

American Society of Interventional Pain Physicians®

"The Voice of Interventional Pain Management"

81 Lakeview Drive, Paducah, KY 42001

Phone: (270) 554-9412 - Fax: (270) 554-5394

www.asipp.org

Society of Interventional Pain Management Surgery Centers Inc.

81 Lakeview Drive, Paducah, KY 42001

Phone: (270) 554-9412 - Fax: (270) 554-5394

www.asipp.org/SIPMS

May 18, 2017

The Honorable Thomas E. Price, MD
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201
Thomas.Price@hhs.gov

Seema Verma
Administrator
U.S. Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244
Seema.Verma@cms.hhs.gov

Demetrios Kouzoukas
Deputy Administrator
U.S. Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244
Demetrios.Kouzoukas@cms.hhs.gov

DELIVERED BY ELECTRONIC EMAIL

RE: ASC Reimbursement Cuts of 16% - 25% for commonly performed interventional techniques in ASCs in 2017

Honorable Secretary, Administrator, and Deputy Administrator

On behalf of the Board of Directors of the American Society of Interventional Pain Physicians (ASIPP), Society of Interventional Pain Management Surgery Centers (SIPMS), 50 state societies and the Puerto Rico Society of Interventional Pain Physicians, as well as the entire membership of ASIPP and SIPMS, we would like to thank you in advance for looking into the various issues we raise in this letter. Firstly, onerous cuts were implemented on January 1, 2017, and these are causing significant hardship on patients who depend on the services of interventional pain management and its providers. These policies in conjunction with decrease in opioid prescriptions, will drive patients to illicit drug use, including further fueling of

heroin and illicit fentanyl abuse. Further, direct consultation with our members indicates that these cuts are leading to employee layoffs and closure of some centers.

The final rule of hospital outpatient prospective payment and ambulatory surgical center payment systems published in November 2016 (effective January 1, 2017), established cuts of 16.3% for epidurals, 25% for facet joint injections, 25% for adhesiolysis, and 16% for sacroiliac joint injections compared to 2016 for facility fee in ASCs. Further, these cuts compound those of 2014 and 2015— around 26%. Above all, these cuts are far greater than in the proposed rule of July 2016.

The issues related to the calculation of ASC payments are likely well know to HHS and CMS. We are detailing our perspective below along with the recommendations from Medicare Payment Advisory Commission (MedPAC) and Office of Inspector General (OIG) for elimination of site-of-service differentials. The majority of interventional pain management procedures are performed in an office setting rather than in ambulatory surgery centers wherein the overwhelming majority of the cases are performed in surgical suites. This skews the estimations of hospital outpatient department (HOPD) rates based on the fluctuation of the mix in the office and HOPD settings. Consequently, the results have been challenging. To address these discrepancies we request that CMS immediately implement the following:

- Reverse the final rule of 2017 for interventional procedures and implement 2016 rates retroactively from January 1, 2017.
- Utilize appropriate methodology for the upcoming proposed rule in June 2017 and subsequent, final rule in November 2017.
 - Meanwhile, due to numerous difficulties involved in calculation and recalibration for the 2018 rule, we request that 2016 payment rates or 80% of HOPD payment rates for ambulatory surgery centers (ASCs) be utilized.

BACKGROUND

ASIPP is a not-for-profit professional organization founded in 1998 now comprising over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 8,500 appropriately trained and qualified physicians practicing interventional pain management in the United States.

SIPMS is a not-for-profit professional organization founded in 2005, with membership involving surgical centers focusing on interventional pain management, dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic pain. There are approximately 500 surgery centers across the nation approved by Medicare providing solely or an overwhelming majority of interventional pain management services.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing sub acute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment.¹

Interventional pain management techniques are minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and

¹ The National Uniform Claims Committee. Specialty Designation for Interventional Pain Management- 09, www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf

some surgical techniques such as laser or endoscopic discectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain.²

SITES OF SERVICE

An overwhelming majority of the interventional techniques are performed in outpatient settings, either in physician's offices, hospital outpatient departments (HOPDs), or ambulatory surgery centers (ASCs). As you likely know, 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. MedPAC was also concerned that payment violations across settings may encourage arrangements among providers that result in care being provided in higher paying settings, thereby increasing the total Medicare spending and beneficiary cost sharing. This concern was reinforced by the Office of Inspector General (OIG) of Health and Human Services (HHS). Data from MedPAC has shown significant increases in HOPD payments compared to freestanding offices or ASCs. It now also appears that there is a reversal of the site of services with HOPDs now dominating. Based on multiple regulations related to the Affordable Care Act (ACA), Accountable Care Organizations (ACOs), and Merit-Based Incentive Payment System (MIPS) services will be migrating to HOPDs. 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 beneficial setup of ASCs. The majority of the IPM 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 physician payment schedule, except in a few circumstances.

Since Medicare is the largest payer and a trendsetter, almost all other payers base their payment rates on Medicare payment and specifically downgrade them and pay them as a percentage of Medicare reimbursement for ASC and physician services. In contrast, for HOPD, as well as hospital inpatient services, they are reimbursed on the basis of a percentage of charges.

The Medicare reimbursement for any setting is also crucial as all other insurers including Medicaid which utilize Medicare reimbursement as a baseline and downgrade from thereon in a majority of cases in ASCs and physician payments, whereas, they reimburse on a percentage basis for hospitals.

ASC CUTS IMPLEMENTED JANUARY 1, 2017

These comments are concerning the four most commonly performed procedures, which constitute 60%-80% of the interventional pain management procedures performed in ASCs.

REDUCTION FOR EPIDURAL INJECTIONS - 16.3%

Epidural injections described here include interlaminar and caudal epidural injections with CPT codes 62310 and 62311 until December 2016. Since January 1, 2017, new CPT codes have been implemented, these CPT codes are from 62320-62323. Instead of 2 codes there are 4 codes provided in this new CPT coding system. One code in each region cervical and thoracic or lumbar and caudal involve imaging guidance. Consequently, one would expect higher reimbursement for the code with imaging guidance. However, CMS has proposed the same pricing of \$308.43 for all 4 codes. Despite multiple comments, the final rule showed a reduction of 11.2% from the proposed rule to \$273.83, with the same rate for all regions with or without fluoroscopy. CMS has not taken into consideration the fluoroscopy (x-ray viewing) and regional complexity in cervicothoracic region with increased expense. The same codes without a

² Medicare Payment Advisory Commission. Report to the Congress: Paying for interventional pain services in ambulatory settings. Washington, DC: MedPAC. December. 2001.

<http://www.medpac.gov/documents/reports/december-2001-report-to-the-congress-paying-for-interventional-pain-services-in-ambulatory-settings.pdf?sfvrsn=0>

description regarding the use of fluoroscopy were reimbursed at \$370.07 in 2014, \$327.22 in 2016 with a total reduction in reimbursement of 26% from 2014, 16% from 2016, and 11.2% reduction from the proposed rule, which appears to be extremely unusual.

Epidural injections were classified as Level III nerve injections in 2000 based on a proposal presented by ASIPP at an Ambulatory Payment Classification (APC) Committee meeting. Since then, these have fluctuated substantially. The following shows fluctuating rates of ASC facility fees for epidural injections since 2013. The same procedures were reimbursed at \$370.07 in 2014 with a reduction of 26% in 2017.

CPT	Description	2013	2014	2015	2016	2017 (P)	2017	% of change from 2017	
								2016	2017 (P)
62321	C/T epidural (62310)	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$273.83	-16%	-11%
62323	L/S epidural (62311)	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$273.83	-16%	-11%

(P): Proposed

Utilization has been implicated as a reason for being caught in a CMS screen ultimately leading to a decrease in reimbursement rates. However, based on Medicare data, interlaminar epidural injections shown above have not increased substantially compared to transforaminal epidural injections, which are not included in this discussion.

In fact, cervical and thoracic interlaminar epidural injections have decreased 1.3% from 2012 to 2013 and 6.9% from 2013 to 2014.³

Similarly, lumbar interlaminar and caudal epidural injections CPT 62311 or CPT 62323 have shown a decrease since 2006. The most significant decrease was from 2012 to 2013 of 5.6% and 2013 to 2014 of 12.2%.

Overall, compared to 2000, cervical epidural injections have increased 104%; however, with a very small number of procedures performed in this category increasing from 75,741 or 191 per 100,000 Medicare population to 208,741 or 390 per 100,000 Medicare population.

In contrast, lumbar interlaminar and caudal epidurals (CPT 62311), which are historically the most utilized procedure, have shown a decline of 2% from 2000 to 2014 per 100,000 fee-for-service Medicare recipients. They were 618,362 services or 1,560 per 100,000 Medicare population in 2000 compared to 815,858 services or 1,525 per 100,000 Medicare population; an obvious reduction.

In contrast, cervical or thoracic transforaminal epidural injections with CPT code of 64479 have increased 169% from 2000 to 2014 per 100,000 Medicare recipients and fee-for-service, but lumbar/sacral transforaminal epidurals with CPT 64483 have increased 566% from 2000 to 2014 per 100,000 Medicare recipients and fee-for-service.

³ Manchikanti L, Pampati V, Hirsch JA. Retrospective cohort study of usage patterns of epidural injections for spinal pain in the US fee-for-service Medicare population from 2000 to 2014. *BMJ Open* 2016; 6:e013042.

REDUCTION FOR FACET JOINT INJECTIONS REIMBURSEMENT - 25%

Facet joint injections performed in the cervical and thoracic regions are coded as follows: CPT 64490 (1st level), 64491 (2nd level), and 64492 (3rd level).

Facet joint injections performed in the lumbar and sacral regions are coded as follows: CPT 64493 (1st level), 64494 (2nd level), and 64495 (3rd level).

The facet joint nerve injections which were classified as Level 4 nerve injections by CMS in 2000 are more complicated. Traditionally, Medicare has reimbursed ASCs for the first procedure and a lower reimbursement for second and third levels as additional procedures. In 2014, CMS changed the reimbursement pattern and combined all add-on codes into primary code by reimbursing only the first level. Consequently, the first level reimbursement increased in 2014 to \$370.07 and to \$459.71 in 2016, which was decreased to \$382.99 in the 2017 proposed rule and the final rule included another 9.9% reduction from the proposed rule to a final payment rate of \$344.95 indicating a reduction of 25% from 2016.

Overall, the reimbursement for these codes has been as follows:

CPT	Description	2013	2014	2015	2016	2017 (P)	2017	% of change from 2017	
								2016	2017 (P)
64490	C/T facet joints, 1st Level	\$317.46	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
64491	C/T facet joints, 2nd Level	\$102.47							
64492	C/T facet joints, 3rd Level	\$102.47							
64493	L/S facet joints, 1st Level	\$317.46	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
64494	L/S facet joints, 2nd Level	\$102.47							
64495	L/S facet joints, 3rd Level	\$102.47							

(P): Proposed

Utilization patterns have shown significant increases for facet joint injections at a rate of 334% per 100,000 Medicare population for cervicothoracic facet joint blocks (64470 or 64490) and 235% per 100,000 Medicare population for lumbosacral facet joint blocks (64475 or 64493) from 2000 to 2014.

REDUCTION FOR PERCUTANEOUS ADHESIOLYSIS - 25%

Percutaneous adhesiolysis procedure has suffered significant negative changes over the years. This code was included in Level V nerve injections, which included other neurolytic blocks and radiofrequency thermoneurolysis, etc. These codes involve CPT code 62264 and 62263, one-day or multiple day procedures. The reimbursement for these procedures has gradually declined from 2014 for 62263 and also was miscalculated for 62264. However, both procedures are performed with same intensity. Further, the required supplies, personnel, and facility setting is more cost intensive than for epidural injections. The reimbursement is at \$344.95 with a 25% reduction from 2016 and 10% reduction from proposed rule, which is the same as a simple epidural. This procedure has been classified in the nerve block category in APC classification with radiofrequency neurotomy procedures, which are reimbursed at \$788.19 in 2017 with a 56% underpayment.

Overall, the reimbursement for percutaneous adhesiolysis has been as follows since 2013:

CPT	Description	2013	2014	2015	2016	2017 (P)	2017	% of change from 2017	
								2016	2017 (P)
62263	Adhesiolysis - 2 or 3 days	\$480.71	\$853.53	\$805.75	\$459.71	\$382.99	\$344.95	-25%	-10%
62264	Adhesiolysis – 1 day	\$480.71	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%

(P): Proposed

In contrast to multiple other procedures in interventional pain management, the use of the percutaneous adhesiolysis procedure has declined substantially with 96% decline for 3-day procedure from 2000 to 2014 per 100,000 Medicare recipients and fee-for-service and 3% decline for one-day procedure from 2001 to 2014 per 100,000 Medicare recipients and fee-for-service.

REDUCTION FOR SACROILIAC JOINT INJECTIONS - 16%

These were classified as Level III nerve injections. However, over the years, the reimbursement patterns have changed substantially for this code. The data below shows various changes. Overall, the highest reimbursement was \$370.07 in 2014, which declined to \$327.22 in 2016 and from there to \$308.43 in the proposed rule of 2017, and, finally, to \$273.83 in the final rule of 2017 with a 16% reduction from 2016 and 11% reduction from 2017 proposed rule. Further, compared to 2014, there was a 26% reduction.

CPT	Description	2013	2014	2015	2016	2017 (P)	2017	% of change from 2017	
								2016	2017 (P)
G0260	Sacroiliac joint	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$273.83	-16%	-11%

(P): Proposed

The use of sacroiliac joint injections has increased significantly over the years, 316.9% from 2000 to 2014 per 100,000 Medicare recipients and fee-for-service. They were 49,554 services or 125 per 100,000 Medicare population in 2000 compared to 378,866 services or 521 per 100,000 Medicare population showing an obvious reduction.

THE PATTERN OF REIMBURSEMENT

The pattern of reimbursement from CMS has changed and continues to change over the years, not only from year to year, but also significantly from proposed rule to final rule as summarized in Table 1. We are unable to discern any logic to the change, outside of possible errors on the part of CMS.

Another major issue is related to the calculation of the costs of procedures. It appears that CMS is looking at 6 million procedures or so in arriving at prices for hospital outpatient departments and then reducing them by 40% to 50% for ASCs. **The critical flaw with this manner of calculation is the majority of IPM procedures in HOPDs are performed outside the surgical suite, whereas the majority of the ASC procedures are performed in surgical suites.**

To accurately determine HOPD rates, not only for interventional techniques, but for all HOPD procedures, CMS must utilize only the procedures performed in surgical suites in the hospital setting and calculate the reimbursement based on that data.

Further, CMS should reduce the payment for HOPDs, which are not performed in surgery suites, but in an office setting. Office settings in hospitals are significantly inferior to surgical suites in the hospital operating rooms or ambulatory surgical centers and equivalent to private office settings.

Consequently, based on the evidence presented thus far with apparent miscalculations and wild fluctuations, we request the CMS to implement the following:

- Update cost calculations of HOPDs once every 3 years
- Separate the procedures performed in operating suites and in-office settings in HOPD settings
 - Reimburse accordingly based on the site of service, either surgical suite or office setting in HOPD rules.
 - Similar to HOPDs reduce the reimbursement for ASCs, which did not perform the procedures in surgical suites.
- Immediately reverse the final rule of 2017 for interventional procedures and implement 2016 rates retroactively from January 1, 2017
- Utilize appropriate reimbursement methodology for the upcoming proposed rule in June and subsequent final rule in November
 - It may be difficult to recalibrate the rates at present time for HOPDs for 2018 and 2019. Consequently, please change the reimbursement rates to 2016 level for interventional pain management procedures until further data is available.
 - As an alternate, CMS may implement the reimbursement rate of 80% of HOPD rates for ASCs.

Thank you for your consideration. If you have any questions, please feel free to contact us at drm@asipp.org.

AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS

Laxmaiah Manchikanti, MD

Chairman of the Board and Chief Executive Officer, ASIPP
Medical Director,
Pain Management Center of Paducah
Clinical Professor,
Anesthesiology and Perioperative Medicine
University of Louisville, Kentucky
2831 Lone Oak Road
Paducah, KY 42003
drm@asipp.org

Francis Riegler, MD

President, ASIPP
Universal Pain Management
819 Auto Center Drive
Palmdale, CA 93551
riegler@upmgt.com

Hans C. Hansen, MD

President-Elect, ASIPP
The Pain Relief Centers, LLC
1224 Commerce Street SW
Conover NC 28613
hhansen@painreliefcenters.com

Aaron K. Calodney, MD

Immediate Past President, ASIPP
Director of Clinical Research
Precision Spine Care
Texas Spine and Joint Hospital
PO Box 130459
Tyler TX 75713-0459
aaroncalodney@me.com

Sudhir Diwan, MD

First Executive Vice President of Regional
Affairs, ASIPP
Executive Director
Manhattan Spine and Pain Medicine, PC
115 East 57th Street
New York, NY 10022
sudhir.diwan63@gmail.com

Frank J.E. Falco, MD

First Executive Vice President, ASIPP
Medical Director, Midatlantic Spine
139 East Chestnut Hill Road
Newark, DE 19713
Clinical Assistant Professor
Temple University Medical School
Philadelphia, PA
casm01@aol.com

Harold Cordner, MD

Second Executive Vice President, ASIPP
Florida Pain Management Associates
13825 U.S. Hwy 1
Sebastian, FL 32958
gassdoc@aol.com

Sanjay Bakshi, MD

Vice President of Strategic Planning, ASIPP
Manhattan Spine & Pain Medicine, PC
115 E 57th Street #610
New York, NY 10022
drbakshi58@gmail.com

Salahadin Abdi, MD, PhD

Academic Director, ASIPP
1400 McKinney Street, Unit 1404
Houston TX 77010
sabdi@mdanderson.org

Sheri L. Albers, DO

Director-at-Large, ASIPP
2178 Morley Way
Sacramento, CA 95864
Sla2oz@aol.com

Sukdeb Datta, MD, MBA

Vice-President of Strategic Alliances, ASIPP
Medical Director
Datta Endoscopic Back Surgery and Pain Center
303 Fifth Avenue, Suite 1102
New York NY 10016d
Professorial Lecturer
Department of Anesthesiology
Mount Sinai School of Medicine
New York, NY
sukdeb@hotmail.com; sdattamd@gmail.com

Bradley Wargo, DO

Secretary, ASIPP
PO Box 66
Huxley IA 50124
drbwargo@gmail.com

Standiford Helm, II, MD

Treasurer, ASIPP
The Helm Center for Pain Management Center
24902 Moulton Parkway
Suite 200
Laguna Hills, CA 92637
drhelm@thehelmcenter.com

Vijay Singh, MD

Chairman of Executive Committee, ASIPP
Lifetime Director, ASIPP
W8090 Millie Hill Estates Dr.
Iron Mountain, MI 49801-6722
vj@wmpnet.net

DIRECTORS:**Steve Aydin, DO**

Young Physician Director, ASIPP
85 Walsh Drive
Mahwah, NJ 07430
steve.aydin@gmail.com

Cyrus E. Bakhit, MD

Lifetime Director, ASIPP
1316 South Jefferson Street
Roanoke, VA 24016
cbakhit@pmcr.org

Ramsin Benyamin, MD
Director Emeritus, ASIPP
Millennium Pain Center
1015 S. Mercer
Bloomington, IL 61701
ramsinbenyamin@yahoo.com

Mark V. Boswell, MD, PhD
Academic Director, ASIPP
Department Chairman
Dept. of Anesthesiology & Perioperative
Medicine
530 S Jackson Street, Room C2A01
Louisville, KY 40202
boswellmv@earthlink.net;
mark.boswell@louisville.edu

Kaylea Boutwell, MD
Young Physician Director, ASIPP
14285 North Outer Forty Road, Ste 360
Chesterfield MO 63017
kboutwell@prsstl.com

Kenneth D. Candido, MD
Academic Director, ASIPP
Chairman and Professor
Department of Anesthesiology
Advocate Illinois Masonic Medical Center
836 W. Wellington Ave, Suite 4815
Chicago, IL 60657
kdcandido@yahoo.com

George C. Chang Chien DO
Young Physician Director, ASIPP
Medical Director of Pain Management
Ventura County Medical Center
1038 Loma Lisa Lane
Arcadia, CA 91006
gchangchien@gmail.com

Christopher Gharibo, MD
Academic Director, ASIPP
Associate Professor of Anesthesiology and
Orthopedics Medical Director of Pain Medicine
NYU Langone-Hospital for Joint Diseases
NYU Center for Musculoskeletal Care
333 East 38th St, 6th floor,
New York, NY 10015
cgharibo@usa.net

Scott Glaser, MD
Director-at-Large, ASIPP
Pain Specialists of Greater Chicago
Burr Ridge IL 60527
sglaser@painchicago.com

Jay Grider, DO, PhD
Academic Director, ASIPP
Medical Director, UK HealthCare Pain Services
Division Chief, Pain and Regional Anesthesia
Professor, Department of Anesthesiology
University of Kentucky
800 Rose Street N-201
Lexington, KY 40536
jsgrid2@email.uky.edu

Sachin “Sunny” Jha, MD
AMA RFS Representative
AMA CPT Advisory Com
235 W Van Buren Street, Unit 1908
Chicago, IL 60607
sunnyjha@gmail.com

Alan D. Kaye, MD, PhD
Academic Director, ASIPP
Director of Pain Services
Professor and Chairman
Dept of Anesthesiology
Professor, Dept of Pharmacology
ABA Cert Pain Mgt, ABPM Cert
LSU School of Medicine, New Orleans
akaye@lsuhsc.edu

Michael C Lubrano, M.D., M.P.H.
Resident/Fellow, ASIPP
Resident Physician, Department of Anesthesia &
Perioperative Care
University of California San Francisco (UCSF)
Medical Center
Michael.Lubrano@ucsf.edu;
Lubrano.Michael@gmail.com

Dharam Mann, MD
Director-at-Large, ASIPP
Garden State Interventional Pain Management
1100 Route 70 West
Whiting, NJ 08759
mannpainmd@gmail.com

Devi E. Nampiaparimpil, MD
Young Physician Director, ASIPP
Assistant Professor, Anesthesiology and
Rehabilitation
NYU School of Medicine
315 West 33rd Street #28G
New York, NY 10001
devichechi@gmail.com

Annu Navani, MD
Director-at-Large, ASIPP
Medical Director, Comprehensive Pain
Management Center
Campbell, CA
Adjunct Clinical Associate Professor, Division of
Pain,
Department of Anesthesiology
Stanford University School of Medicine
Stanford, CA
anavani@spineandsportsctr.com;
anavani@cssctr.com

Vikram B. Patel, MD
AMA RUC Member
AMA CPT Advisory Committee
ACMI Pain Care
1479 Commerce Drive
Alnoquin, IL 60102
vikpatell@yahoo.com

Sanford Silverman, MD
Director-at-Large, ASIPP
Comprehensive Pain Medicine
100 East Sample Road, Ste. 200
Pompano Beach, FL 33064
sanfordsilverman@cpmedicine.com

Lee Snook, MD
AMA Delegate
Metropolitan Pain Management Consultants, Inc
2288 Auburn Blvd, Suite 106
Sacramento CA 95821
lsnook@pain-mpmc.com

Amol Soin, MD
Young Physician Director, ASIPP
Ohio Pain Clinic
8934 Kingsridge Drive, Suite 101
Centerville, OH 45458
ohiopainclinic@gmail.com

Peter Staats, MD
Director Emeritus, ASIPP
Premier Pain Centers
160 Avenue at the Common
Suite 1
Shrewsbury, NJ 07702
peterstaats@hotmail.com

Deborah Tracy, MD
Director-at-Large, ASIPP
Institute of Interventional Pain Management
11319 Cortez Blvd.
Brooksville, FL 34613
tracypain@tampabay.rr.com

Table 1. ASC Payment Rates (Medicare) from 2013 to 2017.

CPT	Description	2013	2014	2015	2016	2017 (P)	2017	% of change from 2017	
								2016	2017 (P)
62263	Adhesiolysis - 2 or 3 days	\$480.71	\$853.53	\$805.75	\$459.71	\$382.99	\$344.95	-25%	-10%
62264	Adhesiolysis – 1 day	\$480.71	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
62321	C/T epidural (62310)	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$273.83	-16%	-11%
62323	L/S epidural (62311)	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$273.83	-16%	-11%
62325	C/T Catheterization (62318)	\$317.46	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
62327	L/S Catheterization, (62319)	\$480.71	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
64479	C/T transforaminal epidural	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$344.95	5%	12%
64480	C/T transforaminal add-on	\$163.70							
64483	L/S transforaminal epidural	\$317.46	\$370.07	\$368.37	\$327.22	\$382.99	\$344.95	5%	-10%
64484	L/S transforaminal add-on	\$163.70							
64490	C/T facet joints, 1st Level	\$317.46	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
64491	C/T facet joints, 2nd Level	\$102.47							
64492	C/T facet joints, 3rd Level	\$102.47							
64493	L/S facet joints, 1st Level	\$317.46	\$370.07	\$368.37	\$459.71	\$382.99	\$344.95	-25%	-10%
64494	L/S facet joints, 2nd Level	\$102.47							
64495	L/S facet joints`, 3rd Level	\$102.47							
64633	C/T RFT single level	\$317.46	\$853.53	\$805.75	\$778.70	\$783.40	\$788.19	1%	1%
64634	C/T RFT, each additional	\$102.47							
64635	L/S RFT single level	\$480.71	\$853.53	\$805.75	\$778.70	\$783.40	\$788.19	1%	1%
64636	L/S RFT, each additional	\$317.46							
G0260	Sacroiliac joint	\$317.46	\$370.07	\$368.37	\$327.22	\$308.43	\$273.83	-16%	-11%

(P): Proposed