Health Policy Review

Proposed Physician Payment Schedule for 2013: Guarded Prognosis for Interventional Pain Management

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As happens every year, on July 1, 2012, the Centers for Medicare and Medicaid Services issued a proposed policy and payment rate for services furnished under the Medicare physician fee schedule for 2013. The proposed rule would provide certified registered nurse anesthetists to practice independent interventional pain management. Other issues, though no less important, include a 27% sustainable growth rate formula cut in reimbursement, along with a 2% sequester, which could lead to a potential cut of 29%.

Since the inception of Medicare programs in 1965, several methods have been used to determine the amounts paid to physicians for each covered service. The sustainable growth rate was enacted in 1997 to determine physician payment updates under Medicare Part B. Its intent was to reduce Medicare physician payment updates to offset the growth and utilization of physician services that exceed gross domestic product growth. This is achieved by setting an overall target amount of spending for physicians' services and adjusting payment rates annually to reflect differences between actual spending and the spending target. Since 2002, the sustainable growth rate has annually been used to recommend reductions in Medicare reimbursements. Payments were cut in 2002 by 4.8%. Since then, Congress has intervened on multiple occasions to prevent additional cuts from being imposed.

In this manuscript, we will describe important proposed changes to the physician fee schedule. Additionally, the impact of multiple changes on interventional pain management will be briefly described.

Key words: Health policy, physician payment policy, physician fee schedule, Medicare, sustained growth rate formula, interventional pain management, regulatory reform.

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In the routine climate of regulations and bad news for physicians, on July 1, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a proposed policy and payment rate for services furnished under the Medicare physician fee schedule for 2013 (1-7). The proposed rule also advocates changes to several quality reporting initiatives, as well as electronic prescribing, multiple procedure payment reductions, care coordination, and various other changes. However, this year's proposed rule is of significant importance for interventional pain physicians. A bombshell provision in this proposed rule is to allow certified registered nurse anesthetists (CRNAs) to practice independent interventional pain management (1,8). Other issues, though no less important, include a 27% sustainable growth rate (SGR) formula cut in reimbursement, topped by a 2% sequester (9,10). While SGR has been a looming issue for many years now, and physicians are used to disappointments each year, the independent practice of nurse anesthetists to perform interventional techniques, and sequester are new phenomena.

Much like the SGR, the budget sequester that also threatens the program in 2013 is cryptically named and arbitrary in nature (10). The sequester is a government-wide spending reduction plan for the next decade. It is not based on health policy, but is a budgeting mechanism functioning as a meat axe or buzz saw, eviscerating federal agency budgets over a period of 9 years, unlike the precision and elegance of a surgical scalpel (10). However, Social Security and Medicaid are exempt from sequester; all other areas of the government will share the budget cuts. In addition, enrollees in Medicare are considered to be safe since it does not cut their benefits, but physicians and other health professionals providing their health care will suffer, which ultimately may also result in suffering for Medicare enrollees.

In 2013, sequestration will begin to hit those contracted to provide Medicare services, including physicians, hospitals, nurses, therapists, medical suppliers, and drug providers. Payments will be reduced 2%, resulting in savings of $11 billion in 2013 and $123 billion through 2021. Otherwise, proposed payment rates, either in a facility or nonfacility setting, show modest cuts, ranging as high as 8% for nonfacility settings to 5% for facility settings.

The additional key provisions of the proposed rule for calendar year 2013 are summarized below.

- **Physician Quality Reporting System (PQRS):** For 2013 and 2014, CMS proposes to include 264 individual measures for PQRS, along with 26 measure groups for 2013, 4 more than 2012. For the purpose of aligning various CMS quality programs, CMS proposes to align PQRS measures available for EHR (electronic health records)-based reporting with measures under the EHR Incentive Program.

Successful participation in the 2013 or 2014 PQRS program will result in a 0.5% incentive payment, based on estimated total allowed charges for all covered services during the reporting period. Qualifying for an incentive payment in 2013 and 2014 allows an eligible professional (EP) to also avoid penalties in 2015 and 2016.

However, there are no quality measures available for interventional pain management.

- **Medicare Shared Savings Program (MSSP):** To promote alignment of the MSSP and PQRS programs, CMS proposes to use the same quality measures in both programs as well as the reporting criteria that are used in the PQRS incentive and payment adjustment program. MSSP EPs are also on the hook for PQRS penalties, and therefore must comply with the MSSP requirements for satisfactory participation in the PQRS Group Practice Reporting Option (GPRO) Web interface.
- Value-Based Payment Modifier (VBM): Created by ObamaCare, the VBM will lead to payment adjustments based on a comparison of physicians' costs and quality. The proposal is budget-neutral, so increases in Medicare payment rates for some physicians will be offset by reductions for others. The VBM must be applied to some physicians in 2015 and to all physicians by 2017.
  - In the first year, CMS is proposing to apply the adjustment only to physicians who practice in groups of 25 or more. Physicians in the affected groups could avoid any adjustment in their payments if the group signed up for and successfully participated in one of several PQRS options.
  - For groups that were not successful PQRS participants, 2015 Medicare payment rates would be cut by 1%. Those that were successful could either take a zero payment adjustment in 2015 or opt to be judged through a 3-tiered system that would incorporate both costs and quality. Low tier participants would face 1% payment cuts; those in the middle would see no change; and those in the high tier would receive an as-yet-undetermined increase.

- **Physician Feedback Reporting Program:** For a preview of the impact of the VBM on physicians' payments, beginning in the fall of 2014 physicians in groups of 25 or more will receive a confidential feedback report that includes the VBM that will be applied to the physician's payments in 2015. Officially known as Quality and Resource Use Reports (QRUR), these reports will compare quality and resource use among physicians. Current versions of the report rely on administrative claims data and PQRS measures (where available) to measure quality. Costs are tied to per-patient costs for all services and to 4 chronic conditions to be used in the VBM program. In concert with state and specialty medical society staff, the AMA has been engaged in an extensive review of the QRURs and has offered CMS many suggestions for making the reports more fair and useful.

- **Physician Compare: C**MS continues to phase in expansion of the Physician Compare Web site by proposing to make public the quality measure performance rates for group practices participating in the 2013 PQRS Web interface GPRO or the MSSP. The 2013 PQRS GPRO Web interface option is only available to practices comprising 25 or more EPs, with different reporting criteria for groups of 25-99 EPs and groups of 100 or more EPs. Patient experience survey data based on 2013, such as the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), will be posted no earlier than 2014 for group practices participating in any PQRS GPRO (not just Web interface reporting). CMS will administer and collect patient experience survey data on a sample of group practices' beneficiaries in 2013. The agency will also publicly report on Physician Compare, beginning in 2013, and patient experience data for Accountable Care Organizations (ACOs) participating in the MSSP. CMS proposes to lower the minimum threshold for reporting performance information on Physician Compare from 25 to 20 patients, and seeks input on proposals to add additional group-level and individual quality measures for public reporting.
- **Electronic Prescribing (eRx) Incentive Program:** CMS proposes improvements to the eRx program as follows:
  - Addition of 2 hardship exemption categories tied to participation in the meaningful use EHR incentive program making it easier to avoid e-prescribing penalties in 2013 and 2014
  - Establishment of a process so that physicians encountering problems associated with 2013 e-prescribing incentives and the 2014 penalty program can request CMS' review of their case
  - Lower the reporting requirement for eligible group practices comprising 2-24 health care professionals.

In addition, CMS proposes updating certain e-prescribing technological standards under Medicare Part D to improve e-prescribing functionality.

- **Care Coordination:** CMS outlines the initiatives developed to date to incentivize and promote improved care coordination, including:
  - MSSP (Pioneer ACO Model and Advance Payment ACO model)
  - Primary Care Incentive Payment (PCIP) Program
  - Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration
  - Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
  - Comprehensive Primary Care (CPC) Initiative.

- **Practice Expense Equipment Interest Rate:** The practice expense (PE) relative value unit (RVU) methodology requires a calculation of equipment cost per minute, including calculation of the interest rate. The interest rate CMS previously used was outdated and applied the same interest rate across all equipment. Consistent with the American Medical Association's recommendation, CMS is proposing a "sliding scale," which is a variable interest rate based on useful life, equipment cost and the Small Business Administration's (SBA) maximum interest rates for different categories of loan size and maturity. This method for interest rates will account for changes in the prime rate or the SBA's formula for maximum allowed interest rates.
- **Geographic Practice Cost Indices (GPCIs):** As required by law, CMS updates the GPCIs every 3 years. The next GPCI update will be in 2014, so CMS has not proposed GPCI changes in the current proposed rule, although it notes that the statutory work GPCI floor of 1.00 is set to expire at the end of 2012. As it considers potential future GPCI policy proposals, CMS is analyzing recommendations from a panel convened by the Institute of Medicine (IOM). Several IOM Phase I recommendations are discussed in the current proposed rule. For example, the rule notes that adoption of the IOM recommendation for employee wage index payment locality changes could potentially increase the number of localities from the current 89 to over 3,000. CMS plans to address the IOM Phase I and II recommendations more fully in future rulemaking.
- **Multiple Procedure Payment Reduction:** CMS would apply a 25% multiple procedure payment reduction to the technical component of diagnostic cardiovascular and ophthalmology services when these services are furnished by the same physician (or physicians in the same group practice) to the same patient on the same day.
- **Elimination of Requirement to Terminate Prepayment Medical Review:** The current one-year limit on nonrandom prepayment medical review would be removed.

- **Face-to-Face Requirement for Durable Medical Equipment:** The Patient Protection and Affordable Care Act requires that a physician have a face-to-face encounter with a beneficiary during the 6-month period prior to a written order for certain Medicare-covered durable medical equipment. CMS proposes to change this 6-month requirement to no more than 90 days before the order is written or within 30 days after the order is written.

Congressional research surveys in December of 2011 (11) evaluated the Medicare physician payment updates and the SGR system. As is well known, in the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare Economic Index (MEI), a price index of inputs required to produce physician services fees. For the next 2 years, in 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years. Beginning in 2002, the actual expenditure exceeded allowed targets, and the discrepancy has grown with each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions.

There has been a growing consensus among observers that the SGR system is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries (11). The SGR system treats all services and physicians equally in the calculation of the annual payment update, which is applied uniformly with no distinction across specialties. In addition, there has been an increased concern that continued declines in physician payment rates, especially among primary care specialists, may potentially jeopardize access to services. However, in contrast to the beliefs of Congress, all specialties are affected. Legislative overrides since 2002 have only provided temporary reprieves from projected reductions in payments under the SGR calculation, requiring even steeper reductions in payment rates in the future.

Table 1 illustrates proposed physician payment rates, however, without cuts at the present time. Consequently, if Congress and the Administration fail to act, the SGR cuts of 27%,sequester of 2%, and any additional cuts CMS makes opposing their final rule, may be devastating to all physicians, specifically interventional pain physicians.

These cuts could lead to serious access to care issues for patients. Medicare physician payments have been nearly frozen for a decade, whereas the cost of caring for patients has increased at least by more than 20%; such cuts will be devastating. Regulations for medicine, specifically for interventional pain management, have been devastating with the proposed implementation of ICD-10, electronic medical records (EMRs), and single-dose vial regulations (12-25). In addition, there are other issues, such as ObamaCare in general (26-30), Patient-Centered Outcomes Research Institute (PCORI) (31-33), comparative effectiveness research (34,35) and Independent Payment Advisory Board (IPAB) (36-38).

Table 2 shows the proposed rule's estimated impact on total allowed charges by specialty. As shown, there is a 3% reduction for anesthesiology, interventions, and radiology, whereas the reductions are 1% for interventional pain management with a 1% increase for physical medicine and rehabilitation, along with physical therapists. Of interest is that increases are much higher for other practitioners, with a 5% increase for nurse practitioners and a 3% increase for physician assistants; however, there is a 3% decrease for clinical psychologists and 4% decrease for nurse anesthetists and anesthesia assistants.

Unless Congress enacts legislation to override projected SGR changes, physician fees would be reduced by 29% in calendar year 2013, including the 2% sequester. For 2012, a one year freeze to physician payments was estimated to cost $11 billion and $21 billion over 10 years from 2012 to 2021, according to the Congressional Budget Office (CBO). However, a long-term fix such as repealing the SGR, combined with a freeze in physician pay rates over the next 10 years, would cost approximately $290 billion.

The Medicare Payment Advisory Commission (MedPAC), in its recommendations for addressing the SGR and Medicare physician payments to Congress, on October 14, 2011, submitted a recommendation that Congress repeal the SGR system and replace it with a 10-year schedule of specified updates for the physician fee schedule (39); however, this recommendation drew significant criticism from various specialties. In this recommendation, specifically, primary care practitioners would have a 0% update over the next 10 years, while nonprimary care practitioners would experience a 5.9% decline in payment rates the first 3 years and 0% thereafter. MedPAC estimated this would cost about $200 billion over 10 years. Further, it also recommended multiple options to offset this cost, which would spread the impact of reductions across other providers and Medicare beneficiaries. Congress passed a law in February 2012 to avoid the cuts through December 30, 2012 (40).

Table 1. *2013 proposed physician payment rates.*

CPT	Description	2011 (CF=$33.9764)		2012 (CF=$34.0376)		2013 Proposed without cut (CF=$34.0376)		% change from 2012	
		Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)
20526	Injection, therapeutic (eg, local anesthetic; corticosteroid), carpal tunnel	$73.73	$56.74	$74.88	$56.50	$75.22	$56.16	0.5%	-0.6%
20550	tendon sheath, ligament injection	$56.06	$40.77	$57.18	$40.85	$57.52	$40.85	0.6%	0.0%
20551	Tendon origin/insertion	$57.08	$42.13	$58.54	$42.21	$59.57	$42.21	1.7%	0.0%
20552	Single or multiple trigger point(s), one or two muscle group(s)	$52.32	$36.69	$53.78	$37.10	$54.80	$37.78	1.9%	1.8%
20553	Single or multiple trigger point(s), three or more muscle groups	$59.12	$41.11	$61.61	$41.87	$62.97	$42.55	2.2%	1.6%
20600	Small joint injection	$53.00	$38.73	$54.12	$38.46	$54.80	$38.46	1.3%	0.0%
20605	Intermediate joint injection	$57.76	$40.77	$57.18	$40.50	$57.18	$40.50	0.0%	0.0%
20610	Major joint injection	$76.79	$49.61	$69.78	$49.69	$68.08	$49.69	-2.4%	0.0%
22520	Vertebroplasty (Thoracic)	$2,229.53	$523.58	$2,251.93	$512.61	$2,254.65	$503.08	0.1%	-1.9%
22521	Vertebroplasty (Lumbar)	$2,187.40	$495.04	$2,241.72	$487.76	$2,257.37	$480.27	0.7%	-1.5%
22522	Vertebroplasty - Additional	NA	$231.04	NA	$226.69	NA	$222.61	NA	1.8%
22526	IDET, single level	$2,090.23	$324.81	$2,261.12	$331.53	$2,396.25	$339.35	6.0%	2.4%
22527	IDET, 1 or more levels	$1,681.15	$145.76	$1,846.54	$148.74	$1,995.62	$152.49	8.1%	2.5%
27093	Injection procedure for HIP arthrography – without anesthesia	$189.25	$70.33	$195.04	$70.12	$189.25	$69.78	-3.0%	-0.5%
27095	Injection procedure for HIP arthrography – with anesthesia	$231.72	$81.88	$241.33	$81.69	$236.56	$81.69	-2.0%	0.0%
27096	(G0260) Injection procedure for Sacroiliac joint, arthrography	$184.49	$70.67	$171.89	$82.03	$166.44	$85.43	-3.2%	4.1%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$708.75	$399.56	$683.48	$340.72	$702.20	$352.63	2.7%	3.5%
62264	Percutaneous epidural adhesiolysis – 1 day	$412.47	$232.40	$433.64	$238.94	$433.98	$240.99	0.1%	0.9%
62268	Percutaneous aspiration, spinal cord cyst or syrinx	$352.34	$259.24	$296.81	$260.05	NA	$261.75	NA	0.7%
62269	Biopsy of spinal cord, percutaneous needle	$379.18	$266.04	$313.49	$264.81	NA	$264.13	NA	-0.3%
62270	Spinal puncture, diagnostic	$155.27	$78.83	$156.91	$78.29	$158.27	$77.95	0.9%	-0.4%
62272	Spinal puncture, therapeutic	$192.65	$84.94	$200.14	$85.09	$202.86	$84.41	1.4%	-0.8%
62273	Epidural, blood patch	$167.50	$111.44	$172.91	$113.35	$174.61	$114.03	1.0%	0.6%
62280	Subarachnoid neurolytic injection	$323.46	$162.07	$335.61	$167.47	$340.38	$177.34	1.4%	5.9%
62281	Neurolytic epidural, C/T	$259.24	$149.84	$250.52	$152.83	$246.09	$160.66	-1.8%	5.1%
62282	Neurolytic epidural, L/S	$293.22	$139.64	$295.45	$142.28	$286.60	$145.00	-3.0%	1.9%
62284	Injection procedure myelography	$213.71	$87.32	$201.50	$85.77	$190.27	$84.75	-5.6%	-1.2%
62287	Disc decompression	NA	$549.40	NA	$560.26	NA	$571.15	NA	1.9%
62290	Discography each level: lumbar	$331.95	$170.56	$344.12	$172.91	$340.72	$175.29	-1.0%	1.4%
62291	Discography each level: C/T	$313.26	$164.45	$326.76	$166.44	$320.63	$168.15	-1.9%	1.0%
62292	Chemonucleolysis	NA	$544.30	NA	$572.51	NA	$605.53	NA	5.8%
62310	Cervical epidural	$230.36	$103.29	$246.77	$107.22	$247.11	$109.94	0.1%	2.5%
62311	Lumbar epidural	$197.74	$84.94	$208.99	$87.82	$206.95	$89.52	-1.0%	1.9%
62318	Epidural or subarachnoid, catheterization, C/T	$236.82	$99.21	$251.20	$101.77	$235.20	$99.73	-6.4%	-2.0%
62319	Catheterization, epidural, L/S	$188.91	$94.11	$185.16	$97.01	$170.87	$96.67	-7.7%	-0.4%

Table 1 (cont.). *2013 proposed physician payment rates.*

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		Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)
62350	Tunneled intrathecal or epidural catheter for long-term medication administration via an external pump or implantable reservoir; w/o laminectomy	NA	$389.71	NA	$398.92	NA	$407.43	NA	2.1%
62355	Removal or previously implanted intrathecal or epidural catheter	NA	$294.24	NA	$261.07	NA	$266.85	NA	2.2%
62360	Implant or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	NA	$300.69	NA	$309.40	NA	$314.85	NA	1.8%
62361	Implantation or replacement of device for epidural drug infusion; non-programmable pump	NA	$388.01	NA	$350.25	NA	$332.55	NA	-5.1%
62362	Implant spine infusion pump	NA	$406.70	NA	$389.05	NA	$393.47	NA	1.1%
62365	Remove spine infusion device	NA	$324.13	NA	$294.43	NA	$297.15	NA	0.9%
62367	Electronic analysis of programmable pump	$40.09	$24.46	$40.85	$24.85	$41.87	$25.53	2.5%	2.7%
62368	Electronic analysis of programmable pump with reprogramming	$57.76	$38.05	$55.14	$34.04	$56.50	$34.72	2.5%	2.0%
63650	Implant neuroelectrodes (NA=National price is Not Available)	NA	$414.85	NA	$427.17	NA	$437.04	NA	2.3%
63655	Implant neuroelectrodes (NA=National price is Not Available)	NA	$855.53	NA	$832.90	NA	$834.60	NA	0.2%
63661	Remove spine electrode percutaneous array(s)	$597.64	$330.25	$601.44	$325.40	$588.85	$325.40	-2.1%	0.0%
63662	Remove spine electrode plate	NA	$716.56	NA	$785.93	NA	$780.14	NA	-0.7%
63663	Remove spine electrode percutaneous array(s)	$853.83	$479.41	$855.36	$474.82	$830.52	$473.12	-2.9%	-0.4%
63664	Remove spine eltrd plate	NA	$745.10	NA	$804.99	NA	$800.90	NA	-0.5%
63685	Implant neuroreceiver	NA	$396.50	NA	$363.18	NA	$368.29	NA	1.4%
63688	Revise/remove neuroreceiver	NA	$358.45	NA	$367.95	NA	$372.71	NA	1.3%
64400	Injection, anesthetic agent; Trigeminal nerve, any division or branch	$112.80	$66.59	$118.11	$68.08	$122.88	$69.10	4.0%	1.5%
64402	Facial nerve	$112.46	$72.71	$118.45	$74.88	$122.54	$76.24	3.4%	1.8%
64405	Greater occipital nerve	$112.46	$79.50	$97.01	$61.95	$99.73	$62.63	2.8%	1.1%
64408	Vagus nerve	$122.65	$90.72	$107.22	$78.63	$98.03	$72.84	-8.6%	-7.4%
64410	Phrenic nerve	$148.14	$83.58	$152.15	$87.48	$126.62	$75.22	-16.8%	-14.0%
64412	Spinal accessory nerve	$149.16	$74.07	$148.74	$74.20	$139.21	$72.84	-6.4%	-1.8%
64413	Cervical plexus	$118.58	$78.83	$123.56	$80.33	$124.92	$80.67	1.1%	0.4%
64415	Brachial plexus	$122.32	$67.27	$124.24	$66.71	$116.75	$63.99	-6.0%	-4.1%
64417	Axillary nerve	$128.43	$69.65	$133.09	$71.14	$127.30	$69.10	-4.3%	-2.9%
64418	Suprascapular nerve	$136.92	$73.39	$138.87	$74.20	$141.26	$74.88	1.7%	0.9%
64420	Intercostal, single	$135.91	$66.59	$125.94	$68.08	$115.05	$69.44	-8.6%	2.0%
64421	Intercostal, multiple, regional block	$195.36	$91.74	$177.68	$94.28	$155.89	$95.31	-12.3%	1.1%
64425	Ilioinguinal, Iliohypogastric	$130.47	$94.11	$134.45	$95.31	$136.15	$95.65	1.3%	0.4%
64445	Sciatic nerve	$133.53	$75.43	$136.15	$74.20	$135.13	$71.48	-0.7%	-3.7%
64450	Other peripheral nerve or branch	$102.27	$68.63	$105.52	$69.10	$108.92	$70.46	3.2%	2.0%
64479	Cervical transforaminal epidural injections	$265.36	$131.15	$260.73	$134.11	$243.71	$136.15	-6.5%	1.5%

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		Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)
64480	Cervical transforaminal epidural injections add-on	$126.39	$66.93	$124.92	$66.37	$116.41	$66.03	-6.8%	-0.5%
64483	Lumbar/sacral transforaminal epidural injections	$240.21	$102.61	$242.01	$111.98	$226.69	$114.03	-6.3%	1.8%
64484	Lumbar/sacral transforaminal epidural injections add-on	$106.35	$53.00	$100.07	$52.76	$89.52	$52.76	-10.5%	0.0%
64490	Cervical and thoracic facet joint injections, 1st Level (Old 64470)	$196.38	$111.44	$202.18	$110.96	$198.78	$109.94	-1.7%	-0.9%
64491	Cervical and thoracic facet joint injections, 2nd Level (Old 64472)	$97.17	$62.86	$98.37	$61.95	$96.33	$61.61	-2.1%	-0.5%
64492	Cervical and thoracic facet joint injections, 3rd Level (New Code - Old 64472)	$98.19	$63.88	$99.05	$62.63	$97.01	$62.29	-2.1%	-0.5%
64493	Paravertebral facet joint or facet joint nerve; lumbar/ sacral, 1st Level (Old 64475)	$174.98	$93.77	$181.08	$93.26	$178.70	$92.58	-1.3%	-0.7%
64494	Paravertebral facet joint or facet joint nerve; lumbar/ sacral, 2nd Level (Old 64476)	$87.66	$53.34	$89.86	$52.42	$88.16	$52.08	-1.9%	-0.6%
64495	Paravertebral facet joint or facet joint nerve; lumbar/ sacral, 3rd Level (New Code - Old 64476)	$89.02	$54.02	$90.54	$53.44	$88.50	$53.10	-2.3%	-0.6%
64505	Injection, anesthetic agent; sphenopalatine ganglion	$97.85	$81.88	$100.41	$83.73	$103.47	$86.12	3.1%	2.8%
64508	Injection, anesthetic agent; Carotid sinus (separate procedure)	$104.31	$74.75	$86.12	$76.93	$66.37	$78.97	-22.9%	2.7%
64510	Injection, anesthetic agent; Stellate ganglion (cervical sympathetic)	$134.89	$69.65	$135.13	$72.50	$130.36	$74.54	-3.5%	2.8%
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	$190.95	$78.15	$197.76	$80.33	$189.93	$81.01	-4.0%	0.8%
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring	$193.33	$90.38	$201.50	$92.92	$197.76	$94.62	-1.9%	1.8%
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	$410.10	$219.83	$410.49	$219.88	$396.54	$219.54	-3.4%	-0.2%
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$646.91	$340.10	$587.15	$336.63	$558.56	$341.06	-4.9%	1.3%
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic	$727.77	$486.88	$755.29	$488.78	$744.74	$486.40	-1.4%	-0.5%
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	$171.24	$155.95	$174.61	$160.32	$177.34	$164.74	1.6%	2.8%
64613	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)	$164.11	$145.42	$166.10	$149.77	$168.15	$154.19	1.2%	3.0%

Table 1 (cont.). *2013 proposed physician payment rates.*

CPT	Description	2011 (CF=$33.9764)		2012 (CF=$34.0376)		2013 Proposed without cut (CF=$34.0376)		% change from 2012	
		Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)	Non-Facility (Office)	Facility (ASC/Hospital)	Non-Facility (Office)	Facility (ASC/ Hospital)
64614	Chemodenervation of muscle(s); extremity(s) and/ or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)	$174.98	$151.87	$177.68	$156.23	$179.38	$159.98	1.0%	2.4%
64620	Destruction by neurolytic agent, intercostal nerve	$238.85	$169.54	$225.33	$173.25	$210.01	$176.66	-6.8%	2.0%
64630	Destruction by neurolytic agent; pudendal nerve	$225.26	$187.89	$230.43	$190.61	$213.08	$180.40	-7.5%	-5.4%
64633	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level (64626)	$398.54	$247.69	$452.36	$235.54	$405.05	$220.56	-10.5%	-6.4%
64634	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (64627)	$170.90	$58.78	$207.29	$70.46	$183.46	$66.71	-11.5%	-5.3%
64635	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level (old 64622)	$335.01	$182.79	$444.53	$230.77	$397.90	$217.50	-10.5%	-5.8%
64636	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (64623)	$125.03	$49.95	$186.53	$61.27	$165.08	$58.54	-11.5%	-4.4%
64640	Destruction by neurolytic agent; other peripheral nerve or branch	$217.79	$168.18	$219.88	$169.85	$221.58	$172.23	0.8%	1.4%
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	$313.60	$163.09	$325.74	$166.44	$319.27	$169.85	-2.0%	2.0%

Based on 2012 Conversion Factor - NA - Not Applicable % change - from 2012 - As of Aug 10, 2012
* - 2013 Conversion Factor will be published by November 1, 2012 as part of the Calendar Year 2013 Physician Fee Schedule final rule, at present the rates are based on 2012 conversion factors.

Table 2. *Calendar Year 2013 Physician Fee Schedule proposed rule estimated impact on total allowed charges by specialty**.

(A)	(B)	(C)	(D)	(E)
Specialty	**Allowed Charges (mil)**	**Impact of Work and MP RVU Changes**	**Impact of PE RVU Changes**	**Combined Impact**
TOTAL	$ 86,000	0%	0%	0%
01-ALLERGY/IMMUNOLOGY	$ 198	-1%	1%	0%
02-ANESTHESIOLOGY	$ 1,970	-1%	-3%	-3%
03-CARDIAC SURGERY	$ 366	-1%	-2%	-2%
04-CARDIOLOGY	$ 6,568	-1%	-2%	-3%
05-COLON AND RECTAL SURGERY	$ 153	-1%	1%	1%
06-CRITICAL CARE	$ 261	-1%	0%	0%
07-DERMATOLOGY	$ 3,008	-1%	0%	0%
08-EMERGENCY MEDICINE	$ 2,819	-1%	0%	-1%
09-ENDOCRINOLOGY	$ 434	-1%	1%	1%
10-FAMILY PRACTICE	$ 5,879	3%	4%	7%
11-GASTROOENTEROLOGY	$ 1,885	-1%	0%	0%
12-GENERAL PRACTICE	$ 579	-1%	1%	0%
13-GENERAL SURGERY	$ 2,261	-1%	0%	0%
14-GERIATIRCS	$ 217	1%	3%	4%

Table 2 (cont.). *Calendar Year 2013 Physician Fee Schedule proposed rule estimated impact on total allowed charges by specialty*.*

(A)	(B)	(C)	(D)	(E)
Specialty	**Allowed Charges (mil)**	**Impact of Work and MP RVU Changes**	**Impact of PE RVU Changes**	**Combined Impact**
15-HAND SURGERY	$ 134	-1%	0%	0%
16-HEMATOLOGY ONCOLOGY	$ 1,900	-1%	0%	-1%
17-INFECTIOUS DISEASE	$ 623	-1%	1%	0%
18-INTERNAL MEDICINE	$ 11,058	2%	3%	5%
19-INTERVENTIONAL PAIN MGMT	$ 534	-1%	0%	-1%
20-INTERVENTIONAL RADIOLOGY	$ 203	-1%	-2%	-3%
21-MULTISPECIALTY CLINIC-OTHER PHY	$ 202	-1%	-1%	-1%
22-NEPGROLOGY	$ 2,065	-1%	0%	-1%
23-NEUROLOGY	$ 1,601	-1%	2%	1%
24-NEUROSURGERY	$ 681	-1%	0%	-1%
25-NUCLEAR MEDICINE	$ 49	-1%	-3%	-3%
26-OBSTETRICS/GYNECOLOGY	$ 698	-1%	0%	1%
27-OPHTHALMOLOGY	$ 5,621	-1%	1%	1%
28-ORTHOPEDIC SURGERY	$ 3,622	-1%	0%	-1%
29-OTOLARYNGOLOGY	$ 1,070	-1%	1%	0%
30-PATHOLOGY	$ 1,185	-1%	-1%	-2%
31-PEDIATRICS	$ 64	2%	3%	5%
32-PHYSICAL MEDICINE	$ 990	-1%	1%	1%
33-PLASTIC SURGERY	$ 351	-1%	0%	0%
34-PSYCHIATRY	$ 1,149	-1%	0%	0%
35-PULMONARY DISEASE	$ 1,691	-1%	1%	0%
36-RADIATION ONCOLOGY	$ 1,983	-1%	-14%	-14%
37-RADIOLOGY	$ 4,791	-1%	-3%	-4%
38-RHEUMATOLOGY	$ 545	-1%	0%	0%
39-THORACIC SURGERY	$ 340	-1%	-1%	-2%
40-UROLOGY	$ 1,909	-1%	-1%	-2%
41-VASCULAR SURGERY	$ 882	-1%	-2%	-3%
42-AUDIOLOGIST	$ 57	-1%	-4%	-5%
43-CHIROPRACTOR	$ 738	-1%	1%	1%
44-CLINICAL PSYCHOLOGIST	$ 567	-1%	-2%	-3%
45-CLINICAL SOCIAL WORKER	$ 400	-1%	-2%	-3%
46-DIAGNOSTIC TESTING FACILITY	$ 875	-1%	-7%	-8%
47-INDEPENDENT LABORATORY	$ 1,064	-1%	-1%	-1%
48-NURSE ANES/ANES ASST	$ 1,142	-1%	-3%	-4%
49-NURSE PRACTITIONER	$ 1,606	1%	3%	5%
50-OPTOMETRY	$ 1,048	-1%	2%	1%
51-ORAL/MAXILLOFACIAL SURGERY	$ 44	-1%	1%	0%
52-PHYSICAL/OCCUPATIONAL THERAPY	$ 2,613	-1%	3%	3%
53-PHYSICIAN ASSISTANT	$ 1,219	1%	2%	3%
54-PODIATRY	$ 1,898	-1%	2%	1%
55-PORTABLE X-RAY SUPPLIER	$ 104	-1%	2%	2%
56-RADIATION THERAPY CENTERS	$ 71	-1%	-18%	-19%
98-OTHER	$ 19	-1%	1%	0%

* Table shows only the proposed payment policy impact on Physician Fee Schedule services. We note that these impacts do not include the effects of the negative January 2013 conversion factor change under current law.

The second major issue relates to scope of practice (41-50). Scope of practice issues are based on the Obama administration's philosophy to reform health care regulations that it views as unnecessary(51). In particular, the Administration said, "the use of advanced practice nurse practitioners and physician assistants in lieu of higher paid physicians could provide immediate savings to hospitals" (51). In the new rules, CMS proposes to remove barriers to the work of physician extenders, for example, by not making them seek out a physician to cosign every order. However, it does not stop there.

The Obama Administration has been in the process of empowering nurses (8). At the same time, they have proposed allowing CRNAs to perform complex interventional pain management services. While we all recognize that midlevel providers are on every team and are essential to health care as long as they are working as part of the team, they should not be replacing physicians. The independent practice of CRNAs started with an opt out mechanism provided by CMS that was signed into law by President Clinton, whose mother was a nurse anesthetist (52). While the opt out was a good idea and was originally intended to help rural areas improve access to care, the rule was transformed into supporting any hospital that seeks to cut costs by allowing nurse anesthetists to provide independent anesthesia, which now is being translated to the independent practice of interventional pain management. Now, with the CMS chief, Marilyn Tavenner, being a nurse, nurses are employing tactics to remove physicians from the equation (42-46).

The Obama Administration rightfully has expressed concern about the impending shortage of physicians as a reason to allow for more latitude to advanced practice nurses. However, there is no one else to blame other than the Obama Administration for the projected shortage. The physician shortage may be alleviated by providing physicians a reprieve rather than replacing them with midlevel providers. The American Medical Association (AMA), American Society of Interventional Pain Physicians (ASIPP), and American Society of Anesthesiologists (ASA) have opposed this proposed regulation that would allow CRNAs to perform interventional procedures. (53-57).

With all the excitement about ObamaCare and its US Supreme Court survival, there are multiple proposals to reform or modernize Medicare. One such proposal is from Senator Ron Wyden (D-OR) and Representative Paul Ryan (R-WI). Their proposal is named "Bipartisan Options for the Future" (58). Wilensky (59) described that the notion that Democrats and Republicans agreed about certain aspects of Medicare might have seemed unthinkable. He hopes that the pairing of a liberal Democrat who has long worked on health care reforms and a fiscally conservative Republican primarily known for work on budget issues, now the Republican vice presidential candidate, suggests that it might be possible for the parties to reach a compromise on Medicare reform. It appears that there is a bipartisan agreement to change Medicare that might make it more efficient, effective, and fiscally sustainable, even if none of these changes are universally accepted by either party as desirable or even tolerable.

In conclusion, interventional pain management continues to face widespread challenges, more so than other specialties in the US health care system. The historic health care reform which was passed by Congress and signed into law by President Obama, and subsequently supported to a great extent by a Supreme Court decision, is affecting medicine drastically in the United States. Emanuel and Fuchs (60) have proposed to shorten medical training by 30% which in their opinion will equalize mid-level practitioners including nurse anesthetists and physician anesthesiologists including interventional pain physicians. An evolving specialty, interventional pain management is being encroached upon by many special interests, including now nurse anesthetists. As a result, our specialty will probably suffer the most in the next year and in the years to come.

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Disclosures

Dr. Caraway is a consultant for Medtronic, Inc., Spinal Modulation, Inc., and Vertos, Inc.

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

Dr. Benyamin is a consultant with Bioness and Nevro, serves on the advisory boards of Vertos Medical and Nuvo Pharma, teaches/lectures for Vertos Medical, Boston Scientific, Neurotherm, and Bioness, and receives research/grants from Alfred Mann Foundation, Teknon Foundation, Spinal Restoration, Inc., Bioness, Boston Scientific, Vertos Medical, Medtronic, Kimberly Clarke, Epimed, BioDelivery Sciences International, Inc., Theravance, Mundipharma Research, Cephalon/Teva, AstraZeneca, and Purdue Pharma, LP.

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