Pain Management Coding Alert

PM Payment: Watch for These Potential Fee Changes in 2015

CMS proposes updates to epidural injection codes and more.

Every provider expects some changes to fee schedules when a new year rolls around. Here's your sneak peek at five changes that could potentially affect your practice next year, based on a proposed rule for updating Medicare Physician Fee Schedule (PFS) payment policies and rates on or after Jan. 1, 2015.

1. A two-tiered change for epidural injection codes, 62310-62311 (Injection[s], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution]), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; ...) and 62318-62319 (Injection[s], including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; ...).

Medicare will reverse the 2014 RVU cuts back to the 2013 values which is good news for providers. However, Medicare is recommending prohibiting the separate billing of image guidance codes, 77001-77003 (Fluoroscopic guidance ...) in conjunction with these epidural injections.

2. A new process for establishing PFS payment rates that will be more transparent and allow for greater public input prior to rates being set. If the new process is approved, payment changes would go through notice and comment rulemaking before being adopted, beginning for 2016.

3. Changes to several of the quality reporting initiatives associated with PFS payments. For example, CMS proposes adding 28 new PQRS individual measures and two measures groups in 2015 to fill existing measure gaps. The rule also proposes removing 73 measures from PQRS reporting, which would bring the PQRS individual measure set to 240 total measures.

Pain management shift: The proposed changes also include deletion of some 2014 measures groups, including the Back Pain measures group which is often reported by pain management providers, as well as increase the number of measures that may be included in a measures group from a minimum of four measures to a minimum of six. Medicare also is proposing, in order to prevent the 2017 2 percent payment adjustment, professionals would need to report nine individual measures covering three National Quality Strategy domains and report each measure for at least 50% of the eligible professional's Medicare Part B patients seen during the 12-month reporting period.

Key: This is a big jump from the 2014 requirements of only 3 individual measures to prevent the 2016 penalty. CMS also proposes requiring eligible professionals who see at least one Medicare patient in a face-to-face encounter to report measures from a newly proposed cost-cutting measures set in addition to any other measures the professional is required to report.

4. Separate payments for chronic care management (CCM) services beginning in 2015. In last year's final rule, CMS established policy to make separate payment for non-face-to-face chronic care management services for Medicare beneficiaries who have two or more significant chronic conditions. Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

$$ factor: The rule proposes a payment rate of $41.92 for the code that can be billed no more frequently than once per month per qualified patient.

Key: One change from last year is that CMS is no longer proposing to establish separate standards that practitioners and practices furnishing CCM would have to meet, as indicated last year. "Upon further review, we believe the scope of service requirements for CCM, most of which were finalized last year, would be sufficient for practitioners to deliver CCM," states the CMS fact sheet concerning the proposed rule.

5. Transform global codes to 0-day by 2017. According to the proposed rule, the Office of the Inspector General (OIG) has identified numerous surgical procedures that include more visits in the associated global period than are being furnished. In order to avoid the potential for misevaluation of surgical services, CMS proposes to transform all 10- and 90-day global codes to 0-day global codes beginning in 2017. CMS would pay separately for any postoperative visits and services provided after the day of the procedure.

More info: For more information, visit http://tinyurl.com/2015CMS-ProposedPhysicianChngs.