Proposed Medicare Reimbursement Changes 2015

In 2014 we saw a number of changes to the physician fee schedule that significantly effected SCS, PNS, and spinal/epidural reimbursement. Again in 2015 we will see a number of changes, some of these are still in the proposal stage and we urged our membership to get involved and provide comment. Below is a summary of the proposed changes for 2015 and some already implanted changes in 2014.

CMS received many comments on the reductions in epidural reimbursement that were seen in 2014 for codes 62310, 62311, 62318, and 62319. In response to these many comments from various stakeholders and also due to some congressional pressure applied by several organizations, CMS has responded with new proposals for epidural code reimbursement. CMS has admitted that there original methodology used in 2013 was incorrect and unfortunately have now proposed another flawed solution.

While at first glance, a reversion to 2013 reimbursement levels would seem like a victory, the bundling of fluoroscopy fees severely dampens any positive effect. In fact, on closer analysis of Tables 1 and 2 below, the total physician reimbursement will decrease in 3 of 4 situations in the hospital and either change minimally or decrease in the office setting. NANS has submitted a comment letter on these proposed changes (which is printed on page X). We hope our members saw our email blast on this issue and where able to submit comments before the September 2nd deadline.

Table 1: Epidural/Spinal Injection Non-Facility 2015 PFS Proposed Rule

Office Site of Service:				
Procedure	**Codes**	**2014 Current Medicare Rate**	**2015 Proposed Medicare rate**	**2015 vs. 2014 Payment**
Inject spine lumbar/sacral	62311	$108.90	$225.33	
Fluoroguide for spine inject	77003	$90.99	$0	
		$199.89	**$225.33**	$25.44
Inject spine cerv/thoracic	62310	$110.69	$244.67	
Fluoroguide for spine inject	77003	$90.99	$0	
		$201.68	**$244.67**	$42.99
Inject spine w/cath lmb/scrl	62319	$114.99	$170.52	
Fluoroguide for spine inject	77003	$90.99	$0	
		$205.98	**$170.52**	($35.46)
Inject spine w/cath crv/thrc	62318	$111.41	$233.21	
Fluoroguide for spine inject	77003	$90.99	$0	
		$202.40	**$233.21**	$30.81

Table 2: Epidural/Spinal Injection Facility 2015 PFS Proposed Rule

Facility Site of Service:				
Procedure	Codes	2014 Current Medicare Rate	2015 Proposed Medicare rate	2015 vs. 2014 Payment
Inject spine lumbar/sacral	62311	$72.72	$92.06	
Fluoroguide for spine inject	77003-26	$30.81	$0	
		$103.53	**$92.06**	($11.47)
Inject spine cerv/thoracic	62310	$74.15	$112.13	
Fluoroguide for spine inject	77003-26	$30.81	$0	
		$104.96	**$112.13**	$7.17
Inject spine w/cath lmb/scrl	62319	$81.32	$98.51	
Fluoroguide for spine inject	77003-26	$30.81	$0	
		$112.13	**$98.51**	($13.62)
Inject spine w/cath crv/thrc	62318	$79.53	$101.74	
Fluoroguide for spine inject	77003-26	$30.81	$0	
		$110.34	**$101.74**	($8.60)

Unfortunately an unrecognized consequence of the SCS physician fee schedule changes last year, which included elimination of L8680 (coding for the lead) from the fee schedule, is that it meant physicians performing PNS in the office setting no longer had a mechanism for billing or being paid for the lead costs by Medicare. As a result CMS received comments from a stakeholder requesting a Non-facility fee schedule for CPT codes 64553 (Percutaneous implantation of neurostimulator electrode array; cranial nerve) and 64555 (Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) when furnished in the non-facility setting which included RVU's for practice expense (PE). In response to these stakeholder(s) comments, this year CMS has nominated PNS codes as potentially misvalued (as was done last year for SCS, CPT 63650) to ascertain whether or not the practice expense values are correct for the Non-facility setting (i.e.- in order to provide practice expenses for PNS in the office setting). NANS will once again try and work with other societies on the AMA RUC to ensure that these codes are evaluated properly.

As it relates to intrathecal therapy, CMS has announced that the current pump refill drug code J2275 preservative free morphine sulfate, per, per 10mg will no longer be recognized or paid by Medicare **effective July 1, 2014**. In its place, providers must submit new drug code Q9974-injection, morphine sulfate, preservative-free or epidural or intrathecal use, 10mg. No other intrathecal medication coding or fee schedules have been changed. See table 3 below for the associated reimbursement changes with these coding changes.

Starting July 1, 2014, providers that purchase and bill for the drug component must stop using J2275 and instead must report Q9974 for preservative free morphine sulfate in conjunction with refills for SODS. Since the drug unit value for Q9974 continues to be 'per 10mg', there is no change in how total drug units are calculated for pump refills. The only change is the code being used to report the drug component. Non-Medicare payers will as usual likely adjust to these changes sporadically and slowly as they convert to these new codes over the next several years. Billing staff should be alerted to watch carefully as insurance carriers transition to the new code to ensure the correct code is billed to each insurance provider.

Table 3: Payment information for Q9974 compared to prior payment information for J2275

4/1/ 14-6/30/14 **HCPCS Code**	**Short Description**	**HCPCS Code Dosage**	**Payment Limit**	**Infusion AWP%**	**DME Infusion Limit**
J2275	Morphine sulfate injection	10 MG	$10.141	95	$4.390
7/1/14-9/30/HCPCS Code	**Short Description**	**HCPCS Code Dosage**	**Payment Limit**	**Infusion AWP%**	**DME Infusion Limit**
Q9974	Morphine Epidural/ Intrathecal	10 MG	$9.029	N/A	N/A

In 2013 there were major changes proposed to Hospital APC coding as part of CMS's overarching plan to create composite APCs which would have affected neuromodulation devices. (Medicare feels this will allow them to pay more appropriately for combinations of devices when provided in the same service). As a result of the many comments CMS received, including from NANS and its members, these changes were averted. As follow up, CMS has provided new proposed fee schedules for comprehensive APCs in 2015 for neurostimulator devices, see table 4. These revisions are consistent with the recommendations made by physicians, societies, and industry and are overall workable. CMS accepted comments on the proposed APC rule until September 2, 2014 and will respond to comments in a **final rule to be issued on or around November 1, 2014.**

NANS will continue to monitor for changes in reimbursement which will affect our members and the institutions within which they work to protect patient access to these important therapies. It is important that our membership stay engaged and submit comment letters when appropriate and asked to ensure that our message is being heard. Please make sure that info@neuromodulation.org is accepted in your address book so that you receive our important notices on proposed reimbursement changes that require physician comment, it is important that CMS hears from many.