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# PAIN PHYSICIAN NEWS

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The Official Publication of the American Society of Interventional Pain Physicians, March, 2001

## ASIPP VICTORIES SWEEP THE WORLD OF INTERVENTIONAL PAIN MEDICINE

**HCFA ADDS NINE PAIN CODES TO ASC PROCEDURE LIST**

**TWO ASIPP-SPONSORED PROVISIONS SIGNED INTO LAW**

**HCFA INCREASES PROPOSED REIMBURSEMENT FOR SEVEN CODES**

**FLORIDA MEDICARE APPROVES LYSIS OF ADHESIONS  
AS A COVERED PROCEDURE**

These are a few of the achievements of the American Society of Interventional Pain Physicians (ASIPP), a dynamic, vibrant organization with 750 members involved in the practice of interventional pain medicine. In only two years of existence, ASIPP, formerly the Association of Pain Management Anesthesiologists (AOPMA), has progressed from an unknown organization to the premier organization preserving interventional pain medicine.

In addition to the above accomplishments, ASIPP also has been able to gain significant support from Congressional leaders. ASIPP, with the help of tremendous grassroots efforts, has written approximately 18,000 letters to various organizations, including Congress.

ASIPP members visited 74 Congressional delegates following the annual meeting in September 2000.

ASIPP obtained 18 letters of Congressional support for various issues, including the ASC rule, addition of new or replacement pain management codes to the ASC-approved list, delay in the implementation of ASC-PPS system, and for subspecialty recognition for interventional pain medicine.

ASIPP, which began as a small organization by a few dedicated physicians in interventional pain medicine, has grown rapidly in two years and conducted highly successful annual meetings in Washington, D.C., in 1999 and 2000 and will meet there again on October 6-8, 2001. This year's annual meeting will again be followed by a Capitol Hill visit by the membership on October 9, 2001.

The result has been great success, with the inclusion of two provisions on the Medicare Refinement Bill that was sponsored by Honorable Congressman Ed Whitfield (R-KY) and Honorable Congressman Frank Pallone (D-NJ). Both the bills passed through the Congress with unanimous bipartisan support and were signed into law by former President Bill Clinton. In the history of medicine, this is an unheard achievement for a small physician organization. For further details on the two bills affecting interventional pain medicine included in the Medicare Refinement Act entitled: MEDPAC Study on Access to Outpatient Pain Management Services; and Delay in Billing Implementation of Prospective Payment System, please **see page 5**.

The same tenacity and dedication of the society led HCFA to reverse proposed cuts in physician fee schedule for 2001, to add nine codes to the ASC procedure list, and led Florida Medicare to reverse its earlier position of classifying lysis of adhesions (CPT 62263) as an experimental procedure.

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## HCFA ADDS 9 PAIN CODES TO ASC PROCEDURE LIST

This was the heading in multiple newsletters distributed to pain specialists, anesthesiologists, surgery centers and other physicians. The newsletters went on stating, "Ambulatory surgery centers now may bill facility fees to Medicare without fear of denial for nine popular pain management procedures. Medicare carriers have routinely denied payment of the ASC fees since April this year." In a program memorandum sent November 17 to Medicare carriers, HCFA placed the following CPT codes in ASC payment group \$320.00 at a national rate:

- 1) 64479 cervical/thoracic transforaminal epidural injection, single level;
- 2) 64480 cervical/thoracic transforaminal injection, each additional level;
- 3) 64483 lumbar/sacral transforaminal epidural injection, single level;
- 4) 64484 lumbar/sacral transforaminal epidural injection, each additional level;
- 5) 64470 cervical/thoracic facet injection, single level;
- 6) 64472 cervical/thoracic facet joint injection, each additional level;
- 7) 64626 cervical/thoracic facet neurolysis, single level;
- 8) 64627 cervical/thoracic facet neurolysis, each additional level;
- 9) 62263 percutaneous epidural adhesiolysis.

And in an unexpected move, HCFA set the effective date of the change as January 1, 2000. That essentially means ASCs can be reimbursed for all the denied claims since the beginning of the year.

This was quite heartening to the ASIPP. The issue of new or replacement codes and the subsequent denial of reimbursement started by AMA's revamping of multiple pain management codes and the creation of replacement codes to describe the procedures more target specifically, appears now to be understood and resolved.

With the efforts of the American Society of Interventional Pain Physicians and some support from Federated Ambulatory Surgery Association, HCFA had issued a program memorandum in December 1999 to reimburse for multiple pain management procedures based on the old codes. However, this memorandum expired March 31, 2000. Subsequently, ASIPP continued to negotiate with HCFA to continue the memorandum until the new rule was issued, possibly as early as February 2000. In April 2000, HCFA issued a memorandum cross-walking the new codes; however, it omitted the nine pain management codes that have been billed with different types of codes in the past. Immediately, in April 2000, ASIPP contacted HCFA and sent about 2,000 letters, not

only from the officers, but also from the membership and patients. These letters were also sent to congressional members. Subsequently, ASIPP obtained support from several congressional members. Letters were written and personal phone calls to HCFA made by Honorable Senator Mitch McConnell (R-KY), Honorable Congressman Ed Whitfield (R-KY), Honorable Congressman Frank Pallone (D-NJ), Honorable Congressman Ken Lucas (D-KY), Honorable Congresswoman Anne Northup (R-KY). ASIPP sent a letter explaining in detail the so-called new codes and their purpose and why they should remain on the ASC-approved list. In addition, a joint letter was sent on July 12, 2000 by the American Society of Anesthesiologists, the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, the North American Spine Society, the American Academy of Pain Medicine, the American Academy of Physical Medicine and Rehabilitation, and the Federated Ambulatory Surgery Association. While the letter was mostly derived from the ASIPP letter, all these organizations failed to provide any credit to ASIPP but jumped on the bandwagon and took credit when the final result was obtained.

That is not all! In spite of this multitude of efforts, HCFA refused to add these codes. Subsequently, the membership of ASIPP met with 74 congressional members and requested their support. This resulted in a personal visit to HCFA by various members of ASIPP, including Laxmaiah Manchikanti, M.D.; David Kloth, M.D.; Peter Wright, M.D.; Joseph Waling, M.D.; and Bill Sarraile, J.D. Following this extremely productive meeting, HCFA agreed to issue a program memorandum. We continued to be in contact with HCFA two to three times a week until the memorandum was issued on November 17. The difference was that HCFA accepted the arguments of ASIPP, which reasonably requested the addition of nine codes. Only those nine codes were added, whereas a joint letter of various organizations also requested addition of sacroiliac joint injection, 27096, which was not added.

Once the memorandum was issued, a multitude of organizations quickly took credit for the achievement. This included, so far as we are aware: the North American Spine Society, the Federated Ambulatory Surgery Association. The American Society of Anesthesiologists (ASA) stated in its newsletter: "ASA additional accomplishments on behalf of the pain medicine community." ASA claimed that they assumed a leadership role in making sure that all pain medicine procedures performed in ambulatory surgical centers would continue to produce a payment to the facility in addition to the fee for our professional services. To obtain this result, ASA

continued: "We initially filed comprehensive formal comments protesting HCFA's first proposal to reduce or eliminate Medicare facility payments." When HCFA published its ASC list for 2000, it was clear that there had been serious omissions. We organized a coalition including neurosurgeons, physical medicine and rehabilitation physicians, and the Federated Ambulatory Surgery Association and made a convincing case for the correction, which has now been implemented and is retroactive to January 1, 2000.

This is a classic example of misinformation and misuse of resources. Basically, none of these organizations have spent any serious time or money on this issue. They were immersed in other issues (for example, the nurse anesthetist issue for ASA) and continue to be involved at

the same level. Production of one letter from seven major organizations and stealing the credit from a small organization, which spent thousands of hours and thousands of dollars mustering support for this issue is beyond fair play.

Following are some of the letters we received from HCFA, one directly written to Laxmaiah Manchikanti, M.D., President of ASIPP, and the second one to Honorable Mitch McConnell, who wrote a letter on behalf of ASIPP. Both of these letters clearly delineate in no uncertain terms the efforts of ASIPP and its achievements. Surprisingly, HCFA responded on July 21, 2000, by which time HCFA had not even reviewed the letter from the other major organizations.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

JAN 23 2001

7500 SECURITY BOULEVARD  
BALTIMORE MD 21244-1850

Laxmaiah Manchikanti, M.D.  
American Society of Interventional Pain Physicians  
2831 Lone Oak Road  
Paducah, Kentucky 42003

Dear Dr. Manchikanti:

I appreciate the opportunity to have met with you and your associates last year concerning Medicare coverage in ambulatory surgical centers (ASCs) for nine nerve injection procedures added to the Physicians' Current Procedural Terminology codes in 2000. I apologize for the delayed response.

I am certain that you are aware that we have in fact added these nine codes to the ASC list of approved procedures. They were added through a program memorandum issued to our Medicare contractors on November 17, 2000.

Thank you for your interest in assuring Medicare beneficiaries access to appropriate ASC services.

Sincerely,

  
Vivian V. Braxton  
Acting Director  
Division of Outpatient Care



JUL 21 2000

FAR-065

Honorable Mitch McConnell  
United States Senate  
Washington, D.C. 20510-1702

Dear Senator McConnell:

Administrator DeParle asked me to thank you for your letter regarding the Health Care Financing Administration's (HCFA's) proposed rule on payment rates and medical procedures performed at ambulatory surgical centers (ASCs) and hospital outpatient departments. You are particularly concerned that our recent program memorandum crosswalked codes deleted from the American Medical Association (AMA) Current Procedural Terminology (CPT) effective January 1, 2000, did not include additional new nerve injection codes to the Medical Ambulatory Surgical Center (ASC) list. Please excuse the delay of this reply.

First, we have not usually added procedures to the ASC list without first going through *Federal Register* notice with public comment as we are required to by law. The exception to this rule, which we adopted a few years back, deals with codes on our list that the AMA deletes and crosswalks to new codes. In order that there be no break in coverage for Medicare beneficiaries in ASCs, we published a program memorandum to add the new codes. The Health Care Financing Administration has a contract with the AMA to utilize the CPT with any modification. In the above instance, we added the new year 2000 codes which the AMA clearly cross-referred the deleted codes in their specific instructions. Since the additional codes you are writing about were not crosswalked by CPT, these codes cannot be immediately added to our list, but must go through the *Federal Register* notice with public comment.

We currently have a final notice pending to our proposed notice of June 12, 1998, and we will review these additional codes for possible proposal in a second round of the final notice. This portion of the notice will be subject to a public comment period as required by law. We plan to publish the final notice this November regarding implementation in April 2001.

Sincerely yours,

Robert A. Berenson, M.D.  
Director  
Center for Health Plans and Providers

## ASIPP SUCCESSFUL IN PASSING TWO VERY IMPORTANT PROVISIONS IN MEDICARE REFINEMENT ACT

ASIPP was finally able to bring news about much awaited bills involving the practice of interventional pain medicine with two favorable laws which passed Congress and were signed by former President Clinton.

We are talking about the Medicare Refinement Act. The two bills involved are related to what originally started out as specialty recognition for interventional pain management, the ambulatory surgery center rule phasing in over a period of four years and extending implementation of the prospective payment system until January 2002.

This only happened because of ASIPP's aggressive grassroots campaigning and bipartisan support in Congress.

The issue of specialty recognition for pain management was conceived by the organization in the early part of 2000. In an article from the president's desk entitled "State of Interventional Pain Medicine" published in *Pain Physician*, Volume 3, the following was noted:

"Recognition of a specialty is an extremely important aspect of the practice of medicine for reimbursement purposes as practice relative values are developed separately for each recognized specialty. Practice expense values for most interventional procedures are derived from anesthesiology, even though a large proportion of the procedures are performed by other specialists. In fact, hourly practice expense data for all physicians is \$68, dermatology is \$115, pathology is \$47, neurology is \$59, physical medicine rehabilitation is \$88, in contrast to anesthesiology practice expense per hour of \$27 as per physician fee schedule. Lack of subspecialty recognition also results in lack of representation on Medicare carrier committees. At the present time, the three specialties — anesthesiology, physical medicine and rehabilitation — and neurology are represented, in many cases, on local Medicare carrier review committee with issues of interventional pain medicine being represented by the anesthesiology representative.

Following this, ASIPP made a concerted effort to cooperate and solicit support in earlier months from the Pain Care Coalition, a group formed by the American Academy of Pain Medicine, the American Pain Society and the Headache Society. However, after long-awaited requests, the Pain Care Coalition refused to go along with us on a specialty recognition, citing ridiculous reasons that were neither scientific nor related to practice or ethics and that stemmed from a lack of understanding and political

maneuvering. Following this, ASIPP decided to proceed with its own efforts to obtain subspecialty recognition of interventional pain medicine rather than pain management. This idea, which was born as having a "snowball's chance" of surviving, has taken shape with individual congressional meetings and culminated with our annual meeting in September 2000, where the members met with 74 congressional delegates in Washington.

Subsequent to this effort, the bill was introduced. However, due to legislative changes and negotiations, the bill transformed into the "MEDPAC Study on Access to Outpatient Pain Management Services." This is actually a better law because it provides us with subspecialty recognition for interventional pain management that will help us to reflect the actual costs of practice expense for the physician portion (not only for the office portion). It also will mandate MEDPAC to study the specific barriers imposed under the Medicare Program on the provision of pain management procedures in hospital outpatient departments, ambulatory surgery centers, and physician's offices. This bill was sponsored by Honorable Congressman Ed Whitfield (R-KY) and Honorable Congressman Frank Pallone (D-NJ). It unanimously passed through the Commerce Committee with bipartisan support. The final version was modified by Honorable Representative Bill Thomas (R-CA) to include an initial study by MEDPAC to demonstrate higher practice expenses for interventional pain physicians. Essentially the study results will be reported in 12 months to Congress, which will act after that. Subsequently, the bill went through the Senate Conference Committee and was signed by President Clinton.

In fact, ASIPP individually achieved both approval of MEDPAC's study on access to outpatient pain management services and consideration by HCFA for specialty recognition right away. We had a favorable response from HCFA on this issue. We continue to negotiate with HCFA with personal meetings, as well as teleconferences. ASIPP has been in regular contact with appropriate personnel at HCFA to obtain specialty recognition for the practice of interventional pain medicine.

However, as usual, our colleagues at the American Academy of Pain Medicine, the American Pain Society and a multitude of other organizations continue to criticize, while HCFA and Congress considered our arguments as compelling. These organizations felt that we were not justified. These major organizations are in the process of applying for a pain management subspecialty recognition that they've probably been trying for the last twenty years or so. For further discussion on this issue, please see Letter from the President, January 2001 issue of *Pain Physician*.

*Continued on page 6*

## HCFA REVERSES PROPOSED CUTS FOR PHYSICIAN FEE SCHEDULE FOR INTERVENTIONAL PAIN PROCEDURES

In a proposed rule released in 2000 for the physician fee schedule for calendar year 2001, HCFA proposed not only insufficient reimbursement for multiple procedures, but also contemplated a multitude of inappropriate reductions. With grassroots support, ASIPP and its membership immediately contacted HCFA with about 2,000 letters – including many from patients – after the release. However, we were unable to receive any response with the letters. Finally, in a face-to-face meeting with HCFA on October 5, 2000, which was attended by Laxmaiah Manchikanti, M.D.; David Kloth, M.D.; Peter Wright, M.D.; Joseph Waling, M.D.; and our counsel, Bill Sarraillie, J.D., ASIPP was finally able to negotiate substantial improvements in these areas. Subsequently,

HCFA has increased the payment for lumbar facet neurolysis from a proposed rate of \$137.67 in non-facility setting and \$46.87 in facility setting to \$268.57 and \$161.01 respectively, for the first level, and a proposed rate of \$129.98 for non-facility setting and \$53.82 for facility setting to \$150.73 and \$55.85 respectively for the second level and subsequent levels. In addition, they also have reinstated the physician fee in a facility setting for various procedures that had been eliminated.

Thus, it is clear that ASIPP has helped interventional pain physicians tremendously by improving the reimbursement for a multitude of these procedures, which may translate into thousands of dollars.

## ASIPP SUCCESSFUL IN PASSING TWO VERY IMPORTANT PROVISIONS IN MEDICARE REFINEMENT ACT

### *Continued from page 5*

The second bill regards concessions for Ambulatory Surgery Centers. This bill was also introduced by Honorable Congressman Ed Whitfield (R-KY) and Honorable Congressman Frank Pallone (D-NJ). The bill passed unanimously through all stages and became law after the President's signature. The bill was passed through the Congress on behalf of ASIPP because of the strong support from Honorable Congressman Ed Whitfield and Honorable Congressman Frank Pallone, even though this was not ASIPP's bill and ASIPP was only a signatory.

Following is the language of the two bills.

### SEC. 438. MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN MANAGEMENT SERVICES.

(a) STUDY. – The Medicare Payment Advisory Commission shall conduct a study on the barriers to coverage and payment for outpatient interventional pain medicine procedures under the Medicare program under title XVIII of the Social Security Act. Such study shall examine –

(1) the specific barriers imposed under the Medicare program on the provision of pain management procedures in hospital outpatient departments, ambulatory surgery centers, and physicians' offices; and

(2) the consistency of Medicare payment policies for pain management procedures in those different settings.

(b) REPORT. – Not later than 1 year after the date of the

enactment of this Act, the Commission shall submit to Congress a report on the study.

(a) DELAY IN IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM. – The Secretary of Health and Human Services may not implement a revised prospective payment system for services of ambulatory surgical facilities under section 1833 (i) of the Social Security Act (42 U.S.C. 13951 (i)) before January 1, 2002.

(b) EXTENDING PHASE-IN TO 4 YEARS. – Section 226 of the BBRA (113 Stat. 1501A-354) is amended by striking paragraphs (1) and (2) and inserting the following:

“(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed 1/4) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

“(2) in each of the following 2 years a proportion (specified by the Secretary and not to exceed 1/2, and 3/4, respectively) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.”

(c) DEADLINE FOR USE OF 1999 OR LATER COST SURVEYS. – Section 226 of BBRA (113 Stat. 1501A-354) is amended by adding at the end the following:

“By not later than January 1, 2003, the Secretary shall incorporate data from a 1999 Medicare cost survey or a subsequent cost survey for purposes of implementing or revising such system.”

## FLORIDA MEDICARE REVERSES ITS POSITION ON LYSIS OF ADHESIONS AND FINALLY SAYS, "IT IS APPROVED."

Florida Medicare published in its guidelines in the middle of the year 2000 a statement that lysis of adhesions is an experimental procedure with CPT code 62263, thus it was not covered under Florida Medicare. (The ASIPP board obtained this information from a Florida member.)

ASIPP contacted all of the Florida members. A strategic plan was developed with our lobbying group at Arent Fox in Washington. Immediately, multiple letters were written by the physicians and ASIPP with presentation of the evidence. Along with this, we also attempted to form an alliance with the Florida Academy of Pain Medicine and the Florida Society of Anesthesiologists (FSA). ASA claims that it guided pain practitioners in Florida through the process of convincing the local Medicare carrier that it must pay for epidural lysis, and ASA also continues to claim that it remains the premier association representing the interests of our members on important matters relating to pain medicine. Unfortunately, the Florida Academy of Pain Medicine was a reluctant bystander during the whole process and belatedly jumped into the fray by taking sole credit, as if it was their achievement. FSA and FSA-appointed Carrier Advisor Committee members representing anesthesiology, to the best of our knowledge, have done nothing at any stage; i.e.

before, at the time or after the onerous regulation was released.

Following the vigorous efforts of ASIPP, Florida Medicare has finally agreed to include CPT 62263 as an approved procedure. They also proceeded to state that the code will apply for endoscopic, as well as non-endoscopic, placement of an epidural catheter and sequential adhesiolysis, performed over a one-, two-, or three-day period. Further information on the Florida Medicare Review Policy on lysis of adhesions may be obtained at <http://www.floridamedicare.com>, which provides the full text of medical policy and procedures for percutaneous lysis of epidural adhesions (CPT 62263) with description of the procedure, indications and limitations of coverage and/or medical necessity, HCPC(s) codes, ICD-9 codes, coding guidelines, documentation requirements, and multiple sources of information which includes publications in *Pain Physician*, along with multiple publications by Manchikanti and co-workers.

The addition of multiple references from Dr. Manchikanti and all the references provided by ASIPP that were included in the interventional pain practice guidelines is a clear indication that ASIPP efforts have paid off, no matter what ASA, FSA and the Florida Academy of Pain Medicine claim at this stage.

### INTERVENTIONAL PAIN CENTER LISTING

**\*\* If you have more than one clinic, please complete one form for each clinic**  
(You may also register on the website, for members only)

NAME OF CLINIC \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

E-MAIL \_\_\_\_\_

PLEASE LIST NAMES OF ALL PROVIDERS

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

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## HEALTHCARE UPDATE

### SWEEPING MEDICAL RECORD PRIVACY RULE

The Final Medical Record Privacy Rule was released by the Department of Health and Human Services on December 20, 2000. This rule sets forth standards for the protection of the privacy of patients' medical records. It is scheduled to become effective in early 2003.

The rule essentially is made up of five components:

- ◆ Protecting consumer control over health information
- ◆ Establishing boundaries on medical record use and release
- ◆ Ensuring the security of personal health information
- ◆ Establishing accountability for medical record use and release
- ◆ Balancing public responsibility with privacy protections

Key components of the Medical Record Privacy Rule are as follows:

- ◆ Physician practices must maintain physical security of all health care information.
- ◆ Access to individually identifiable health information is restricted to a "need to know basis."
- ◆ You can disclose only the "minimum information necessary."
- ◆ Patients have significant new rights of control over their health information.
- ◆ You have to provide your patients a written notification of their rights.
- ◆ Patients must give written consent before you share their information.
- ◆ All entities covered by the rule must have a privacy officer.
- ◆ Staff must receive training on your privacy policies and procedures every three years.
- ◆ You must make sure that anyone with whom you share confidential patient information follows the HIPAA privacy regulations.

### NEEDLESTICK SAFETY AND PREVENTION

The Needlestick Safety and Prevention Act was signed into law by former President Clinton on November 6<sup>th</sup>, 2000. This legislation will impact all interventional pain physicians. The new legislation requires OSHA to make specific changes in the bloodborne pathogen standard of 1991. Even though OSHA has revised its compliance directive on enforcement procedures for the occupational exposure to bloodborne pathogens in 1999, the current legislation on the Needlestick Safety and Prevention Act is intended to update OSHA directives. The main provisions include:

- ◆ An expanded definition of "engineering controls" in the standard, to include devices with engineered sharps-injury protection, meaning devices with built-in safety features or mechanisms. The previous standard only listed sharps disposal containers and self-sheathing needles as examples of devices that removed the bloodborne pathogens hazard from the workplace.
- ◆ A requirement that healthcare facilities create written exposure-control plans that reflect changes in technology that reduce exposure to bloodborne pathogens. Facilities must document the consideration and use (at least annually) of devices designed to minimize exposure.
- ◆ A requirement that each facility maintain a sharps-injury log with detailed information on percutaneous injuries. This includes the department where the injury occurred, the type and brand of device involved, and an explanation of how it happened.
- ◆ The participation of non-managerial healthcare workers in the identification, evaluation, and selection of safety-engineered sharps devices and other safety controls. Facilities must document this involvement in the exposure-control plan.

The facilities need to be in full compliance by August 2001. For a detailed account, an article on the Needlestick Safety and Prevention Act and its impact on interventional pain medicine will be published in the next issue of the *Pain Physician*, April 2001.

## HEALTHCARE UPDATE

### STARK II REGULATIONS

The Healthcare Financing Administration (HCFA) published a portion of the final regulations, implementing the physician self-referral prohibitions under the Stark II statute on January 4, 2001.

The final Stark II regulations are separated into two phases. Phase I contains approximately 85% of the final Stark II regulations and clarifies the definitions of the individual DHS. Some of the major issues addressed are:

#### In-office ancillary services exception:

- ◆ Supervision requirement has been revised to conform to Medicare coverage and payment policies largely with efforts of ASIPP. (The proposed rule required "direct supervision.")
- ◆ Use of shared facilities for providing DHS is permitted under certain circumstances.
- ◆ Referrals for DME will be permitted under certain circumstances.
- ◆ Third-party billing companies may bill for DHS under this exception.

#### Group practices:

- ◆ Separate offices and specialties within the same group practice may operate as separate profit centers.
- ◆ Physicians may be compensated directly for productivity, including DHS which is personally performed by the physicians, provided the bonus calculation is not based directly on the volume or value of referrals for DHS.

#### New exceptions:

- ◆ Referrals to academic medical centers by employee physicians.
- ◆ Risk sharing arrangements between managed care organizations and physicians under certain circumstances.
- ◆ Catch-all exception for "fair market value" compensation.
- ◆ Medical staff incidental benefits.
- ◆ Compliance training provided by hospitals to local physicians.

For a detailed discussion on the impact of Stark II regulations on the practice of interventional pain medicine, look for an article in the April 2001 issue of *Pain Physician*.

### OIG'S WORK PLAN FOR 2001 - WATCH OUT!

The Office of the Inspector General (OIG) has made its next year's agenda known, and the projects entailed in the plan will certainly have significant effects on the practice of interventional pain medicine. Parts of the agenda will become the component of special fraud alerts. Some of the projects included in OIG's work plan for 2001 which are relevant to interventional pain medicine are as follows:

- ◆ **Reassignment of physician benefits** - Under this arrangement, the physician never sees what is billed under his or her physician number, shifting the accountability and liability for billing abuses away from the physician to the clinics. OIG will examine past reassignment abuses to determine specific vulnerabilities.
- ◆ **Advanced beneficiary notices** - Physicians must provide advanced notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment.
- ◆ **Bone density screening** - The number of claims for bone density screening have been increasing. Hence, there are questions about the appropriateness and quality of some services.
- ◆ **Role of non-physician practitioners** - Physician assistants, nurse practitioners, and clinical nurse specialists practice either in collaboration with or under the supervision of a physician and provide services according to their state's scope-of-practice requirements. Recent changes in HCFA policy have increased payments to the non-physician practitioners.
- ◆ **Incident to physicians' services** - At the present time, incident-to-services are paid at 100% of the Medicare physician fee schedule. However, very little information is available on the types of services being billed, with questions persisting about the quality and appropriateness of these billings.

## INTERVENTIONAL PAIN PHYSICIANS HELP YOURSELF! GET INVOLVED: IT'S ABOUT TIME!

If you are an Interventional Pain Medicine Physician, you are aware of the problems we all face because of a lack of understanding of our specialty. In fact, the reality that we are not formally recognized as a specialty is a huge part of the problem. One of the greatest difficulties we face is lack of understanding on the part of third party payors, whether private or Medicare/Medicaid. Therefore, ASIPP, "The Voice of Interventional Pain Medicine," has published Practice Guidelines in the January, 2001 issue of the *Pain Physician*, (the official journal of ASIPP), in the form of a 76 page article entitled: *Interventional Techniques in the Management of Chronic Pain: Part 2.0*. A copy of this issue has been sent to all Medicare Directors and the Medical Directors of all the major Health Insurance Companies across the United States.

Now, we need your help to encourage these carriers to consider these guidelines and to recognize them as a step toward mutual understanding of what our specialty has to offer not only in terms of the latest interventional techniques, but also the research references to support these interventions and the

history and demographics to establish the need.

In order to make a significant difference, we need to raise a collective voice to gain the attention and respect of health insurers, both public and private, whose decisions determine what diagnostic as well as therapeutic interventions will be recognized and reasonably reimbursed. Without adequate reimbursement, access to effective interventions will languish and eventually cease. Therefore, our voice must be heard regarding issues of interest to Interventional Pain Medicine and encouragement to adopt the ASIPP Guidelines. To do so effectively will require the formation of state associations who can deal directly with their own state's Medicare Directors and gain access to the Carrier Advisory Committees.

If you are interested in forming a state association, you may do so within your own state using your own attorney. It only takes one person to start. However, you may want to consider contacting Jeff Peters at Arent Fox at (202) 857-6295, or through their website at [www.arentfox.com](http://www.arentfox.com) for assistance. Contact us if you need more information.

## DO YOU WANT TO CONTINUE TO RECEIVE *PAIN PHYSICIAN* OR ARE YOU READY TO STOP THIS MOST INFORMATIVE AND PRACTICAL JOURNAL? THE CHOICE IS YOURS!

For the past two years, many of you have been receiving complimentary copies of the informative and practical *Pain Physician*. As a result, many physicians on our mailing list have concluded that they are members of the American Society of Interventional Pain Physicians when in fact they are not. Some also believe that they don't need to be a member to reap all the benefits. Nothing is for free forever.

Beginning with the publication of the April 2001, issue (Vol. 4, No. 2), you must be a member of ASIPP or have a paid subscription to receive the *Pain Physician*. Join ASIPP now using the enclosed application form and receive the *Pain Physician* as a membership benefit. Non-members may subscribe by using the accompanying order form. Do so now and avoid missing out on the contents of the April 2001 issue including:

- ◆ Role of Stark II in interventional pain practices
- ◆ Growing Pains: Can any willing provider laws overcome the challenges of the teenage years?
- ◆ Role of epidural adhesiolysis in the management of chronic low back pain: a randomized clinical trial
- ◆ Characteristics of chronic low back pain in patients in an interventional pain management setting: a prospective evaluation
- ◆ Contributions of facet joint to chronic low back pain in post lumbar laminectomy syndrome: controlled comparative prevalence
- ◆ An outcome study of therapeutic selective nerve root block for whiplash induced cervical radicular pain
- ◆ Sacroiliac joint syndrome - Focused review

# Act Now! • Join ASIPP!



**American Society of  
Interventional Pain Physicians**

**(Formerly the Association of  
Pain Management  
Anesthesiologists)**

***Professional Membership Application***

**2831 Lone Oak Road  
Paducah, Kentucky 42003  
(270) 554-9412, fax: (270) 554-8987**

1. Name \_\_\_\_\_  
Last First MI

2. Address \_\_\_\_\_  
Number and street City State Zip  
Telephone (area code) \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

3. Personal Data (for statistical purposes only)

i. Date of birth \_\_\_\_\_ ii. Gender [ ] Male [ ] Female

4. Social Security Number \_\_\_\_\_

5. Medical Degree [ ] MD [ ] DO [ ] other \_\_\_\_\_ (specify)

6. I am currently certified by the following board(s)

- [ ] American Board of Anesthesiology
- [ ] American Board of PMR
- [ ] American Board of Psychiatry and Neurology
- [ ] Other Primary Board(s) \_\_\_\_\_
- [ ] Subspecialty in Pain Management

7. What percentage of your clinical practice is in the field of Pain Management, Spinal Injections or Neural Blockades

[ ] 0% [ ] 1 – 25% [ ] 26 – 50% [ ] 51 – 74% [ ] 75 – 100%

8. My primary professional practice setting is (please check all that apply)

- [ ] Ambulatory surgery – based [ ] Office practice, solo
- [ ] Hospital – based [ ] Office practice, group

9. I hereby make application for

Membership – Must be a physician specializing in Pain Management, spinal Injections or Neural Blockade.

Life Membership dues	\$ 5,000.00
Annual Membership dues	\$ 200.00
Fellows and Residents	\$ 100.00
Honorary Member	\$ _____
Additional contribution	\$ 100 \$250 \$500 \$1000 Other _____
Total-Dues and/or contributions	\$ _____

Associate Membership - Non-Pain Management Physicians, Scientists, Nurses, Physician Assistants, Nurse Practitioners, Administrators, Pharmacists, Physical Therapists and Psychologists, etc. (associated with active practice of Pain Management)

Annual Associate Membership dues \$ 100.00

**METHOD OF PAYMENT**

Check # \_\_\_\_\_ (Payable to ASIPP)  
Bill my: [ ] Mastercard [ ] Visa [ ] Discover [ ] American Express  
Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Authorized Signature \_\_\_\_\_ (Required on all credit card orders)

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

Sponsoring Member \_\_\_\_\_

(Not required - for Statistical Purposes Only)

# INVITATION

To join the most dynamic, vigorous, organization of the new millennium



**“The Voice of Interventional  
Pain Medicine”**

To view the many contributions of ASIPP to the  
interventional pain medicine community, or to join:

**Visit our website at [www.asipp.org](http://www.asipp.org)**

Attend the semi-annual and annual interventional pain medicine symposiums  
in Las Vegas (April 6 - 8, 2001) and Washington, D.C. (October 6 - 8, 2001).

Visit your Senator and Congressman on October 9, 2001,  
after the annual meeting in Washington, D.C.

Register online at [www.asipp.org](http://www.asipp.org)

For 2002 meetings, check our website

**JOIN TODAY!  
(APPLICATION ENCLOSED)**



## American Society of Interventional Pain Physicians Announces

### THIRD ANNUAL INTERVENTIONAL PAIN MEDICINE SYMPOSIUM WASHINGTON DC, OCTOBER 6-8, 2001 CAPITOL HILL VISITS OCTOBER 9, 2001 PRELIMINARY PROGRAM

This program is designed for physicians, nurses, and other medical and health care personnel involved in the field of interventional pain medicine.

#### Lectures include:

- |                                                                                       |                                                                            |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| 1. Fraud and Abuse Investigations in Interventional Pain Medicine                     | 12. Cervical Discogenic Pain                                               |
| 2. HCFA's Views on Interventional Pain Medicine                                       | 13. Lumbar Discogenic Pain                                                 |
| 3. Congressional Views on Interventional Pain Medicine                                | 14. Advanced Minimally Invasive Techniques in Interventional Pain Medicine |
| 4. Views from the Secretary of Health and Human Resources                             | 15. Non-Endoscopic and Endoscopic Adhesiolysis                             |
| 5. Evaluation and Management Services: New Developments                               | 16. Implantable Technologies Advances and Controversies                    |
| 6. Documentation in Interventional Pain Medicine – Not Optional                       | 17. Epidural Injections – Why They Don't Work All the Time?                |
| 7. Maze of Policy & Procedure Manuals and Accreditation                               |                                                                            |
| 8. Outcome Studies and Publications – Art and Science of Interventional Pain Medicine |                                                                            |
| 9. Impairment Evaluation in Chronic Pain Management                                   |                                                                            |
| 10. Lumbar Facet Joint Mediated Pain                                                  |                                                                            |
| 11. Cervical Facet Joint Mediated Pain                                                |                                                                            |

#### Workshops include:

1. Spinal Radiology for Interventionalist: Intensive 2 Day (6 hour) Workshop
2. Billing and Coding in Interventional Pain Medicine
3. Compliance in Interventional Pain Medicine
4. Practice Development

*American Society of Interventional Pain Physicians*

*Introduces a New Tool for Efficient Practice Management*



*Pain Management  
Evaluation Report*

**This all inclusive, affordable program is bound to improve your productivity  
It is a customized program, crucial for pain specialists to document patient encounters**

**This program will contribute to**

- ◆ Appropriate documentation
- ◆ Appropriate billing and coding
- ◆ Reduction in errors
- ◆ Reduction in upcoding
- ◆ Improvement in successful practice

**It will provide**

- ◆ Comprehensive initial evaluation
- ◆ Letter to referring physician
- ◆ History and Physical for ASCs and Hospital Outpatient Departments
- ◆ Notes from non-procedural follow-ups

**The price is only a fraction of other generic programs**

Members	\$2000
Non-members	\$3000

**Special Offer**

Purchase this software at Las Vegas Symposium April 6 - 8, 2001 for a bargain price of \$1499.

Purchase includes free updates for one year.

Patient questionnaires and initial assessment forms are included with program.

You may customize these with your practice name and logo.

1000 Customized copies of both booklets - **\$3000**

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# ASIPP Order Form

FOR OFFICE USE ONLY

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For your convenience, please photocopy this form

Mail to: American Society of Interventional Pain Physicians  
 2831 Lone Oak Road  
 Paducah, Kentucky 42003

Phone: (270) 554-9412

Fax: (270) 554-8987

See our online ordering form at [www.asipp.org](http://www.asipp.org)

Description	Product Code	Quantity	Unit Price Member	Unit Price Non-Member	Total
Model Compliance Plan	MCP		\$250.00	\$450.00	
Subscription to <u>Pain Physician</u> Journal and News - One Year	SUB-1		Free	\$100.00	
Pain Management Policy & Procedure Manual - Hard Copy	PM-HC		\$400.00	\$600.00	
Pain Management Policy & Procedure Manual - Computer Disk	PM-CD		\$400.00	\$600.00	
Pain Management Policy & Procedure Manual - Both Hard Copy & Computer Disk	PM-B		\$500.00	\$700.00	
Ambulatory Surgery Policy & Procedure Manual - Hard Copy	ASC-HC		\$400.00	\$600.00	
Ambulatory Surgery Policy & Procedure Manual - Computer Disk	ASC-CD		\$400.00	\$600.00	
Ambulatory Surgery Policy & Procedure Manual - Both Hard Copy & Computer Disk	ASC-B		\$500.00	\$700.00	
Membership Dues (Fill out Membership Application Form)	Fellow or Resident \$100.00		Associate \$100.00	Active \$200.00	
Back Issues <u>Pain Physician</u> Journal Per Issue (Postage included)	BIPP-J		\$20.00	\$40.00	
2001 "Real" New Millennial Guidelines Issue of <u>Pain Physician</u>	BIPP-JG		\$20.00	\$40.00	
Back Issues <u>Pain Physician</u> News (Newsletter) Per Issue	BIPP-N		\$10.00	\$20.00	
Pain Management Evaluation Report <sup>®</sup>	PMER <sup>®</sup>		\$2,000	\$2,500	
Customized copies for PMER <sup>®</sup> - 1000 copies of each	PMER <sup>®</sup> CC		\$3,000	\$3,500	
Please Make Checks Payable to ASIPP					Subtotal
Bill my: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa					KY Residents add 6% Sales Tax
<input type="checkbox"/> Discover <input type="checkbox"/> American Express					Postage & Handling*
_____ Acct. #					Grand Total

Month Year

Expiration Date

Signature

(required on all credit card orders)

For Policy and Procedure Manuals (Hard Copy), you will receive the entire two (2) volume set together with instructions

\* Add: \$20.00 shipping and handling for each policy and procedure manual

Add: \$10.00 shipping and handling for the model compliance program

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Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone:

Area Code \_\_\_\_\_ Number \_\_\_\_\_



AMERICAN SOCIETY  
OF INTERVENTIONAL  
PAIN PHYSICIANS  
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## **INSIDE . . .**

- ◆ **Addition of 9 Codes to ASC List**
- ◆ **Lysis of Adhesions Approved**
- ◆ **Medical Record Privacy Rule**
- ◆ **Needlestick Safety**
- ◆ **Stark II Regulations**
- ◆ **OIG's Work Plan for 2001**