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PAIN PHYSICIAN NEWS

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

Hon. Tommy Thompson, HHS Secretary, Hon. Ed Whitfield (R-KY), and Hon. Dr. Ernie Fletcher (R-KY) on October 6, 2001 -at ASIPP Third Annual Meeting provide strong support to Intreventional Pain Medicine

On Interventional Pain Management Designation . . .

“Do not lose heart! - - -You have to keep pushing. You have to keep making your case ...”



Hon. Dr. Ernie Fletcher

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Hon. Ed Whitfield

ASIPP

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Honorable Tommy Thompson, HHS Secretary
October 6, 2001 - ASIPP Third Annual Meeting

On Designation of Interventional Pain Management. “ - - - The reasons we haven’t yet recognized Interventional Pain Management has to do with technical rules under user Health Insurance Accountability Act of 1996.

Do not lose heart! - - -You have to keep pushing. You have to keep making your case ... ”



Thank you very much for inviting me to be here, I believe it is the first time you have had the Secretary of Health to come to your organization and speak and I thank you for that. I have several very close friends in this organization. I have had several of you come into my office and talk to me and had a chance to meet with you to discuss some of your goals and objectives and all I would like to say at this point and time, thank you so very much for your vision and for what you are doing to relieve pain in Americans. I want to thank Dr. Manchikanti who is here and who also has been to my office. I appreciate that and I believe he is the head of the organization. I also have some very good friends from Wisconsin, a very close friend of mine is Dr. Saini. Dr. Patel is also from my home state of Wisconsin.

I am very pleased to see so many of you here. I mean that from the bottom of my heart. Let me thank you for coming, for not being deterred by the terrible events of the recent weeks.

Your pride in our country is evident by your presence here this weekend. As the President has reminded us, we cannot let the terrorists intimidate us from conducting the business of America and we will not. In your case, that means meeting to discuss how you can assist people in pain. I applaud you for meeting to share your knowledge and learn about the latest advances in this field.

Pain is a critical national health problem. It is the most common reason for medical appointments. Pain costs its victims and the healthcare system as a whole more than \$100 billion each year in health care and lost productivity.

Pain has a profound impact on the quality of human life. You know it better than anybody. In addition to often destructive effects on the immune system, pain can cause disruptions in sleep, eating, mobility and a person’s overall ability to function.

Now, let me highlight some good news that I know you’ve been anticipating for a long time. On September 21, the Centers for Medicare and Medicaid Services announced a specialty designation for pain management. It’s called “Specialty Code 72,” and becomes effective on January 1, 2002.

The code can be used in studies to determine procedure costs and practice expenses for pain management. It’s adoption signals Medicare’s recognition of the importance of “pain management” as an emerging medical sub-specialty. As time goes on, this will be useful in distinguishing between your specialty and other specialties in fields such as anesthesiology, neurology or physical medicine.

I know how important that is to you and I actively supported this initiative after your Board of Directors came in to see me. But I also know this is not everything you wanted. “Pain Management” is not the same as “Interventional Pain Management.” The reason we haven’t yet recognized Interventional Pain Management has to do with technical rules under the Health Insurance Portability and Accountability Act of 1996, or “HIPAA.”

Under HIPAA, the only specialties that Medicare can recognize are those recognized by the National Uniform Claim Committee, also called the NUCC.

But, I wanted to tell you today and that’s why I wanted to come out here. Do not lose heart. The NUCC uses an industry-led, consensus driven process to establish what specialties can be on its list.

In other words, you have to keep pushing. You have to keep making your case. If I could, I would simply instruct the NUCC to act, but the rules prevent me from doing that. But I have taken action I believe will help your organization and your profession significantly.



I have instructed the people at CMS to work with your organization to help move your applications through the NUCC for inclusion in its list.

It's important that Medicare recognize emerging medical technologies and practices that yield measurable improvements in patient care – in other words, specialties just like yours.

We are committed to regulatory relief that will enable physicians, nurses and other caregivers to spend more time with patients. I have instructed CMS to hold listening sessions in the field to better understand what both physicians and their patients are thinking. In fact, CMS officials have already held some sessions and many more are being planned for coming months.

We are going to be working to make the practice of medicine less bureaucratic and more effective for you. We will work and provide you with the knowledge you need to serve your patients more effectively. As we work to provide you with that knowledge, we are always mindful that we are working not just for today but for tomorrow, as well. One of my great heroes is Abraham Lincoln, who once said, "The struggle of today is not altogether for today — it is for a vast future also." In your work to heal and bring release from pain, you are serving patients today and you are building a vast, stronger and healthier future for everyone. Thank you for all you are doing for your patients and for America and for yourselves and your families. God bless you and God bless America.

For full text of Secretary's Speech please visit www.asipp.org

Congressman Ed Whitfield

October 6, 2001 - ASIPP Third Annual Meeting



I want to thank you all for giving me the opportunity to be with you. I guess this is the third annual meeting that you have had, and I spoke at all of them.

As the Secretary said, HCFA is just a bureaucratic mess even though they changed the name, it is still a mess. We can't solve all the problems unless we have help and input from the people out there on the front lines that are delivering the health care. We sit around all the time, we complain about CMS, HCFA: whatever you want to call it - and, yet, when we try to think up a solution or an alternative, we have lots of problems. So, I also would just like to encourage you to come to the Hill, talk to us, make phone calls, because we need that input and when some people say; oh well they don't have time to listen; or 'they're too busy on this or that', well you are also very busy and we want to hear from you, because we can't solve these problems in health care without input of people like you.

I know you all are frustrated very much with the government and the way it interferes with your practice and how it is not responsive to your needs and those of us in government are also frustrated many times. As was discussed earlier last year when you all came and we talked about a specialty designation for interventional pain management.

I'm the guy who got off in Savannah because we didn't get what we wanted on this interventional pain management at this time. But, we are going to continue our efforts on that and know that the designation is pain management and not interventional pain management.

We want to find out because we heard some people say that there was no existing medicare designation, there could not be a designation if it was not in the American Board of Medical Specialty and so there is no American Board of

Medical Specialty for interventional pain management. But, yet we do know that there are some specialty designations for surgical oncology, addiction medicine and other things. Then other people we hear say, 'well there are not enough interventional pain management professionals to make a specialty designation,' even though I guess there are over 5000 or so and we know that there are some specialty designations with only 1200 professionals.

All of this just sort of come to a head recently and we need to spend the next three to four months really looking into this and finding out really what the answer. Even though we feel like the guy that got thrown off the train in Savannah we have got to keep working on this and not give up and keep making our point for this, and that is what I intend to do with others on this issue. I know that your organization was trying to get additional services for the ambulatory surgery center approved list and we were able to add 9 last year but those were all old procedures and there have not been any new procedures added to the ambulatory surgery center approved list in years despite a statutory requirement that this should be undertaken. So that is a problem!

So let me just close by simply reiterating once again that we don't always get what we want, but if we are committed and we are going to continue our activities and continue our efforts to get an interventional pain management designation then I think we can accomplish that and we have accomplished quite a bit so far. We are not where we want to be, but we are on the road and so I hope that we can stay in touch and on all of these issues, not only interventional pain management as a specialty designation, but other issues in Medicare and Medicaid and in health care in general.

For full text of Whitfield's Speech please visit www.asipp.org

Congressman Ernie Fletecher, M.D. October 6, 2001 - ASIPP Third Annual Meeting

Thank you all very much. It is great to be here. Let me talk now about the Patient's Bill of Rights just in a sense of what it does.

Most states have some type of Patient's Bill of Rights, some of them substantial, others less than substantial. First we feel it is very important as we move to managed care and it was Federal Regulation that allowed us to move it to managed care, open the door to managed care and thought it was going to be an answer to the rising costs of healthcare that were increasing at double digit rate. We had a lot of things ushered in with managed care and a lot of folks call it mangled care and a few other things because it didn't provide the kind of care that most of us wanted to see patients get. And not only that, it came between the physician and the patient and had a tremendous impact on patient/physician relationship. There was another individual, another entity that become an arbitrator of that negotiation that takes place or that recommendation that takes place. There are some folks that think we don't need a Patient's Bill of Rights but most people feel like we do and we want to get one done. There was one passed out of the Senate, very similar to the one passed out of the House, the only differences were liability. Let me talk just briefly on that. When you look at access to the specialists both the House and the Senate version have good access to specialists. We provide a point of service option that every business, actually every insurance, a product has to offer which means that they have to offer a plan that says if you want to get a plan with POS so that you could go to a provider that is not in the network, that you could. We also tried to look and make sure the network of physicians is adequate and if it is not, they would have to give you, even if you didn't have the POS plan, access to the proper specialists that were needed. I think that would have a direct effect on you profession and your area of specialty and subspecialty. Additionally, as we look at emergency room care, it's much covered that on a lay person's definition you can get to the emergency room and be assured that the insurance company will pay for it and make sure women get direct access to OB/GYN, children can get direct access to the pediatrician and designate either of those as a primary care physician, basically an HMO plan. We also made sure that there are no gag clauses. I don't think there are many of those directly that have been included in contracts and most of them have been taken out but there is several ways of doing gag clauses. This prevents any



such gag clauses so that you can fully disclose treatment options to your patients, regardless of whether it is covered by a particular insurance company that covers that patient or not. We also provide some redress.

As the president has said, and Tommy Thompson said very clear, that we are very interested in moving forward in healthcare. There has been some informal discussions with Kennedy and the White House so far. Daschle, the majority leader in the Senate, seems to have indicated that he wants to see something done. Will it get done? It is going to be very difficult. It is actually in the Senate's court and they'll have to decide whether they want to come back and really move the Patient's Bill of Rights now or want to call a Conference Committee and began to work on this. I think we have an excellent opportunity. There is an unprecedented bipartisanship not only within both Houses but between them and I think it gives us a great opportunity to get some of these things done.

One of the things I want to make sure is done in the bill is there is something called Association Health Plans which would even allow for example, this organization to self insure, provide you all and all of your different practices to buy into a self insured national plan, probably reduce rates anywhere from 50 to 35% and it gives you that opportunity to pull nationally, which you do not have at this time and that is in the bill that we passed out of the House. It was an amendment that I worked very hard on. So those are some of the things that we are looking at. The president is very interested in healthcare moving on, Tommy Thompson, again is.

For full text of Fletecher's Speech please visit www.asipp.org

Saga of Specialty Designation

ASA's Role in Elimination of "INTERVENTIONAL"

"... Pain management is not the same as interventional pain management. The reason why we haven't yet recognized interventional pain management has to do with technical rules under Health Insurance Portability and Accountability Act of 1996 or HIPAA. . . but, I wanted to tell you today that that is why I wanted to come out here. Do not lose heart. . . In other words, you have to keep pushing. You have to keep making your case.

... Specialty code -72 can be used in studies to determine procedure costs and practice expenses for pain management. Its adoption signals Medicare's recognition of the importance of "pain management" as an emerging medical subspecialty. . . ."

Tommy Thompson, Secretary of Health and Human Services, October 6, 2001

"... We didn't get what we wanted on interventional pain management at this time but, we are going to continue our efforts on that"

Congressman Ed Whitfield, October 6, 2001

"... We prefer a broader 'pain medicine' subspecialty not the narrower interventional pain management. The organization I represent (Pain Care Coalition – PCC) doesn't think it is the appropriate fix. Instead, the PCC is lobbying for a Medicare pain medicine category that would include physiatrists, chiropractors, and other non-anesthesiology practitioners. If interventional pain medicine physicians receive a special recognition from HCFA, it would only help anesthesiologists. Payers would pay for procedures done by anesthesiologists but not by a neurologist, even though that doctor would be as specialized. This bill will not have any influence on physician reimbursement because pain specialists do not bill based on the time and units as anesthesiologists do. PCC is not aggressively lobbying for Medicare's recognition for pain medicine as opposed to interventional pain management. PCC will not try to affect the pending Medicare bill but will renew its lobbying efforts next year through members of Congress and HCFA. . . ."

Robert Saner, Lobbyist for Pain Care Coalition, October 2000

"... We are very concerned, though, by reports that the agency is being urged to revoke or amend the Program Memorandum and to narrow the designation to 'interventional pain management', as advocated by some pain physicians who limit their practice or concentrate on that modality. Such a step would leave in limbo a large number of pain practitioners who do not focus primarily on interventional techniques – including among others, anesthesiologists, neurologists, surgeons, physiatrists, and psychiatrists. . . . The reasons suggested in support of the narrow designation (increased practice expense relative values; correction of under-representation on the Carrier Advisor Committees) do not make sense to us analytically. . . . In view of the potential adverse impact of a single – modality pain management designation – the full extent of which is not currently understood"

Neil Swissman, MD, President of ASA, October 1, 2001

The saga of specialty designation started with non-cooperation and ended with non-cooperation; at least for now. The idea of specialty designation was born approximately a year after the American Society of Interventional Pain Physicians, then known as the Association of Pain Management Anesthesiologists, was established. At the time, we reached out to a number of pain management organizations to see if we could work together, to secure specialty designation for "pain management". We hoped to gain the support of the American Academy of Pain Medicine, American Pain Society, and others. During this same time, we were trying to improve relations with the American Society of Anesthesiologists, but some per-

sons associated with ASA were pressing for dissolution of ASIPP. Following this, we contacted the Pain Care Coalition (PCC), which is a group of societies, namely the American Academy of Pain Medicine, the American Pain Society, and the American Headache Society. We asked for their support. They indicated to us through a representative that they did not "want to do a ... joint approach to HCFA on this".

At that time, for a few weeks, the idea of specialty designation for pain management was dead but not bereaved. Following consultations with Honorable Ed Whitfield (R-KY), the idea of asking for "interventional pain management" was born. Immediately, the board of ASIPP and our

advisors started to shape legislation to be introduced for interventional pain management designation, as we had received no encouragement about obtaining it administratively from then Healthcare Financing Administration (now CMS).

Following the 2nd ASIPP annual meeting in November 2000, a bill was introduced for specialty designation by Honorable Ed Whitfield (R-KY) and Honorable Frank Pallone (D-NJ). The bill unanimously passed the Energy and Commerce Committee. Subsequently in Ways and Means House Committee, then Chairman of Health Subcommittee, Honorable Bill Thomas (R-CA), now chairman of Ways and Means Committee, changed the bill to convert it into a study for Med-PAC to assess access to interventional pain management in all settings.

Following this, as expected, criticism was forwarded:

In an interview focused on what is working in “Pain Practice Management: success strategies to build your pain practice”, Bob Saner, an attorney representing the Pain Care Coalition (PCC), a lobbying group made up of pain associations, stated, “the organization I represent doesn’t think it is the appropriate fix. Instead, the PCC is lobbying for a Medicare pain medicine category that would include physiatrists, chiropractors, and other non-anesthesiology practitioners”. Saner believes that if interventional pain medicine physicians receive a special recognition from HCFA, it would only help anesthesiologists. He says payors would pay for procedures done by an anesthesiologist but not by a neurologist, even though that doctor would be as specialized. Saner also stated that most of the procedures done under interventional pain management are performed by anesthesiologists, which might trigger payors to decide to recognize only anesthesiologists for reimbursement purposes. It appears that, at the moment, the PCC is not aggressively lobbying for Medicare’s recognition of pain medicine as opposed to interventional pain management, the reporter added. In addition, Saner also stated that his group is not trying to affect the pending Medicare bill but will renew its lobbying efforts next year through members of Congress and HCFA. It was also reported that Mr. Saner stated, “This bill will not have any influence on physician reimbursement because pain specialists do not bill based on the time and units as anesthesiologists do.” The Secretary of Health and Human Services does not agree with that conclusion.

These statements were detrimental to the specialty of interventional pain medicine. In fact, specialty designation for interventional pain management could increase the practice expense for interventional procedures for ALL types of providers performing the procedures, as much as 8% to

10%, depending on whether a significant number of interventionalists, redesignate themselves. However, this will not have any effect on the practice management expenses for general anesthesiology. In addition, the American Society of Interventional Pain Physicians represents ALL types of physicians, not just anesthesiologists.

Even though we were successfully able to get the bill for the Med-PAC study, we continued our efforts with then HCFA, now CMS, for specialty designation for interventional pain management. Fortunately, we had substantial support from Congress, which included Congressman Ed Whitfield (R-KY), Congressman Sherrod Brown (D-OH), Congressman Frank Pallone (D-NJ), Congressman Bart Stupak (D-MI), Congresswoman Anne Northup (R-KY), Congressman Ron Lewis (R-KY), Congressman Jerry Kleczka (D-WI), Congressman Ken Lucas (D-KY), Senator Don Nickles (R-OK), and Senator Mitch McConnell (R-KY). They have made substantial efforts on our behalf for specialty designation. Following the appointment of Honorable Secretary Tommy Thompson as Secretary of Health and Human Services, we contacted him personally and he also has extended his strong support for specialty designation. Subsequently, we received assurances from Centers for Medicare and Medicaid in writing that an ‘Interventional Pain Management’ specialty designation would be awarded soon. This was communicated to congressional offices.

During this period, ASIPP was attempting to better relationships with the American Society of Anesthesiologists. The president of the American Society of Anesthesiologists, Neil Swissman, came to our semi-annual meeting in Las Vegas and told ASIPP that he came with an olive branch in his hand. He stated, “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.p --” This was on April 7, 2001 in Las Vegas.

On July 22, 2001, Barry M. Glazer, MD, then president elect and now president of ASA, wrote a letter to me which stated, “Please allow me to assure you that it is not my intent, nor that of the American Society of Anesthesiologists, to oppose the efforts of interventional pain medicine. In fact, I would hope that ASA and ASIPP will have a cooperative relationship to the greatest extent practical.

In areas in which we agree, it would be best worked in concert and with open communication whenever possible. In areas in which we disagree, such open communication should also be the order of the day, in order to better understand our differences and I would hope that most of our disagreements would be sufficiently mild that we would not work against each other.”

On September 21, 2001, Neil Swissman, MD, then president and now past president of the American Society of Anesthesiologists, when I had requested support on various pain management procedures to be included to the ASC list, including discography, spinal endoscopy, intradiscal electrothermal annuloplasty, replied, “We are working with a coalition of other specialists, as well as the Federated Ambulatory Surgery Association and the American Association of Ambulatory Surgery Centers to pursue CMS to update the ASC list. -- We also know that you have been instrumental in CMS’s likely abandonment of the proposal to delete. On behalf of all of our members performing these important procedures, we thank you for your contribution to the effort.—” Finally, he closed the letter stating that, “It is clear to us that there are many areas in which we can support each other’s efforts.”

That very same day (September 21, 2001), the Centers for Medicare and Medicaid released a program memorandum establishing a new specialty code for pain management, rather than interventional pain management. Obviously, to all the members of ASIPP, board members, our advisors, and congressional members who worked so hard on this issue, it was shocking.

Therefore, CMS and the Secretary of HHS were contacted by ASIPP as well as by members of Congress.

What we found out was more than shocking.

On October 1, 2001, a letter signed by Neil Swissman, MD, then president of the ASA, was delivered to Tim Hill, Director, Program Integrity Group, CMS. Dr. Swissman, in his capacity as president of the ASA, supported the designation of pain management, rather than “interventional pain management.” He admitted that ASA was opposing our efforts of interventional pain management. Dr. Swissman stated that ASA learned of the proposal to create a new specialty code during the final stages of discussion within the agency, through another organization. However, ASA was informed of this issue in December of 2000, again personally on April 6, 2001 and repeatedly thereafter. Following are excerpts of Dr. Swissman’s letter to CMS dated October 1, 2001.

ASA represents more than 9,000 anesthesiologists who report that they are engaged in whole or in part in the practice of pain medicine. The new Medicare specialty designation will be very helpful to these physicians in their efforts to educate various private and workmen’s compensation payers that anesthesiologists may indeed be pain medicine physicians.

Thus, ASA is very pleased that CMS has formally recognized the specialty of pain medicine (a term that is somewhat more accurate and accepted than pain “management”). We are very concerned, though by reports that the agency is being urged to revoke or amend the Program Memorandum and to narrow the designation to “interventional pain management,” as advocated by some pain physicians who limit their practice or concentrate on that modality. Such a step would leave in limbo a large number of pain practitioners who do not focus primarily on interventional techniques – including, among others, anesthesiologists, neurologists, surgeons, physiatrists and psychiatrists. For purposes of tracking utilization and avoiding inappropriate suspensions of Medicare claims, the new designation should apply to the broader spectrum of pain medicine physicians.

We are aware that upon implementation of provisions of the Health Insurance and Portability Act of 1996 (HIPAA) next October, a new provider taxonomy currently in the final stages of development by the National Uniform Claims Committee will replace existing CMS specialty codes. The NUCC provider taxonomy recognizes the subspecialties of “pain medicine/anesthesia” and pain medicine without other specialty association; it does not list “interventional pain management.” It appears as though a new Program Memorandum changing the new designation to “interventional pain management” would become meaningless upon HIPAA implementation. During its short existence, however, it could create considerable confusion.

We understand the urgency that drove the publication of the Program Memorandum on September 21st, as well as the urgency of making any changes. We learned of the proposal to create a new specialty code only during the final stages of discussion within the agency, through another organization. That was when we urged the adoption of a broader designation. The reasons suggested in support of the narrow designation (in-

creased practice expenses relative values; correction of under-representation on the Carrier Advisory Committees) do not make sense to us analytically. As you can see, we are very interested in the entire issue, and we sincerely hope to be a part of any discussion concerning pain medicine now and in the future.

In view of the potential adverse impact of a single-modality pain management designation- the full extent of which is not currently understood – we believe that the more equitable and conservative course of CMS action would be to let the broader specialty designation established in the Program Memorandum stand. The only modification should be to substitute the word “medicine” for “management.” “Pain medicine” has the added virtue of paralleling the specialty and subspecialty structure recognized by the American Board of Medical Specialties. Recognition of this subspecialty is greatly appreciated.

It was still not enough! ASA, in a memo from Dr. Neil Swissman, then president, on October 5, sent a memo dated October 6, 2001, to members of the 107th Congress. Contents of the memo are as follows:

Several Members of both the Senate and House of Representatives have, at the apparent request of the American Society of Interventional Pain Practitioners (ASIPP), contacted the Centers for Medicare and Medicaid Services (CMS) to object to its recent decision to create a new medical specialty designation for pain management. The objection has centered on the fact the designation is broader than that supported by ASIPP, that is, *interventional* pain management. A significant number of our members are also ASIPP members.

ASA has advised CMS that it supports the broader specialty designation, out of a concern that the narrower term effectively disenfranchises those thousands of pain practitioners who treat patients by non-interventional means. ASA also finds support for the broader term in the fact that pain medicine, in all its manifestations, is recognized by the American Board of Medical Specialties. We have also drawn CMS’s attention to the fact that the National Uniform Claims Committee, co-chaired by the American Medical Association (AMA), recognizes the provider taxonomy of “pain medicine/anesthesia” and “pain medicine”.

ASA also claimed that they were joined in its support for

CMS’s action by the AMA, the American College of Surgeons, the Pain Care Coalition, and several medical specialty organizations. Thus, the following are the facts on specialty designation for pain management starting September 21, as we see them.

1. CMS’s lack of a Medicare “specialty designation” for interventional pain management may continue to present a series of problems for effective and efficient access to interventional pain techniques.
2. “Pain management” may open the flood gates for medical services that do not fall within the purview of complicated interventional pain management procedures that are designed to reduce the chronic debilitating pain experienced by millions of Americans across the country.
3. Interventional pain management is not a single modality pain management. The full extent is fully understood and proven, as much as any other modality. In addition, almost all anesthesiologists practice predominantly interventional pain management.
4. ASIPP strongly feels that interventional pain management needs a code of its own to:
 - ◆ help ascertain appropriate payment rates for interventional pain physician services, such as recognizing the substantial capital and operating costs (for sterile rooms, drugs, supplies, fluoroscopy units, nursing personnel, and many other items), of providing interventional pain management services;
 - ◆ allow focused utilization data to be collected for better policy making;
 - ◆ to recognize the distinctive nature of interventional pain management, and to be represented on Carrier Advisory Committees of Medicare to assist with formation of local Medicare Review Policies for interventional pain management.
5. CMS based on information provided by ASA and AMA has given three reasons for its decision not to provide what it promised; none of these reasons appear valid in our opinion.
 - i. CMS contends that there are not enough interventional pain physicians, but we have an active list of 5,000 involved in interventional pain (which is many more than a number of already existing designations, such as peripheral vascular disease, neuropsychiatry and others have – in some cases several

- times as many). There are more than 1.5 million interventional pain procedures done in the Medicare program alone each year.
- ii. CMS contends that it can not give a specialty code unless the descriptor for the code is the same as an ABMS-approved board certification, but we have presented a list of five or more existing specialty codes that do not have any approved board or that are not in the same name as an approved board. Interventional pain is boarded as the most significant part of an ABMS-approved board.
 - iii. CMS says that it should not recognize a specialty designation that does not have the same precise working as a HIPAA code, but CMS "pain management" designation does not match the "anesthesia/pain medicine" or "pain medicine" HIPAA codes. In any event, those HIPAA codes are not yet in use, (recent indications are that HIPAA codes will

now be delayed for many months for another year) applications are still being taken for codes, and CMS has graciously agreed to support our request for an "interventional" code. We are confident, then, that this will not create any impediment.

Since the issuance of the memo on pain management designation, ASIPP has had several contacts with approximately 85 congressional members, many administrative officials, and finally, Honorable Secretary of Health and Human Services, Tommy Thompson, and Honorable Congressman Ed Whitfield also spoke extensively about this issue in their speeches at the 3rd annual ASIPP meeting.

We are encouraging all interventional pain physicians to enroll in this specialty designation. Despite comments made by others to the contrary, we do not oppose a designation for non-interventional practitioners.

American Society of Interventional Pain Physicians Call for Manuscripts and Communications

Pain Physician is a quarterly journal which is the official publication of the American Society of Interventional Pain Physicians. It is devoted entirely to the practice and development of interventional pain medicine. *Pain Physician* publishes newsworthy items and ideas along with original articles, clinical reports, review articles, and correspondence that are relevant to interventional pain medicine.

At this time, *Pain Physician* is encouraging the submission of materials for publication.

The subjects may include:

- ◆ Interventional Pain Management
- ◆ Psychology
- ◆ Education
- ◆ Economics
- ◆ Practice Management

Manuscripts may be submitted in the following categories:

- ◆ Original Contributions
- ◆ Reviews
- ◆ Case Reports
- ◆ Letters to the Editor

Please check Information for Authors in the back of any issue of *Pain Physician* or go to our web-site at www.asipp.org. **Submitted manuscripts must follow the guidelines found in Information for Authors to be considered.**

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**Mark your calendar for the 4th Annual ASIPP Meeting and Interventional Pain
Medicine Symposium September 21-23, 2002, Washington, D.C.,
Followed by Capitol Hill Visits on September 24, 2002.**

Reply to ASA Newsletter Interventional Pain Management is the Current Medical Speciality

In the June 2001, issue of ASA newsletter, Dr. Lema wrote a “so-called” explosive article entitled: Algology, the next medical specialty? in the Ventilation section. He criticized ASIPP as a mushrooming organization without focus.

Dr. Lema refused to publish the response from ASIPP Board, so we are publishing it in this newsletter. The original letter to ASA Newsletter was written and submitted for publication in July, 2001.

To the Editor,

To say we are a society of different philosophies, but continue to preach only your way of doing is to say listen to what I say, but only do what I do!

Interventional pain physicians across the country read with interest the ventilations by Dr.Lema in his article: Algology – the next medical specialty?, in the June 2001, issue of ASA newsletter. While this ventilation, as it is titled, reflects problems of anesthesiologists doing part time pain management, it does not reflect the current state of interventional pain management. The American Society of Interventional Pain Physicians (ASIPP), an organization consisting of interventional pain physicians was distressed to find that Dr.Lema not only compared the American Society of Interventional Pain Physicians with various organizations but also described it as part of the mushrooming of pain societies. We are sure that Dr.Lema understands the difference between the American Academy of Pain Management, The American Pain Society, and The American Academy of Pain Medicine. The American Society of Interventional Pain Physicians, in fact was started as the Association of Pain Management Anesthesiologists.

The second issue is what, in our opinion appears to be inconsistent information ASA officials. Manuel Bonilla wrote in the May issue of ASA Newsletter that it was necessary to spend funds on lobbying related to Managed Care Reform, and Pain Related Legislation. However, in another letter that ASIPP received from Mike Scott, who is the Director of Governmental Affairs, he stated, perhaps accurately, that ASA was involved only in the nurse anesthesiologists’ supervision issue.

Thirdly, some of the members of ASA in powerful positions have continuously in our opinion, denigrated the American Society of Interventional Pain Physicians. ASIPP

in its less than three year history has cultivated a membership of over 1000 (now over 1200), had significant legislative achievements and finally, for the first time in history, has been able to create a specialty designation for pain management (Dr.Lema notes, most of them are anesthesiologists). ASIPP also was able to obtain congressional legislation to study access to interventional pain management. Further, ASIPP has achieved various other victories including the addition of various codes to ambulatory surgery centers, increased reimbursement for hospital outpatient departments for interventional procedures and has been instrumental in fighting for various procedures in multiple states. For further information visit www.asipp.org. We do agree that introducing independent pain practice bills requires a concerted effort by established groups. However, we do not agree that representations and lobbyists of ASA are respected by congressional legislative aides more than ASIPP representatives or lobbyists.

We also disagree with Dr. Lema’s statement that “fractionating efforts may become inefficient and counterproductive as evidenced by a certain pain society (in what seems to have been a reference to ASIPP), which has spent over \$100,000 in Political Action Committee monies to lobby against the Healthcare Financing Administration ruling from a pain specialists perspective”. ASIPP has spent much more than \$100,000 in Political Action Committee monies, in individual fundraisings and personal sacrifices by many members. There is no “fractionating” because there was nobody else doing it; the whole effort to our knowledge was by ASIPP. Besides, it has been repeatedly proven that the efforts of smaller, more focused organizations are, oftentimes more effective and superior to larger, more complex organizations because of their flexibility, rapid consensus, decision making and action; qualities essential for adapting to unreasonable deadlines and the fast - paced environment of political policy making.

In one of the newsletters it was questioned if we need AMA? We can pose the same question and ask; “do we need ASA?” It is the opinion of the Board of ASIPP that we do need ASA and we want to work together cooperatively. However, we want to stop the pirating of and sending out information that hurts interventional pain physicians. We encourage all anesthesiologists who are members of ASIPP to also join ASA if they are not already members. We continue to work with ASA on multiple issues.

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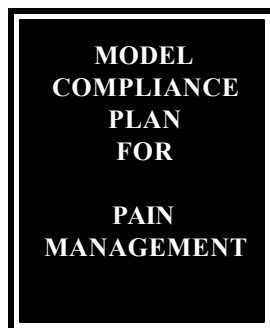


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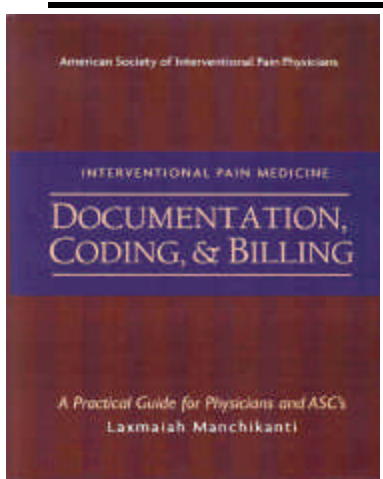
Prepared by attorneys at Arent Fox,
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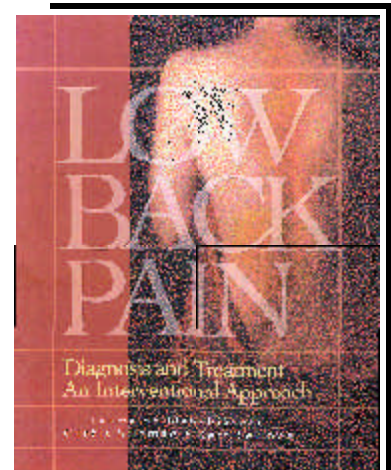
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ASIPP Capitol Hill Visits and Legislative Agenda

Preservation of interventional pain medicine, communication with legislators, legislative agenda, and the American Society of Interventional Pain Physicians – PAC have been cornerstones of ASIPP. Legislative visits were started following the annual meeting in the year 2000 with our membership visiting 74 congressional representatives. The board of ASIPP also has visited the Secretary of Health and Human Services and a multitude of legislators in February and June 2001. ASIPP also is continuously focused on promoting our legislative agenda through Congress to preserve interventional pain management in all settings.

Following the annual meeting on October 6-8, 2001, several members of ASIPP once again made numerous Capitol Hill visits in spite of negative publicity. ASIPP members visited 80 members of Congress.

Legislative Agenda

ASIPP has a broad legislative agenda which includes three issues per year as suggested by Secretary of Health and Human Services. These issues include, but are not limited to:

1. Preservation of interventional pain medicine in ambu-

latory surgery settings where all interventional pain procedures are facing cuts of over 50% for facility fee reimbursement. In addition, our agenda includes the addition of multiple other procedures including discography, spinal endoscopy, intradiscal electrothermal annuloplasty and percutaneous disc decompression.

2. National Reporting System for controlled substances.
3. To improve access for patients for spinal cord stimulation and intrathecal delivery systems by permitting these procedures to be performed on a cost effective outpatient basis in hospital outpatient settings and ambulatory surgery center settings.

While all legislators and administrative officials are extremely important, key legislative importance lies in **three committees**, two in the House and one in the Senate, namely **Energy and Commerce and Ways and Means Committees in the House and Finance Committee in the Senate**. Each committee also has health subcommittees, thus it is extremely important for our legislative agenda to establish contacts with the members of the health subcommittees and committees in general to gain their support

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All ASIPP members are requested to establish connections with their Congressional representatives and have direct contacts with all the members of the committee members listed above in the respective committees is extremely crucial.

ASIPP FACT SHEET

Mission Statement

To promote the development and practice of safe, high quality, cost-effective interventional pain medicine techniques for the diagnosis and treatment of pain and related disorders, and to ensure patient access to these interventions.

Goals

1. To preserve coverage for interventional pain medicine
2. To advance patient safety, cost effectiveness, and accountability
3. To provide state of the art and interventional pain medicine services
4. To communicate with legislators, patients, public, CMS (HCFA), & third party payors
5. To uphold high principles, policies, and practices
6. To pursue excellence in education in interventional pain medicine
7. To improve practice management
8. To improve compliance
9. To eliminate fraud and abuse
10. To provide total pain care

Major Achievements

1. Specialty Designation for “**Pain Management**”
2. Inclusion of nine (9) new or replacement codes in ASC approved list
3. Approval of new classification for interventional techniques, with higher reimbursement in Hospital Out Patient Settings, including Intrathecal Pumps.
4. CPT coding for Interventional Pain Management:
 - ◆ Level III CPT code for Spinal Endoscopy.
 - ◆ A new code for one day Percutaneous Adhesiolysis .
5. Restoration of reimbursement at a higher level for multiple procedures.
6. Approval of lysis of adhesions by Florida Medicare, which had been classified as experimental
7. Passage of Bill delaying the implementation of the Prospective Payment System (PPS) until January 1, 2002, extending phase-in to 4 years in 25% increments in conjunction with FASA.
8. Instrumental in the passage of the MedPAC Study Bill which examines barriers to coverage and payments for outpatient interventional pain procedures.
9. Campaign for Interventional Pain Medicine

- ◆ Letter campaign on multiple issues- ASIPP has sent over 18,000 letters to HCFA, as well as to legislators
 - ◆ Almost 30 letters of congressional support on various issues
 - ◆ Meeting with Secretary of HHS, Hon. Tommy Thompson
 - ◆ ASIPP members met with over 150 congressional members during Capitol Hill days
 - ◆ Multiple meetings with KEY Congressional contacts and with CMS
10. MedPAC study on access to Interventional Pain Management
 - ◆ Multiple presentations revealing barriers to coverage and payment for interventional pain procedures to MedPAC

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2002 Medicare Fee Schedule

Table. 2002 Medicare Fee Schedule for Physicians, Ambulatory Surgery Centers (Based on 2001), and 2002 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	Tendon sheath, ligament, Inj	43.44	20.63	64.07	64.07	-0-	43.44	114.02
20551	Tendon origin/insertion Inj	47.42	14.11	61.53	61.53	-0-	47.42	114.02
20552	Single or multiple T.P. Inj	47.42	14.11	61.53	61.53	-0-	47.42	114.02
20553	Single or multiple T.P. Inj	47.42	14.11	61.53	61.53	-0-	47.42	114.02
20600	Small-joint injection	39.46	10.86	50.32	50.32	-0-	39.46	114.02
20605	Intermediate-joint	40.54	14.48	55.02	55.02	-0-	40.54	114.02
20610	Large-joint injection	47.42	18.82	66.24	66.24	-0-	47.42	125.73
27096	SI-joint injection	66.24	308.06	374.30	374.30	-0-	66.24	-0-*
62263	Epidural adhesiolysis	312.40	111.49	423.89	312.40	323.00	312.40	803.77
62270	Spinal puncture	60.45	130.32	190.77	60.45	323.00	60.45	182.75
62273	Epidural blood patch	128.87	10.86	139.73	128.87	323.00	128.87	182.75
62280	Neurolytic subarachnoid	126.70	111.85	238.55	126.70	323.00	126.70	182.75
62281	Cervical / epi neurolytic	124.53	140.45	264.98	264.98	-0-	124.53	272.85
62282	Lumbar / epi neurolytic	111.86	179.18	291.04	111.86	323.00	111.86	272.85
62287	Decompression of nucleus pulposus	499.19	NA	NA	499.19	-0-	499.19	692.29
62290	Lumbar diskography	162.90	158.55	321.45	321.45	-0-	162.90	-0-
62291	Cervical/thoracic diskography	154.93	182.45	337.38	337.38	-0-	154.93	-0-
62310	Cervical/thoracic epidural	88.69	118.73	207.42	88.69	323.00	88.69	182.75
62311	Lumbar/caudal epidural	72.40	139.37	211.77	72.40	323.00	72.40	182.75
62318	Continuous C/T epi	94.12	122.71	216.83	94.12	323.00	94.12	182.75
62319	Continuous epi lumbar	86.15	118.38	204.53	86.15	323.00	86.15	182.75
62350	Implant of catheter	409.05	NA	NA	409.05	433.00	409.05	3837.65
62355	Removal of catheter	323.62	NA	NA	323.62	-0-	323.62	751.34
62361	Implant of non-programmable pump	347.15	NA	NA	347.15	433.00	347.15	7103.65
62365	Removal of reservoir	361.63	NA	NA	361.63	433.00	361.63	751.34
63650	Implant of neurostimulator	368.87	NA	NA	368.87	433.00	368.87	13619.87
63660	Removal of neurostimulator	379.37	NA	NA	379.37	323.00	379.37	2155.28
63685	Implant of pulse generator	439.82	NA	NA	439.82	433.00	439.82	15399.99
63688	Removal of pulse generator	354.03	NA	NA	354.03	323.00	354.03	7394.82
64400	Trigeminal nerve block	52.85	87.24	140.09	140.09	-0-	52.85	114.02
64402	Facial nerve block	64.07	142.27	206.34	206.34	-0-	64.07	114.02
64405	Greater occipital nerve block	64.07	35.12	99.19	99.19	-0-	64.07	114.02
64413	Cervical plexus blocks	66.24	90.41	156.65	156.65	-0-	66.24	114.02
64415	Brachial plexus block	68.05	84.35	152.40	68.05	323.00	68.05	114.02
64417	Axillary nerve block	69.14	102.44	171.58	69.14	323.00	69.14	114.02
64418	Suprascapular N.B.	60.81	79.64	140.45	140.45	-0-	60.81	114.02

*Reimbursed to Hospital Outpatient Department for supervision and interpretation of radiology codes

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 (\$)
64420	Intercostal N.B. single	55.02	76.02	131.04	55.02	323.00	55.02	272.85
64421	Intercostal N.B. multiple	78.19	91.58	169.77	78.19	323.00	78.19	272.85
64425	Ilioinguinal N.B.	82.17	69.50	151.67	151.67	-0-	82.17	114.02
64445	Sciatic nerve block	71.67	42.72	114.39	114.39	-0-	71.67	114.02
64450	Peripheral nerve block	60.81	52.86	113.67	113.67	-0-	60.81	114.02
64470	Facet injection-C/T -single	88.69	128.14	216.83	88.69	323.00	88.69	272.85
64472	Facet injection-C/T/-addi.	61.90	129.23	191.13	61.90	323.00	61.90	272.85
64475	Facet injection-lumbar/sacral-single	68.42	124.16	192.58	68.42	323.00	68.42	272.85
64476	Facet injection-L/S addi.	47.06	130.32	177.38	47.06	323.00	47.06	272.85
64479	C/T Transforaminal-single	107.87	136.11	243.98	107.87	323.00	107.87	272.85
64480	C/T Transforaminal -addi.	77.10	129.24	206.34	77.10	323.00	77.10	272.85
64483	L/S Transforaminal single	93.39	140.46	233.85	93.39	323.00	93.39	272.85
64484	L/S Transforaminal addi.	65.52	132.13	197.65	65.52	323.00	65.52	272.85
64505	Sphenopalatine ganglion block	64.80	74.57	139.37	139.37	-0-	64.80	114.02
64510	Stellate ganglion block	56.11	82.17	138.28	56.11	323.00	56.11	272.85
64520	L/T sympathetic block	62.99	115.11	178.10	62.99	323.00	62.99	272.85
64530	Celiac plexus block	73.85	97.73	171.58	73.85	323.00	73.85	272.85
64600	Neurolytic-trigeminal-small branches	209.59	33.31	242.90	209.59	323.00	209.59	803.77
64605	Neurolytic-trigeminal-2/3 division	327.24	26.06	353.30	327.24	323.00	327.24	803.77
64610	Neurolytic-trigeminal-at foramen ovale	451.04	NA	NA	451.04	323.00	451.04	803.77
64612	Neurolytic block-muscles of facial nerve	133.94	48.87	182.81	182.81	-0-	133.94	114.02
64613	Neurolytic block-cervical spinal muscles	128.15	12.30	140.45	140.45	-0-	128.15	114.02
64620	Intercostal neurolysis	133.21	83.62	216.83	133.21	323.00	133.21	803.77
64622	L/S Facet neurolysis-single	141.54	145.88	287.42	141.54	323.00	141.54	803.77
64623	L/S Facet neurolysis -addi.	46.70	130.68	177.38	46.70	323.00	46.70	803.77
64626	C/T/ Facet neurolysis-single	155.66	128.14	283.80	155.66	323.00	155.66	803.77
64627	C/T Facet neurolysis- addi	55.38	124.89	180.27	55.38	323.00	55.38	803.77
64630	Pudendal nerve neurolysis	146.24	100.64	246.88	146.24	433.00	146.24	272.85
64640	Peripheral neurolysis	166.15	70.59	236.74	236.74	-0-	166.15	272.85
64680	Celiac plexus neurolysis	127.78	77.11	204.89	127.78	433.00	127.78	803.77
72275	Epidurography radiological S&I	36.20	78.55	114.75	114.75	-0-	36.20	266.74
72285	C/T Diskography, radiological S & I	58.28	301.18	359.46	359.46	-0-	58.28	266.74
72295	L/S Diskography, radiological S & I	41.99	282.35	324.34	324.34	-0-	41.99	266.74
73542	SI joint arthrography – radiological S&I	28.60	75.65	104.25	104.25	-0-	28.60	131.84
76005	Fluoroscopic guidance	28.96	47.06	76.02	28.96	-0-	28.96	-0-

NA – Not approved
Not applicable

*Reimbursed to Hospital Outpatient Department for supervision and interpretation of radiology codes

Positions Available

PAIN MANAGEMENT OPPORTUNITY, PADUCAH, KENTUCKY: Excellent opportunity for an Interventional Pain Specialist in an accredited multidisciplinary pain management and ambulatory surgery practice. Position includes pain management at two clinics and outpatient anesthesia with clinical research. No Anesthesia Call. Medium size city with advanced medical community. Excellent recreational opportunities and lifestyle. Excellent benefit package with early partnership or immediate partnership for a qualified candidate. Send your current CV to: **Laxmaiah Manchikanti, M.D. 2831 Lone Oak Road Paducah, Kentucky, 42003 E-Mail: drm@asipp.org**

INTERVENTIONAL PAIN PHYSICIAN: Join our thriving regional center of excellence in pain management, spinal diagnostics and musculoskeletal health. This state of the art facility which features onsite fluoro-scopy suite, CT, MRI and electro-diagnostics is under the direction of Joseph D. Fortin, D.O., Medical Director of STAR, and Clinical Professor of PM&R at Indiana University. Perform all image-guided procedures (discography, epidurals, facet and sacroiliac blocks), implantable pumps and stimulation units, as well as peripheral joint injections / arthrography. Participate as a faculty member in workshops and seminars. Become an author/contributor in our numerous publications and exciting national and international research endeavors. Candidates Board Certified in Anesthesia or Physiatry can look forward to an area with a booming economy, a great place to raise a family, excellent public and private school systems, universities and community colleges. Send CV to: **Dr. Joseph Fortin, Medical Director, 7230 Engle Road Ste 210, Fort Wayne, IN 46804 Phone: (219) 459-7313.**

PAIN PHYSICIAN WANTED CENTRAL OHIO: Fellowship trained pain management physician BC, BE, needed to join a highly trained group of Ohio Physicians. Offering multimode treatment for all types of chronic and cancer pain. Excellent compensation and benefits commensurate with experience. Knowledge of advance therapies needed. Please contact: **740-375-0200.**

PAIN PHYSICIAN WANTED, SAN DIEGO: Seeking full time BE/BC pain management specialist to join mature, growing state-of-the-art pain management group. Partnership Opportunity Excellent Benefits & Compensation Program. Fax cover letter and CV to: **760-934-6494**

INTERVENTIONAL PAIN MANAGEMENT PHYSICIAN WANTED: Growing private Pain Management practice specializing in the diagnosis and treatment of back and spinal pain, has an immediate opening for an anesthesiologist who is BE/BC in pain management. Medical director of clinic is nationally known educator in interventional pain management and minimally invasive spinal medicine and surgery, and will train candidate in latest diagnostic and therapeutic procedures. Excellent career opportunity with busy practice in central Indiana with strong referral base. Indianapolis is the 12th largest metropolitan area in U.S. with high quality of life and family-oriented community. The area has a wide variety of sports, arts, and cultural activities, with a stable and diverse economy. Send CV to: **Midwest Pain Institute, 13431 Old Meridian St., #190, Carmel, IN 46032, phone: (866) 815-8950 Attn: Michael Ryan. E-mail: mryan@midwestpain.net.**

PAIN PHYSICIAN WANTED: Interventional Pain Management Associates Elmira, NY / Finger Lakes Region Busy Progressive Private Pain Practice / Expanding, Excellent Referral Source Base, Multi-Discipline Setting, 2 Fluoroscopic Procedure Suites, Competitive salary & Benefit Package, Partnership opportunity offered. Must be trained in most advanced inter-ventional procedures. Board certification in pain management required for partnership. Send CV: **Interventional Pain Management Associates, 11 Prospect Ridge, Horseheads, NY-14845.**

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Email: cbourbeau@brishosp.chime.org

For more information about CLASSIFIED ADVERTISING in PAIN PHYSICIAN call BERT FELLOWS (270) 554-9412 OR e-mail to editor@asipp.org



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Professional Membership Application

Please type or print

1. Name _____

Last	First	MI
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Organization _____ Home Address: _____

Address: _____ City: _____ State: _____ Zip _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Phone: _____ Fax: _____ Email: _____

Email: _____ Preferred Mailing Address: Organization Home

2. Personal Data: (for statistical purposes only) Date of Birth ____/____/____ Male Female
 Medical Degree: MD DO other _____ (specify)

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

<input type="checkbox"/> American Board of Anesthesiology	<input type="checkbox"/> American Board of PMR
<input type="checkbox"/> American Board of Psychiatry and Neurology	<input type="checkbox"/> ABA Subspecialty in Pain Management
<input type="checkbox"/> Other ABMS Primary Board(s) _____	

4. Member of American Medical Association

5. What percentage of your clinical practice is in the field of Interventional Pain Management: 0% 1 – 49% 50 – 100%

6. Primary professional practice setting (please check all that apply): Ambulatory surgery Hospital Office practice

7. I hereby make application for

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

Life Membership dues	\$ 5,000.00 or \$500.00 each month for 1 year
Annual Membership dues	\$ 200.00
Fellows and Residents	\$ 100.00
Additional contribution	\$ 100.00 \$250.00 \$500.00 \$1000.00 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
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8. State Society Information

- I am a member of _____ State Association(s)
- I am interested in joining _____ State Association(s)
- I am not interested in joining or working with the State Association(s)

9. 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)

10. Signature of Applicant Date _____ Sponsoring Member: _____

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Description	Product Code	Quantity	Unit Price Member	Unit Price Non-Member	Total
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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	
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Pain Management Evaluation Report *	PMER*		\$2,000	\$2,500	
Interventional Pain Medicine: Documentation, Coding, & Billing: Book	DCB- Book		\$200.00	\$250.00	
Interventional Pain Medicine: Documentation, Coding, & Billing : Book and CD	DCB-BCD		\$225.00	\$275.00	
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