Lumbar or sacral (caudal) interlaminar epidural injection(s); without fluoro	$159.84	$89.64	$155.00	$87.59	-3.0%	-2.3%
62323	Lumbar or sacral (caudal) interlaminar epidural injection(s); with fluoro	$250.56	$102.60	$252.68	$100.93	0.8%	-1.6%
62324	Cervical or thoracic continuous interlaminar epidural Injection(s),; without fluoro	$149.04	$93.60	$148.51	$93.72	-0.4%	0.1%
62325	Cervical or thoracic continuous interlaminar epidural Injection(s),; with fluoro	$225.72	$108.00	$238.99	$110.66	5.9%	2.5%

Table 4 (cont.). *2019 proposed physician payment rates compared to 2018 rates.*

CPT	Description	2018 (CF=35.9996)		2019 Proposed (CF: 36.0463)		% of change from 2018	
		Non-Facility (Office)	Facility (ASC/ HOPD)	Non-Facility (Office)	Facility (ASC/ HOPD)	Non-Facility (Office)	Facility (ASC/ HOPD)
62326	Lumbar or sacral (caudal) continuous interlaminar epidural Injection(s),; Without fluoro	$156.96	$92.88	$153.20	$91.56	-2.4%	-1.4%
62327	Lumbar or sacral (caudal) continuous interlaminar epidural Injection(s),; With fluoro	$230.04	$98.64	$238.27	$99.49	3.6%	0.9%
62350	Tunneled intrathecal or epidural catheter for long-term medication administration via an external pump or implantable reservoir; w/o laminectomy		$414.36		$410.21		-1.0%
62355	Removal or previously implanted intrathecal or epidural catheter		$278.28		$277.20		-0.4%
62360	Implant or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir		$323.64		$328.74		1.6%
62361	Implantation or replacement of device for epidural drug infusion; non-programmable pump		$448.56		$454.90		1.4%
62362	Implant spine infusion pump		$398.52		$395.07		-0.9%
62365	Remove spine infusion device		$307.80		$306.75		-0.3%
62367	Electronic analysis of programmable pump	$43.56	$26.28	$40.01	$25.23	-8.1%	-4.0%
62368	Electronic analysis of programmable pump with reprogramming	$58.68	$36.36	$54.79	$35.33	-6.6%	-2.8%
63650	Implant neuroelectrodes (NA=National price is Not Available)	$1,353.23	$425.88	$1,613.43	$418.50	19.2%	-1.7%
63655	Implant neuroelectrodes (NA=National price is Not Available)		$866.51		$877.37		1.3%
63661	Remove spine eltrd perq aray	$602.27	$335.88	$620.36	$332.71	3.0%	-0.9%
63662	Remove spine eltrd plate		$875.87		$888.54		1.4%
63663	Remove spine eltrd perq aray	$809.63	$467.27	$824.74	$459.23	1.9%	-1.7%
63664	Remove spine eltrd plate		$911.87		$919.90		0.9%
63685	Implant neuroreceiver		$376.92		$372.00		-1.3%
63688	Revise/remove neuroreceiver		$387.36		$384.61		-0.7%
64400	Injection, anesthetic agent; Trigeminal nerve, any division or branch	$134.64	$74.52	$138.78	$74.62	3.1%	0.1%
64402	Facial nerve	$144.72	$85.68	$155.00	$88.31	7.1%	3.1%
64405	Greater occipital nerve	$105.48	$65.88	$85.43	$54.43	-19.0%	-17.4%
64408	Vagus nerve	$119.16	$88.92	$116.43	$85.43	-2.3%	-3.9%
64410	Phrenic nerve	$158.40	$87.12	$161.49	$87.95	2.0%	1.0%
64413	Cervical plexus	$130.68	$84.24	$129.77	$84.35	-0.7%	0.1%
64415	Brachial plexus	$121.32	$67.32	$122.56	$67.77	1.0%	0.7%
64417	Axillary nerve	$132.84	$72.72	$136.98	$73.17	3.1%	0.6%
64418	Suprascapular nerve	$120.24	$64.08	$97.33	$58.76	-19.1%	-8.3%
64420	Intercostal, single	$114.48	$69.48	$113.91	$69.57	-0.5%	0.1%
64421	Intercostal, multiple, regional block	$154.80	$95.04	$158.24	$93.72	2.2%	-1.4%
64425	Ilioinguinal, Iliohypogastric	$137.52	$96.84	$140.58	$97.33	2.2%	0.5%
64430	Pudendal nerve	$140.76	$83.16	$147.79	$82.19	5.0%	-1.2%
64445	Sciatic nerve	$140.76	$75.24	$141.66	$75.34	0.6%	0.1%
64450	Other peripheral nerve or branch	$82.08	$46.80	$77.86	$45.42	-5.1%	-3.0%

Table 4 (cont.). *2019 proposed physician payment rates compared to 2018 rates.*

CPT	Description	2018 (CF=35.9996)		2019 Proposed (CF: 36.0463)		% of change from 2018	
		Non-Facility (Office)	Facility (ASC/ HOPD)	Non-Facility (Office)	Facility (ASC/ HOPD)	Non-Facility (Office)	Facility (ASC/ HOPD)
64479	Cervical transforaminal epidural injections	$240.48	$136.08	$247.28	$133.37	2.8%	-2.0%
64480	Cervical transforaminal epidural injections add-on	$115.92	$65.16	$121.84	$64.52	5.1%	-1.0%
64483	L/S transforaminal epidural injections	$223.20	$115.92	$229.98	$113.91	3.0%	-1.7%
64484	L/S transforaminal epidural injections add-on	$94.32	$53.64	$98.41	$52.27	4.3%	-2.6%
64490	C/T facet joint injections, 1st Level (Old 64470)	$193.68	$109.44	$190.32	$107.06	-1.7%	-2.2%
64491	C/T facet joint injections, 2nd Level (Old 64472)	$95.40	$62.28	$95.16	$61.28	-0.2%	-1.6%
64492	C/T facet joint injections, 3rd Level	$96.12	$63.00	$95.52	$62.00	-0.6%	-1.6%
64493	Paravertebral facet joint or facet joint nerve; L/S, 1st Level	$175.68	$93.60	$174.46	$91.92	-0.7%	-1.8%
64494	Paravertebral facet joint or facet joint nerve; L/S, 2nd Level	$88.20	$53.64	$87.95	$52.27	-0.3%	-2.6%
64495	Paravertebral facet joint or facet joint nerve; L/S, 3rd Level	$88.20	$54.36	$87.59	$52.99	-0.7%	-2.5%
64505	Injection, anesthetic agent; sphenopalatine ganglion	$112.32	$93.60	$121.12	$96.60	7.8%	3.2%
64510	Injection, anesthetic agent; Stellate ganglion (cervical sympathetic)	$130.32	$75.96	$133.37	$75.34	2.3%	-0.8%
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	$191.88	$83.52	$205.82	$83.99	7.3%	0.6%
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring	$192.96	$93.96	$202.58	$93.36	5.0%	-0.6%
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	$416.52	$234.00	$439.76	$237.91	5.6%	1.7%
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$559.07	$351.00	$585.03	$353.25	4.6%	0.6%
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	$762.83	$509.39	$803.11	$518.71	5.3%	1.8%
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	$137.16	$121.32	$139.14	$122.56	1.4%	1.0%
64620	Destruction by neurolytic agent, intercostal nerve	$210.24	$177.84	$208.35	$176.63	-0.9%	-0.7%
64630	Destruction by neurolytic agent; pudendal nerve	$236.16	$197.64	$242.59	$195.73	2.7%	-1.0%
64633	Destroy cerv/thor facet jnt	$429.12	$232.56	$418.14	$227.09	-2.6%	-2.4%
64634	Destroy c/th facet jnt addl	$192.96	$70.56	$187.80	$69.57	-2.7%	-1.4%
64635	Destroy lumb/sac facet jnt	$424.44	$229.32	$415.25	$224.93	-2.2%	-1.9%
64636	Destroy l/s facet jnt addl	$175.32	$61.56	$170.86	$59.84	-2.5%	-2.8%
64640	Destruction by neurolytic agent; other peripheral nerve or branch	$135.72	$96.12	$136.26	$95.52	0.4%	-0.6%
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	$309.96	$168.84	$324.42	$166.17	4.7%	-1.6%

It appears that CMS has recognized the importance of implanting of neuroelectrodes by increasing the reimbursement for non-facility setting by 19.2%; however, at the same time it reduces physician reimbursement by 1.7%.

Facet joint nerve blocks and facet joint neurolytic procedures are facing reductions in the range of 1.5% to 3%; however, increases for nerve blocks and sympathetic blocks, especially in non-facility setting is appreciable.

Table 5 *Schedule of facility 2019 proposed payments for soft tissue and intraarticular injections in multiple settings.*

		Office Overhead	ASC	HOPD	% of HOPD over Office Overhead
20600	Small joint injection	$11.90	$21.97	$248.68	1991%
20605	Intermediate joint injection	$12.62	$23.41	$248.68	1871%
20550	tendon sheath, ligament injection	$13.34	$23.41	$248.68	1765%
20551	Tendon origin/insertion	$12.98	$24.13	$248.68	1816%
20552	Trigger point(s), 1 or 2 muscle group(s)	$17.30	$30.25	$248.68	1337%
20553	Trigger point(s), 3 or more muscle groups	$20.55	$35.29	$248.68	1110%
20526	Injection, therapeutic, carpal tunnel	$19.47	$39.25	$248.68	1178%
64640	Destruction by neurolytic agent; other peripheral nerve or branch	$40.64	$87.86	$772.30	1800%

Finally, CMS continues to provide inadequate reimbursement for peripheral neurolytic procedures (CPT 64640) of $136.26 for non-facility and physician reimbursement of $95.52. These procedures require blockade of multiple nerves with expensive equipment; however, CMS continues to consider this as a single procedure and thus reimburses inadequately. This procedure should be reimbursed similar to other radiofrequency neurotomy procedures such as facet joint neurotomy (CPT 64633-64637). There is substantial evidence showing the effectiveness of peripheral nerve blocks in managing chronic knee pain, hip pain, among multitude of other conditions. The code is often utilized to report sacroiliac joint neurotomy procedures. Thus, reflecting the HOPD rates, these reimbursement patterns must be addressed and increased. The procedure also carries an extremely low reimbursement in ASC settings. Similarly, though not to the same extent, another procedure the neurolytic block of pudendal nerves (CPT 64630) also carries a low reimbursement of $242.59 in a non-facility setting and $195.73 in a facility setting. The neurolytic procedure of intercostal nerve also faces the same path with $208.35 for non-facility setting and $176.63 for facility setting. Consequently, it is time for CMS while making so many changes to make the appropriate changes for the future.

Recognizing Communication Technology-based Services

CMS is proposing to pay separately for 2 newly defined physicians' services furnished using communication technology including brief communication in technology-based service i.e., virtual check-in (HCPCS code GVCI1) and remote evaluation of recorded video and/or images submitted by the patient (HCPCS code GRAS1). This is expected to increase efficiency for practitioners and convenience for beneficiaries. Both services of brief communication technology-based service and remote evaluation of recorded video and/or images may be used to assess the patient visit needs.

In addition, CMS also has proposed to pay separately for new coding describing chronic care remote physiologic monitoring (CPT codes 990X0, 990X1, and 994X9) and interprofessional internet consultation with multiple CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449.

Discontinuation of Functional Status Reporting Requirements for Outpatient Therapy

The proposed payment rule for 2019 will discontinue the functional status reporting requirements for services furnished on or after January 1, 2019 for outpatient therapy. Since January 1, 2013, as required by the Middle Class Tax Relief and Jobs Creation Act of 2012, all providers of outpatient therapy services have been required to include functional status information on claims for therapy services. The data was collected using a non-payable HCPCS G-codes and modifiers to describe a patient's functional limitation and severity at periodic intervals during outpatient therapy services. Since the Bipartisan Budget Act of 2018 repealed the therapy caps, these requirements served no purpose.

Quality Payment Program

The proposed changes to quality payment program (QPP) aim to reduce clinician burden, focus on outcomes, and promote intraoperability of electronic health records by removing Merit-based Incentive Payment System (MIPS) process-based quality measures

and overhauling the MIPS. Quality payment program is a subject of a separate manuscript.

Conclusion

The proposed fee schedule includes seismic shifts for E/M services, which is garnering significant attention in the medical community. Interventional pain management continues to face many challenges in the present environment. It is important for IPM specialists to understand the multitude of changes in the regulations including the proposed fee schedule so as to preserve interventional pain management into the future.

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Appendix

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