



PAIN PHYSICIAN NEWS

Official Publication of the Association of Pain Management Anesthesiologists, April, 2000

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Dear Interventional Pain Specialists:

We are bringing you a lot of news this time. It may be interpreted as good news or bad news but, no doubt, it is news and we just have to live with it. Meanwhile, we continue in our struggle to preserve interventional pain management.

PROSPECTIVE PAYMENT FOR HOSPITAL OUTPATIENT SERVICES

Health Care Financing Administration (HCFA) officially released the Hospital Outpatient Department (HOPD) rule Friday, April 7, 2000. The printed version is available from HCFA, or online at <http://www.access.gpo.gov>. The implementation date for the hospital outpatient department rule is July 1, 2000.

Commentators contended that there are no similarities among the procedures in the proposed APC groups 601 and 602 encompassing nervous system injections.

HCFA responded as follows: The range of services included in an APC group are generally consistent from a clinical perspective. And, even though an injection into the subarachnoid space may be a more complex injection than some of the others in the group, no institution is likely to specialize solely on one kind of injection. Because all the services within an APC group are offered by most hospitals, the impact of the variation in resource consumption among the different codes should average out at the hospital level.

---Additionally, HCFA will determine whether the implantable neurostimulator system is eligible for treatment as a "pass through" device under Section 201(b) of the BBRA 1999.

As expected, HCFA deleted interventional pain management codes which were deleted from CPT 2000. These are listed in Current Procedural Terminology: CPT 2000; as well as CPT 2000: Interventional Pain Management Coding in the New Millennium, **Pain Physician**, Volume 3, Number 1, pages 73-85 on page 74 Table 1. Various new CPT codes for the year 2000 for multiple types of injections, as well as radiological applications have been included. These are listed in Tables 2 and 3 of the above mentioned article, as well as in the CPT 2000.

Table 1. Illustration of physician fee schedule for year 2000 and facility payments for hospital outpatient settings for epidural and facet joint procedures.*

	Physician Fees ¹ \$	Office Expense ² \$	Proposed Hospital Payment ³ \$
62263 Percutaneous epidural adhesiolysis	332	89	176
62310 Cervical/thoracic epidural	93	105	176
62311 Lumbar/caudal epidural	78	122	176
64479 Transforaminal cervical/thoracic - single	106	115	161
64480 Transforaminal cervical/thoracic - additional	74	126	161
64483 Transforaminal lumbar/sacral - single	90	114	161
64484 Transforaminal lumbar/sacral - additional	64	125	161
62318 Continuous epidural - cervical/thoracic	101	106	176
62319 Continuous epidural - lumbar/sacral	92	110	176
62281 Cervical/thoracic epidural - neurolytic	131	54	176
62282 Lumbar/sacral epidural - neurolytic	134	87	176
62270 Spinal puncture	67	57	145
72275 Epidurography - radiological supervision and interpretation	27**	84#	234
76005 Fluoroscopic guidance	29**	50#	121
64470 Facet injection - cervical/thoracic - single	89	115	161
64472 Facet injection - cervical/thoracic - additional	63	107	161
64475 Facet injection - lumbar/sacral - single	68	114	161
64476 Facet injection - lumbar/sacral - additional	47	124	161
64622 Facet neurolysis - lumbar/sacral - single	166	62	161
64623 Facet neurolysis - lumbar/sacral - additional	60	58	161
64626 Facet neurolysis - cervical/thoracic - single	162	98	161
64627 Facet neurolysis - cervical/thoracic - additional	58	98	161
27096 SI-joint injection	57	351	NA-N.
73542 SI-joint arthrography - radiological supervision and interpretation	27**	80#	133

Adapted and modified from Federal Registers.

*=payments are for participating physicians, national, unadjusted for locality. N: Incidental services, packaged into APC rate. **=professional component; #=technical component; N/A=not available; 1=physicians fees – shows out of office payments – also defined as facility total – total payments for the service when performed in a facility setting. 2=office expense differential – payment differences between total payment under the 2000 Medicare physician fee schedule for the service when performed in a nonfacility setting. A service performed in a nonfacility setting may be attained by adding the amount in the "physician fees" column with the amount in the "Office Expense" column; 3=payment for procedure when performed in hospital outpatient department based on HOPD final rule (4/7/200).

Table 2. Illustration of physician fee schedule for year 2000 and facility payments for hospital outpatient settings for other invasive procedures*

		Physician Fees ¹ \$	Office Expense ² \$	Proposed Hospital Payment ³ \$
62287	Decompression of nucleus pulposus	546	0	677
62290	Lumbar diskography	173	59	NA-N.
62291	Cervical/thoracic diskography	160	64	NA-N.
20550	Trigger-point injection	41	32	102
20600	Small-joint injection	36	21	102
20605	Intermediate-joint injection	36	26	102
20610	Large-joint injection	41	32	102
62350	Implantation of catheter	406	0	307
62355	Removal of catheter	335	0	307
62360	Implantation or replacement of drug infusion reservoir	163	0	1235
62361	Implant of non-programmable pump	326	0	1235
62362	Implant of programmable pump	419	0	1235
62365	Removal of reservoir	333	0	773
63650	Implantation of neurostimulator	464	0	773
63660	Removal of neurostimulator	454	0	773
63685	Implantation of pulse generator	514	0	773
63688	Removal of pulse generator	402	0	773
64400	Trigeminal nerve block	53	39	161
64405	Greater occipital nerve block	64	42	161
64420	Intercostal nerve block - single	63	36	161
64421	Intercostal nerve block - multiple	88	41	161
64425	Ilioinguinal nerve block	87	33	161
64450	Peripheral nerve block	61	28	161
64505	Sphenopalatine ganglion block	66	38	161
64510	Stellate ganglion block	66	37	161
64520	Lumbar or thoracic sympathetic block	72	57	161
64530	Celiac plexus block	91	44	161
64600	Neurolytic - trigeminal - small branches	207	20	161
64605	Neurolytic - trigeminal - 2/3 division	296	20	161
64610	Neurolytic - trigeminal - at foramen ovale	528	0	161
64620	Intercostal neurolysis	142	42	161

Adapted and modified from Federal Registers.

*=payments are for participating physicians, national, unadjusted for locality. N: Incidental services, packaged into APC rate. **=professional component; #=technical component; N/A=not available; 1=physicians fees – shows out of office payments – also defined as facility total – total payments for the service when performed in a facility setting. 2=office expense differential – payment differences between total payment under the 2000 Medicare physician fee schedule for the service when performed in a nonfacility setting. A service performed in a nonfacility setting may be attained by adding the amount in the "physician fees" column with the amount in the "Office Expense" column; 3=payment for procedure when performed in hospital outpatient department based on HOPD final rule (4/7/2000).

The facility fee for various interventional pain medicine procedures ranging from trigger point injections CPT 20550 with \$102.31 to most injection procedures falling into the group with reimbursement of \$176.49 to decompression of nucleus pulposus CPT 62287 with payment rate of \$676.88 and for implantables of \$1235.45. The final payment rules for physician fees, office expense, and final hospital payment are shown in Tables 1 and 2.

The future of interventional pain medicine in a hospital setting definitely appears to be unstable during the interim. Hospitals are gauging the feasibility of keeping their interventional pain centers open. This is largely based at the present time on Medicare patient mix.

AMBULATORY SURGERY CENTER RULE

HCFA has recently stated that the final ASC rule will be published by November 2000 with implementation in April 2001.

That really puts pain management in a limbo. Hence, AOPMA has been actively pursuing the extension of use of the old codes through the year 2001 or until the new ASC rules are finalized and implemented. This is the only alternative as Medicare is not willing to accept the use of new codes.

Apparently, HCFA has agreed to the extension of the time period to use 1999 codes in ASC's following significant correspondence from congressional representatives, as well as AOPMA membership and our legal and lobbying firm. The program memorandum, indicating the extension of the use of 1999 pain management codes, of course is not ready for release yet. Initially, we were told that this document required only one more signature to finalize it, however, later on we were informed that the document is still in the hands of superiors at HCFA. However, this delay is related to a "systems issue" in that the individual who must make the changes to the system to accept the codes is out ill. We are hoping that this document will be ready early next week. We expressed our distress over the delay because ASC's are canceling cases out of concern that they will not be paid for these services. However, HCFA stated that cases should not be canceled because the services will be covered. However, **HCFA also recommended that ASC's simply hold the claims until the memorandum is released. Alternatively, it is stated that the claims could be submitted but that they likely would be kicked out of the system or denied so it seems easier just to hold the claims.** We will be following this issue on a daily basis until a resolution is achieved.

This is probably a blessing in disguise.

It also appears that now HCFA will be using data from its 1999 Medicare ambulatory surgery center survey into the forthcoming ASC payment rule. Hence, the alternate proposal of a phase-in of the APC system's new ASC rates over a period of at least three years most likely will not be utilized.

EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES

It appears that even with the developments that have taken place over the last two years, there are still several steps HCFA must take before it launches and completes pilot testing of the new guidelines. At this time it appears that HCFA is not committed to a timeline as pilot tests will take a while. Hence, new evaluation and management documentation guidelines may not be implemented until late year 2000 or early 2001.

Meanwhile, physicians should continue to use, either 1997 or 1995 guidelines.

OIG SPECIAL FRAUD ALERT

On February 23, the HHS-OIG issued a special fraud alert, warning physicians that rental amounts for office space must reflect fair market value for the space actually used. In particular, the OIG cautioned that physician landlords who rent space to medical suppliers and/or providers should be aware of the significant anti-kickback statute risk if the rental events are greater than fair market value. The OIG listed the factors it believes are important in evaluating the legality of such arrangements. These factors are:

- ◆ The appropriateness of the existence of a rental relationship
- ◆ The rental amounts
- ◆ Time and space considerations

The OIG strongly recommended that suppliers and landlord physicians comply with the office space rental safe/harbor to the anti-kickback statute.

COMPLIANCE GUIDANCE FOR PHYSICIANS

Interventional physician practices and other small physician practices are bracing for a soon-to-be released document from the Office of the Inspector General for the Department of Health and Human Services that will provide guidance to physician practices interested in developing compliance programs for their practices.

The AOPMA submitted written recommendations to the OIG, emphasizing the need for flexibility, as well as recognition of the large variety of size and specialties among physician practices. Among the many points raised, the AOPMA urged the OIG to keep in mind that: smaller providers have vastly different compliance program needs and capabilities than other, larger providers. In addition, the AOPMA recommended that the OIG adapt a user-friendly and practical document, so that physicians or practice administration would actually be able to use the document as a convenient and comprehensible reference.

The AOPMA further urged the OIG to adapt a flexible approach in proffering guidance to physicians and small practices, because smaller practices and individual physicians must have compliance programs designed to meet their particular needs. Among the suggestions offered by the AOPMA:

HOTLINE: The AOPMA suggested the OIG approve the use a suggestion/concern box where notes may be placed anonymously.

TRAINING: The AOPMA recommended to the OIG that it should not state a specific training standard, but rather should articulate a standard that would permit practices to establish training levels appropriate to their resources and needs. In particular, the AOPMA stated its belief that for most small practices, written training materials or perhaps audio visual training materials, should be sufficient.

RELIANCE ON OIG OR GOVERNMENT ADVICE/GUIDANCE: AOPMA proposed that the OIG permit reasonable reliance on such advice, if appropriately documented in written communication from or the government agency or agent.

An encouraging note is that the model compliance plan for pain management custom developed by Arent Fox for AOPMA membership is a comprehensive, up to date, pain management specific, step-by-step

easy to follow manual meets the regulations expected to be released. We will also have workshops at our annual meeting consisting of billing, coding, and compliance in interventional pain management.

OTHER MATTERS OF IMPORTANCE

- ◆ As you see, we continue to struggle to preserve interventional pain management.
- ◆ Once again we are actively attempting to address Medicare carrier payment restrictions and to set up a meeting with HCFA to discuss physician fee schedules which will be a major priority for us this year.
- ◆ Cadaver workshop in Boston for May 6th and 7th is well on its way. If you would like to attend, please feel free to do so since there are a few more openings available, however, attendance is strictly limited. You may register by mail, fax, or online.
- ◆ Preparations for the annual meeting continue. The program is taking shape with didactic lectures, afternoon didactic workshops, as well as cadaver workshops.
- ◆ If you are already not a member, please join the association as soon as possible and support it. We need you and you need the association. The organization has a lot to offer for \$200.00 membership dues. I personally believe we have achieved tremendous progress in interventional pain management in a very short amount of time with a tiny speciality. The advantages of membership include:
 - Updates of issues of interventional pain management by way of the interventional Pain Physician Newsletter.
 - The official journal (Pain Physician) with clinical research as well as practice management articles. We have applied for Index Medicus listing for this journal.
 - A dynamic web site with the latest information on interventional pain management
 - Lobbying for the cause of interventional pain management by one of the best health care lobbying groups in Washington.
 - Discounted cadaver workshops and annual meetings.
 - The opportunity to link your web site to the AOPMA web site.
 - Ability to publish quality interventional pain management and practice management articles in the **Pain Physician** Journal.
 - Ability to join the **Interventional Pain Physician PAC** after becoming a member to establish our role in the political process affecting our specialty of interventional pain medicine, and protecting interests of our patients and all interventional pain physicians.

The process of name change has been set into motion. All active members have received letters from our law firm Jeff Peters from Arent Fox. The members were desirous of changing the name. Please respond immediately.

To all the members, please complete member solicitation form as soon as possible.

For non-members, we prefer that you join the organization, however, you can still play a role in the continued success of this organization. While you won't be able to participate in IPP PAC or other major activities, we still invite you to submit manuscripts to **Pain Physician**.

Since the release of the millennial issue of **Pain Physician**, we have been receiving an inordinate number of calls with comments about the issue in general and various articles, specifically Practice Guidelines. While we appreciate all the support, the comments and suggestions can be best incorporated if they are sent in the form of Letter(s) to the Editor. In addition, your participation can also be guaranteed if you complete one of the enclosed member solicitation form.

- ◆ Finally, I would like to thank the board members and officers, specifically Ken Varley and Vijay Singh for their unwavering support, Bill Sarraille, Allison Shuren, and Jeff Peters our counsel at Arent Fox, and Mike McNamara, IPP PAC advisor. I also would like to thank the tireless efforts of Bert Fellows and the staff of the Pain Management Center of Paducah for making this organization as successful as it already is. Thank you.

Sincerely,



Laxmaiah Manchikanti, M.D.
President and Executive Director

CALL FOR MANUSCRIPTS

Manuscripts related to interventional pain management are solicited for *Pain Physician*. This quarterly publication, the official journal of the Association of Pain Management Anesthesiologists is devoted entirely to interventional pain management and various aspects of practice of interventional pain management. Manuscripts are solicited for the following departments:

Original Contributions

Descriptions of original research of interest to interventional pain physicians.

Review Articles

State-of-the-art reviews entailing a survey of the literature, highlighting the most recent developments in a given area of the focus in interventional pain medicine.

Correspondence

Letters to the editor in response to issues of professional practice or in response to articles published in *Pain Physician*.

Information for Authors will be found in the journal, or will be mailed upon request. All articles will be peer-reviewed prior to final acceptance. Review comments will be shared with authors on a blinded basis.

SUBMISSION

Please mail your manuscripts to:

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