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Health Policy

Reversal of Epidural Cuts in 2015 Physician Payment Schedule: Two Steps Forward One Step Back

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This year, 2014, has been a tumultuous year for interventional pain management (1,2). A clear example of that is the reversal of cuts for epidural steroid injections set to go into effect in the 2015 physician payment schedule, but now includes a proposal to bundle fluoroscopy into primary codes (3). We believe these challenges embody the philosophy of two steps forward, one step back with the tumult continuing into the foreseeable future. As readers may recall, interventional pain physicians received a "Thanksgiving surprise" when the Centers for Medicare and Medicaid Services (CMS) published its Final Rule later than normal because of the government shutdown that had occurred earlier in 2013. The final rule included unexpected and draconian cuts for epidural injections, amounting to 33% for cervical epidurals when performed in a facility and 56% when performed in a physician office; and 19% for lumbar interlaminar epidural injections in a facility setting for the physician fee and 49% when performed in a physician office (1,2). Thus, CMS essentially determined the work value of interventional pain management physicians with high skills, extensive and expensive training and practices, and who perform time consuming, stressful, and high risk procedures, to be $42 to assess a patient preoperatively, to perform an invasive high-risk procedure, and follow the patient postoperatively (2). At the same time, the 2014 fee schedule paid slightly higher than level 3 (99213) follow-up visit ($74.15 vs. $73.08). Interventional pain physicians are struggling to keep their practices open and survive into the future because of the multiple challenges of expensive expansion of information technology requirements, increased regulations, investigations, and continued increases in practice expenses. Due to the tremendous efforts of interventional pain physicians, and over 65,000 letters to members of Congress, over 10,000 letters to CMS, 40 letters from congressional leaders, American Society of Interventional Pain Physicians' (ASIPP) meeting with CMS, efforts by other societies, and multiple personal calls from members of Congress to administration officials, the 2015 proposed schedule reflects a reversal of the cuts for epidural injections current procedure terminology (CPT) 62310, CPT 62311, CPT 62318, and CPT 62319 to 2013 levels (3).

Not unexpectedly, CMS has introduced a detrimental factor with the bundling of fluoroscopy into the physician payment code, as well as office facility payments, which reduces the value of the reversal significantly. Thus, this unfortunate action by CMS can be described as "two steps forward, one step back." This is an allusion to the anecdote about a frog trying to climb out of a water well: for every 2 steps the frog climbs, it falls back by one step, making its progress synonymous with the efforts of interventional pain physicians, which may also be described as being similar to that frog in a well. This situation also illustrates that success is not always linear and partial success is not fatal.

The impact of these cuts would have been disastrous; however, neither the cuts for 2014, nor the reversal of the cuts by CMS are based on history or evidence (2,3)

The physician reimbursement in 2014 is $74.15 for 62310 - cervical epidural, and is $72.72 for 62311 - lumbar epidural, with an overhead payment of $36.54 for cervical and $36.18 for lumbar, leading to an office payment of $90.99 for either of the procedures, with the addition of $90.99. However, with the addition of $60.16 for office facility and $30.81 for physician fee for a total of $90.97 for fluoroscopy performed in an office setting, the payment increased to $201.68 and $225.33 for cervical and lumbar (caudal) epidural injections, respectively (Table 1). Physician fee only in facility setting with the addition of fluoroscopy ($30.81) increased to $104.96 from $74.15 for cervical epidural and to $103.53 from $72.72 for lumbar epidural (Table 1). This is in contrast to $347.03 and $307.22 in 2013 with fluoroscopy in-office procedures and physician fees of $140.17 and $119.76 with fluoroscopy for cervical (62310) and lumbar epidurals (62311), respectively.

Consequently, with the bundling of fluoroscopy into the primary codes and the elimination of payment for fluoroscopy codes, the proposed fee in 2015 for the physician is $112.13 for cervical/thoracic epidural injection, which is similar to the $110.23 fee in 2013 without fluoroscopy, whereas with fluoroscopy in 2013, the fee was $140.17. For lumbosacral epidural injections, including caudal and interlaminar approaches, the proposed physician fee in 2015 is $92.06 due to the bundling of fluoroscopy into the primary code. This fee was $89.82 in 2013 without fluoroscopy and $119.76 with fluoroscopy. Thus, with the bundling of fluoroscopy, there is an increase in physician fee of 7% or $7.17 for cervical epidural injections from 2014, but a decrease of 20% or $28.04 compared to 2013. For lumbosacral epidural injections the results are unfavorable even compared to 2014, with a final proposed payment combined with fluoroscopy of $92.06, a decrease of 23% from $119.76 in 2013 with fluoroscopy, and an 11% decrease or $11.47 in 2015 per physician fee when compared to the 2014 fee of $103.53 with the inclusion of fluoroscopy (physician fee $72.72 plus fluoroscopy $30.81) (Tables 1 and 2).

Similar results emerge with the assessment of payments for in-office settings, since a fluoroscopy payment has been bundled into the primary code. As shown in Tables 1 and 2, the reductions have been drastic. However, compared to physician payments, small increases are proposed for in-office procedures even with the bundling of fluoroscopy. Consequently, this is a modest reversal of cuts in 2014; however, compared to 2013, the cuts continue, though at a lower, but still high rate. The total payment for cervical/thoracic epidural injections (CPT 62310) in an office setting, including physician fee and office as a facility with fluoroscopy, was $347.03 in 2013, $201.68 in

Table 1. *Epidural payments for physician fee and for procedures in office settings.*

	62310 – Cervical/Thoracic Epidural					62311 – Lumbosacral Epidural (Caudal/Interlaminar)				
	2013	2014	2015	2015 Fee Schedule		2013	2014	2015	2015 Fee Schedule	
				Difference from 2013	Difference from 2014				Difference from 2013	Difference from 2014
Physician (in facility)										
Facility	$110.23	$74.15	$112.13	$1.90 (↑ 2%)	$37.98 (↑ 51%)	$89.82	$72.72	$92.06	$2.24 (↑ 2%)	$19.34 (↑ 27%)
77003-26	$29.94	$30.81	$0.00	(-$29.94) (↓ 100%)	(-$30.81) (↓ 100%)	$29.94	$30.81	$0.00	(-$29.94) (↓ 100%)	(-$30.81) (↓ 100%)
Total	$140.17	$104.96	$112.13	(-$28.04) (↓ 20%)	$7.17 (↑ 7%)	$119.76	$103.53	$92.06	(-$27.70) (↓23%)	(-$11.47) (↓ 11%)
In-office (Including Physician)										
Office	$251.77	$110.69	$244.67	(-$7.10) (↓ 3%)	$133.98 (↑121%)	$211.96	$108.90	$225.33	$13.37 (↑6%)	$116.43 (↑107%)
77003	$95.26	$90.99	$0.00	(-$95.26) (↓ 100%)	(-$90.99) (↓ 100%)	$95.26	$90.99	$0.00	(-$95.26) (↓ 100%)	(-$90.99) (↓ 100%)
Total	$347.03	$201.68	$244.67	(-$102.36) (↓ 29%)	$42.99 (↑ 21%)	$307.22	$199.89	$225.33	(-$81.89) (↓ 27%)	$25.44 (↑13%)

Table 2. *Comparison of interventional procedures 2015 proposed payments in various settings.*

CPT	Description	Physician	Overhead / Facility payments			Office Overhead	
			Office	ASC	HOPD	ASC%	HOPD%
62310	Cervical/Thoracic Epidural	$112.13	$ 132.54	$369.82	$683.24	36%	19%
62311	Caudal/Lumbar Interlaminar Epidural	$ 92.06	$ 133.26	$369.82	$683.24	36%	20%
62318	Cervical/Thoracic Epidural Catheterization	$ 101.74	$ 131.47	$369.82	$683.24	36%	19%
62319	Lumbar/Sacral Catheterization, epidural	$ 98.51	$ 72.00	$369.82	$683.24	19%	11%
64420	Intercostal, single	$ 70.21	$ 44.06	$203.20	$375.40	22%	12%
64479	Cervical/Thoracic Transforaminal Epidural Injections	$136.84	$ 103.17	$369.82	$683.24	28%	15%
64480	Cervical/Thoracic Transforaminal Epidural Injections, add-on	$ 65.20	$ 49.79	-	-	-	-
64479 & 64480	Cervical/Thoracic Transforaminal Epidural Injections with additional	$ 202.04	$ 152.96	$369.82	$683.24	41%	22%
64483	Lumbar/Sacral Transforaminal Epidural Injections	$ 115.71	$ 106.75	$369.82	$683.24	29%	16%
64484	Lumbar/Sacral Transforaminal Epidural Injections, add-on	$ 53.73	$ 35.46	-	-	-	-
64483 & 64484	Lumbar/Sacral Transforaminal Epidural Injections with additional	$ 169.44	$ 142.21	$369.82	$683.24	38%	21%
64490	Cervical/Thoracic Facet Joint Injections, 1st level	$ 109.62	$ 83.47	$369.82	$683.24	23%	12%
64491	Cervical/Thoracic Facet Joint Injections, 2nd level	$ 62.33	$ 33.67	-	-	-	-
64492	Cervical/Thoracic Facet Joint Injections, 3rd level	$ 63.05	$ 33.32	-	-	-	-
64490 & 64491	Cervical/Thoracic Facet Joint Injections, with 2 levels	$ 171.95	$ 117.14	$369.82	$683.24	32%	17%
64490, 64491 & 64492	Cervical/Thoracic Facet Joint Injections, with 3 levels	$ 280.36	$ 150.46	$369.82	$683.24	41%	22%
64493	Lumbar/Sacral Facet Joint Nerve, 1st level	$ 94.21	$ 80.96	$369.82	$683.24	22%	12%
64494	Lumbar/Sacral Facet Joint Nerve, 2nd level	$ 53.38	$ 34.75	-	-	-	-
64495	Lumbar/Sacral Facet Joint Nerve, 3rd level	$ 54.45	$ 34.39	-	-	-	-
64493 & 64494	Lumbar/Sacral Facet Joint Nerve, with 2 levels	$ 147.59	$ 115.71	$369.82	$683.24	31%	17%
64493, 64494 & 64495	Lumbar/Sacral Facet Joint Nerve, with 3 levels	$ 202.04	$ 150.10	$369.82	$683.24	41%	22%
64633	Cervical/Thoracic Destroy Facet Joint	$233.92	195.23	$824.64	$1,523.50	24%	13%
64634	Cervical/Thoracic Destroy Facet Joint, add-on	$ 70.21	$ 122.16	-	-	-	-
64633 & 64634	Cervical/Thoracic Destroy Facet Joint with additional level	$ 304.13	$ 317.39	$824.64	$1,523.50	38%	21%
64635	Destroy Lumbar/Sacral Facet Joint	$230.70	$ 194.16	$824.64	$1,523.50	24%	13%
64636	Destroy Lumbar/Sacral Facet Joint, add-on	$ 61.97	$ 113.56	-	-	-	-
64635 & 64636	Destroy Lumbar/Sacral Facet Joint with additional level	$ 292.67	$ 307.69	$824.64	$1,523.50	37%	20%

2014, and is proposed to be $244.67 in 2015 including fluoroscopy, which is similar to the office payment when the procedure was performed blindly. This is a continued cut of 29% or $102.36 compared to 2013 and a modest increase of 21% or $42.99 compared to the draconian cuts of 2014 (Tables 1 and 2).

In assessing the payment system for lumbosacral epidurals, which includes caudal and interlaminar epidural injections with a CPT code of 62311, the total payment in 2013 was $307.22 and in 2014 is $199.89

with the inclusion of fluoroscopy. The proposed payment in 2015 is $225.33 with the bundling of fluoroscopy, which is similar to 2013 when the procedure was performed blindly without fluoroscopy. This is a total increase of 13% or $25.44 compared to the 2014 total payment and a continued decrease in comparison of 2013 payment of 27% or $81.

Thus, the reversal of the cuts with the bundling of fluoroscopy into the primary code is not a situation for despondence, but at the same time, not one for rejoicing either. This situation describes 2 steps forward, one step back with only a modest reversal of the cuts. The actions do provide the interventional pain management community an opportunity to add higher values to both the physician fees and office settings by requesting and advocating for the partial or complete value of fluoroscopy into the final rule to be released in November 2014.

The issue is very similar to previous encounters, wherein CMS, through the Correct Coding Initiative, attempted to propose bundling fluoroscopy into transforaminal, facet joint intervention, and sacroiliac joint injection codes. Due to objections, CMS has stopped the proposed implementation. Subsequently, CMS asked the American Medical Association (AMA) Relative Value Update Committee (RUC) service for all the procedures. Following these, the values were increased to incorporate expenses for fluoroscopy. At the time, it was hard to recognize the burden as interlaminar epidurals were not bundled. Subsequently, there have been multiple discussions between CMS and AMA RUC to change the definitions of CPT codes 62310 and 62311, which has not yet taken place.

As shown in Table 2, the physician payment rates for cervical and lumbar interlaminar epidural injections are lower than for transforaminal epidural injections, but similar to facet joint injections. In-office payments are very similar to transforaminal epidural injections for the first level and higher than facet joint injections; however, the advantage of transforaminal epidural injections and facet joint injections is the payment for the second level or even the third level. If both are combined, then transforaminal and facet joint injections receive a higher payment.

The CMS proposed rule provided an extensive explanation for interventional techniques and the valuing process. They explained that based upon their analysis of Medicare claims data and comments received on calendar year (CY)2014 final rule with comment period, these codes were typically furnished with imaging guidance. Consequently, they believed that it would be appropriate for the injection and imaging guidance codes to be bundled and the inputs for image guidance to be included in the evaluation of the epidural injections codes as it is for transforaminal and paravertebral codes. However, CMS has ignored the fact that transforaminal and facet joint procedures have undergone repeated analyses by RUC with inclusion of fluoroscopy as a component code of the procedure (4-8). Further, they also stated that they do not believe that epidural injection codes can be appropriately valued without considering the typical use of image guidance (3). Consequently, they also proposed to include CPT 62310, 63211, 62318, and 62319 on the potentially misvalued code list so that they can obtain information to support their evaluation with the image guidance included. In considering these issues, CMS also has not included or accounted for the value of a preoperative visit which is mandated by local coverage determinations (LCDs). The preoperative visit often includes performing a history and physical which is equivalent to 99213, an evaluation and management service which will be paid at $73.43 in 2015. Thus, even without considering a postoperative visit, the procedure is paid at $38.70 for cervical epidural (CPT 62310) and $18.63 for lumbar epidural (CPT 62311). We believe these valuations to be, for obvious reasons, unreasonable.

CMS, in its proposed rule, described that the recommendations include the "removal of the radiographic-fluoroscopic room for 62310, 62311, and 62318, and a portable C-arm for 62319." As it is widely interpreted, CMS is proposing to remove the radiographic-fluoroscopic room. It does not indicate that they are removing any other practice expense or physician work expense. The bundling of the fluoroscopic code essentially removes all other practice expenses as well as physician work value. CMS also reported that their data shows that epidural codes are frequently billed with imaging guidance. Further, they reported CPT code 62310 was billed with CPT code 77003 79% of the time in both facility and nonfacility settings in 2013, and 62319, which is the epidural injection code that is least frequently billed with CPT code 77003 in a nonfacility setting, was still billed with this guidance code 40% of the time. Further, in a facility setting, CPT codes 62318 and 62319 were much less frequently billed with CPT code 77003, only 3% and 11% of the time, respectively. These numbers indicate that 62318 and 62319 are infrequently used for chronic pain purposes; consequently, they do not require fluoroscopic utilization. Indeed, catheter-

ization procedures are performed for postoperative or obstetric pain management rather than chronic pain management. Thus, CMS' conclusion is that, based on the frequency with which these codes are reported with fluoroscopic guidance codes, fluoroscopic guidance is typically reported separately in conjunction with epidural injection services. However, CMS has not taken into consideration the high variability of 3% to 79%. CMS also stated that they have looked at the values for other injection procedures, including transforaminal epidural injections and facet joint injections. Considering the multiple codes available for them, they concluded that these codes are typically furnished with imaging guidance. However, CMS has not looked at the issue in which fluoroscopy was separate prior to establishing the new codes and bundling required issuing new codes by the CPT committee and reevaluation by the RUC (4-8).

Recognizing all the deficiencies described above, CMS proposed to revert to the CY2013 input values for CPT codes 62310, 62311, 62318, and 62319 for CY2015. CMS also stated that, specifically, they will use CY2013 work relative value units, work times, and direct practice expense inputs to establish payment rates for CY2015. Finally, they concluded that proposed practice expense inputs for epidural injection codes include items that are specifically related to image guidance, such as a radiographic fluoroscopic room. They believe separate reporting of the image guidance codes would overestimate the resources used in furnishing the 2 services together.

The CMS decision to propose cuts in payments for epidural injections was based on assumptions that epidural injections have been increasing disproportionately and were misvalued. As shown in Fig. 1, there has been rather explosive growth in spinal interventional pain management techniques of 228% from 2000 to 2011 with an annual growth of 11.4%, whereas the growth of the Medicare population has been 18% with an annual growth of 1.5% over the same period (8,9). However, the implication of the explosive growth of epidural injections for interlaminar epidural injections has been, in our opinion, inappropriate. As shown in Table 3, interlaminar injections grew 36% from 2000 to 2011 with an annual growth of 2.8%, whereas transforaminal epidural injections grew 583% with an annual growth of 19.1%, with a total growth of epidural injections, which are less than overall interventional

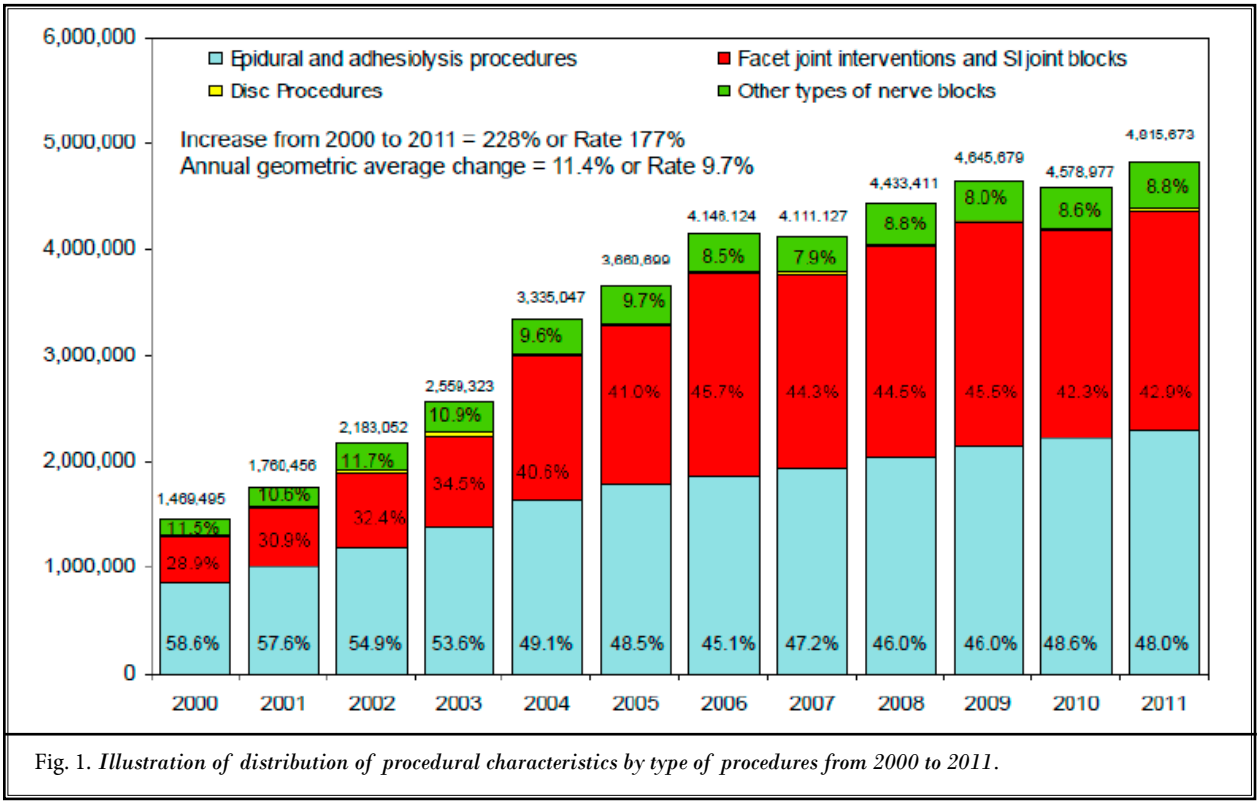

Fig. 1. *Illustration of distribution of procedural characteristics by type of procedures from 2000 to 2011.*

Table 3. *Utilization of epidural injections in the Medicare population from 2000 to 2011.*

Year	Interlaminar Epidurals				Transforaminal Epidurals								Total Epidural Injections	
					Cervical/Thoracic				Lumbar/Sacral					
	Cervical/Thoracic CPT 62310		Lumbar/Sacral CPT 62311		CPT 64479	CPT 64480	Total		CPT 64483	CPT 64484	Total			
	Services	Rate	Services	Rate	Services	Services	Services	Rate	Services	Services	Services	Rate	Services	Rate
2000	75,741	191	618,362	1,560	13,454	9,434	22,888	58	85,006	37,477	122,483	309	839,474	2,118
2001	84,385	211	702,713	1,755	14,732	8,537	23,269	58	125,534	53,133	178,667	446	989,034	2,470
2002	99117	245	786919	1,943	18583	10835	29,418	73	177679	79115	256,794	634	1,172,248	2,894
2003	109783	267	838858	2,040	21882	15769	37,651	92	242491	114046	356,537	867	1,342,829	3,265
2004	130,649	313	878,174	2,104	25,182	18,094	43,276	104	363,744	196,044	559,788	1,341	1,611,887	3,863
2005	141,652	333	945,350	2,225	27,844	20,525	48,369	114	395,508	216,892	612,400	1,441	1,747,771	4,113
2006	146,748	339	946,961	2,185	29,822	23,073	52,895	122	452,125	245,453	697,578	1,610	1,844,182	4,255
2007	156,415	353	926,029	2,092	29,938	22,266	52,204	118	506,274	274,305	780,579	1,764	1,915,227	4,327
2008	165,636	365	905,419	1,994	32,286	24,003	56,289	124	572,340	317,448	889,788	1,959	2,017,132	4,442
2009	175,503	383	888,166	1,939	37,012	27,487	64,499	141	632,658	351,685	984,343	2,149	2,112,511	4,612
2010	184,750	394	888,421	1,894	40,003	29,888	69,891	149	679,117	383,128	1,062,245	2,264	2,205,307	4,701
2011	200,134	427	914,324	1,949	38,970	26,628	65,598	140	710,638	398,519	1,109,157	2,364	2,289,213	4,879
Overall Change														
	164%	123%	48%	25%	190%	182%	187%	142%	736%	963%	806%	665%	173%	130%
Annual Change														
	9.2%	7.6%	3.6%	2.0%	10.2%	9.9%	10.0%	8.4%	21.3%	24.0%	22.2%	20.3%	9.5%	7.5%

Table 4. *Reimbursement history for CPT 62310 (cervical/thoracic epidural injection).*

CPT	Physician Payments	Facility/Overhead Payments including Fluoroscopy			Proportion of Office Overhead Payments over ASC & HOPD	
		Office	ASC	HOPD	ASC	HOPD
2001	$93.73	$173.31	$323.00	$180.53	54%	96%
2002	$88.69	$165.78	$333.00	$182.75	50%	91%
2003	$93.07	$211.87	$333.00	$249.63	64%	85%
2004	$94.84	$213.20	$333.00	$288.49	64%	74%
2005	$101.57	$209.95	$333.00	$331.91	63%	63%
2006	$101.57	$210.33	$333.00	$357.90	63%	59%
2007	$100.81	$186.46	$333.00	$390.95	56%	48%
2008	$100.17	$164.92	$322.77	$449.34	51%	37%
2009	$95.22	$134.89	$295.98	$473.78	46%	28%
2010	$101.08	$140.64	$295.98	$485.34	48%	29%
2011	$103.29	$160.03	$294.00	$522.67	54%	31%
2012	$107.22	$174.27	$300.76	$521.88	58%	33%
2013	$110.23	$206.86	$317.46	$565.75	65%	37%
2014	$74.15	$96.72	$370.07	$669.91	26%	14%
2015 (P)	$112.13	$132.54	$369.82	$683.24	36%	19%
Change from 2001 to 2014	-21%	-44%	15%	271%		
Change from 2001 to 2015(P)	20%	-24%	15%	278%		

Table 5. *Reimbursement history for CPT 62311 (lumbosacral epidural injection).*

CPT	Physician Payments	Facility/Overhead Payments including Fluoroscopy			Proportion of Office Overhead Payments over ASC & HOPD	
		Office	ASC	HOPD	ASC	HOPD
2001	$76.52	$186.31	$323.00	$180.53	58%	103%
2002	$72.42	$186.40	$333.00	$182.75	56%	102%
2003	$76.51	$218.13	$333.00	$249.63	66%	87%
2004	$78.41	$218.05	$333.00	$288.49	65%	76%
2005	$84.51	$216.40	$333.00	$331.91	65%	65%
2006	$84.13	$216.78	$333.00	$357.90	65%	61%
2007	$83.75	$187.60	$333.00	$390.95	56%	48%
2008	$83.41	$162.25	$322.77	$449.34	50%	36%
2009	$78.99	$127.68	$295.98	$473.78	43%	27%
2010	$83.74	$130.68	$295.98	$485.34	44%	27%
2011	$84.94	$145.76	$294.00	$522.67	50%	28%
2012	$87.82	$155.89	$300.76	$521.88	52%	30%
2013	$89.82	$187.46	$317.46	$565.75	59%	33%
2014	$72.72	$96.36	$370.07	$669.91	26%	14%
2015	$92.06	$133.27	$369.82	$683.24	36%	20%
Change from 2001 to 2014	-5%	-48%	15%	271%		
Change from 2001 to 2015	20%	-39%	15%	278%		

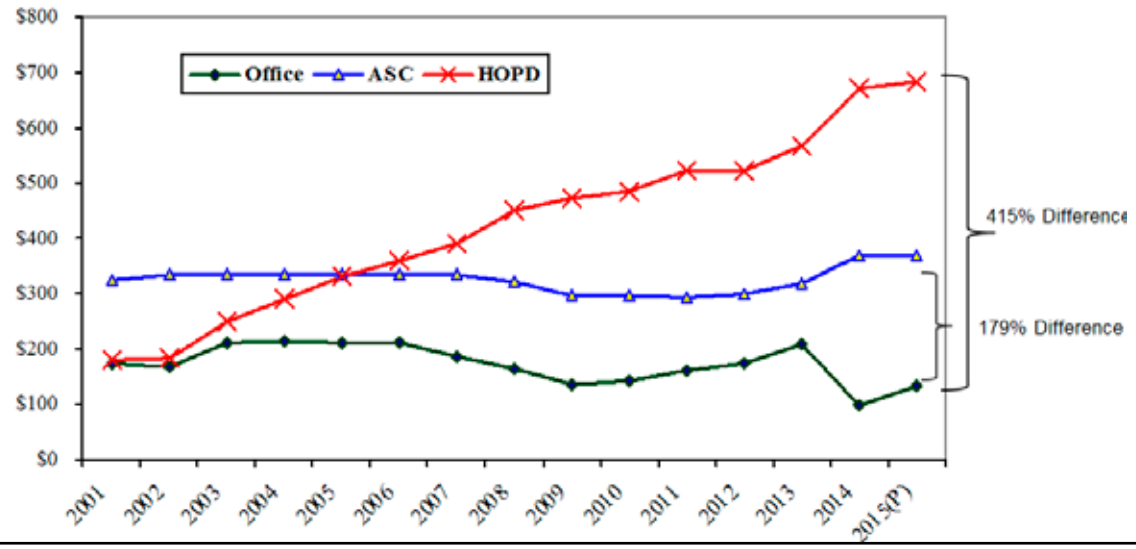

Fig. 2. *Reimbursement history of facility payments in multiple settings for CPT 62310 (Cervical/Thoracic Epidural Injection).*

techniques of 130% and an annual growth of 7.5% (8). In addition, as shown in Tables 4 and 5 and Figs. 2 and 3, the reimbursement history for CPT 62310 and CPT 62311 has been dismal with a 21% decline in physician payments, a 44% decline for office procedures, 15% increase for ambulatory surgery centers (ASCs), and 217%

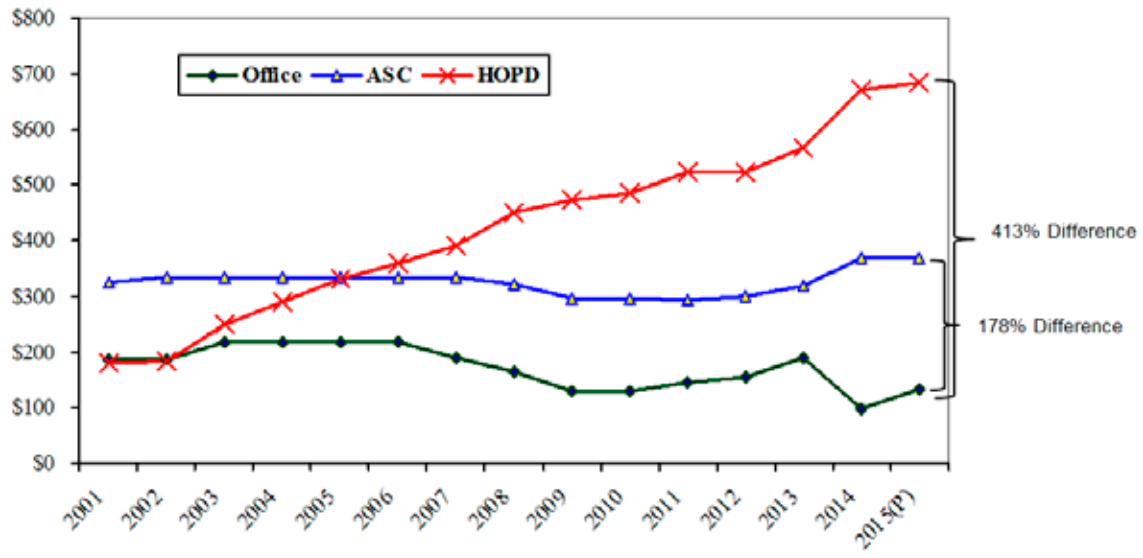

Fig. 3. *Reimbursement history of facility payments in multiple settings for CPT 62311 (Lumbosacral Epidural Injection).*

increase for hospital outpatient departments (HOPDs). These tables also show that office payment as a percentage was 54% of ASC and 96% of HOPD in 2001, which declined to 26% of ASC and 14% of HOPD for cervical epidural injections in 2011. Tables 4 and 5 and Figs. 2 and 3 also show that in 2014, there was a 282% difference between ASC and office-based payments, whereas the difference was 593% between the ASC and HOPD payment rates.

Further, the authors of this opinion 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 (10-14). Thus, the remarkable discrepancy exists as the payment is $670 in an office setting owned by a hospital, which is reduced to $132.54 for cervical epidural injection procedures and $133.26 for lumbar interlaminar and caudal epidural procedures with the bundling of fluoroscopy into the primary code. These patterns increase expenses by paying a much higher rate for HOPDs, even though they are just physician offices. This issue also favors inappropriate performance of the procedures with bundling.

It is the opinion of the authors that CMS should embrace the evidence-based principles that are increasingly used to guide medical practice. With increasing frequency, CMS is revising downward the input from the RUC (4). At the same time, they seem unwilling to provide rationales for their actions. As an example from a different field, radiology organizations have repeatedly challenged the methodology employed in establishing the Multiple Procedure Payment Reduction (MPPR) policy for the professional component of certain advanced imaging procedures. In the face of that uncertainty, one year later CMS added the professional MPPR policy to individuals in group practice. On its face, this is a very difficult decision to understand methodologically (15).

The IPM community continues to face significant difficulties, even though the burden has been reduced somewhat. A survey of interventional pain management physicians has shown that approximately 40% of them focus their practices mainly in an office setting (16). If all patients are moved to a hospital setting through acquisition of practices, this will continue to increase Medicare costs in excess of $100 million in additional reimbursements. Thus, it is imperative that the IPM community demonstrate the inappropriateness of such cuts and advocate for further reversal of the cuts in the Final Rule to be published in November of 2014.

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