Health Policy Review

Facility Payments for Interventional Pain Management Procedures: Impact of Proposed Rules

Laxmaiah Manchikanti, MD[1], Vijay Singh, MD[2], and Joshua A. Hirsch, MD[3]

From: 1Pain Management Center of Paducah, Paducah, KY, and University of Louisville, Louisville, KY; 2 Spine Pain Diagnostics Associates, Niagara, WI; and 4Massachusetts General Hospital and Harvard Medical School, Boston, MA

Dr. Manchikanti is Medical Director of the Pain Management Center of Paducah, Paducah, KY, and Clinical Professor, Anesthesiology and Perioperative Medicine, University of Louisville, Louisville, KY. Dr. Singh is Medical Director, Spine Pain Diagnostics Associates, Niagara, WI Dr. Hirsch is Vice Chief of Interventional Care, Chief of NeuroInterventional Spine, Service Line Chief of Interventional Radiology, Director Interventional and Endovascular Neuroradiology, Massachusetts General Hospital; and Associate Professor, Harvard Medical School, Boston, MA.

Address Correspondence:
Laxmaiah Manchikanti, M.D.
2831 Lone Oak Road
Paducah, Kentucky 42003
E-mail: drlm@thepainmd.com

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In the face of the progressive implementation of the Affordable Care Act (ACA), a significant regulatory regime, and the Merit-Based Incentive Payment System (MIPS), the Centers for Medicare and Medicaid Services (CMS) released its proposed 2017 hospital outpatient department (HOPD) and ambulatory surgery center (ASC) payment rules on July 14, 2016, and the physician payment schedule was released July 15, 2016. U.S. health care costs continue to increase, occupying 17.5% of the gross domestic product (GDP) in 2014 and surpassing $3 trillion in overall health care expenditure. Solo and independent practices face unique challenges and many are being acquired by hospitals or larger groups. This transfer of services to hospital settings is indisputably leading to an increase in the net cost to the system.

Comparison of facility payments for interventional techniques in HOPD, ASC, and in-office settings shows wide variation for multiple interventional techniques. Major discrepancies in payment schedules are related to higher payments for hospitals than comparable treatments in in-office settings and ASCs. In-office procedures, which have been converted to ASC procedures, are reimbursed at as high as 1,366% higher than ASCs and 2,156% higher than in-office settings. The Medicare Payment Advisory Commission (MedPAC) has made recommendations on avoiding the discrepancies and site-of-service differentials in in-office settings, hospital outpatient settings, and ASCs. These have not been implemented by CMS. In addition, there have been slow reductions in reimbursements over the recent years, which continue to accumulate, leading to significant reductions in payments

In conclusion, equalization of site-of-service differentials will simultaneously improve reimbursement patterns for interventional pain management procedures, increase access and quality of care, and finally, reduce costs for CMS, extending Medicare solvency.

Key words: Hospital outpatient departments, ambulatory surgery centers, physician in-office services, interventional pain management, interventional techniques

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U.S. health care costs represented 17.5% of the gross domestic product (GDP) in 2014, with a $3 trillion health care expenditure and individual expenses, increasing to $9,523 (1-3). The Affordable Care Act (ACA) has increased the number of insured Americans without a clear improvement in quality of care. In quality ratings among 11 developed countries, the United States went from fifth in 2004 to

eleventh in 2014 in overall rating (4). Along with overall health care spending, Medicare spending continues to increase. The ACA and subsequent regulations (1-24), while seemingly bending the cost curve, has not led to actual reductions in cost (1-4,11,12,25-34). Multiple services are provided in various settings including inpatient settings, outpatient hospital settings, ambulatory surgical centers (ASCs), physician offices, and other outpatient settings. The Medicare Payment Advisory Commission (MedPAC) and the Office of Inspector General (OIG) report have focused on equalizing the payment differences across ambulatory settings to attain significant savings (35,36,37).

In 2014, Medicare fee-for-service (FFS) paid 4,700 hospitals a total of $173 billion for 9.7 million Medicare inpatient admissions, 193 million outpatient services, and $9.4 billion of uncompensated care costs, representing a 4% increase in hospital spending from 2013 (38). Medicare also paid $69.2 billion for physician and other health professional services, accounting for 16% of FFS Medicare spending (39). Approximately 892,000 clinicians billed Medicare, of which 576,000 were physicians and 315,000 were nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners (39). Medicare also paid $3.8 billion to ASCs for 3.4 million FFS Medicare beneficiaries treated in 5,400 ASCs (40).

On July 14 and July 15, 2016, Medicare released its proposed fee schedule for physician and clinical services (41) and for hospital outpatient departments (HOPDs) and ASCs (42). Almost all interventional techniques are performed in outpatient settings (43-50). This review is undertaken to assess the new proposed payment rules for 2017 and compare them in multiple settings for interventional pain management (41,42).

Interaction of Ambulatory Health Care Payment Systems

Medicare payment rates continue to vary for the same ambulatory services provided to similar patients in different settings, such as physician's offices, HOPDs, and ASCs (2,35-51). In 2012, MedPAC recommended that if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another (35,36). MedPAC was also concerned that payment variations across settings may encourage arrangements among providers that result in care being provided in high paid settings, thereby increasing total Medicare spending and beneficiary cost sharing. Thus, the MedPAC's recommendation is that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting, adjusting for differences in patient severity, to the extent severity differences affect costs. The OIG of Health and Human Services (HHS) also made similar recommendations as MedPAC (35-37). Several of the authors of this review outlined a similar approach for interventional pain management (51). However, payment rates are set in different manners for HOPDs, ASCs, and physician offices.

The Centers for Medicare and Medicaid Services (CMS) sets payment rates for physicians and other practitioner services in the Medicare physician fee schedule, also known as the PFS, based on American Medical Association (AMA) Current Procedural Terminology (CPT) coding and Specialty Society Relative Value Update Committee (RUC) systems (35-42,52-54). In contrast, payment rates for most HOPD services are based on the outpatient prospective payment system (OPPS), determined by Medicare (38,42). ASC rates are also determined by Medicare based on prospective payment system as a percentage of OPPS (40,42). Consequently, for services provided in HOPDs and ASCs, Medicare makes 2 payments that involve physicians' professional fees and a PFS and a facility fee for the HOPD or ASC under the OPPS or ASC payment system. This applies for all types of surgical and non-surgical services. To further complicate matters, an outpatient facility that has provider-based status is considered part of the hospital and provider-based status is available for hospital-owned entities that meet criteria rules, such as being located on the hospital campus or off campus but within 3 to 5 miles. Recently, the administration has proposed this facility designation be available to only those services provided within the hospital campus (41,42). In general, the non-facility rate is higher than the facility rate in the PFS because physicians' practice costs are higher when physicians provide care in their offices due to direct costs such as equipment, supplies, and staff resulting in higher overhead costs. Thus, when a physician provides a service in an office setting, Medicare makes a single payment for all the services provided in an office, including the facility or overhead expenses and physician fee.

MedPAC has explored the differences between payments for evaluation and management (E/M) and multiple other services provided in a freestanding physician office and an HOPD. They noted an over 50% higher payment in an HOPD than in an office setting for E/M services and 141% more for certain echocardio-

gram services. In a recent report to the Congress, MedPAC once again expressed concern about the growth in outpatient hospital services which in part reflected incentives to shift patients to higher cost sites of care (38). From 2000 to 2014, the use of outpatient services increased by 3.7% per Medicare Part B beneficiary. Further, over the past 8 years, the cumulative increase was 44%. They also showed that approximately one quarter of the growth in outpatient volume in 2014 was due to an increase in the number of E/M visits billed as outpatient services. This growth in part reflects hospitals purchasing freestanding physician practices and converting the billing from the PFS to the higher paying HOPD visits. From 2012 to 2014, hospital-based E/M visits per beneficiary grew by 16%, compared with a 1% decline in visits to physician's offices. Other categories of services, such as echocardiograms and nuclear cardiology, are also shifting to hospital-based billing. Hospitals are also performing a large number of outpatient surgical services.

Thus, MedPAC and OIG explored a policy that would equalize payment rates for certain ambulatory surgical procedures between HOPDs and ASCs including interventional pain management procedures. It has been shown that HOPDs are reimbursed at 85% to 90% more than ASCs for multiple interventional techniques (35-42), and as high as 2,156% more than in-office settings (35-37,41,42,51).

The migration of these services is not only increasing costs, but are also leading to the diminution of independent practices (32). Solo physician practices have declined from 54% in 1980 to 17% in 2014 and independent practices have declined from 62% in 2008 to 35% in 2014 (Fig. 1) (55). With the implementation of meaningful use (MU), Physician Quality Reporting System (PQRS), Merit-Based Incentive Payment System (MIPS), ACA, Accountable Care Organizations (ACOs), and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), independent practices are coming under even greater pressure (4-34,56-75). The percentage of workers with employer-based single coverage without an annual limit on out-of-pocket spending and the rate of change in real per enrollee spending by payer have declined significantly, a combination which dictates that provider payments are declining rapidly (6-10). Historically, HOPD payments were low in early 2000s and at the time ASIPP presented a classification to preserve the hospital practice of interventional pain management. This classification included multiple nerve block groups as shown in Table 1 based on complexity, facility, personnel, and equipment requirements (43,76,77). CMS changed some components of this classification over the ensuing years. Overall, HOPD payments skyrocketed based on the payment classification from $165 to $181 in 2001 to $573 to $1,557 in 2017 with significant decreases in

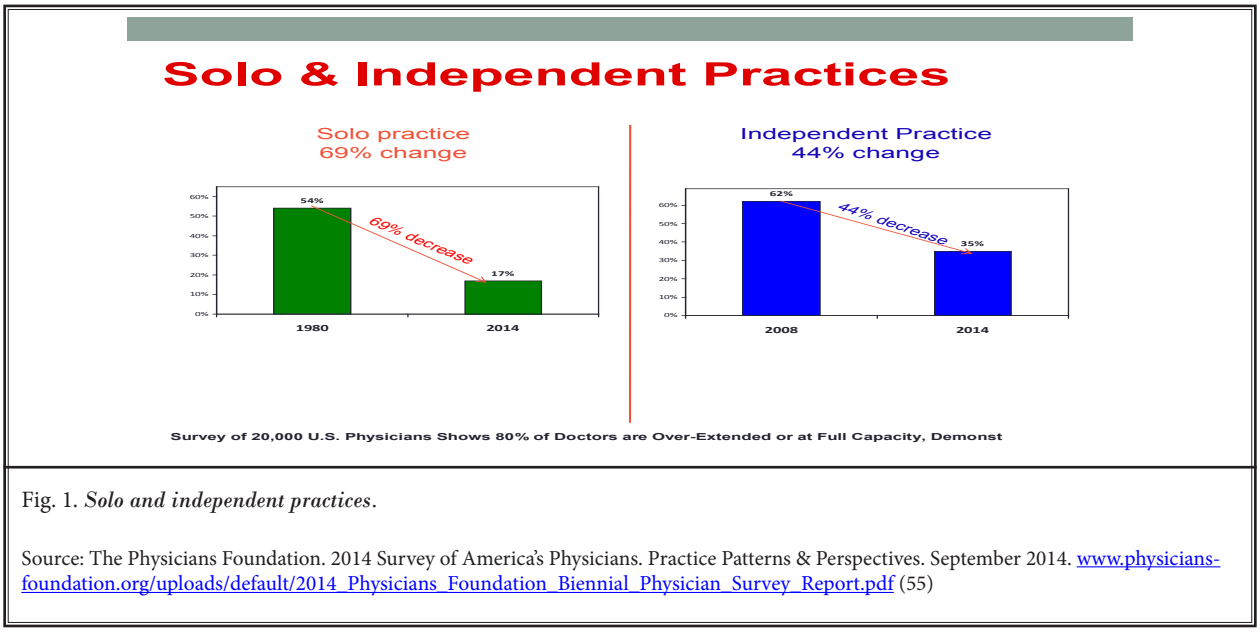


Fig. 1. *Solo and independent practices.*

Source: The Physicians Foundation. 2014 Survey of America's Physicians. Practice Patterns & Perspectives. September 2014. www.physicians-foundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf (55)

ASC and in-office payments.

Despite recommendations from MedPAC to equalize payments across various settings (35,36), in 2016, they have recommended against updating ASC payments (38-42). Despite the differences in payments, surgical services have been moving from inpatient to hospital outpatient with a significant proportion of services provided by ASCs and physician offices (44-47,50,78). A survey of the ASC industry showed that 70% of growth in ASCs from 2000 to 2017 is the result of moving procedures from HOPDs into the less expensive ASC setting (78); however, the trend may be reversed in 2017 and 2018 with significantly more practices moving out of independent practices or being integrated into hospital systems (4-15,32,57-62). In a report describing 2011 ASC financial and operational research (50), interventional pain management was the third most frequent category of services performed behind gastroenterology and orthopedics with ophthalmology a close fourth. However, payment per case was approximately 20% to 30% of other specialties for pain management. This report also showed the proportion of outpatient surgery continues to increase compared to inpatient surgery even though a significant proportion of them are performed in HOPDs as shown in Fig. 2 (50). Similarly, there has been shift in interventional pain management services from facility/HOPD to office settings over the years and the majority of the cases moving from HOPD to other settings, even though expenses seem to be high in HOPD settings (44-49). Figure 3 shows the shifting of epidural services from HOPDs to ASCs and offices (48). In addition, Tables 2 and 3 show the variable costs in different settings for interventional pain management procedures (35-37,44,47,79). Recent data looking at 3 interventional pain management categories showed a decline in overall services in the past 3 years (Table 4) (45,46).

Table 1. *Ambulatory payment classification for interventional techniques in HOPD settings as proposed by ASIPP and accepted by CMS.*

Level III nerve injections
(proposed as Level II interventional techniques)
These codes include:
62270 – spinal puncture, lumbar, diagnostic
62272 – spinal puncture, therapeutic, for drainage of spinal fluid (by needle or catheter)
62273 – injection, epidural, of blood or clot patch
62310 – cervical/thoracic epidural
62311 – lumbar/caudal epidural
62318 – continuous epidural – cervical/thoracic
62319 – continuous epidural – lumbar/sacral
64614 – chemodenervation extremity(s) and/or trunk muscle(s)
Level IV nerve injections
(proposed as Level III interventional techniques)
These were moderately high complexity procedures including epidurals, facet blocks and disk injections. These codes include:
62280 – neurolytic subarachnoid
62281 – cervical/thoracic epidural - neurolytic
62282 – lumbar/sacral epidural - neurolytic
64420 – intercostal nerve block - single
64421 – intercostal nerve block - multiple
64470 – facet injection – cervical/thoracic - single
64472 - facet injection – cervical/thoracic - additional
64475 – facet injection – lumbar/sacral- single
64476 - facet injection – lumbar/sacral- additional
64479 – transforaminal cervical/thoracic - single
64480 - transforaminal cervical/thoracic - additional
64483 - transforaminal lumbar/sacral - single
64484 - transforaminal lumbar/sacral - additional
64510 – stellate ganglion block
64520 – lumbar or thoracic sympathetic block
64530 – celiac plexus block
64630 – pudendal nerve neurolysis
64640 – peripheral neurolysis
Level V nerve injections
(proposed as Level IV interventional techniques)
These codes include:
62263 – percutaneous epidural adhesiolysis
64600 – neurolytic – trigeminal – small branches
64605 – neurolytic – trigeminal – 2/3 division
64610 – neurolytic – trigeminal – at foramen ovale
64620 – intercostal neurolysis
64622 – facet neurolysis – lumbar/sacral - single
64623 - facet neurolysis – lumbar/sacral - additional
64626 - facet neurolysis – cervical/thoracic - single
64627 - facet neurolysis – cervical/thoracic - additional
64680 – celiac plexus neurolysis

Source(s): Manchikanti L, Boswell MV. Interventional techniques in ambulatory surgical centers: A look at the new payment system. Pain Physician 2007; 10:627-650 (43); Department of Health and Human Services, Health Care Financing Administration. 42 CFR Part 419. Medicare Program; Prospective Payment System for Hospital Outpatient Services; Interim Final Rule. November 13, 2000 (76); and Manchikanti L. Interventional pain medicine: A specialty in the new millennium. Pain Physician 2001; 4:296-304 (77).

Hospital Outpatient Department Payment System

The Medicare FFS program paid acute care hospitals $54 billion for outpatient care with an average annual increase of 8% from 2006 to 2013 and 11% increase from 2013 to 2014 (38). Similarly, outpatient spending per FFS beneficiary grew by 11%, driving a 4% increase in overall Medicare inpatient and outpatient payments in 2014. Figure 4 shows Medicare inpatient discharges per beneficiary continue to decline, whereas outpatient visits per beneficiary continue to increase. MedPAC indicated that the growth in outpatient hospital services in part reflects incentives to shift patients to higher cost sites of care. Table 5 shows the proposed 2017 HOPD rates for commonly used interventional techniques. The fee schedule ranges from approximately 300% to 2,156% higher than office facility payments except for augmentation procedures which are higher in office

settings, but lower in ASC settings as show in Tables 5-8. The payments are 85% higher for most commonly performed ASC procedures and as high as 1,366% higher for the procedures which were considered as office procedures and now allowed to be performed in HOPDs and ASCs (i.e., CPT 20526 to 20610, 64450, and other procedures). Even though hospitals provide services in the majority of the cases, similar to offices and inferior to ASCs, they are reimbursed at much higher levels. Further, payments for ASCs are derived from ambulatory payment classification (APC) systems, which are based on hospital expenses, which are derived in the

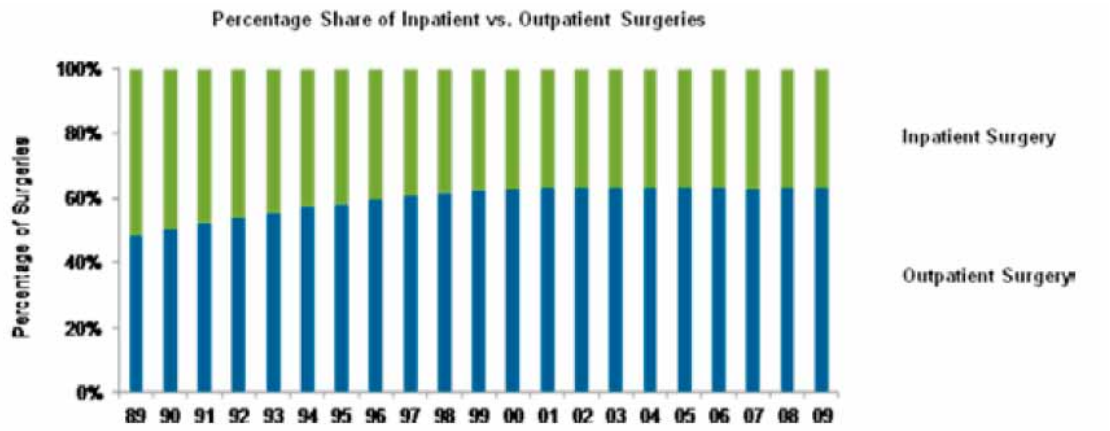


Fig. 2. *ASC industry trends*.
Source: Intellimarker Multi-Specialty ASC Study: Ambulatory Surgical Centers Financial & Operational Benchmarking Study, Sixth Ed. VMG Health, November 2011. http://www.vmghealth.com/Downloads/VMG_Intellimarker11.pdf

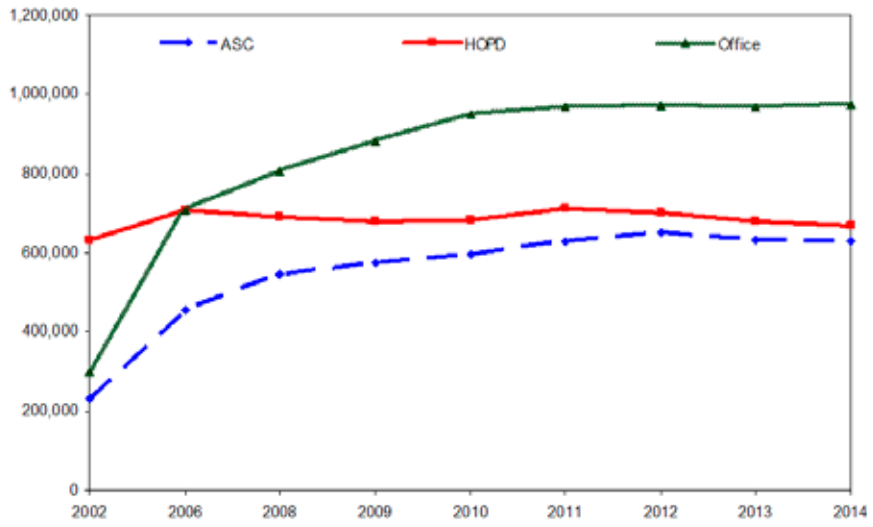


Fig. 3. *Geographic display of pattern of epidural services provided by place of services for Medicare Beneficiaries from 2002 to 2014*.
Source(s):Manchikanti L, Pampati V, Falco FJE, Hirsch JA. Growth of spinal interventional pain management techniques: Analysis of utilization trends and Medicare expenditures 2000 to 2008. Spine (Phila Pa 1976) 2013; 38:157-168 (44); Manchikanti L, Pampati V, Hirsch JA. Utilization of interventional techniques in managing chronic pain in Medicare population from 2000 to 2014: An analysis of patterns of utilization. Pain Physician 2016; 19:E531-E546 (45); Manchikanti L, Pampati V, Falco FJE, Hirsch JA. An updated assessment of utilization of interventional pain management techniques in the Medicare population: 2000 – 2013. Pain Physician 2015; 18:E115-E127 (46); and Manchikanti L, Pampati V, Hirsch JA. A retrospective cohort study of utilization patterns of epidural injections for spinal pain in U.S. fee-for-service Medicare population from 2000 to 2014. BMJ 2016; in press (48).

Table 2. *Characteristics of spinal interventional techniques by place of service.*

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	% of Change From 2000	Average Annual Percent Change
Patients											
ASC	60,320	83,220	111,600	130,300	162,080	193,680	215,100	236,620	254,720	322.3	19.7
HOPD	282,140	322,420	343,520	365,020	386,020	390,800	387,100	376,520	375,020	32.9	3.6
Office	92,440	128,560	164,380	210,040	264,980	315,780	361,820	378,720	405,800	339.0	20.3
Total	434,900	534,200	619,500	705,360	813,080	900,260	964,020	991,860	1,035,540	138.1	11.5
Visits											
ASC	127,520	187,120	252,620	295,140	370,220	442,340	485,840	540,340	570,460	347.3	20.6
HOPD	549,380	641,480	689,240	733,660	776,800	784,720	774,880	750,500	752,280	36.9	4.0
Office	207,060	301,340	399,440	507,460	648,460	799,260	958,600	951,920	1,017,360	391.3	22.0
Total	883,960	1,129,940	1,341,300	1,536,260	1,795,480	2,026,320	2,219,320	2,242,760	2,340,100	164.7	12.9
Procedures											
ASC	184,440	267,960	361,300	433,580	579,680	706,980	806,660	926,800	979,540	431.1	23.2
HOPD	729,180	850,400	921,920	990,100	1,077,100	1,120,340	1,131,800	1,100,720	1,123,560	54.1	5.6
Office	293,920	436,780	611,500	793,280	1,059,840	1,414,560	1,841,160	1,729,760	1,865,080	534.6	26.0
Total	1,207,540	1,555,140	1,894,720	2,216,960	2,716,620	3,241,880	3,779,620	3,757,280	3,968,180	228.6	16.0
Procedures per visit											
ASC	1.45	1.43	1.43	1.47	1.57	1.60	1.66	1.72	1.72	18.7	2.2
HOPD	1.33	1.33	1.34	1.35	1.39	1.43	1.46	1.47	1.49	12.5	1.4
Office	1.42	1.45	1.53	1.56	1.63	1.77	1.92	1.82	1.83	29.1	3.2
Total	1.37	1.38	1.41	1.44	1.51	1.60	1.70	1.68	1.70	24.1	2.7
Visits per patient											
ASC	2.11	2.25	2.26	2.27	2.28	2.28	2.26	2.28	2.24	5.9	0.8
HOPD	1.95	1.99	2.01	2.01	2.01	2.01	2.00	1.99	2.01	3.0	0.4
Office	2.24	2.34	2.43	2.42	2.45	2.53	2.65	2.51	2.51	11.9	1.4
Total	2.03	2.12	2.17	2.18	2.21	2.25	2.30	2.26	2.26	11.2	1.4
Procedures per patient											
ASC	3.06	3.22	3.24	3.33	3.58	3.65	3.75	3.92	3.85	25.8	2.9
HOPD	2.58	2.64	2.68	2.71	2.79	2.87	2.92	2.92	3.00	15.9	1.9
Office	3.18	3.40	3.72	3.78	4.00	4.48	5.09	4.57	4.60	44.5	4.7
Total	2.78	2.91	3.06	3.14	3.34	3.60	3.92	3.79	3.83	38.0	4.1

ASC indicates ambulatory surgery center; HOPD, hospital outpatient department.

Adapted with permission from Manchikanti L, Pampati V, Falco FJE, Hirsch JA. Growth of spinal interventional pain management techniques: Analysis of utilization trends and Medicare expenditures 2000 to 2008. Spine (Phila Pa 1976) 2013; 38:157-168 (44).

Table 3. *Characteristics of average charges per patient, per visit, and per procedure code by place of service.*

Place of Service	2000	2008	% of Change From 2000
Ambulatory surgery center			
Facility charges	$63,597,475	$281,356,400	342
Per patient	$1054.33	$1104.57	5
Per visit	$498.73	$493.21	−1
Per procedure code	$344.81	$287.23	−17
Total charges (facility and physician)	$90,155,325	$360,693,700	300
Per patient	$1494.62	$1416.04	−5
Per visit	$706.99	$632.29	−11
Per procedure code	$488.81	$368.23	−25
Hospital outpatient department			
Facility charges	$134,356,800	$421,741,560	214
Per patient	$476.21	$1124.58	136
Per visit	$244.56	$560.62	129
Per procedure code	$184.26	$375.36	104
Total charges (facility and physician)	$202,804,150	$508,134,340	151
Per patient	$718.81	$1354.95	88
Per visit	$369.15	$675.46	83
Per procedure code	$278.13	$452.25	63
Office			
Overhead charges	$43,790,150	$218,039,880	398
Per patient	$473.71	$537.31	13
Per visit	$211.49	$214.32	1
Per procedure code	$148.99	$116.91	−22
Total charges (facility and physician)	$69,387,550	$362,352,380	422
Per patient	$750.62	$892.93	19
Per visit	$335.11	$356.17	6
Per procedure code	$236.08	$194.28	−18
Overall			
Facility/overhead charges	$241,744,425	$921,137,840	281
Per patient	$555.86	$889.52	60
Per visit	$273.48	$393.63	44
Per procedure code	$200.20	$232.13	16
Total charges (facility and physician)	$362,347,025	$1,231,180,420	240
Per patient	$833.17	$1188.93	43
Per visit	$409.91	$526.12	28
Per procedure code	$300.07	$310.26	3

Adapted with permission from Manchikanti L, Pampati V, Falco FJE, Hirsch JA. Growth of spinal interventional pain management techniques: Analysis of utilization trends and Medicare expenditures 2000 to 2008. Spine (Phila Pa 1976) 2013; 38:157-168 (44).

Table 4. *Utilization/frequency of interventional techniques in the fee-for-service Medicare population from 2000 to 2014.*

	Epidural and adhesiolysis procedures		Facet joint interventions and SI joint blocks		Disc Procedures and other types of nerve blocks		Utilization of all interventional techniques*			
	Services (Facility %)	Rate	Services (Facility %)	*Rate*	Services (Facility %)	*Rate*	Services (Facility %)	*% of Change in services*	Rate	% of Change in Rate
2000	860,787 (79%)	2,172	424,796 (67%)	*1,072*	183,912 (87%)	*464*	1,469,495 (72%)		3,708	
2001	1,013,552 (78%)	2,531	543,509 (62%)	*1,357*	203,395 (87%)	*508*	1,760,456 (69%)	*19.8%*	*4,396*	18.6%
2002	1,199,324 (74%)	2,961	708,186 (58%)	*1,748*	275,542 (81%)	*680*	2,183,052 (64%)	*24.0%*	*5,390*	22.6%
2003	1,370,862 (71%)	3,333	884,035 (53%)	*2,150*	304,426 (80%)	*740*	2,559,323 (60%)	*17.2%*	*6,223*	15.5%
2004	1,637,494 (65%)	3,924	1,354,242 (46%)	*3,245*	343,311 (79%)	*823*	3,335,047 (54%)	*30.3%*	*7,992*	28.4%
2005	1,776,153 (65%)	4,180	1,501,222 (47%)	*3,533*	383,324 (78%)	*902*	3,660,699 (54%)	*9.8%*	*8,614*	7.8%
2006	1,870,440 (63%)	4,316	1,896,688 (40%)	*4,376*	378,996 (75%)	*874*	4,146,124 (49%)	*13.3%*	*9,567*	11.1%
2007	1,940,454 (62%)	4,384	1,820,695 (46%)	*4,113*	349,978 (73%)	*791*	4,111,127 (52%)	*-0.8%*	*9,288*	-2.9%
2008	2,041,155 (61%)	4,495	1,974,999 (46%)	*4,349*	417,257 (70%	*919*	4,433,411 (51%)	*7.8%*	9,763	5.1%
2009	2,136,035 (59%)	4,664	2,111,700 (46%)	*4,611*	397,944 (69%)	*869*	4,645,679 (49%)	*4.8%*	*10,143*	3.9%
2010	2,226,486 (57%)	4,746	1,937,582 (48%)	*4,130*	414,909 (62%)	*884*	4,578,977 (52%)	-1.4%	*9,760*	-3.8%
2011	2,309,906 (58%)	4,782	2,064,227 (50%)	*4,274*	441,540 (61%)	*914*	4,815,673 (48%)	*5.2%*	*9,970*	2.2%
2012	2,324,563 (58%)	4,621	2,159,057 (50%)	*4,292*	464,354 (57%)	*923*	4,947,974 (53%)	*2.7%*	*9,837*	-1.3%
2013	2,278,790 (58%)	4,391	2,197,766 (51%)	*4,235*	456,394 (51%)	*879*	4,932,950 (53%)	*-0.3%*	*9,505*	-3.4%
2014	2,273,104 (57%)	*4,249*	2,370,000 (50%)	*4,430*	382,800 (47%)	*716*	5,025,904 (52%)	*1.9%*	*9,394*	-1.2%
Change	165%	96%	458%	313%	108%	54%	242%		153%	
Average	7.2%	4.9%	13.1%	10.7%	5.4%	3.1%	9.2%		6.9%	

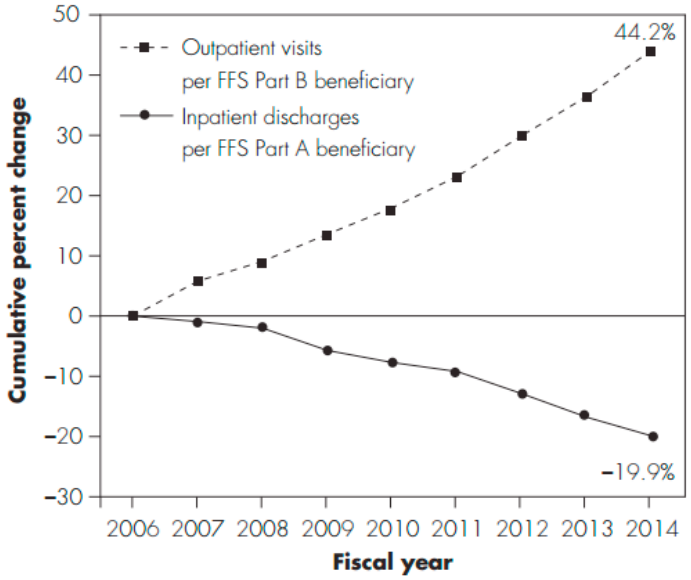
Rate - IPM services per 100,000 Medicare Beneficiaries

*(Excluding continuous epidurals, intraarticular injections, trigger point and ligament injections, peripheral nerve blocks, vertebral augmentation procedures, and implantables)

majority of the cases based on these procedures being performed in nonoperative surgery suites. While this reduces the costs of HOPDs, it also significantly reduces the reimbursement patterns for ASCs.

The majority of the interventional pain management procedures in HOPDs are performed outside the surgical suite, whereas the majority of the ASC procedures are performed in surgical suites. Despite these differences, hospitals are reimbursed over 85% more than ASCs for the procedures which are approved for ASCs and as high as 1,366% more for the procedures which are based on the physician payment schedule, except in a few circumstances. In addition, payments to HOPDs are 400% to 2,156% higher than to offices.

A significant reduction has been proposed for kyphoplasty (26.4%), with a minor increase of 1.2% for vertebroplasty. There are significant differences among the fee schedules also. Ironically, the reimbursements



Note: FFS (fee-for-service). Data include general and surgical, critical access, and children's hospitals.

Source: MedPAC analysis of CMS's inpatient and outpatient claims and enrollment data.

Fig. 4. *Medicare inpatient discharges per beneficiary continued to decline as outpatient visits per beneficiary continued to increase.*

are higher in office settings over HOPD and ASC. Since ASC reimbursements are based on a percentage of HOPD payment, ASCs also suffer with these CPT codes.

It is ironic that if a procedure is performed at one level in an HOPD setting for thoracic or lumbar kyphoplasty ($5,199.03), offices are reimbursed ($6,658.82) at $1,459.79 higher, or 28% more, than hospital settings. Further, offices are also reimbursed for add-on codes, which is not so for HOPDs. This translates into the difference for office overhead of $4135.60 or a 107.6% higher reimbursement for a 2-level procedure in an office setting. ASIPP believes that hospital payments should be increased for these procedures.

In 2016, percutaneous epidural adhesiolysis CPT codes 62263 and 62264 were transferred from the original nerve block classification group in which it was classified along with radiofrequency neurotomy and other major procedures to a lower intensity group. Consequently, the reimbursement rates for HOPDs have declined 13.5% from 2016 to 2017, similar to epidural injections in 2017. There is moderate to good evidence for clinical and cost-effectiveness of percutaneous adhesiolysis (47,80-85)

ASIPP requested that CMS reconsider this rate structure and utilize the original nerve block classifications in which percutaneous adhesiolysis is classified along with radiofrequency neurotomy procedures which are reimbursed in 2017 at $1,557, an increase of 11.8%. Based on this, physician in-office reimbursement as well as ASC reimbursement also may be adjusted.

Ambulatory Surgical Center Payment System

An ASC is a distinct entity that primarily provides all patient procedures to patients who do not require an overnight stay after the procedure. Medicare has covered and paid for surgical procedures provided in ASCs since 1982 (40). Now, Medicare covers about 3,400 procedures under the ASC payment system. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operat-

Table 5. *2017 HOPD proposed payment rates.*

CPT	Description	2007	2016	2017P	% of Change from	
					2016	2007
20526	Injection, therapeutic, carpal tunnel	$139.00	$223.76	$231.04	-3.15%	-39.84%
20550	tendon sheath, ligament injection	$139.00	$223.76	$231.04	-3.15%	-39.84%
20551	Tendon origin/insertion injection	$139.00	$223.76	$231.04	-3.15%	-39.84%
20552	Single or multiple trigger point(s), one or two muscle group(s)	$139.00	$223.76	$231.04	-3.15%	-39.84%
20553	Single or multiple trigger point(s), three or more muscle groups	$139.00	$223.76	$231.04	-3.15%	-39.84%
20600	Small joint injection	$139.00	$223.76	$231.04	-3.15%	-39.84%
20605	Intermediate joint injection	$139.00	$223.76	$231.04	-3.15%	-39.84%
20610	Major joint injection	$139.00	$223.76	$231.04	-3.15%	-39.84%
22510	Vertebroplasty (Cervicothoracic)	$1,544.67	$2,395.59	$2,424.86	-1.21%	-36.30%
22511	Vertebroplasty (Lumbosacral)	$1,544.67	$2,395.59	$2,424.86	-1.21%	-36.30%
22513	Kyphoplasty, thoracic	$4,092.54	$7,064.07	$5,199.03	35.87%	-21.28%
22514	Kyphoplasty, lumbar	$4,092.54	$7,064.07	$5,199.03	35.87%	-21.28%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$748.08	$822.10	$711.01	15.62%	5.21%
62264	Percutaneous epidural adhesiolysis – 1 day	$748.08	$822.10	$711.01	15.62%	5.21%
62270	Spinal puncture, diagnostic	$139.00	$585.17	$572.60	2.20%	-75.72%
62272	Spinal puncture, therapeutic	$139.00	$585.17	$572.60	2.20%	-75.72%
62273	Epidural, blood patch	$351.92	$585.17	$572.60	2.20%	-38.54%
62287	Disc decompression	$2,037.79	$3,396.78	$4,104.85	-17.25%	-50.36%
62350	Tunneled intrathecal or epidural catheter for long-term medication	$1,895.64	$3,396.78	$4,104.85	-17.25%	-53.82%
62355	Removal or previously implanted intrathecal or epidural catheter	$748.08	$1,392.56	$1,556.99	-10.56%	-51.95%
62360	Implant or replacement; subcutaneous reservoir	$6,923.28	$15,350.22	$15,507.38	-1.01%	-55.35%
62361	Implantation or replacement of non-programmable pump	$10,720.36	$15,350.22	$15,507.38	-1.01%	-30.87%
62362	Implant spine infusion pump; programmable pump, including preparation of pump, with or without programming	$10,720.36	$15,350.22	$15,507.38	-1.01%	-30.87%
62365	Remove spine infusion device; programmable pump, including preparation of pump, with or without programming	$2,037.79	$3,396.78	$4,104.85	-17.25%	-50.36%
62367	Electronic analysis of programmable pump	$177.90	$241.18	$255.38	-5.56%	-30.34%
62368	Electronic analysis of programmable pump with reprogramming	$177.90	$241.18	$255.38	-5.56%	-30.34%
623X5	Cervical or Thoracic interlaminar epidural injection(s); without fluoro			$572.60		
623X6	Cervical or Thoracic interlaminar epidural injection(s); with fluoro			$572.60		
623X7	Lumbar or caudal epidural injection(s); without fluoro			$572.60		
623X8	Lumbar or caudal interlaminar epidural injection(s); with fluoro			$572.60		
623X9	Cervical or thoracic continuous epidural Injection(s),; without fluoro			$711.01		
62X10	Cervical or thoracic continuous epidural Injection(s),; with fluoro			$711.01		
62X11	Lumbar or caudal continuous epidural Injection(s); without fluoro			$711.01		
62X12	Lumbar or caudal continuous epidural Injection(s); with fluoro			$711.01		
630X1	Endoscopic decompression of lumbar spine			$5,199.03		
63650	Implant neuroelectrodes	$3,477.28	$5,244.37	$5,839.83	-10.20%	-40.46%
63655	Implant neuroelectrodes	$5,175.40	$17,359.37	$17,533.66	-0.99%	-70.48%
63661	Remove spine eltrd perq aray		$1,392.56	$1,556.99	-10.56%	
63662	Remove spine eltrd plate		$2,188.64	$2,665.24	-17.88%	
63663	Remove spine eltrd perq aray		$5,244.37	$5,839.83	-10.20%	
63664	Remove spine eltrd plate			$17,533.66		

Table 5. (cont) *2017 HOPD proposed payment rates*.

CPT	Description	2007	2016	2017P	% of Change from	
					2016	2007
63685	Implant neuroreceiver	$11,164.12	$26,728.39	$26,701.46	0.10%	-58.19%
63688	Revise/remove neuroreceiver	$2,186.43	$2,188.64	$2,665.24	-17.88%	-17.96%
64400	Injection, Trigeminal nerve block	$139.00	$223.76	$231.04	-3.15%	-39.84%
64402	Facial nerve block	$139.00	$91.18	$265.56	-65.67%	-47.66%
64405	Greater occipital nerve block	$139.00	$223.76	$231.04	-3.15%	-39.84%
64408	Vagus nerve block	$139.00	$223.76	$231.04	-3.15%	-39.84%
64410	Phrenic nerve block	$351.92	$585.17	$572.60	2.20%	-38.54%
64413	Cervical plexus block	$139.00	$585.17	$572.60	2.20%	-75.72%
64415	Brachial plexus block	$139.00	$822.10	$711.01	15.62%	-80.45%
64417	Axillary nerve block	$139.00	$585.17	$572.60	2.20%	-75.72%
64418	Suprascapular nerve block	$139.00	$585.17	$572.60	2.20%	-75.72%
64420	Intercostal, single block	$139.00	$585.17	$572.60	2.20%	-75.72%
64421	Intercostal, multiple, regional nerve block	$351.92	$585.17	$572.60	2.20%	-38.54%
64425	Ilioinguinal, Iliohypogastric nerve block	$139.00	$585.17	$572.60	2.20%	-75.72%
64445	Sciatic nerve block	$139.00	$585.17	$572.60	2.20%	-75.72%
64450	Other peripheral nerve or branch block	$139.00	$223.76	$572.60	-60.92%	-75.72%
64479	Cervical transforaminal epidural injections	$390.95	$585.17	$572.60	2.20%	-31.72%
64483	Lumbar/sacral transforaminal epidural injections	$390.95	$585.17	$711.01	-17.70%	-45.01%
64490	Cervical and thoracic facet joint injections, 1st Level	$390.95	$822.10	$711.01	15.62%	-45.01%
64493	Paravertebral facet joint or facet joint nerve; lumbar/sacral, 1st Level	$390.95	$822.10	$711.01	15.62%	-45.01%
64505	Injection, sphenopalatine ganglion	$139.00	$223.76	$231.04	-3.15%	-39.84%
64510	Injection, Stellate ganglion (cervical sympathetic)	$390.95	$585.17	$572.60	2.20%	-31.72%
64520	Injection, lumbar or thoracic (paravertebral sympathetic)	$390.95	$585.17	$711.01	-17.70%	-45.01%
64530	Celiac plexus block, with or without radiologic monitoring	$390.95	$822.10	$711.01	15.62%	-45.01%
64600	Destruction by neurolytic agent, trigeminal nerve	$748.08	$822.10	$711.01	15.62%	5.21%
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$748.08	$1,392.56	$1,556.99	-10.56%	-51.95%
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	$748.08	$1,392.56	$1,556.99	-10.56%	-51.95%
64612	Chemodenervation of muscle(s); muscle(s) innervated	$139.00	$223.76	$231.04	-3.15%	-39.84%
64620	Intercostal nerve - neurolysis	$748.08	$822.10	$711.01	15.62%	5.21%
64630	Pudendal nerve - neurolysis	$351.92	$822.10	$711.01	15.62%	-50.50%
64633	Paravertebral facet joint nerve; C/T, single level - - neurolysis	$748.08	$1,392.56	$1,556.99	-10.56%	-51.95%
64635	Paravertebral facet joint nerve; L/S, single level - - neurolysis	$748.08	$1,392.56	$1,556.99	-10.56%	-51.95%
64640	Other peripheral nerve or branch - - neurolysis	$351.92	$822.10	$711.01	15.62%	-50.50%
64680	Celiac plexus - - neurolysis	$390.95	$822.10	$711.01	15.62%	-45.01%
72265	Contrast x-ray, lower spine	$157.01	$667.93	$440.92	51.49%	-64.39%
72270	Contrast x-ray of spine	$157.01	$667.93	$440.92	51.49%	-64.39%
72285	Discography C/T Radiological supervision and interpretation	$982.00	$2,718.83	$1,556.99	74.62%	-36.93%
72295	Discography lumbar radiological supervision and interpretation	$982.00	$2,718.83	$1,556.99	74.62%	-36.93%
73525	Hip, arthrography, radiological supervision and interpretation	$226.91	$351.71	$440.92	-20.23%	-48.54%
76000	Fluoroscopic examination	$79.34	$191.97	$218.74	-12.24%	-63.73%
G0260	Sacroiliac joint, arthrography	$351.92	$585.17	$572.60	2.20%	-38.54%

Table 6. *2017 ASC proposed payment rates.*

CPT	Description	2007	2016	2017P	% of Change from	
					2016	2007
20526	Injection, therapeutic, carpal tunnel		$39.76	$39.38	-0.96%	
20550	tendon sheath, ligament injection		$30.09	$23.63	-21.47%	
20551	Tendon origin/insertion injection		$31.52	$31.87	1.11%	
20552	Single or multiple trigger point(s), one or two muscle group(s)		$30.09	$30.08	-0.03%	
20553	Single or multiple trigger point(s), three or more muscle groups		$35.10	$35.09	-0.03%	
20600	Small joint injection		$22.57	$22.56	-0.04%	
20605	Intermediate joint injection		$24.00	$23.63	-1.54%	
20610	Major joint injection		$29.01	$28.64	-1.28%	
22510	Vertebroplasty (Cervicothoracic)	$1,339.00	$1,339.58	$1,213.15	-9.44%	-9.40%
22511	Vertebroplasty (Lumbosacral)	$1,339.00	$1,339.58	$1,213.15	-9.44%	-9.40%
22513	Kyphoplasty, thoracic		$3,532.70	$2,681.86	-24.08%	
22514	Kyphoplasty, lumbar		$3,532.70	$2,681.86	-24.08%	
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$333.00	$459.71	$382.99	-16.69%	15.01%
62264	Percutaneous epidural adhesiolysis – 1 day	$333.00	$459.71	$382.99	-16.69%	15.01%
62270	Spinal puncture, diagnostic	$139.00	$327.22	$308.43	-5.74%	121.89%
62272	Spinal puncture, therapeutic	$139.00	$327.22	$308.43	-5.74%	121.89%
62273	Epidural, blood patch	$333.00	$327.22	$308.43	-5.74%	-7.38%
62287	Disc decompression	$1,339.00	$1,899.43	$1,882.09	-0.91%	40.56%
62350	Tunneled intrathecal or epidural catheter for long-term medication	$446.00	$1,899.43	$1,882.09	-0.91%	321.99%
62355	Removal or previously implanted intrathecal or epidural catheter	$446.00	$778.70	$783.40	0.60%	75.65%
62360	Implant or replacement; subcutaneous reservoir	$446.00	$12,887.49	$12,039.46	-6.58%	2599.43%
62361	Implantation or replacement of non-programmable pump	$446.00	$12,887.49	$12,774.99	-0.87%	2764.35%
62362	Implant spine infusion pump; programmable pump, including preparation of pump, with or without programming	$446.00	$12,887.49	$12,829.26	-0.45%	2776.52%
62365	Remove spine infusion device; programmable pump, including preparation of pump, with or without programming	$446.00	$1,899.43	$1,882.09	-0.91%	321.99%
62367	Electronic analysis of programmable pump		$23.28	$22.56	-3.09%	
62368	Electronic analysis of programmable pump with reprogramming		$31.88	$30.79	-3.42%	
623X5	Cervical/thoracic interlaminar epidural injection(s); without fluoro	$0.00		$308.43		
623X6	Cervical/thoracic interlaminar epidural injection(s); with fluoro	$0.00		$308.43		
623X7	Lumbar or caudal epidural injection(s); without fluoro	$0.00		$308.43		
623X8	Lumbar or caudal interlaminar epidural injection(s); with fluoro	$0.00		$308.43		
623X9	Cervical or thoracic continuous epidural Injection(s),; without fluoro	$0.00		$382.99		
62X10	Cervical or thoracic continuous epidural Injection(s),; with fluoro	$0.00		$382.99		
62X11	Lumbar or caudal continuous epidural Injection(s),; Without fluoro	$0.00		$382.99		
62X12	Lumbar or caudal continuous epidural Injection(s),; With fluoro	$0.00		$382.99		
630X1	Endoscopic Decompression of Lumbar Spine			$3,623.63		
63650	Implant neuroelectrodes	$446.00	$3,993.90	$4,534.35	13.53%	916.67%
63655	Implant neuroelectrodes		$14,797.32	$14,069.64	-4.92%	
63661	Remove spine eltrd perq aray		$778.70	$783.40	0.60%	
63662	Remove spine eltrd plate		$1,223.86	$1,435.63	17.30%	
63663	Remove spine eltrd perq aray		$3,993.90	$4,643.16	16.26%	
63664	Remove spine eltrd plate		$3,993.90	$12,923.68	223.59%	
63685	Implant neuroreceiver	$446.00	$21,258.56	$21,540.41	1.33%	4729.69%

Table 6 (cont.). *2017 ASC proposed payment rates.*

CPT	Description	2007	2016	2017P	% of Change from	
					2016	2007
63688	Revise/remove neuroreceiver	$333.00	$1,223.86	$1,435.63	17.30%	331.12%
64400	Trigeminal nerve, any division or branch block		$82.75	$81.28	-1.78%	
64405	Greater occipital nerve block		$63.04	$61.58	-2.32%	
64408	Vagus nerve block		$52.30	$63.73	21.85%	
64410	Phrenic nerve block	$333.00	$327.22	$308.43	-5.74%	-7.38%
64413	Cervical plexus block		$73.07	$71.97	-1.51%	
64415	Brachial plexus block	$139.00	$459.71	$382.99	-16.69%	175.53%
64417	Axillary nerve block	$139.00	$327.22	$308.43	-5.74%	121.89%
64418	Suprascapular nerve block		$97.07	$94.52	-2.63%	
64420	Intercostal, single block	$139.00	$327.22	$308.43	-5.74%	121.89%
64421	Intercostal, multiple, regional nerve block	$333.00	$327.22	$308.43	-5.74%	-7.38%
64425	Ilioinguinal, Iliohypogastric nerve block		$67.34	$64.81	-3.76%	
64445	Sciatic nerve block		$82.03	$78.77	-3.97%	
64450	Other peripheral nerve or branch block		$52.30	$51.56	-1.41%	
64479	Cervical transforaminal epidural injections	$333.00	$327.22	$308.43	-5.74%	-7.38%
64483	Lumbar/sacral transforaminal epidural injections	$333.00	$327.22	$382.99	17.04%	15.01%
64490	Cervical/thoracic facet joint injections, 1st Level	$333.00	$459.71	$382.99	-16.69%	15.01%
64493	Paravertebral facet joint or facet joint nerve; lumbar/sacral, 1st Level	$333.00	$459.71	$382.99	-16.69%	15.01%
64505	Injection, sphenopalatine ganglion		$53.01	$52.63	-0.72%	
64510	Injection, Stellate ganglion (cervical sympathetic)	$333.00	$327.22	$308.43	-5.74%	-7.38%
64520	Injection, lumbar or thoracic (paravertebral sympathetic)	$333.00	$327.22	$382.99	17.04%	15.01%
64530	Celiac plexus block, with or without radiologic monitoring	$333.00	$459.71	$382.99	-16.69%	15.01%
64600	Destruction by neurolytic agent, trigeminal nerve	$333.00	$459.71	$382.99	-16.69%	15.01%
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$333.00	$778.70	$783.40	0.60%	135.26%
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	$333.00	$778.70	$783.40	0.60%	135.26%
64612	Chemodenervation of muscle(s); muscle(s) innervated		$73.43	$72.32	-1.51%	
64620	Intercostal nerve - neurolysis	$333.00	$459.71	$382.99	-16.69%	15.01%
64630	Pudendal nerve - neurolysis	$351.92	$459.71	$382.99	-16.69%	8.83%
64633	Paravertebral facet joint nerve; cervical/thoracic, single level - - neurolysis	$333.00	$778.70	$783.40	0.60%	135.26%
64635	Paravertebral facet joint nerve; lumbar/sacral, single level - - neurolysis	$333.00	$778.70	$783.40	0.60%	135.26%
64640	Other peripheral nerve or branch - - neurolysis		$88.48	$86.29	-2.48%	
64680	Celiac plexus - - neurolysis	$390.95	$459.71	$382.99	-16.69%	-2.04%
G0260	(27096) Sacroiliac joint, arthrography	$333.00	$327.22	$308.43	-5.74%	-7.38%

ing and recovery rooms, medical staff, nursing services, and other aspects of care (38,40,41). Facility payment for ASCs is similar to HOPDs which bundles nursing, recovery care, anesthetics, and supplies, through a system that is primarily linked to the OPPS, which Medicare uses to set payment rates for most services provided in HOPDs (38,40,41). The ASC payment system is also partly linked to the PFS (38,39,41). The ASC system underwent substantial revisions in 2008 (86). The most significant changes included a substantial increase in the number of surgical procedures covered, allowing ASCs to bill separately for certain ancillary services, and making

Table 7. *Proposed physician payment schedule for top codes for interventional procedures.*

CPT	Description	2016		2017 Proposed		% of change from 2016	
		Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
20526	Injection, therapeutic, carpal tunnel	$79.18	$59.47	$79.06	$59.74	-0.15%	0.45%
20550	Tendon sheath, ligament injection	$60.19	$42.99	$54.02	$40.78	-10.25%	-5.14%
20551	Tendon origin/insertion injection	$61.98	$44.07	$61.18	$43.29	-1.30%	-1.77%
20552	Single or multiple trigger point(s), one or two muscle group(s)	$56.25	$39.05	$56.17	$38.99	-0.15%	-0.15%
20553	Single or multiple trigger point(s), three or more muscle groups	$64.85	$44.43	$64.40	$44.00	-0.70%	-0.95%
20600	Small joint injection	$48.73	$36.54	$48.65	$36.49	-0.15%	-0.15%
20605	Intermediate joint injection	$51.23	$38.34	$50.44	$37.92	-1.54%	-1.08%
20610	Major joint injection	$61.62	$47.65	$61.18	$47.58	-0.73%	-0.15%
22510	Vertebroplasty (Cervicothoracic)	$1,803.93	$469.35	$1,684.65	$450.05	-6.61%	-4.11%
22511	Vertebroplasty (Lumbosacral)	$1,786.02	$440.68	$1,669.27	$422.50	-6.54%	-4.13%
22512	Vertebroplasty - Additional	$1,001.03	$218.19	$960.20	$215.72	-4.08%	-1.13%
22513	Kyphoplasty, thoracic	$7,504.15	$560.71	$7,198.31	$539.49	-4.08%	-3.78%
22514	Kyphoplasty, lumbar	$7,495.91	$522.73	$7,160.03	$501.21	-4.48%	-4.12%
22515	Kyphoplasty, Additional	$4,541.90	$236.82	$4,369.21	$233.61	-3.80%	-1.36%
27093	Injection procedure for HIP arthrography – without anesthesia	$191.32	$72.73	$188.18	$71.91	-1.64%	-1.13%
27095	Injection procedure for HIP arthrography – with anesthesia	$247.21	$85.63	$245.42	$85.86	-0.73%	0.27%
27096	Sacroiliac joint, arthrography	$165.52	$87.42	$160.99	$85.86	-2.74%	-1.78%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$669.98	$351.47	$613.54	$333.07	-8.42%	-5.24%
62264	Percutaneous epidural adhesiolysis – 1 day	$437.10	$248.65	$425.37	$244.70	-2.68%	-1.59%
62268	Percutaneous aspiration, spinal cord cyst or syrinx		$269.07		$266.17		-1.08%
62269	Biopsy of spinal cord, percutaneous needle		$280.17		$274.75		-1.94%
62270	Spinal puncture, diagnostic	$162.30	$80.61	$159.91	$80.49	-1.47%	-0.15%
62272	Spinal puncture, therapeutic	$207.44	$87.06	$203.20	$86.58	-2.04%	-0.56%
62273	Epidural, blood patch	$179.14	$118.59	$174.58	$116.98	-2.54%	-1.35%
62287	Disc decompression		$589.01		$588.86		-0.03%
62290	Discography each level: lumbar	$343.23	$179.14	$333.07	$175.30	-2.96%	-2.14%
62291	Discography each level: C/T	$339.65	$176.99	$334.50	$174.22	-1.52%	-1.56%
62350	Tunneled intrathecal or epidural catheter for long-term medication		$419.19		$411.41		-1.85%
62355	Removal or previously implanted intrathecal or epidural catheter		$275.52		$275.11		-0.15%
62360	Implant or replacement; subcutaneous reservoir		$327.11		$318.76		-2.55%
62361	Implantation or replacement of device for epidural drug infusion; non-programmable pump		$377.63		$439.32		16.34%
62362	Implant spine infusion pump; programmable pump, including preparation of pump, with or without programming		$405.21		$396.75		-2.09%
62365	Remove spine infusion device; programmable pump, including preparation of pump, with or without programming		$310.27		$306.95		-1.07%
62367	Electronic analysis of programmable pump	$42.64	$26.51	$41.14	$25.76	-3.50%	-2.85%
62368	Electronic analysis of programmable pump with reprogramming	$58.40	$36.54	$57.24	$36.49	-1.99%	-0.15%
623X5	Cervical or Thoracic interlaminar epidural injection(s); without fluoro			$155.98	$104.82		
623X6	Cervical or Thoracic interlaminar epidural injection(s); with fluoro			$238.26	$113.41		

Table 7 (cont.). *Proposed physician payment schedule for top codes for interventional procedures.*

CPT	Description	2016		2017 Proposed		% of change from 2016	
		Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
623X7	Lumbar or caudal epidural injection(s); without fluoro			$145.25	$90.87		
623X8	Lumbar or caudal interlaminar epidural injection(s); with fluoro			$233.61	$103.75		
623X9	Cervical or thoracic continuous epidural Injection(s),; without fluoro			$137.02	$95.52		
62X10	Cervical or thoracic continuous epidural Injection(s),; with fluoro			$211.43	$110.19		
62X11	Lumbar or caudal continuous epidural Injection(s),; Without fluoro			$143.82	$94.09		
62X12	Lumbar or caudal continuous epidural Injection(s),; With fluoro			$214.65	$99.81		
630X1	Endoscopic decompression of lumbar spine				$688.31		
63650	Implant neuroelectrodes	$1,370.42	$429.93	$1,325.83	$422.50	-3.25%	-1.73%
63655	Implant neuroelectrodes		$859.87		$858.96		-0.11%
63661	Remove spine eltrd perq aray	$596.18	$333.20	$589.57	$331.64	-1.11%	-0.47%
63662	Remove spine eltrd plate		$872.05		$867.19		-0.56%
63663	Remove spine eltrd perq aray	$818.31	$471.85	$797.07	$464.00	-2.60%	-1.66%
63664	Remove spine eltrd plate		$896.41		$894.74		-0.19%
63685	Implant neuroreceiver		$381.21		$376.71		-1.18%
63688	Revise/remove neuroreceiver		$383.36		$382.44		-0.24%
64400	Trigeminal nerve, any division or branch block	$130.77	$73.45	$128.79	$72.98	-1.52%	-0.63%
64402	Facial nerve block	$133.64	$81.33	$135.95	$83.00	1.73%	2.05%
64405	Greater occipital nerve block	$103.54	$65.21	$102.32	$65.11	-1.18%	-0.15%
64408	Vagus nerve block	$107.48	$78.46	$121.28	$89.44	12.83%	13.99%
64410	Phrenic nerve block	$128.98	$73.09	$137.73	$77.99	6.79%	6.71%
64412	Spinal accessory nerve block						
64413	Cervical plexus block	$130.41	$83.84	$129.51	$83.71	-0.70%	-0.15%
64415	Brachial plexus block	$124.68	$68.07	$118.06	$66.54	-5.31%	-2.25%
64417	Axillary nerve block	$136.50	$74.52	$129.15	$71.91	-5.39%	-3.51%
64418	Suprascapular nerve block	$149.04	$79.18	$146.32	$77.99	-1.83%	-1.50%
64420	Intercostal, single block	$115.72	$70.58	$111.98	$69.40	-3.24%	-1.67%
64421	Intercostal, multiple, nerve block	$155.13	$95.30	$151.33	$93.73	-2.45%	-1.65%
64425	Ilioinguinal, Iliohypogastric nerve block	$136.50	$97.09	$133.80	$96.24	-1.98%	-0.88%
64430	Pudendal nerve block	$141.88	$84.91	$138.09	$83.00	-2.67%	-2.25%
64445	Sciatic nerve block	$140.80	$75.24	$137.38	$74.41	-2.43%	-1.10%
64450	Other peripheral nerve or branch block	$81.69	$47.29	$80.85	$46.51	-1.02%	-1.66%
64479	Cervical transforaminal epidural injections	$242.20	$137.22	$237.55	$135.95	-1.92%	-0.93%
64480	Cervical transforaminal epidural injections add-on	$116.08	$65.57	$114.12	$65.11	-1.69%	-0.69%
64483	Lumbar/sacral transforaminal epidural injections	$225.36	$116.80	$220.37	$115.91	-2.21%	-0.76%
64484	Lumbar/sacral transforaminal epidural injections add-on	$90.29	$54.10	$88.01	$52.95	-2.52%	-2.13%
64490	Cervical/thoracic facet joint injections, 1st Level	$195.62	$110.71	$191.40	$109.47	-2.16%	-1.12%
64491	Cervical/thoracic facet joint injections, 2nd Level	$96.38	$62.70	$94.45	$61.89	-2.00%	-1.29%
64492	Cervical/thoracic facet joint injections, 3rd Level	$97.09	$63.42	$95.16	$62.61	-1.99%	-1.28%
64493	Paravertebral facet joint or facet joint nerve; Lumbar/sacral, 1st Level	$177.71	$94.94	$173.15	$93.02	-2.56%	-2.03%

Table 7 (cont.). *Proposed physician payment schedule for top codes for interventional procedures.*

CPT	Description	2016		2017 Proposed		% of change from 2016	
		Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
64494	Paravertebral facet joint or facet joint nerve; Lumbar/sacral, 2nd Level	$89.21	$54.10	$87.65	$53.66	-1.75%	-0.81%
64495	Paravertebral facet joint or facet joint nerve; Lumbar/sacral, 3rd Level	$89.57	$54.82	$88.01	$54.38	-1.75%	-0.80%
64505	Injection, anesthetic agent; sphenopalatine ganglion	$107.13	$89.93	$107.68	$90.51	0.52%	0.65%
64510	Injection, anesthetic agent; Stellate ganglion (cervical sympathetic)	$131.49	$76.67	$128.07	$75.13	-2.60%	-2.01%
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	$192.04	$84.20	$187.10	$83.00	-2.57%	-1.42%
64530	Celiac plexus block, with or without radiologic monitoring	$196.70	$96.02	$190.68	$93.73	-3.06%	-2.38%
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	$403.78	$228.58	$399.25	$227.17	-1.12%	-0.62%
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$773.17	$429.93	$619.98	$357.75	-19.81%	-16.79%
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	$769.94	$512.34	$758.79	$507.65	-1.45%	-0.92%
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	$135.07	$121.10	$133.08	$119.49	-1.47%	-1.33%
64620	Destruction by neurolytic agent, intercostal nerve	$211.03	$178.42	$207.50	$176.01	-1.67%	-1.35%
64630	Destruction by neurolytic agent; pudendal nerve	$238.97	$199.56	$235.04	$196.76	-1.64%	-1.40%
64633	Paravertebral facet joint nerve; cervical/thoracic, single level - neurolysis	$434.95	$235.39	$422.86	$231.11	-2.78%	-1.82%
64634	Paravertebral facet joint nerve; cervical/thoracic, single level - addl	$195.62	$71.30	$189.97	$70.12	-2.89%	-1.65%
64635	Paravertebral facet joint nerve; Lumbar/sacral, single level - neurolysis	$429.93	$232.16	$418.57	$228.25	-2.64%	-1.69%
64636	Paravertebral facet joint nerve; Lumbar/sacral, single level - addl	$177.71	$62.34	$172.79	$61.89	-2.76%	-0.72%
64640	Destruction by neurolytic agent; other peripheral nerve or branch	$136.15	$96.02	$133.80	$95.16	-1.72%	-0.89%
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	$317.79	$171.97	$308.74	$168.50	-2.85%	-2.02%
72285	Diskography cervical/thoracic radiological supervision and interpretation	$115.72		$113.41		-2.00%	
72295	Diskography lumbar radiological supervision and interpretation	$99.96		$98.02		-1.94%	
73525	Hip, arthrography, radiological supervision and interpretation	$102.47		$101.60		-0.85%	
76000	Fluoroscopic examination	$47.65		$47.58		-0.15%	
76942	Ultrasonic guidance for needle placement	$61.98		$61.53		-0.72%	
77002	Needle localization by xray	$93.87		$85.14		-9.3%	
99201	Office/outpatient visit new	$44.43	$27.23	$43.65	$26.83	-1.76%	-1.46%
99202	Office/outpatient visit new	$75.60	$50.88	$75.13	$50.80	-0.62%	-0.15%
99203	Office/outpatient visit new	$109.28	$77.75	$109.11	$77.99	-0.15%	0.31%
99204	Office/outpatient visit new	$166.24	$131.49	$165.28	$130.94	-0.58%	-0.42%
99205	Office/outpatient visit new	$208.52	$170.90	$208.21	$171.01	-0.15%	0.06%
99211	Office/outpatient visit established	$20.06	$9.32	$20.03	$9.30	-0.15%	-0.15%
99212	Office/outpatient visit established	$44.07	$25.80	$43.65	$25.76	-0.96%	-0.15%
99213	Office/outpatient visit established	$73.45	$51.59	$73.34	$51.52	-0.15%	-0.15%
99214	Office/outpatient visit established	$108.20	$79.18	$108.40	$79.42	0.18%	0.30%
99215	Office/outpatient visit established	$145.82	$111.78	$145.96	$112.69	0.10%	0.81%

Table 8. *2017 proposed payment rates in various settings.*

CPT	Description	Physician Payment	Office Overhead	ASC Payment	HOPD Payment	HOPD paid more than ASC (%)	HOPD paid more than Office Overhead (%)
20526	Injection, therapeutic, carpal tunnel	$59.74	$19.32	$39.38	$231.04	486.69%	1095.95%
20550	Tendon sheath, ligament injection	$40.78	$13.24	$23.63	$231.04	877.74%	1645.44%
20551	Tendon origin/insertion injection	$43.29	$17.89	$31.87	$231.04	624.95%	1191.63%
20552	Single or multiple trigger point(s), one or two muscle group(s)	$38.99	$17.17	$30.08	$231.04	668.09%	1245.45%
20553	Single or multiple trigger point(s), three or more muscle groups	$44.00	$20.39	$35.09	$231.04	558.42%	1033.00%
20600	Small joint injection	$36.49	$12.16	$22.56	$231.04	924.11%	1799.45%
20605	Intermediate joint injection	$37.92	$12.52	$23.63	$231.04	877.74%	1745.18%
20610	Major joint injection	$47.58	$13.59	$28.64	$231.04	706.70%	1599.51%
22510	Vertebroplasty (Cervicothoracic)	$450.05	$1,234.60	$1,213.15	$2,424.86	99.88%	96.41%
22511	Vertebroplasty (Lumbosacral)	$422.50	$1,246.76	$1,213.15	$2,424.86	99.88%	94.49%
22513	Kyphoplasty, thoracic	$539.49	$6,658.82	$2,681.86	$5,199.03	93.86%	-21.92%
22514	Kyphoplasty, lumbar	$501.21	$6,658.82	$2,681.86	$5,199.03	93.86%	-21.92%
G0260	(27096) Sacroiliac joint, arthrography	$85.86	$75.13	$308.43	$572.60	85.65%	662.17%
62263	Percutaneous epidural adhesiolysis - 2 or 3 days	$333.07	$280.48	$382.99	$711.01	85.65%	153.50%
62264	Percutaneous epidural adhesiolysis – 1 day	$244.70	$180.66	$382.99	$711.01	85.65%	293.55%
62270	Spinal puncture, diagnostic	$80.49	$79.42	$308.43	$572.60	85.65%	620.97%
62272	Spinal puncture, therapeutic	$86.58	$116.63	$308.43	$572.60	85.65%	390.97%
62273	Epidural, blood patch	$116.98	$57.60	$308.43	$572.60	85.65%	894.13%
62287	Disc decompression	$588.86		$1,882.09	$4,104.85	118.10%	
62350	Tunneled intrathecal or epidural catheter for long-term medication	$411.41		$1,882.09	$4,104.85	118.10%	
62355	Removal of previously implanted intrathecal or epidural catheter	$275.11		$783.40	$1,556.99	98.75%	
62360	Implant or replacement, subcutaneous reservoir	$318.76		$12,039.46	$15,507.38	28.80%	
62361	Implantation or replacement of non-programmable pump	$439.32		$12,774.99	$15,507.38	21.39%	
62362	Implant spine infusion pump, ; programmable pump, including preparation of pump, with or without programming	$396.75		$12,829.26	$15,507.38	20.88%	
62365	Remove spine infusion device; programmable pump, including preparation of pump, with or without programming	$306.95		$1,882.09	$4,104.85	118.10%	
62367	Electronic analysis of programmable pump	$25.76	$15.38	$22.56	$255.38	1032.00%	1560.11%
62368	Electronic analysis of programmable pump with reprogramming	$36.49	$20.75	$30.79	$255.38	729.43%	1130.77%
623X5	Cervical or Thoracic interlaminar epidural injection(s); without fluoro	$104.82	$51.16	$308.43	$572.60	85.65%	1019.27%
623X6	Cervical or Thoracic interlaminar epidural injection(s); with fluoro	$113.41	$124.86	$308.43	$572.60	85.65%	358.61%
623X7	Lumbar or caudal epidural injection(s); without fluoro	$90.87	$54.38	$308.43	$572.60	85.65%	953.00%

Table 8. (cont) *2017 proposed payment rates in various settings.*

CPT	Description	Physician Payment	Office Overhead	ASC Payment	HOPD Payment	HOPD paid more than ASC (%)	HOPD paid more than Office Overhead (%)
623X8	Lumbar or caudal interlaminar epidural injection(s); with fluoro	$103.75	$129.86	$308.43	$572.60	85.65%	340.92%
623X9	Cervical or thoracic continuous epidural Injection(s),; without fluoro	$95.52	$41.50	$382.99	$711.01	85.65%	1613.31%
62X10	Cervical or thoracic continuous interlaminar epidural Injection(s),; with fluoro	$110.19	$101.24	$382.99	$711.01	85.65%	602.28%
62X11	Lumbar or caudal continuous epidural Injection(s); Without fluoro	$94.09	$49.73	$382.99	$711.01	85.65%	1329.82%
62X12	Lumbar or caudal continuous epidural Injection(s); With fluoro	$99.81	$114.84	$382.99	$711.01	85.65%	519.14%
630X1	Endoscopic decompression of lumbar spine	$688.31		$3,623.63	$5,199.03	43.48%	
63650	Percutaneous for implantation of neuroelectrodes	$422.50	$903.32	$4,534.35	$5,839.83	28.79%	546.48%
63655	Laminectomy for implantation of neuroelectrodes	$858.96		$14,069.64	$17,533.66	24.62%	
63661	Remove spine eltrd perq aray	$331.64	$257.94	$783.40	$1,556.99	98.75%	503.63%
63662	Remove spine eltrd plate	$867.19		$1,435.63	$2,665.24	85.65%	
63663	Remove spine eltrd perq aray	$464.00	$333.07	$4,643.16	$5,839.83	25.77%	1653.35%
63664	Remove spine eltrd plate	$894.74		$12,923.68	$17,533.66	35.67%	
63685	Implant neuroreceiver	$376.71		$21,540.41	$26,701.46	23.96%	
63688	Revise/remove neuroreceiver	$382.44		$1,435.63	$2,665.24	85.65%	
64400	Injection, Trigeminal nerve block	$72.98	$55.81	$81.28	$231.04	184.25%	313.98%
64405	Greater occipital nerve block	$65.11	$37.21	$61.58	$231.04	275.19%	520.97%
64408	Vagus nerve block	$89.44	$31.84	$63.73	$231.04	262.53%	625.63%
64410	Phrenic nerve block	$77.99	$59.74	$308.43	$572.60	85.65%	858.42%
64413	Cervical plexus block	$83.71	$45.79	$71.97	$572.60	695.61%	1150.43%
64415	Brachial plexus block	$66.54	$51.52	$382.99	$711.01	85.65%	1280.17%
64417	Axillary nerve block	$71.91	$57.24	$308.43	$572.60	85.65%	900.35%
64418	Suprascapular nerve block	$77.99	$68.33	$94.52	$572.60	505.80%	737.99%
64420	Intercostal, single block	$69.40	$42.57	$308.43	$572.60	85.65%	1245.00%
64421	Intercostal, multiple, nerve block	$93.73	$57.60	$308.43	$572.60	85.65%	894.13%
64425	Ilioinguinal, Iliohypogastric nerve block	$96.24	$37.56	$64.81	$572.60	783.51%	1424.34%
64430	Pudendal nerve block	$83.00	$55.09	$308.43	$572.60	85.65%	939.32%
64445	Sciatic nerve block	$74.41	$62.96	$78.77	$572.60	626.93%	809.41%
64450	Other peripheral nerve or branch block	$46.51	$34.34	$51.56	$572.60	1010.55%	1567.24%
64479	Cervical transforaminal epidural injections	$135.95	$101.60	$308.43	$572.60	85.65%	463.58%
64483	Lumbar/sacral transforaminal epidural injections	$115.91	$104.46	$382.99	$711.01	85.65%	580.63%
64490	Cervical and thoracic facet joint injections, 1st Level	$109.47	$81.93	$382.99	$711.01	85.65%	767.88%
64493	Paravertebral facet joint or facet joint nerve; lumbar/sacral, 1st Level	$93.02	$80.14	$382.99	$711.01	85.65%	787.25%
64505	Injection, sphenopalatine ganglion	$90.51	$17.17	$52.63	$231.04	338.99%	1245.44%
64510	Injection, Stellate ganglion (cervical sympathetic)	$75.13	$52.95	$308.43	$572.60	85.65%	981.45%

Table 8. (cont) *2017 proposed payment rates in various settings.*

CPT	Description	Physician Payment	Office Overhead	ASC Payment	HOPD Payment	HOPD paid more than ASC (%)	HOPD paid more than Office Overhead (%)
64520	Injection, lumbar or thoracic (paravertebral sympathetic)	$83.00	$104.11	$382.99	$711.01	85.65%	582.97%
64530	Celiac plexus block, with or without radiologic monitoring	$93.73	$96.95	$382.99	$711.01	85.65%	633.37%
64600	Destruction by neurolytic agent, trigeminal nerve	$227.17	$172.08	$382.99	$711.01	85.65%	313.19%
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$357.75	$262.23	$783.40	$1,556.99	98.75%	493.75%
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	$507.65	$251.14	$783.40	$1,556.99	98.75%	519.97%
64620	Intercostal nerve - neurolysis	$176.01	$31.48	$382.99	$711.01	85.65%	2158.46%
64630	Pudendal nerve - neurolysis	$196.76	$38.28	$382.99	$711.01	85.65%	1757.43%
64633	Paravertebral facet joint nerve; C/T, single level - - neurolysis	$231.11	$191.75	$783.40	$1,556.99	98.75%	711.97%
64635	Paravertebral facet joint nerve; L/S, single level - - neurolysis	$228.25	$190.32	$783.40	$1,556.99	98.75%	718.08%
64640	Other peripheral nerve or branch - - neurolysis	$95.16	$38.64	$86.29	$711.01	723.98%	1740.23%
64680	Celiac plexus - - neurolysis	$168.50	$140.24	$382.99	$711.01	85.65%	407.00%
G0260	(27096) Sacroiliac joint, arthrography	$0.00		$308.43	$572.60	85.65%	

large changes in payment rates for many procedures. Even though ASC payment rates are linked to the OPPS, payment rates for all services covered under both systems are lower in ASCs (42,86,87). The relative weights have been lower in the ASC system compared to HOPD system. CMS also makes proportional adjustments with the relative weights from the OPPS to maintain budget neutrality in the ASC system. In 2016 and 2017, this adjustment has reduced the ASC relative weights by over 6% below the relative weights in the OPPS (42,87). In addition, for most procedures covered under the ASC system, the payment rate is the product of its relative weight and a conversion factor, set at $44.190 for 2016 and $43.801 for 2017, lower than the OPPS conversion factor of $73.73 for 2016 and $74.909 for 2017 (38,40,42,86,87). MedPAC also has recommended increases for HOPD services, but recommended no increase for ASC services (2). In addition, CMS also uses a different method than the one described above to determine payment rates for procedures that are predominantly performed in physician's offices and were first covered under the ASC payment system in 2008 or later (86). Payments for these office-based procedures are the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided in a physician's office. CMS sets this limit on the rate for office-based procedures to prevent migration of these services from physician's offices to ASCs for financial reasons. However, there is no such mechanism to prevent the migration to hospitals. In fact, hospital rates are higher for these services (Tables 5-8).

The total number of ASCs in 2014 was 5,446, a 1.9% increase from 2013. Overall, the average annual percentage change in the growth of Medicare certified ASCs was 5.8% from 2000 to 2009, 1.5% from 2009 to 2013, and 1.9% from 2013 to 2014. This lack of significant growth since 2009 largely coincides with the passage and implementation of the ACA, which also coincided with moving surgical services to hospital settings (38,40). Further, hospitals have been expanding their outpatient surgery capacity by acquiring and integrating ASCs into their hospitals or developing new surgery centers, which obviously limits the market for new free-

standing ASCs and also reduces the volume in existing ASCs (38,40,57-62,87-90). It is also obvious that hospitals' decision to increase their outpatient surgery capacity is influenced by the higher rates Medicare pays for ambulatory surgical services provided in HOPDs relative to ASCs. In fact, in 2016 and 2017, the Medicare rates are 85% higher in HOPDs than in ASCs. For some procedures, they are over 800% to 2,156% higher in HOPDs.

In addition, physicians are increasingly choosing to be employed by hospitals rather than work in an independent practice (2,32,36,39,57-62,91,92). These shifts may not be voluntary or by desire, but to avoid stress, burnout, and survive into the future.

Despite all the issues of migration of physicians, MedPAC (40) has described that ASC growth has been influenced by the following:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings.
- ASCs may offer patients greater convenience than HOPDs, such as the ability to schedule surgery more quickly.
- For most procedures covered under the ASC payment system, beneficiaries' co-insurance is lower in ASCs than in HOPDs.
- Physicians have greater autonomy in ASCs than HOPDs, which enables them to design and customize surgical environments and hire specialized staff.
- Physicians who invest in ASCs and perform surgery there can increase their revenue by receiving a share of ASC facility payments.
- The federal Stark law does not apply to ASC services.
- Because physicians are able to perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more revenue from professional fees with better utilization of their time and greater satisfaction.

Overall, the number of beneficiaries treated in volume of services grew from 2009 to 2013 but decreased in 2014. It appears that these services may see even further decline in future years. Table 9 shows the volume of ASC services for FFS beneficiary, which declined in 2013 and further in 2014. However, the services that have historically contributed the most to overall volume continue to constitute a large share of the total in 2014, which included ophthalmic services, gastroenterologic services, pain management services, and orthopedics. However, recently, many of the gastroenterology services and orthopedic services continue to move to HOPD settings.

In 2014 outpatient surgical procedures grew faster in HOPDs than in ASCs showing the potential increase of HOPD share and also the reduction in ASC volumes, increasing costs and reducing the efficiency. MedPAC also postulates that higher growth in HOPDs could be due to the shift of surgical services from freestanding physician offices to HOPDs, rather than ASCs. At present, sufficient data are not available to reach any conclusions. Finally, Medicare recommends that it is desirable to maintain beneficiaries' access to ASCs because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs. Table 10 shows Medicare payments to ASCs which have grown from 2009 to 2014. In 2014, ASCs received over $3.8 billion in Medicare payments and beneficiaries' cost sharing. Spending for FFS beneficiary increased by an average of 2.6% per year from 2009 through 2013 and by 3.1% in 2014. Medicare payments per FFS beneficiary increased in 2014, despite a 0.8% decline in the volume of ASC services per beneficiary and 0.4% decrease in payments because of the sequester. Table 6

Table 9. Volume of ASC services per FFS beneficiary declined slightly in 2014.

	2009	2010	2011	2012	2013 (actual)	2013* (adjusted)	2014
Volume of services (in millions)	6.3	6.5	6.7	6.9	6.9	6.3*	6.2
Volume per 1,000 FFS beneficiaries	199.3	202.6	206.1	209.2	210.3	189.7*	188.3
Percent change in volume per FFS beneficiary from previous year	3.6%	1.7%	1.7%	1.5%	0.5%		–0.8%

Note: ASC (ambulatory surgical center), FFS (fee-for-service).
*The adjusted 2013 values reflect adjustments we made to the larger actual values for 2013. The adjusted 2013 values reflect policies established in 2014 that changed the status of many services that had been separately payable in 2013 to packaged with another service in 2014. The purpose is to make the method for counting services in 2013 consistent with the method for counting services in 2014.

Source: MedPAC analysis of physician/supplier standard analytic files, 2009–2014.

shows ASC proposed payment rates for commonly used interventional techniques. Comparative analysis of the payments in HOPDs, ASCs, in-office settings, and overall comparison are shown in Tables 5-8.

An overwhelming majority of the interventional techniques are performed in outpatient settings, either in physician's offices, HOPDs, or ASCs (43-49). HOPDs are ineffective at cost control and they provide the same level of quality as physician offices and are probably somewhat inferior because of the setup to ASCs when performed outside operating rooms. The majority of the interventional pain management procedures in HOPDs are performed outside the surgical suite, whereas the majority of the interventional pain management procedures in ASCs are performed in surgical suites. Despite these differences, hospitals are reimbursed over 85% more than ASCs for the procedures which are approved for ASCs and as high as 1,366% more for the procedures which are based on the physician payment schedule, except in a few circumstances (42). Table 8 shows these differences.

For vertebral augmentation procedures, the reimbursement rates are facing a 9.4% to 24.1% cut with reimbursement of $2,681.86 for kyphoplasty and $1,213.15 for vertebroplasty procedures. Thus, it is not cost efficient to perform the procedures in ASC settings. Offices are reimbursed 148% higher than ASCs for overhead expenses. HOPDs are reimbursed 94% to 100% more than ASCs. In fact, as an example, kyphoplasty, which harbors higher global reimbursement than vertebroplasty in all settings across the board, specifically in office setting, is reimbursed for multiple procedures. In HOPD and ASC settings, it is reimbursed for only one procedure without reimbursement for additional codes. Consequently, an office may receive a reimbursement of $10,794.42, 302% higher, for one patient for 2 levels in contrast to an ASC receiving $2,681.86. CMS data indicates that these procedures are predominantly performed either in office settings or HOPDs, both of which are more expensive than ASC settings. At minimum, ASCs should be reimbursed the same as the offices.

In reference to percutaneous epidural adhesiolysis, CPT codes 62264 and 62263, one-day or multiple day procedures (47,80-85), the reimbursement has gradually declined from 2014 for 62263 and was, in our opinion, miscalculated for 62264. Further, the required supplies, personnel, and facility setting is more than for an epidural injection. The reimbursement is $382.99, a 16.7% reduction, which is similar to continuous epidural injections and facet joint nerve blocks. This procedure has been classified in the nerve block category in APC classification with radiofrequency neurotomy procedures which are proposed to be reimbursed at $1,557 in 2017.

Consequently, CMS should reconsider their assessment criteria and transfer 62264 and 62263 into the appropriate APC classification category rather than downgrading them. Further, 62263 is performed in only rare settings, whereas 62264 is commonly performed.

The proposal related to new codes for epidural injections is problematic.

In HOPDs, continuous epidurals, with or without fluoroscopy, are reimbursed at a much higher level of $572.60 versus $711, similar to complicated procedures such as percutaneous adhesiolysis 62264. This appears to be without logic and rationale. It is surprising that we are seeing these unnecessary procedures covered and there is no payment for surgery centers for utilizing fluoroscopy. Thus, there is no advantage to doing these procedures under fluoroscopy for surgery centers.

CMS should determine an appropriate payment of $382.99 for fluoroscopic epidural injections, which can be eliminated or reduced to $280 for procedures without fluoroscopy. The same rates can be applied to the use of fluoroscopy for all 4 epidural codes.

Multiple nerve blocks, including peripheral nerve

Table 10. *Medicare payments to ASCs have grown, 2009-2014.*

	2009	2010	2011	2012	2013	2014
Medicare payments (in billions of dollars)	$3.2	$3.3	$3.4	$3.6	$3.7	$3.8
Medicare payments per FFS beneficiary	$102	$104	$106	$110	$113	$116
Percent change per FFS beneficiary from previous year	5.3%	2.0%	2.0%	4.2%	2.1%	3.1%

Note: ASC (ambulatory surgical center), FFS (fee-for-service). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new technology intraocular lenses.

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

blocks, seem to be misclassified with different payments. These include CPT codes 64413 to 64450. Ironically, other peripheral nerve branch blocks are performed on multiple nerves, yet are only reimbursed for one procedure at $51.56 for surgery centers, which is not cost effective.

Radiofrequency of the peripheral nerve branch, 64640, has a reimbursement rate of $86.29 in ASC settings and $711.00 HOPD settings (774% higher in HOPDs than ASCs), which is inappropriate and not cost effective. The disposable equipment itself costs over $250, thus, the neurolytic procedure with 64640 should be reimbursed the same as neurolytic blocks of facet joints.

ASIPP requested that CMS reconsider the pricing on these procedures and revise the reimbursement rates.

CMS also has classified multiple procedures which are performed overwhelmingly with fluoroscopy such as sympathetic blocks (CPT 64510, 64520, 64530, 64420, 64421, 60260, and G0260) as if they are performed without fluoroscopy eliminating the payment differential for fluoroscopy.

ASIPP requested that CMS reassess these procedures with additional reimbursement to include fluoroscopy similar to epidural injections and facet joint injections.

Payments For Procedures Performed In In-Office Setting

Offices may provide many services including some surgical procedures. In 2014, the Medicare program paid $69.2 billion for physician and other health professional services or 16% of benefit spending in Medicare's traditional FFS program for 576,000 physicians and 315,000 other providers. Medicare uses a fee schedule to pay for physician and other health professional services based on a list of 7,000 services and their payment rates. In determining payment rates for each service, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and professional liability insurance. These 3 factors are adjusted by variation in the input prices in different markets and the sum is multiplied by the fee schedules conversion factor. The calculations are, to a great extent, based on AMA, CPT, and drug committees (34,35). The conversion factor was $35.9335 in 2015 and $35.8279 in 2016, and will be $35.7751 in the 2017 proposed schedule.

Overall, hospitals are reimbursed for facility costs as shown in Table 8, sometimes as high as 2,156% more than office overhead expenses. For interventional techniques, numerous discrepancies continue with site of service differentials in office, HOPD and ASC settings. The majority of the procedures performed in an in-office setting are synonymous to HOPD procedures. For interventional pain management procedures performed in hospital settings, hospitals do not utilize operating rooms.

As Table 8 shows, multiple procedures from CPT 20526 to 20610 involving injections into ligaments, joints, and trigger points are expected to be reimbursed for HOPDs at $231, a 3.3% increase compared to 2016 and 66% increase compared to 2007. Unfortunately, the same procedures provided in an in-office setting are reimbursed at a rate of $13 to $20, a reduction from 2016 as high as 10.3%. These rates are inadequate for these procedures which must be performed in a sterile fashion following the guidance set by the CDC.

CPT codes 62263 and 62264 have been the subject of comments in the past on multiple occasions. CPT 62263, involving multiple percutaneous epidural adhesiolysis sessions on 2 or 3 days, is performed very infrequently or rarely; whereas, CPT 62264 is commonly performed (47,80-84). There is a reduction of 1.6% in the fee schedule for physicians. In reference to in-office procedures, there is a significant difference in payment rates for 3-day procedures versus one-day procedures, $613.54 versus $425.37 whereas for physicians, it is $333.07 versus $244.70. Consequently, this does not represent the actual work involved. A second day injection is performed in an office setting without fluoroscopy, contrast injection, etc.; however, the first procedure with catheterization and repeat injections is the most extensive one. The payment rates are significantly different considering that there is not much work. This is in contrast to HOPPS and ASC payment rates. Further, $181 reimbursed for a one-day procedure in an in-office facility is inadequate considering the extensive supplies required for this procedure. This procedure was described similar to radiofrequency neurotomy procedures (CPT 64622, 64623, 64626, 64627), which should have very similar reimbursement (43,76,77). Once again, the discrepancy is substantial compared to hospital payments which are reimbursed at $711 and ASC settings which are reimbursed at $382.99.

The approval of a new code and its coverage for endoscopic disc decompression (CPT 630X1) is encouraging. However, the proposed reimbursement is $688.31 with relative value units (RVUs) of 9.09. There are multiple discrepancies surrounding this assessment related to microdiscectomy RVUs and recommended values by

RUC. The current valuation for lumbar microdisectomy is 13.18 RVUs for physician services; whereas, for lumbar endoscopic microdiscectomy the recommended RVUs were 10.47 which has been reduced to 9.09 by CMS. Microdiscetomy is a more complex procedure for physicians to perform with a steep learning curve. Consequently, we request that RVUs should be at least the same as microdisectomy (i.e., 13.18 RVUs rather than proposed 9.09 RVUs).

There is also significant variation in reimbursement for peripheral nerve blocks and neurolytic blocks of peripheral nerves. This is extremely important as CMS no longer reimburses for multiple procedures or peripheral nerves and also multiple developments with genicular nerve blocks, as well as nerve supply of the hip showing moderate evidence of effectiveness to value these procedures appropriately to maintain access to the patient care. CPT 64450 is reimbursed in an office setting at a total of $80.85 with a physician payment of $46.51 and office overhead of $34.34. However, in a hospital setting it is reimbursed at $572.60, a 1,567% increase from the prior year and 1,567% higher than the office procedure and 1,010% higher than the ASC reimbursement of $51.56.

ASIPP has requested that CMS look at this issue and revise it adequately to reimburse for these procedures. Once again, multiple procedures are considered as only one procedure when performed on a single patient in a single setting. The same applies to other nerve block codes considered peripheral nerve blocks (CPT 64400-64445).

Another important code is CPT 64640 which describes neurolytic block of a peripheral nerve or branch. Once again the same philosophy is applied here. There blocks are performed on multiple nerves, yet they are considered as one. The reimbursement for this in an office setting is $133.80, $95.16 for physicians and $38.64 for office expenses. This is an expensive procedure similar to radiofrequency neurotomy of facet joints (CPT 64633, 64634, 64636, 64637). Also it is performed very frequently because of multiple issues related to knee and hip pain with emerging evidence. These procedures involve utilization of fluoroscopy, radiofrequency needles, and contrast injection. These are time consuming and labor intensive, and multiple supplies are utilized which approximate to over $100 in a sterile setting. Thus, offices are reimbursed at one-third of the cost of supplies. In contrast, HOPDs are reimbursed for the same $711, a 13.5% reduction from 2016, but an increase of 102% from 2007. Unfortunately these procedures are also not feasible in an ASC setting since surgery centers are proposed to be reimbursed at $86.29 which is way below the expenses incurred.

The other codes with similar issues are neurolytic block of the pudendal nerves (CPT 64630) reimbursed at $235.04, a physician payment of $191.75 and an office overhead cost of $38.28. Once again, the equipment, personnel, and supplies way exceed this reimbursement level. Hospitals are reimbursed for the same at $711, a decrease of 13.5% from 2016 but an increase of 102% from 2007, providing 1,757% more payment for hospitals. Further, ASCs are reimbursed at $382.99, a decrease of 16.7% from the previous year, and only a 9% increase since 2007.

ASIPP has requested that CMS look at this issue and revise it adequately to reimburse for CPT 64400 to 64450 and neurolytic blocks CPT 64640 and 64630. Facet joint interventions, including nerve blocks and radiofrequency neurotomy (CPT 64490-64495 and CPT 64622, 64623, 64626, 64627) also have seen decreases for in-office procedures and physician payment which can be cumulative over the years.

Finally, E/M services are one of the major sources of discrepancies and site-of-service differentials with hospitals reimbursed $98, which is $80.00 higher than in-office visits for Level 1 follow-ups and $60.00 – 70.00 higher than in-office visits for complex visits.

Conclusion

Facility payments for IPM services continue to provide multiple challenges. This leads to 85% to 2,156% higher reimbursement for hospital settings than ASCs and in-office settings, even though the quality and the settings are very similar. These findings are in line with findings of MedPAC and OIG; however, CMS has not heeded the recommendations of MedPAC and OIG to eliminate the discrepancies and site of service differentials for in-office, hospital, outpatient, and ASC services. Further, there have been slow reductions in reimbursements each year accumulating to a larger number of significant cuts overall. Thus, we recommend equalization of site of service differentials, appropriate utilization of cost indices and, finally, logical and fair application of the regulations for all settings. For IPM practices, it is important to understand physician payment regulations and facility payments which may influence practice patterns, overall reimbursement, and expenses.

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