



The Voice of Interventional Pain Medicine

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PAIN PHYSICIAN NEWS

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

Tenacity and Dedication: The words ASIPP continues to live by



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Neil Swissman, MD President of ASA at ASIPP in Las Vegas



Sen. Mitch McConnell and Laxmaiah Manchikanti



David Kloth, MD at ASIPP in Las Vegas

ASIPP

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June 22, 2001

Dear Friends:

I am writing in support of the American Society of Interventional Pain Physicians, a dynamic and vibrant organization providing a voice for interventional pain medicine across the nation to physicians and other providers, in the halls of Congress and in the offices of HCFA and state Medicare directors. ASIPP is fighting for the preservation of interventional pain medicine.

If you are already a member of ASIPP, I congratulate you for your support and encourage you to become even more involved by helping to establish and form state affiliate programs, joining the ASIPP-PAC, attending the annual and spring meetings, submitting outcomes research manuscripts to ASIPP's quarterly journal, *Pain Physician*, volunteering for committee work, making cash contributions, and encouraging many others to join the organization.

If you are not already a member, I suggest that you will benefit significantly from joining. You may feel burdened by the number of annual dues you are already paying. Rest assured, ASIPP membership will be an investment in the future of interventional pain medicine and as such, will be an investment in your own future and the future of your patients.

So please, give careful consideration to joining this important organization without delay.

I also want to encourage you to join me and many others in Washington, DC, October 6-8, 2001, at the ASIPP annual meeting in Washington, DC, October 6-8, 2001 followed by a visit to Capitol Hill on the morning of October 9, 2001 to educate and inform face to face, state by state, our congressional representatives about the crucial issues facing interventional pain medicine, especially recognition as a specialty. Of course, members receive a generous discount at this meeting and early bird registrants get an even bigger discount. Join with us as we shape the future of interventional pain medicine.

Sincerely yours

A handwritten signature in black ink, appearing to read "Gabor Racz".

Gabor Racz, MD
Grover E. Murray Professor
Professor and Chair Emeritus
Director Pain Services
GBR/pb

**EXCERPTS FROM SPEECH OF PRESIDENT OF ASA
NEIL SWISSMAN, MD**

I appreciate having this opportunity to come here and eat with you and I want to make it very clear to you that I come with an olive branch in my hand. I believe that for the years that have passed, we have, with both organizations, become divisive with mixed messages and mixed purposes that have not served my specialty or your subspecialty well, and I would hope that by the end of the day we can look to each other as colleagues and friends and then we will be able to help each other, represent each other, and know that we will not agree on everything, but that those things we do agree on will far outnumber the things that we didn't agree on and that we must recognize that my society and your society are not single purpose societies. Because if we are, we are not representing our members and more importantly we are not representing our patients adequately.

Scope of practice is a major issue. I want to read something to you. I want you to know in New Hampshire there is a hospital called Cottage Hospital which serves New Hampshire and Vermont. They are in Woodson and I am just going to read a couple of lines here. 'Cottage Hospital is the only hospital in New Hampshire and Vermont with an accredited pain management clinic certified through the American Academy of Pain Management. It is staffed by two anesthesiologists.' Those 'anesthesiologists' are CRNAs. If you are worried about what you do, if you are worried about your patients and you are worried about the survival of your subspecialty, you need to be involved in this scope of practice issue. CRNAs are not physicians. They are not trained to do what you do. I am going to read part of a letter to you that I sent out having nothing to do with my being here today but I extend this to you, it should actually, I think it is not going out until Monday and it is going to the presidents of all

state societies. In that letter, I remind them that the Medicare Carrier Advisory Committees allow anesthesia to have a member and an alternative representative on their committee, and I have asked that they try to make sure that either their principle or the alternate representative have an active pain medicine practice. I also encouraged them if they don't have an alternate representative to get one, because they can't be in two places at once. I also want to read you this last little bit that I said, and this is where I am coming from. Pain medicine is a growing field and more importantly to which Medicare carriers are paying close attention when they try and establish rules defining medical necessity. Both our patients and our members will be best served if a pain medicine specialist serves on CAC. I certainly believe that, we need to stand together with one voice.

I have a letter that I would like to read from Doug Merrill. Doug Merrill is a current chairman of the Pain Management Committee. Doug Merrill said I am glad you are going to talk to this society, it is time that we establish communication and it is time that we look for commonality of interests and that is the message I bring you today. I want to pledge to you that we will communicate, we will try to work on common issues. One of the areas that I think we have common interest is facility fees. ASA has not been involved in that and maybe we shouldn't be, I don't know; but, we certainly should be able to talk to you because I think this is probably more of a majority of our members that practice pain medicine in some form or another have connections with facilities. Thank you very much for your hospitality, thank you for lunch, and I thank you for having this meeting in my city so I didn't have to travel anywhere. This is my first weekend home in 7, and it is nice to be here. Thank you.

The speech and the letters following this, sent to interventional pain physicians and officials, have stirred substantial controversy with the American Academy of Pain Management and the American Association of Nurse Anesthetists. The controversy, with copies of the letters, are presented in this newsletter starting on page 4.

CRNA AND AAPM CONTROVERSY. CRNA RULE POSTPONED

“Every truth has two faces, every rule two surfaces, every precept two applications.”

Joseph Joubert

Neil Swissman, MD, President of the American Society of Anesthesiologists spoke at the successful semi-annual meeting in Las Vegas of the American Society of Interventional Pain Physicians co-sponsored by the American Society of Minimally Invasive Medicine and Surgery.

Dr. Swissman received a rousing reception by ASIPP membership. Following the above, concerned with state of the affairs of interventional pain medicine, the president of ASIPP, Laxmaiah Manchikanti, MD, with the consent of the board and membership, mailed a letter to all listed interventional pain physicians in the U.S.A., requesting them to write to various officials on the issue of independent practice of “pain management” by nurse anesthetists. This raised significant protest from American Academy of Pain Management (AAPM) and the American Association of Nurse Anesthetists (AANA). To summarize the events, in April Dr. Manchikanti wrote:

- 1) In our opinion, nurse anesthetists neither have education nor training to practice interventional pain medicine.
- 2) Due to a loophole in the regulation, they can do not only anesthesia but all aspects of pain management without any supervision.
- 3) Nurse anesthetists are receiving certification by the American Academy of Pain Management and opening their clinics which are being accredited by the American Academy of Pain Management.

In spite of the multiple letters we received from Dr. Weiner, executive director of AAPM, and one letter from Mr. Beutler, CRNA, executive director of AANA, the following questions remain. I believe all of you know the answers.

- 1) Does AAPM certify nurse anesthetists in pain management?
- 2) Does AAPM accredit pain management programs managed by nurse anesthetists?

Meanwhile, the CRNA supervision rule was delayed by the Health Care Financing Administration. Health Care Financing Administration (HCFA) announced that it was delaying the implementation date for an additional six months of a final rule allowing states to determine whether Certified Registered Nurse Anesthetists (CRNAs) must be supervised by a physician while providing care to Medicare patients. The rule, which was originally expected to

take effect in March, is staunchly opposed by the American Society of Anesthesiologists and the American Medical Association. ASIPP has provided support on this issue as well.

On May 17, 2001, Honorable Tommy Thompson, Secretary of Health and Human Services, issued the following:

Today, I am announcing that the administration is taking steps to ensure that all Medicare beneficiaries receive the safe, high quality anesthesia services they need. Anesthesia services are a crucial part of modern medicine, and the Medicare program has always been attentive to both the safety and availability of these services for our beneficiaries. Anesthesia services have become much safer in recent years. At the same time, however, states have encountered increasing challenges in providing access to anesthesia services to all their citizens, particularly residents of rural areas or other areas with few anesthesiologists.

The Department will shortly issue a notice asking for a public comment on a rule that would permit a state’s governor, after consultation with the state’s Boards of Medicine and Nursing, and consistent with state law, to certify that it is in the best interests of the state’s citizens to permit Certified Registered Nurse Anesthetists (CRNAs) to administer anesthesia services without direct physician supervision. Although the federal requirement that CRNAs must work under a physician’s supervision would continue to apply generally, the proposed new rule would give states the flexibility to ensure that its citizens receive needed anesthesia services, while also ensuring that such changes can be done safely. We anticipate that this rule will be particularly beneficial to those states with rural or other areas where anesthesiologists are not available. The rule will also propose that the Department undertake a prospective study comparing different state anesthesia practices.

To give the Department an opportunity to consider these refinements to our regulations and gather additional comment, I am today delaying for 180 days the effective date of the January 18 regulation on anesthesia services under Medicare. My goal is to give states flexibility to improve access to anesthesia services, while at the same time ensuring that safety issues have been fully addressed. I look forward to receiving comments and developing a final rule that will serve all Medicare beneficiaries in all regions of the country in the safest and best way possible.

HCFA published a notice in today's Federal Register announcing a six-month delay of the final rule changing the physician supervision requirement for certified registered nurse anesthetists. The agency said it would be issuing a proposal that would allow a governor to permit nurse anesthetists to provide services for Medicare patients without supervision.

It also said it would undertake a study to assess the impact of different state nurse anesthetist practices. HCFA said it needed more time to obtain comment on the modifications to the rule. HCFA will issue a proposed rule soliciting additional comment.

At this point, ASIPP believes the following:

- 1 Pain Management is not within the professions defined scope of practice of CRNAs.
- 1 Nurse anesthetists are not qualified by education and clinical experience to provide pain management and are not granted such practice privileges in the same manner that physicians are credentialed through the clinical privileging process.
- 1 Pain management services should not be provided by CRNAs upon request or referral from a physician.
- 1 If CRNAs receive certification from AAPM or another organization, we are concerned that they will call themselves "pain specialists." We are not quite sure what else they would call themselves. Would they call themselves pain anesthetists?
- 1 ASIPP recognizes the multi-disciplinary nature of interventional pain medicine. However it appears that multi-disciplinary approach means different things to different organizations based on self interests.

The following letters illustrate the present situation. Only relevant excerpts are included, however, no material relevant to the issues has been removed:

- 1) The first letter is from ASIPP to all interventional pain specialists.
- 2) The second letter is a sample letter to Secretary of HHS recommended from ASIPP which required customization based on each physician's experience, and desire. Thus, the contents of this letter are only a sample.
- 3) The third letter is from Richard Weiner, PhD, expressing his opinions.
- 4) The fourth letter is also from Dr. Weiner, once again expressing his opinions and discomfort.
- 5) The fifth letter is from Dr. Weiner expressing cooperation.

- 6) The sixth letter is from Dr. Weiner (AAPM) to Dr. Kloth (ASIPP).
- 7) The seventh letter is from Dr. Weiner in the form of an announcement which he described as correction and classification. We are reprinting only the relevant portions of the letter.
- 8) Finally, the eighth letter is from Jeffery M. Beutler, CRNA, MS, Executive Director of AANA.

#1 LETTER FROM ASIPP TO INTERVENTIONAL PAIN SPECIALISTS

Once again it is time to act whether you are an anesthesiologist practicing pain medicine or non-anesthesiologist practicing pain medicine. You will be affected by the last minute Clinton Administration Rule providing unlimited freedom to nurse anesthetists to practice not only anesthesia but interventional pain medicine.

As you know, nurse anesthetists neither have education nor training to practice interventional pain medicine. However, due to a loophole in the regulation they can do not only anesthesia but all aspects of pain management without any supervision. This can lead to substantial abuses. Nurse anesthetists are already opening clinics. They are getting certified by the American Academy of Pain Management and opening their clinics which are being accredited by the American Academy of Pain Management claiming themselves to be pain specialists. I believe this is the most outrageous activity yet in the history of American medicine. So, please don't delay. It is time to act. Please customize these letters on your letterhead.

Laxmaiah Manchikanti, M.D.

#2 SAMPLE LETTER TO SECRETARY OF HHS, REQUIRED TO CUSTOMIZE

I am writing to express my profound concern over issuance by the Clinton Administration on January 18, 2001, of a final rule eliminating physician supervision of nurse anesthetists from the Medicare/Medicaid Conditions of Participation for hospitals and ambulatory surgical centers. We urge you to take the action necessary to rescind that final rule.

I am a member of the American Society of Interventional Pain Physicians which is an organization representing providers of interventional pain medicine across the country. This is a vibrant organization the majority of whose membership comes from the primary speciality of anesthesiology. In addition to the issues of anesthesiology, it also has come to our attention that nurse anesthetists are in preparation to practice pain management as it is written into the law. Essentially, this provides nurse anesthetists with the opportunity to perform interventional pain medicine, which

should only be performed by physicians with special training and abilities. Nurse anesthetists neither have the education, the training nor the ability to perform these procedures. This will pose a grave risk to the Medicare population. Organizations, such as the American Academy of Pain Management, which do not have a board certification which is authorized by the American Board of Medical Specialties, are willing to certify these nurse anesthetists as pain specialists and provide accreditation, thus providing the appearance of legitimacy to these practices. This is the most outrageous activity yet in the history of American medicine.

One may argue that patients should have a choice to select. However, nurse anesthetists are advertising themselves as physicians and pain specialists. As you well know, there is no way each and every patient will understand the difference between a physician and a nurse anesthetist providing, not only anesthesia, but pain management services. This will also provide another opportunity for fraudulent practices to improve the bottom line of the hospitals and also increase the bottom line of certain physicians who would like to use the nurse anesthetists to provide these services even though they are without qualifications and safeguards. The issue is further complicated by hospitals embracing newfound powers to provide exclusive contracts to nurse anesthetists.

I support the position of the American Society of Anesthesiologists and Anesthesia Patient Safety Foundation that revision of the pre-existing physician supervision requirement should be considered only after development and review of current scientific outcomes data.

#3 FROM AAPM ADDRESSED TO DR. MANCHIKANTI 4/23/2001

I have appreciated receiving your Journal and watching enthusiastically the growth and important work that the American Society of Interventional Physicians provides. Your letters to the ASIPP membership requesting that they send letters to: Secretary Tommy Thompson, their U.S. Senators, and to their U.S. House of Representatives is misleading and incorrect as to the position of the American Academy of Pain Management. I am saddened that you did not call me or check your facts before causing this material to be published and distributed. A correction is warranted.

Pain management often requires a multidisciplinary approach. Interventional care can be effective. However, interventional care is not the only aspect of treatment that a comprehensive approach to pain management requires. While I salute the advocacy work that you are attempting, I note, however, that within the last couple of issues of the

Pain Physician News, that editorials have castigated various pain management organizations because they chose to work to advance the field with a different approach than the method you have taken. Do you really think that there is only one path for advancement? We must learn from each other and remember that our goal is to help people in pain reduce their pain and suffering. No one discipline and no one approach has all the answers.

The American Academy of Pain Management takes no position regarding the scope of license for any clinician. Scope of license is a State specific issue. Those clinicians who hold a valid license, that entitles them to practice their discipline, and who meet our credentialing criteria are invited to seek credentialing in pain management with our Academy. Those pain management programs that meet our published standards for accreditation, satisfy an onsite inspection, abide by our Code of Ethics and Patients Bill of Rights, may apply for accreditation. Accreditation is not based upon one's discipline, but rather meeting these standards and the lawful ability to provide such services within each clinician's State.

I wish you and the American Society of Interventional Pain Physicians continued progress on behalf of pain clinicians and the public. I hope you will keep all of the issues clear and separate. Together, we advance the field of pain management. Seeking individual gains for one group at the expense of all of the others, only keeps our discipline from advancing.

Richard S. Weiner, PhD
Executive Director

#4 FROM AAPM ADDRESSED TO DR. MANCHIKANTI 5/16/2001

I previously wrote to you expressing my disappointment over your letter to Interventional Pain Specialists which misstated the position of the American Academy of Pain Management. You will recall that I pointed out to you factual errors that you made which were misleading about requirements for credentialing and accreditation, and asked that you correct your mistake. My disappointment arose from the fact that you made misleading statements without calling to verify your assumptions. You never responded to my letter or request.

Now, I write to you once again, expressing chagrin over your behavior and action. It has come to my attention that you have used the mailing list owned by the American Academy of Pain Management without permission, authorization and payments for the rental fee for such use. Un-

authorized use of private property is wrong and may be subject to penalty. I have a hard time reconciling your conflicting behavior. On the one hand, the work that your group does in advancing Pain Management is to be congratulated. On the other hand, when you make misleading statements in writing about another organization and claim that the activity which you describe is” . . . The most outrageous activity yet in the history of American Medicine;” without ever verifying your facts and now with unauthorized use of a private mailing list, I wonder if your zeal has caused you to cross both a moral and legal line. Your behavior can only be mitigated by a correction. You are not to use our mailing list again without proper authorization. I hope that you have not put the American Academy of Pain Management’s mailing list into your data bank based upon a previous one time use authorized by rental of our mailing list.

In the future, I hope that you will verify your assumptions before you make misleading statements. Such action hurts your reputation and does not advance your cause. This is especially true when private property is not respected. I remain convinced that more can be accomplished to advance the field of Pain Management when groups work together. I hope that you will recognize that fact. In my opinion, you are sincere and zealous, but misrepresentation and misappropriation undermine my high opinion of your work.

Richard S. Weiner, PhD
Executive Director

#5 FROM AAPM ADDRESSED TO DR. MANCHIKANTI 5/18/2001

I write to you at the suggestion of Vijay Singh, MD. Dr. Singh called me to clarify issues described in my letter to you on April 23, 2001. Dr. Singh advised me that he serves on the ASIPP Board and that you had sent him a copy of that letter. Dr. Singh and I had a marvelous conversation. We both agreed that the more groups advocating on behalf of pain management, the better. We discussed the fact that AAPM does not approve of misleading advertising. I advised Dr. Singh that we spent several (many) hours investigating the New Hampshire Nurse Anesthetist advertisement and closed our investigation when the newspaper ran a statement that the mistakes it had printed were the reporters and not the nurse anesthetists. Again, the American Academy of Pain Management does not take a position on scope of license as that is strictly a states rights issue.

Dr. Singh and I discussed our view that ASIPP is doing important work in helping to advance the field of pain management. However, there are often different paths to reach a goal. My caution to you is to look into facts before writing negative letters. Having said this in my last correspondence let me assure you that we desire to work collaboratively and to work on projects of mutual interest.

Richard Weiner, PhD
Executive Director

#6 AAPM LETTER TO DR. KLOTH

President Denny has asked that I respond to your inquiry of April 20, 2001. False advertising is harmful and the American Academy of Pain Management does not support such advertisement or claims. Scope of license is a state-by-state legislative issue. The AAPM takes no official position with respect to state rights on these matters. The American Academy of Pain Management encourages full disclosure in all matters, especially those relating to the public.

With respect to the confusion in a New Hampshire paper over Nurse Anesthetists, the Academy spent several hours on investigation. When the newspaper admitted that they (newspaper) had made misstatements and not the Nurse Anesthetists, our inquiry was closed.

In this era of great advances in Clinical Pain Management combined with regulatory access dilemmas, all advocates of quality pain management are friends of the public. Congratulations on the Presidency of the Connecticut Pain Society. Many roads can lead to a destination. I echo and support your closing remarks that we must find ways to all work together.

We are more than happy to work with you an with interventionalists. Look at the different membership services that you and you colleagues may use. Let me know if we can of any creative service.

Richard Weiner, PhD
Executive Director

#7 ANNOUNCEMENT SUGGESTED BY DR. WEINER

The facts are:

- 1 American Academy of Pain Management views false advertisement as harmful and the American Academy of Pain Management does not support false and misleading advertisement.
- 1 American Academy of Pain Management takes no official position with respect to scope-of-license. American Academy of Pain Management views scope-of-license as a States Rights' issue and recognizes scope-of-license as a State-by-State legislative matter.
- 1 American Academy of Pain Management encourages full disclosure in all matters, especially those relating to the public.

The American Academy of Pain Management is the largest multi-disciplinary pain management organization in North America. Its mission is to promote quality pain management, reduce pain and suffering, and encourage proper multi-disciplinary pain care. Clinicians from different disciplines, including interventional pain care, belong to the American Academy of Pain Management. The goal of the American Academy of Pain Management is to provide quality care within the limitation of the scope of each clinician's license. The American Academy of Pain Management does not have a political agenda to increase the scope of any practice. The purpose of American Academy of Pain Management credentialing is to provide quality care within the scope of a clinician's existing license.

The American Academy of Pain Management standards for individual credentialing and pain program accreditation can be read at www.aapainmanage.org.

American Academy of Pain Management is supportive of many of ASIPP's goals. ASIPP recognizes the quality and leadership that American Academy of Pain Management provides, and both organizations are committed to a fraternal relationship to advance quality health care. The public benefits when the various pain management groups work together on matters of mutual interest.

Richard Weiner, PhD
Executive Director

#8 LETTER FROM AANA TO DR. MANCHIKANTI

A physician colleague has brought to our attention your letter to the members of the American Society of Interventional Pain Physicians (ASIPP) urging them to write to Secretary Tommy Thompson and their members of Congress to oppose the Health Care Financing Administration's (HCFA) January 18, 2001 final rule removing the physician supervision requirement for Certified Registered Nurse Anesthetists (CRNAs).

You stated in your sample letter addressed to Secretary Thompson that nurse anesthetists are advertising themselves as "physicians and pain specialists." If this is so, I would like to see such evidence.

Pain management has long been within the profession's defined scope of practice of CRNAs. Nurse anesthetists are qualified by education and clinical experience to provide pain management and are granted such practice privileges in the same manner that physicians are credentialed through the clinical privileging process. Both the administration of anesthesia and pain management services provided by CRNAs is provided upon request or referral from a physician. This has always been the practice and the final rule will not change that practice.

Unless you are able to produce concrete evidence that nurse anesthetists are advertising themselves as "physicians and pain specialists" as your sample letter to Secretary Thompson states, I would advise that you cease defaming our profession for its legitimate practice of a modality long recognized as an integral part of the practice of anesthesia. It has been recognized that the provision of optimal pain services and pain therapy should not reside within any single discipline and that a multidisciplinary approach to the practice of pain management is in the best interest of patient care. To disregard these facts and to grossly misrepresent the practice of qualified pain management professionals and the American Academy of Pain Management which has made significant contributions to this field of practice is inexcusable.

Jeffery M. Beutler, CRNA, MS
Executive Director

SPECIALTY DESIGNATION FOR INTERVENTIONAL PAIN MEDICINE

ASIPP and Arent Fox have been busy working with the Health Care Financing Administration (HCFA) to establish a specialty designation under the Medicare program for interventional pain physicians. The lack of a Medicare “specialty designation” for interventional pain management has presented a series of problems for effective and efficient access to interventional pain techniques. For example, the lack of a specialty designation has led to inadequate data collection on the use and related costs of interventional pain management procedures. Consequently, the Medicare program is paying for interventional pain physician services at a rate that, in many cases, does cover the cost of providing those services. Further, the lack of specialty designation means that the practice expense for pain management services is not based solely on the practice expense of interventional pain management practitioners, but on the basis of the (lower) rates for the specialties from which interventional pain physicians are originally trained. Without change, the tremendous costs that interventional pain management physicians must bear in order to safeguard their patients from the potentially life-threatening complications associated with pain management procedures, cannot be sustained.

The specialty recognition will also enhance our ability to present our views on evaluation and management services

and also will provide an avenue to provide examples or vignettes for evaluation and management services.

The carrier actions add to an already acute access problem. Last year, the House Commerce Committee marked-up a provision that would have created a specialty designation for interventional pain physicians. Although that provision was not included in the Medicare Benefits Improvement and Protection Act, the House Commerce Committee recently confirmed that HCFA (to its credit) will be providing a specialty designation for interventional pain physicians; however, a time line for implementation was not established. Therefore, ASIPP is requesting the Congressional offices contact HCFA by letter encouraging a timely implementation no later than the end of July 2001. At the time of the publication, Congressman Ed Whitfield (R-KY) by personal contact with HCFA, Congressman Sherrod Brown (D-OH), Congresswoman Anne Northup (R-KY) and Congressman Bart Stupak (D-MI) had notified HCFA by letter expressing their support for speedy action on this matter. ASIPP greatly appreciates their continued support and encourages Kentucky, Ohio and Michigan members to contact their offices to pass our organization’s gratitude.

ASIPP PRESENTS CONGRESSIONAL AWARDS

“Appreciation is thanking, recognition is seeing, and encouragement is bringing hope for the future.”

The difference between a politician and a statesman is : A politician thinks of the next election, and a statesman thinks of the next generation.

James F. Clarke

ASIPP has been the fortunate benefactor of bi-partisan congressional support on a number of issues affecting interventional pain medicine. To honor this support, early this year we sent a very attractive walnut plaque to our congressional supporters, with the following inscription:

In recognition of your outstanding support for the rights of chronic pain sufferers and the interventional pain medicine community.

These were hand delivered to each of the following recipients:

Honorable Mitch McConnell (R-KY)
 Honorable John Rockefeller (D-WV)
 Honorable Ron Wyden (D-OR)

Honorable Ron Lewis (R-KY)
 Honorable Anne Northup (R-KY)
 Honorable William Thomas (R-CA)

Honorable Sherrod Brown (D-OH)
 Honorable Ken Lucas (D-KY)
 Honorable Frank Pallone (NJ)
 Honorable Pete Stark (D-CA)
 Honorable Bart Stupak (D-MI)

The award was personally presented by Dr. Manchikanti to Senator Mitch McConnell. An award was also presented to Honorable Ed Whitfield (R-KY) at our second annual meeting in Washington, DC.

MEDPAC CONDUCTS HEARINGS ON ACCESS TO INTERVENTIONAL PAIN MEDICINE

ASIPP presented to MEDPAC various issues involving interventional pain medicine. The meeting was attended by Laxmaiah Manchikanti, MD, President and Executive Director, Kenneth Varley, MD, Vice President, Bentley A. Ogoke, MD, Board Member, Joseph Waling, MD, Executive Director of Indiana Society of Interventional Pain Physicians, William Sarraille, JD, Chief Counsel, and Anna Spencer, JD, Associate Counsel. ASIPP representatives introduced interventional pain medicine and ASIPP to the MEDPAC representatives. ASIPP also provided background on the BIPA study (for further information, please see legislative update in January issue of Pain Physician or the Pain Physician News of March 2001). ASIPP also articulated various issues faced by today's interventional

pain medicine practitioners as decision makers do not understand what interventional pain specialists do, nor why it is important, and the massive phenomenon of chronic pain and the vital need for interventional pain medicine. We also discussed the specialty designation issue, local Medicare Review Policy problems, issues of carriers adopting payment policies that actually discourage taking appropriate safety precautions, hospital outpatient rule, threatening hospital outpatient access, inexcusable delays in getting payment approval for new procedures, inadequate and inconsistent payment audits, and various other inconsistencies. We also provided them with a list of recommendations. The full text of the white paper presented to MEDPAC can be found on our website at www.asipp.org.

ASIPP TESTIFIES BEFORE APC PANEL

The panel consisting of 16 healthcare providers and HCFA officials met in February in Washington to advise the agency on various aspects of APCs including how to refine and improve ambulatory payment classification (APC).

APCs are the system HCFA uses to group similar procedures that are clinically related for payment. The panel reimbursement procedures and suggested changes, all the providers and makers of equipment, etc, had an opportunity to present their cases. Unfortunately, none of the companies producing various types of equipment to provide interventional pain management procedures nor the hospital association nor the individual hospitals presented the concerns related to interventional pain medicine. Other troubling issues were that there was not enough data for review because HCFA reviews only single claim data. However, on the bright side, HCFA expects to have more

current claims data to use when refining APC ratings and groupings for 2002.

ASIPP President and Executive Director, Laxmaiah Manchikanti, MD, attended the hearings on APC and presented defense of interventional pain medicine procedures performed in hospital outpatient departments. Even though hospital services do not affect physicians directly it will affect them indirectly as access to interventional pain procedures will be denied. Dr. Manchikanti classified interventional pain procedures into four separate categories and presented them as such with very good reception from the APC Commission. However, the hospital cost data which was available was quite inappropriate and low, thus, the achievement in increasing payment for hospital outpatient departments has been only in the range of 20% rather than what we have expected.

THIRD ANNUAL MEETING

Finally, we are looking forward to a wonderful, exciting and dynamic annual meeting in Washington. Application forms and schedule are enclosed inside this newsletter. In addition, we are taking bold steps by inviting all Medicare Directors to attend the meeting. We are also planning on inviting Medical Directors of 850 major insurers. We are expecting several honorable and powerful guests including Health and Human Resources Secretary Tommy Thompson, Honorable Senator Mitch McConnell and Honorable Ed Whitfield.

Similar to the second annual meeting last year, we will be visiting multiple congressional offices for Capitol Hill day on Tuesday, October 9th. Please be prepared to meet your senators and representative. We hope to meet at least 100 Senators and 100 representatives which will increase the presence of interventional pain medicine on Capitol Hill and hopefully at the White House as well. See meeting program and registration materials at the end of the newsletter.

HCFA IS GONE. CMS IS IN. SWEEPING MEDICARE REFORM

Bush administration is planning on modernizing and eliminating bureaucracy from HCFA. Above all, plans to strengthen Medicare and save it from extinction. The changes include major changes in top positions, bipartisan commission and even change of name.

On 6/14/2001, at 2:00 p.m., Secretary Tommy Thompson announced the first wave of improvements to reform and strengthen HCFA operations and to improve access to information available to nearly 70 million Medicare and Medicaid beneficiaries and the health care providers who serve them. As part of this effort, Secretary Thompson unveiled the new name for HCFA – the Centers for Medicare & Medicaid Services (CMS). Lou Polise, Spencer Schron and Irene Dustin were winners in the “Name the Agency Contest.” I want to thank each of you who suggested a new name. The three winners get lunch with me, who says there is no free lunch!

We are also putting the finishing touches on some organizational changes, which will be completed by the middle of next month. When the reorganization is approved, it will be posted on HCFANet for you to see. The changes are being made in order to better serve our beneficiaries.

- 1) The Center for Medicare Management (CCM) will focus on management of the traditional fee-for-service Medicare program. This includes development of payment policy and management of the Medicare fee-for-service contractors.
- 2) The Center for Beneficiary Choices (CBC) will focus on the Medicare+Choice program and providing beneficiaries with information on Medicare, Medicare Select, Medicare+Choice and Medigap options. It also includes management of the Medicare+Choice plans, consumer research and demonstrations, and grievance and appeals functions.
- 3) The Center for Medicaid and State Operations (CMSO) will focus on programs administered by States. This includes Medicaid, the State Childrens’ Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act (CLIA).

The leadership team for CBC will include Michael McMullan as the Deputy Director for Beneficiary Education and Mark Miller as the Deputy Director for Health Plans. Michael will also serve as the Acting Director for CBC until the permanent Director is named. CMM will be led by Tom Grissom with Marjorie Kanof, MD, as the Deputy Director for Payment Policy, Elizabeth Cusick as the Deputy Director for Contractor Management, and

Stewart Streimer as the Associate Director for Operations. CMSO will be lead by Dennis Smith with the existing CMSO management team.

The Secretary’s top priorities (and mine) are clearly reflected in this announcement:

- Educate beneficiaries
- Respond to all constituencies faster and better, and
- Reform our contractors to make this easier

HIPAA PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the Secretary of Health and Human Services to create and implement medical privacy guidelines if Congress failed to do so in a self-imposed three year time limit. As a result, the Department of Health and Human Services (HHS) released privacy rules in December 2000 in the final days of the Clinton Administration. Due to a technical glitch, implementation of the new regulation known as the Standards for Privacy of Individually Identifiable Health Information, was delayed until February, at which point the new Secretary, Tommy Thompson, opened the rule for a public comment period. HHS received approximately 7500 comments and has promised to review them and has promised to review them and modify the rule as necessary, in spite of its April 2001 effective date. Health care providers have two years to implement the new regulations.

There are a number of concerns with the new rules including the cost of implementation and the written consent provision that currently requires providers to obtain a patients signature “before using or disclosing protected health information to carry out treatment, payment, or health care operations.” This provision, therefore, effectively will prohibit friends and family from picking up a patient’s prescription without the written consent of the individual for whom the medication is prescribed. Given that it is estimated that forty percent of prescription medications are retrieved by someone other than the patient, consumer groups and health business groups fear this new requirement is simply unworkable. Furthermore, there is general concern that the new privacy regulations are only intended to establish a minimum level of protection, thereby allowing higher state protections to stand. However, despite the existing concerns, providers should begin implementing the new rules and should expect to hear of possible modifications from HHS throughout the two-year period.

For a related article on HIPAA privacy rule, please see the July issue of [Pain Physician](#).

HEALTH CARE NEWS

Professional courtesy discounts. Are they endorsements to get referrals?

In OIG's compliance program for individual and small group physician practices, OIG has stated that professional courtesy discounts are sometimes permissible. However, OIG urged caution in providing the discounts along with providing concrete guidance on this issue. It is presumed that this guidance also applies not only to physician practices but also to ASCs and other healthcare facilities. To avoid antactac violations when giving professional courtesy discounts, please use the following rules and make it clear that discounts are not endorsements to get referrals. The penalties for violating the Federal antactac back law are severe with up to \$25,000 per claim, fine, imprisonment up to 5 years, or both. However, the Federal antactac back law is not the only statute that can apply. A provider can also be at risk for professional courtesy discount programs which are poorly designed, can also violate state antactac back laws and other laws which may restrict waiver of copayments and deductibles. Further, such discounts may also violate the Federal Stark "anti-self – referral law, especially the provider is providing the surfaces covered and/or designated health services".

To avoid disastrous consequences providers should have appropriate policies covering the discounts. Centers professional courtesy discount is intended to comply with all the federal and state laws and regulations and is not intended to induce referrals to the center.

Providers, if at all possible, should describe the following:

- 1 How the provider sets policy on eligibility for a level of discounts
- 1 Describe clearly the recipients of the discounts
- 1 The amount of the discounts
- 1 Appropriate rationale for such discounts
- 1 Document all of your discounts
- 1 Clearly state that you provide discounts, but never offer waivers of copayments
- 1 For further safety to avoid claims from insurers that you are fraudulently billing, you may want to pass the discount on to the insurance company. Thus, you will be billing only for the remaining amount after the discount to the insurance company.

News from Administar

Administar Federal of Kentucky and Indiana published the following:

Medicare has recently been advised that some physicians may not be aware that they are liable for any false or fraudulent claims filed on their behalf by staffing/billing agencies.

Please be advised that when applying for a Medicare Provider Identification Number (PIN) section 18 #9 clearly states that you as a provider of service: will not knowingly present or cause to be presented a false or fraudulent claim for payment by the Medicare or other federal health care programs, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

By signing the certification statement you are attesting that you are aware of the information submitted by your staffing/billing agency.

Clarification by HCFA for site of service payments for interventional pain physicians

On January 5th, 2001 HCFA issued a transmittal to Medicare Carriers clarifying its site of service billing policy. The transmittal specified how the physician payment policy that HCFA developed in 1997 applied to procedures performed in ASCs that are not on the list of Medicare approved procedures in ASCs. HCFA explained that the choice of payment depends on where the physician performed the services except that nonfacility payment will apply to all therapy procedures. Facility payments apply to procedures performed in: hospitals; ASCs – if the procedures are included on the list of ASC – approved procedures; nonfacility payment will apply to procedures performed in ASCs – if the procedures are not on the ASC list. However, confusion continues with the various codes which are not approved for ASCs including 76005 which describes the needle placement and multiple other codes with epidurography, discography, etc, for supervision and interpretation. At a hearing of providers held with HCFA in Paducah, KY, arranged by Congressman Ed Whitfield, HCFA has taken the position that for 76005, if the procedure is performed in ASC, there should be a modifier 26 designating that it is the physician component of the service which is paid at a much lower level.

ASIPP continues to work on this issue and monitor the developments.

ASIPP SUBMITS EVIDENCE ON ADHESIOLYSIS TO MEDICARE CARRIERS

“Don’t stand shivering upon the bank; plunge in at once, and have it over with.”

Sam Glick

“People forget how fast you did a job - but they remember how well you did it.”

Howard W. Newton

“Progress always involves risk; you can’t steal second base and keep your foot on first.”

Fredrick Wilcox

A number of Medicare carriers have issued local medical review policies that deny reimbursement for percutaneous lysis of epidural adhesions on the grounds that the procedure is “not considered medically reasonable or necessary” or that the procedure “has not yet been proven effective” or in other words, investigational. To address this problem, ASIPP, through Dr. Laxmaiah Manchikanti, and its Washington DC representative Bill Sarraile, contacted the Medicare medical directors in the states of Georgia, Washington, Colorado and Iowa by letter to advance the merits of reimbursement for this treatment for patients with chronic back pain. The letters argued that:

- 1 The vast majority of Medicare carriers pay for this procedure, serving as an example of their medical necessity and reasonableness;
- 1 Medicare carriers should not declare a procedure to be investigational when there is medical research that supports its usefulness;
- 1 The carriers failed to comply with the applicable requirements for creating a local medical review policy (LMRP) on the issue;
- 1 The LMRPs do not present the “convincing” evidence necessary to support a prohibition on the payment of these services; and
- 1 Scientific literature supports performing the procedure on one day with multiple injections rather than the three day procedure as previously administered, adding to costeffectiveness.

ASIPP and Arent Fox continue to follow this issue, and are hopeful that it will be resolved in a timely and fair manner for patients in need of these services.

We are pleased to report that Gabor Racz, MD also kindly sent a letter to all Medicare directors. If you would like a

copy of the letter, please contact us at www.asipp.org. A copy of the letter has been sent to each ASIPP member in the affected states. Important references on this subject are listed below. Reprints may be obtained from:

Epimed International

6 Division Street

PO Box 1128, Gloversville, NY 12078

or from

American Society of Interventional Pain Physicians

2831 Lone Oak Road, Paducah KY 42003

THESE REFERENCES INCLUDE:

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- 8) Anderson SR, Racz GB, Heavner J. Evolution of epidural lysis of adhesions. *Pain Physician* 2000; 3:262-270.
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- 11) Manchikanti L, Paganati RR, Pampati V. The value and safety of epidural endoscopic adhesiolysis. *Am J Anesthesiol* 2000; 27:275-279.
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THE 2001 MEDICARE FEES FOR INTERVENTIONAL PAIN MANAGEMENT PROCEDURES

“Government is like a big baby. An alimentary canal with a big appetite at one end and no sense of responsibility at the other.”

Ronald Reagan

“You can’t solve a problem on the same level that created the problem.”

Albert Einstein

“There’s only a slight difference between keeping our chin up and sticking your neck out, but it’s a difference worth knowing.”

Victor Hugo

Following is a list of national allowable rates based on physician fee conversion factor of 38.2581 for most commonly performed interventional pain procedures. The new fees took effect as of January 1, 2001.

Table 1. 2001 Medicare Fee Schedule for Physicians, Ambulatory Surgery Centers, and Hospital Outpatient Payment for interventional pain procedures.

CPT Code	Abbreviated Description of Procedure	Office Setting			ASC		Hospital Outpatient	
		Professional or Physician Fee (\$)	Office or Overhead Fee (\$)	Total (\$)	Professional or Physician Fee (\$)	Facility or ASC (\$)	Professional or Physician Fee (\$)	Facility or Hospital (\$)
20550	Trigger-point injection	43.61	57.65	95.26	95.26	NA	43.61	104.65
20600	Small-joint injection	37.88	33.28	71.16	71.68	NA	37.88	104.65
20605	Intermediate-joint injection	38.64	42.47	81.11	81.11	NA	38.64	104.65
20610	Large-joint injection	51.65	45.91	97.56	97.56	NA	51.65	104.65
27093	Hip arthrography - without anesthesia	76.52	315.63	392.15	392.15	NA	76.52	NA
27095	Hip arthrography -with anesthesia	86.08	264.36	350.44	350.44	NA	86.08	NA
27096	SI-joint injection	77.28	403.24	480.52	480.52	NA	77.28	NA
62263	Percutaneous epidural adhesiolysis	338.58	130.46	469.04	338.58	320	338.58	180.53
62270	Spinal puncture	66.19	86.84	153.03	66.19	320	66.19	148.79
62273	Epidural blood patch	135.05	1.91	136.96	135.05	320	135.05	180.53
62280	Neurolytic subarachnoid	134.69	78.41	213.10	134.69	320	134.69	180.53
62281	Cervical/thoracic epidural-neurolytic	134.29	90.67	224.96	134.29	320	134.29	180.53
62282	Lumbar/sacral epidural-neurolytic	129.69	132.76	262.45	129.69	320	129.69	180.53
62284	Myelography	100.24	99.08	199.32	199.32	NA	100.24	NA
62287	Decompression of nucleus pulposus	541.35	NA	NA	541.35	NA	541.35	692.36
62290	Lumbar diskography	178.28	112.86	291.14	291.14	NA	178.28	NA
62291	Cervical/thoracic diskography	169.48	118.60	288.08	288.08	NA	169.48	NA
62310	Cervical/thoracic epidural	93.73	121.28	215.01	93.73	320	93.73	180.53
62311	Lumbar/caudal epidural	76.52	134.28	210.80	76.52	320	76.52	180.53
62318	Continuous epidural-cervical/thoracic	100.24	122.42	222.66	100.24	320	100.24	180.53
62319	Continuous epidural-lumbar/sacral	90.67	105.21	195.88	90.67	320	90.67	180.53
62350	Implantation of catheter	428.49	NA	NA	428.49	429	428.49	349.65
62355	Removal of catheter	342.41	NA	NA	342.41	NA	342.41	746.92
62361	Implant of non-programmable pump	355.80	NA	NA	355.80	429	355.80	553.99
62365	Removal of reservoir	352.74	NA	NA	352.74	429	352.74	746.92
63650	Implantation of neurostimulator	438.82	NA	NA	438.82	429	438.82	878.84

Table 1 (cont.) 2001 Medicare Fee Schedule for Physicians, Ambulatory Surgery Centers, and Hospital Outpatient Payment for interventional pain procedures.

CPT Code	Abbreviated Description of Procedure	Office Setting			ASC		Hospital Outpatient	
		Professional or Physician Fee (\$)	Office or Overhead Fee (\$)	Total (\$)	Professional or Physician Fee (\$)	Facility or ASC (\$)	Professional or Physician Fee (\$)	Facility or Hospital (\$)
63660	Removal of neurostimulator	434.99	NA	NA	434.99	320	434.99	746.92
63685	Implantation of pulse generator	509.60	NA	NA	509.60	429	509.60	6,171.23
63688	Removal of pulse generator	399.80	NA	NA	399.80	320	399.80	746.92
64400	Trigeminal nerve block	55.09	72.31	127.40	127.40	NA	55.09	164.66
64402	Facial nerve block	70.01	99.09	169.10	169.10	NA	70.01	164.66
64405	Greater occipital nerve block	65.80	66.57	132.37	132.37	NA	65.80	164.66
64415	Brachial plexus block	71.54	89.14	160.68	71.54	320	71.54	164.66
64420	Intercostal nerve block-single	62.36	62.74	125.10	62.36	320	62.36	164.66
64421	Intercostal nerve block-multiple	87.99	70.78	158.77	87.99	320	87.99	164.66
64425	Ilioinguinal nerve block	88.76	57.38	146.14	146.14	NA	88.76	164.66
64445	Injection, anesthetic agent; sciatic nerve	71.93	90.67	162.60	162.60	NA	71.93	164.66
64450	Peripheral nerve block	63.89	41.71	105.60	105.60	NA	63.89	164.66
64470	Facet injection-cervical/thoracic-single	94.50	131.61	226.11	94.50	320	94.50	164.66
64472	Facet injection-cervical/thoracic-additional	66.19	125.48	191.67	66.19	320	66.19	164.66
64475	Facet injection-lumbar/sacral-single	71.93	129.69	201.62	71.93	320	71.93	164.66
64476	Facet injection-lumbar/sacral-additional	49.74	149.20	198.94	49.74	320	49.74	164.66
64479	Transforaminal cervical/thoracic-single	113.24	130.85	244.09	113.24	320	113.24	164.66
64480	Transforaminal cervical/thoracic-additional	78.81	145.38	224.19	78.81	320	78.81	164.66
64483	Transforaminal lumbar/sacral-single	97.94	129.31	227.25	97.94	320	97.94	164.66
64484	Transforaminal lumbar/sacral-additional	68.10	144.62	212.72	68.10	320	68.10	164.66
64505	Sphenopalatine ganglion block	68.48	61.98	130.46	130.46	NA	68.48	164.66
64510	Stellate ganglion block	64.27	68.10	132.37	64.27	320	64.27	164.66
64520	Lumbar or thoracic sympathetic block	70.39	92.59	162.98	70.39	320	70.39	164.66
64530	Celiac plexus block	86.46	82.26	168.72	86.46	320	86.46	164.66
64600	Neurolytic-trigeminal-small branches	219.22	30.22	249.44	219.22	320	219.22	164.66

Table 1 (cont.) 2001 Medicare Fee Schedule for Physicians, Ambulatory Surgery Centers, and Hospital Outpatient Payment for interventional pain procedures.

CPT Code	Abbreviated Description of Procedure	Office Setting			ASC		Hospital Outpatient	
		Professional or Physician Fee (\$)	Office or Overhead Fee (\$)	Total (\$)	Professional or Physician Fee (\$)	Facility or ASC (\$)	Professional or Physician Fee (\$)	Facility or Hospital (\$)
64605	Neurolytic-trigeminal-2/3 division	330.93	40.17	371.10	330.93	320	330.93	164.66
64610	Neurolytic-trigeminal-at foramen ovale	500.42	NA	NA	500.42	320	500.42	164.66
64612	Neurolytic block-muscles of facial nerve	133.52	44.76	178.28	178.28	NA	133.52	164.66
64613	Neurolytic block-cervical spinal muscles	125.87	14.15	140.02	140.02	NA	125.87	164.66
64620	Intercostal neurolysis	145.76	68.87	214.63	145.76	320	145.76	164.66
64622	Facet neurolysis-lumbar/sacral -single	161.07	107.50	268.57	161.07	320	161.07	164.66
64623	Facet neurolysis-lumbar/sacral -additional	55.86	94.88	150.74	55.86	320	55.86	164.66
64626	Facet neurolysis-cervical/thoracic-single	167.57	117.45	285.02	167.57	320	167.57	164.66
64627	Facet neurolysis-cervical/thoracic-additional	59.30	114.39	173.69	59.30	320	59.30	164.66
64630	Pudendal nerve neurolysis	162.21	78.43	240.64	240.64	NA	162.21	164.66
64640	Peripheral neurolysis	148.82	135.44	284.26	284.26	NA	148.82	164.66
64680	Celiac plexus neurolysis	141.17	66.57	207.74	141.17	429	141.17	164.66
72275	Epidurography radiological S & I	39.79	---	126.25	126.25 or 39.79	NA	39.79	239.55
72285	Diskography, cervical or thoracic, radiological S & I	61.60	---	397.50	397.50 or 61.60	NA	61.60	239.55
72295	Diskography L/S spine, radiological S & I	44.38	---	355.42	355.42 or 44.38	NA	44.38	239.55
76005	Fluoroscopic guidance	31.37	---	83.40	83.40 or 31.37	NA	31.37	123.49

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Ronald Reagan

“You can’t solve a problem on the same level that created the problem.”

Albert Einstein

“There’s only a slight difference between keeping your chin up and sticking your neck out, but it’s a difference worth knowing.”

STATE ASSOCIATIONS AND CAC COMMITTEE MEMBERSHIP

“The road to success runs uphill, so don’t expect to break any speed records.”

“A diamond is a chunk of coal that stuck to its job.”

CAC is another acronym which stands for Carrier Advisory Committee which is part of each state’s Medicare program. Carrier Advisor Committees advise Medicare director on the formation of LMRPs (local medical review policies).

Thus, it is extremely important to have state associations, as well as CAC committees.

As of now we have state associations in Connecticut, Kentucky, Indiana, Illinois, Wisconsin, Florida, Washington, Louisiana and Alabama. Other states which are looking at this option are New York, New Jersey, Arizona, Colorado, Nevada, Georgia. It is crucial that we have state associations in all 50 states. If we do obtain specialty recognition, hopefully we will have the ability to represent CAC committees as a member of each state society of interventional pain physicians.

At the present time, various avenues to serve on state committees are through the state society of anesthesiologists, state society of physical medicine and rehabilitation, or the state society of neurology. All these societies have two members serving on the CAC committee as you have seen from Dr. Neil Swissman, ASA’s president, presentation in Las Vegas. He has requested all state anesthesiology associations to appoint at least one interventional pain medicine physician to the CAC committee and if necessary, both representatives be from interventional pain medicine. We do not yet have any such commitment from either the American Academy of Physical Medicine and Rehabilitation or the National Society of Neurology. Thus, you can contact your state societies and see if interventional pain physicians can serve on CAC committees.

As of now, several interventional pain physicians are serving on CAC committees in Connecticut, Kentucky, Indiana and Nevada. Unless an interventional pain physician is serving on the CAC committee, we will not know what regulations will come into effect. It will take approximately one year to reverse any regulation and many more resources to reverse any type of regulation. Therefore, it is extremely important that we vigorously pursue membership on these committees.

UNLESS YOU ARE AN ASIPP MEMBER OR SUBSCRIBER, YOU ARE MISSING THE MOST INFORMATIVE AND PRACTICAL JOURNAL PAIN PHYSICIAN

“United we stand; divided we fall.”

Aesop

“Taking first things first often reduces the most complex human problem to a manageable proportion.”

Dwight D. Eisenhower

For the past two years, many of you had been receiving complimentary copies of the informative and practical Pain Physician. As a result, many physicians on our mailing list concluded that they were members of the American Society of Interventional Pain Physicians when in fact they were not. Some also believed that they didn’t need to be a member of ASIPP to reap all the benefits. Nothing is 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. Non-members and non-subscribers received only the cover and table of contents of the April 2001 issue with an invitation to join or subscribe. Still, many have yet to respond to this invitation. So, once again, we invite you to join ASIPP 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 July 2001 issue including:

- 1 Legislative Update from Washington
- 1 HIPAA Privacy Regulations: Practical Information for Physicians
- 1 Provocative Discography in Low Back Pain Patients With or Without Somatization Disorder:
A randomized prospective evaluation
- 1 Transforaminal Ventral Epidural Neuroplasty
- 1 Spinal Endoscopy and Lysis of Epidural Adhesions in the Management of Chronic Low Back Pain
- 1 The Role of Diagnostic Selective Nerve Root Blocks in Management of Spinal Pain

SEMI-ANNUAL MEETING IN LAS VEGAS

A very successful ASIPP semi-annual meeting was held April 6-8, 2001, at the Circus Circus Hotel in Las Vegas, NV and was attended by over 100 members and several corporate sponsors. There was so much positive feedback about Las Vegas that ASIPP has decided to hold next year's semi-annual meeting in Las Vegas again, but at the Monte Carlo Hotel, March 15-17, 2002. Mark your calendar for this event. Some of the speakers and topics included:

How a Compliance Plan Can Help You in a Government Investigation by Kimberly Dunne, JD

Epidural Adhesiolysis by Gabor Racz, MD

Understanding E/M Services by Laxmaiah Manchikanti, MD

Spinal Endoscopy by Kenneth Varley, MD

Role of Radiofrequency in Managing Facet Joint Mediated Pain by Mary Jo Curran, MD

Saga of Documentation by Laxmaiah Manchikanti, MD

Pathophysiology of Discogenic Pain by Vijay Singh, MD

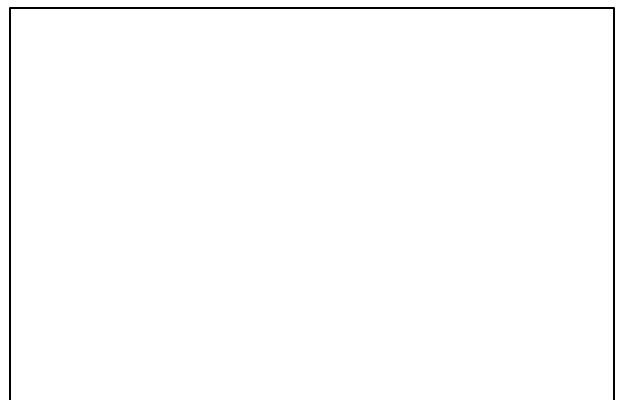
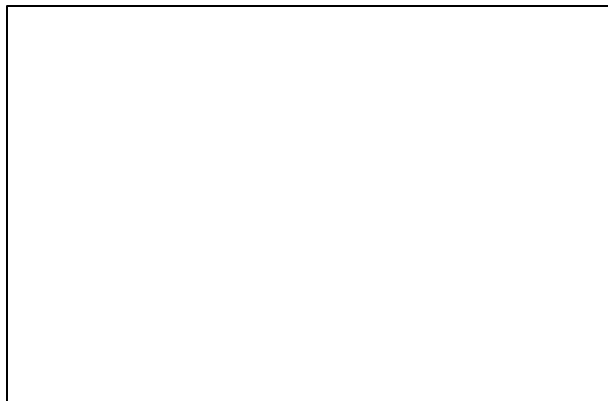
Impact of HIPAA Regulations on Interventional Pain Practices by William Sarraille, JD

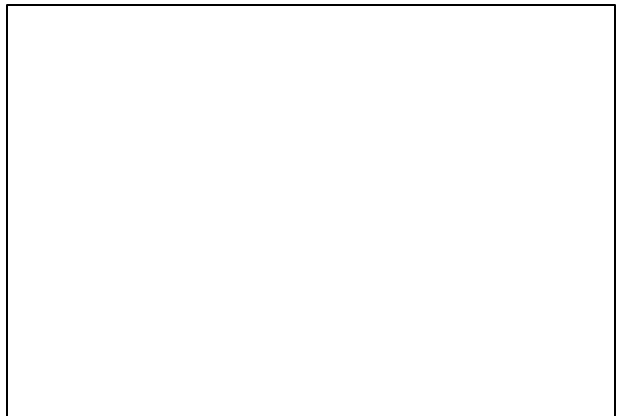
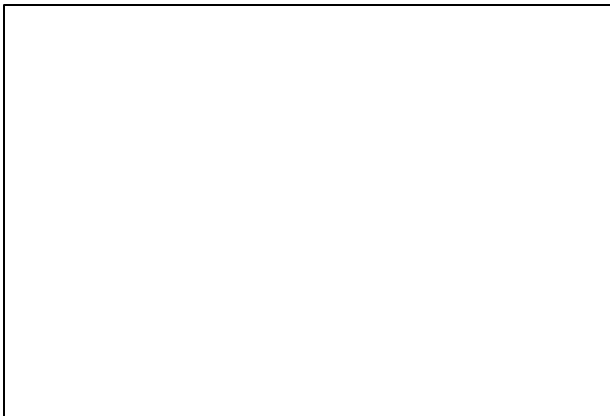
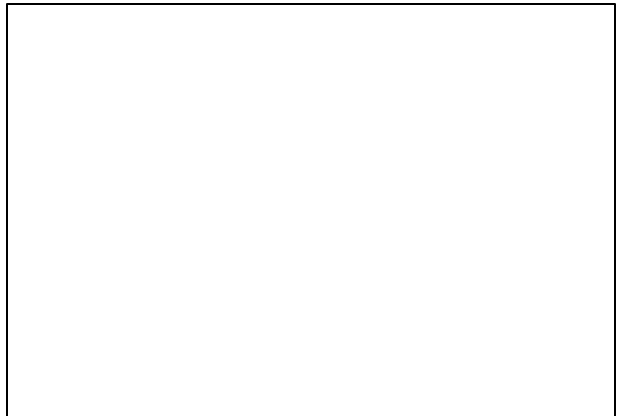
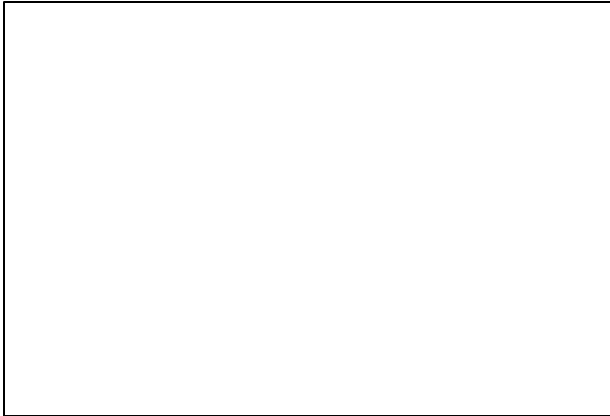
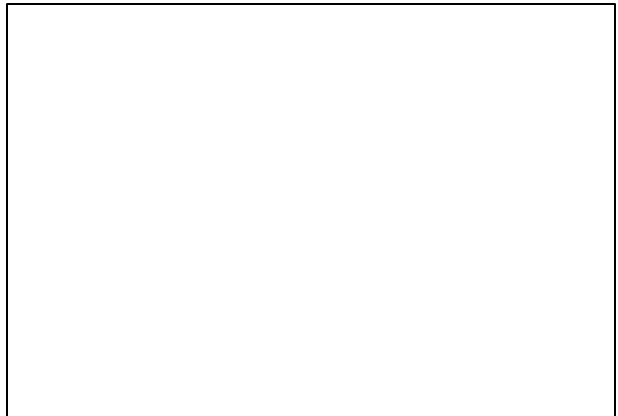
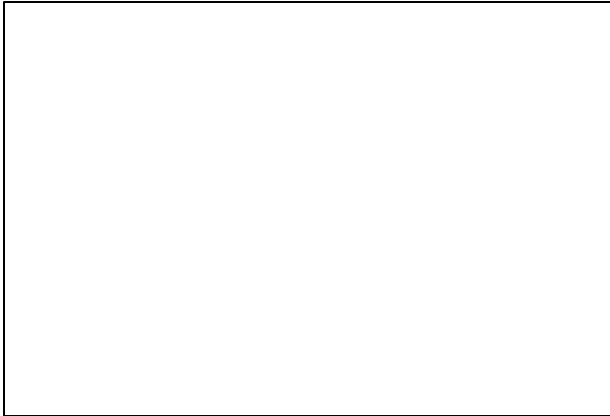
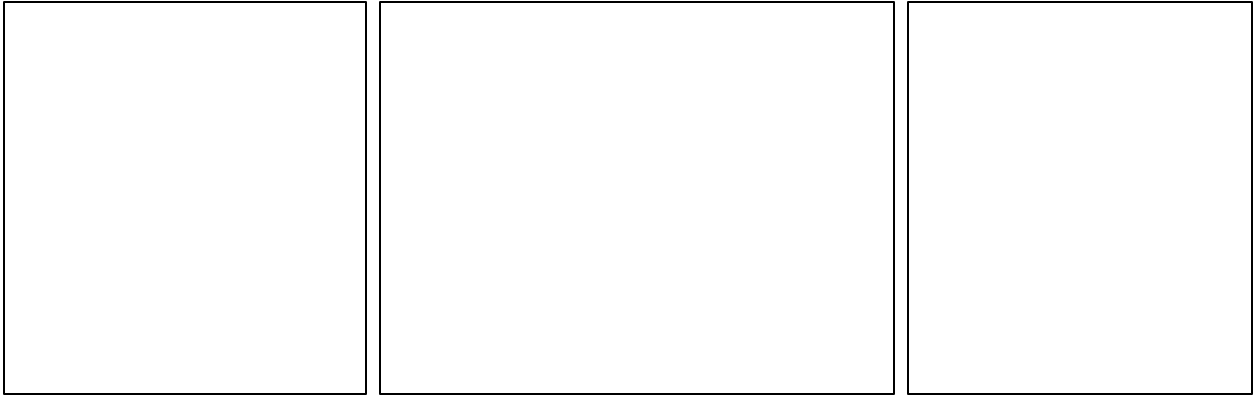
Spinal Cord Stimulation by Gabor Racz, MD

Cryoneurolysis by Andrea Trescot, MD

Radiology in Interventional Pain Medicine, along with dynamic workshops by Joseph Fortin, DO

One of the highlights of the meeting was the luncheon address by Neil Swissman, MD, President of the American Society of Anesthesiologists. An excerpt of his address is at the beginning of this newsletter. This meeting made significant progress toward a collaborative working relationship with ASA. The quality of the general presentations and the workshops was outstanding. The quality of the participants was also very high. Don't miss our next year's semi-annual meeting in Las Vegas, March 15-17, 2002.





LATEST CORRECT CODING INITIATIVE INVOLVES INTERVENTIONAL PAIN MEDICINE

CCI 7.2, which is not available yet to the public but portions are published in some newsletters, apparently involves interventional pain medicine. Approximately 5000 new Correct Coding (CCI) Code-Pair edits will go into effect next month as per Part B News published by UCG of Rockville, Maryland. Among the hardest hit by these changes will be interventional pain physicians even though almost all of the specialties are affected. Version 7.2, which takes effect July 1, adds more than 5000 comprehensive-component edits, and 500 mutually exclusive edits. The following are of interest to interventional pain medicine and are available from the Part 'B' Medicare News, and Physician Practice Coder, both UCG publications. The CCI publication is not available for another two weeks. Hence, this information may not include all codes.

Evaluation and management services:

1 Comprehensive E/M codes 99201 to 99292 and 99301 to 99440 will include the following as component codes:

- 95834 muscle testing
- 95851 and 95852 range of motion measurements

Interventional pain procedures

1 CPT 22520 percutaneous vertebroplasty, a comprehensive code which also includes several component codes as follows:

- 36005 injection for contrast venography
- 72128 and 72129 CT scan with or without contrast
- 72130 CT scan without contrast followed with contrast and further sections
- 75872 venography, epidural
- 76000 to 76005 fluoroscopy

1 CPT 27096 injection procedure for sacroiliac joint, arthrography, a comprehensive code includes several component codes as follows:

- 20600 to 20610 arthrocentesis
- 69990 operating microscope
- 76003 - 76005 fluoroscopy
- 90782 administration of therapeutic substance

1 CPT 62263 percutaneous lysis of epidural adhesions, a comprehensive code, includes the following component codes

- 62281 epidural, cervical / thoracic neurolytic substance
- 62282 epidural, lumbar / sacral neurolytic substance
- 62284 injection procedure for myelography
- 62310 injection, single, epidural or subarachnoid; cervical or thoracic
- 62311 injection, single; epidural, lumbar (caudal)
- 62318 catheter placement, infusion or intermittent bolus; epidural or subarachnoid; cervical or thoracic
- 62319 catheter placement, infusion or intermittent bolus; epidural, lumbar, sacral (caudal)
- 64479 transforaminal epidural; cervical or thoracic, single level
- 64483 transforaminal epidural lumbar, single level
- 64722 decompression; unspecified nerve(s)
- 69990 use of operating microscope
- 76003 fluoroscopic localization for needle biopsy
- 76005 fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction

1 CPT 62281 injection of neurolytic substance with or without other therapeutic substance (epidural, cervical or thoracic); a comprehensive code, includes the following component codes:

- 62270 spinal puncture, lumbar, diagnostic
- 62272 spinal puncture, therapeutic, for drainage of spinal fluid
- 62273 injection, epidural, of blood or clot patch
- 62284 injection procedure for myelography
- 62310 injection, single, epidural or subarachnoid; cervical or thoracic
- 62318 catheter placement, continuous infusion or intermittent bolus; epidural or subarachnoid; cervical or thoracic
- 64479 transforaminal epidural; cervical or thoracic, single level
- 69990 use of operating microscope
- 76000 - 76003 fluoroscopy codes

- 1 CPT 62282 injection of neurolytic substance with or without other therapeutic substance (epidural, lumbar, sacral (caudal)); a comprehensive code, includes the following component codes:
- 62270 spinal puncture, lumbar, diagnostic
 - 62272 spinal puncture, therapeutic, for drainage of spinal fluid
 - 62273 injection, epidural, of blood or clot patch
 - 62311 injection, single; epidural, lumbar sacral (caudal)
 - 62319 catheter placement, continuous infusion or intermittent bolus; epidural, lumbar, sacral (caudal)
 - 64483 transforaminal epidural; lumbar or sacral, single level
 - 69990 use of operating microscope
 - 76000 - 76003 fluoroscopy codes
- 1 CPT 62310 cervical or thoracic epidural injection, a comprehensive code includes the following component codes:
- 20605 intermediate joint, bursa or ganglion injection
 - 20601 major joint or bursa injection
 - 36140 introduction of intracatheter
 - 62284 injection procedure for myelography
 - 76000 - 76003 fluoroscopy
- 1 CPT 62311 lumbar (caudal epidural injection) a comprehensive code includes the following component codes:
- 20605 intermediate joint, bursa or ganglion injection
 - 20601 major joint or bursa injection
 - 36140 introduction of needle or intracatheter; retrograde extremity artery
 - 62284 injection procedure for myelography
 - 76000 - 76003 fluoroscopy
- 1 CPT 62318 continuous infusion with catheter placement (cervical or thoracic) a comprehensive code, includes the following component code:
- 01996 daily management of epidural
 - 20605 injection, intermediate joint
 - 20610 injection, major joint
 - 36000 introduction of intravenous needle
 - 36140 introduction of needle, extremity artery
 - 36410 venipuncture, child over age 3 years or adult
- 1 CPT 62319 injection, catheter placement, lumbar or caudal epidural space, both comprehensive codes include the following component codes:
- 20605 intermediate joint injection
 - 20601 major joint or bursa injection
 - 36140 introduction of needle or intracatheter; retrograde extremity artery
 - 62270 spinal puncture, lumbar, diagnostic
 - 62272 spinal puncture, therapeutic
 - 62284 injection procedure for myelography
 - 62310 epidural or subarachnoid; cervical or thoracic
 - 69990 use of operating microscope
 - 76000 - 76003 fluoroscopy
- 1 CPT 62361 implantation or replacement of device for intrathecal or epidural drug infusion, comprehensive code, includes the following of component codes:
- 62310 epidural, cervical or thoracic
 - 62311 epidural, lumbar (caudal)
 - 62318 catheter placement, infusion or intermittent bolus; epidural or subarachnoid; cervical or thoracic
 - 62319 catheter placement, infusion or intermittent bolus; epidural, lumbar, sacral (caudal)
 - 64479 transforaminal epidural; cervical or thoracic, single level
 - 64483 transforaminal epidural; lumbar or sacral, single level
- 1 Somatic nerve block codes from 64400 to 64484; and sympathetic nerve block codes 64505 - 64520 also have many new component codes which are not available to us until the new CCI Edit book is released and published as per Medicare Part B News and Physician Practice Coder
- 1 64470 cervical/thoracic facet joint nerve block, a comprehensive code includes component codes as follows:
- 20550 trigger point injection
 - 20600 injection of small joint
 - 20605 injection of intermediate joint
 - 20610 injection of major joint
 - 36140 introduction of intracatheter
 - 76000 - 76003 fluoroscopy
- Most of this information is based on the following newsletters:
- Part B News and Physician Practice Coder
11300 Rockville Pike #1100
Rockville, MD 20852-3030
- A complete description of interventional pain management codes is now available on our website: www.asipp.org