

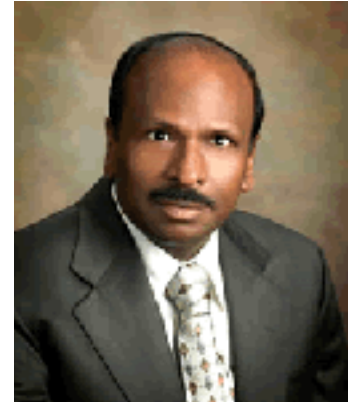
# Pain Physician News

The Newsletter of the American Society of Interventional Pain Physicians

Winter 2004



# A Retrospective Look At ASIPP Since Inception: A Dynamic Organization



The American Society of Interventional Pain Physicians (ASIPP) was started by Laxmaiah Manchikanti, MD, with the help of a few colleagues and friends, in November 1998, with the single purpose of preserving interventional pain management. ASIPP took birth as the Association of Pain Management Anesthesiologists (AOPMA), with much controversy, and opposition from other organizations supposedly representing interventional pain physicians.

In 1999, the name was changed to the American Society of Interventional Pain Physicians, to reflect the multidisciplinary nature of interventional pain management encompassing a multitude of other physicians separate from anesthesiologists. Since birth, this society has struggled to survive, has grown remarkably, and the achieved numerous benefits for the interventional pain management community and the patients they serve. This has happened in spite of continued opposition by established organizations. In anyone's terminology, the growth of ASIPP has been remarkable and the achievements are even more impressive. ASIPP reminds us of a 12-year old kid completing his residency in interventional pain management and starting practice.

In 1998, we started with members from our own practice. In a few months, our membership had slowly started growing. By 1999, when we

held our First Annual Meeting in Washington, DC, our membership was 265. Our attendance at the meeting was approximately 60 members, even though there were congressional speakers (Representatives Ed Whitfield and Frank Pallone). Since then, our membership has grown by leaps and bounds and today it is almost 2,600 (Fig. 1). Since then, we have instituted a semi-annual meeting, along with an annual meeting, followed by legislative visits and a separate legislative session, along with cadaver workshops offered to interventionalists. We also offered a Comprehensive Board Review course in 2003, with an impressive outcome, with the majority of the people attending the meeting passing the examination.

The organization started with a \$25,000 contribution from the undersigned and with few members. For 2003, our revenues exceeded \$1.3 million. Table 1 illustrates the balance sheet of ASIPP for the last 5 years. In the beginning, all work and contributions were by one person and one office, but now we have many volunteers sharing the responsibility with an excellent Board of Directors. However, the founding organization and the founding members still continue to bear a significant portion of the burden.

With growing enthusiasm, we also started a Political Action Committee named the American Society of

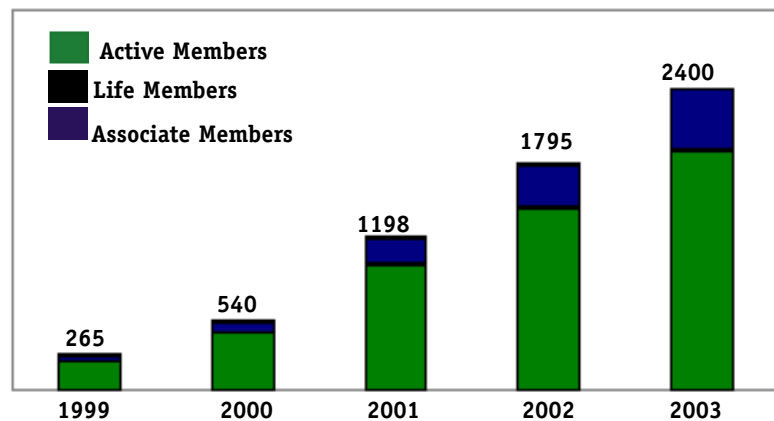


Fig 1. Growth of ASIPP Membership from first annual meeting September 1999 to fifth annual meeting in September 2003

Table 1. ASIPP Statement of revenues and expenses – cash basis for the years ended December 31, 1999 through December 31, 2003\*

INCOME	12/31/99	12/31/00	12/31/01	12/31/02	12/31/03
Membership Dues	\$ 61,235	\$ 128,400	\$ 240,375	\$ 241,325	\$ 262,415
Corporate Dues and Sponsorship	10,000	44,500	103,500	142,500	145,400
Member Contributions	2,200	4,925	26,530	65,250	40,301
Sales (books, Manuals, & Journals)	20,380	48,027	45,213	168,255	93,402
Advertising	950	27,710	12,015	21,675	12,750
Meeting Fees	24,700	78,440	171,829	256,855	407,170
Cadaver Workshop Fees	-	33,700	-	137,445	387,370
Other Income	-	-	1,773	9,150	9,813
<b>Total Income</b>	<b>\$ 119,465</b>	<b>\$ 365,702</b>	<b>\$ 601,235</b>	<b>\$ 1,042,455</b>	<b>\$ 1,358,620</b>
<b>EXPENSES</b>					
Employee Expenses	\$ -	\$ -	\$ -	\$ 53,886	\$ 94,379
Legal	78,381	156,583	173,050	202,092	271,304
Accounting	1,602	3,224	9,492	15,231	26,951
Legislative Session	-	-	-	5,469	95,827
Meeting Expenses	18,637	37,733	103,007	269,509	499,898
Cadaver Workshop Expenses	-	34,954	-	74,656	212,557
Journal Expense	-	-	52,000	59,442	55,324
Newsletter Expense	-	-	53,675	35,875	28,654
Book Printing	-	-	-	73,272	10,000
Credit Card Fees	1,845	4,048	6,338	16,606	26,312
Interest	-	-	-	56	-
Depreciation	-	-	-	14,726	7,497
Other Expenses	29,068	73,263	71,810	73,075	72,954
<b>Total Expenses</b>	<b>\$ 129,533</b>	<b>\$ 309,805</b>	<b>\$ 469,372</b>	<b>\$ 893,894</b>	<b>\$ 1,401,657</b>
<b>NET INCOME (LOSS)</b>	<b>\$ (10,068)</b>	<b>\$ 55,897</b>	<b>\$ 131,863</b>	<b>\$ 148,561</b>	<b>\$ (43,037)</b>

\* Expenses on behalf of Laxmah Manchikanti, MD, Pain Management Center of Paducah, and Ambulatory Surgery Center ranging from \$150,000.00 to \$300,000.00 per year are not included in this statement.

Interventional Pain Physicians –PAC. This also has grown by leaps and bounds with only \$30,000 contributed in 1999 to a total exceeding \$200,000 in 2003. In such a short period, ASIPP-PAC is in the top 20 PACs of medical organizations. PAC has assisted us in helping the legislators who are helping us (Table 2).

While initially we were opposed by many organizations, now almost all of them are friendly to us and we work on common issues together. Our relationship with the World Institute of Pain, while it always has been good, has been more cordial recently with our assistance to WIP in offering the 3rd FIPP Examination.

The phenomenal achievements of ASIPP are listed in Table 3. The most memorable and impressive of these achievements are:

- ◆ Preservation of interventional pain management, which was facing a certain death
- ◆ Specialty designation for interventional pain management
- ◆ Membership in AMA Specialty and Service Society
- ◆ Introduction of National All Schedules Electronic Prescription (NASPER) Reporting Act
- ◆ Membership on Carrier Advisory Committees

Table 2. Statement of ASIPP-PAC

Year	Total Receipts	Total Candidate Contributions	Interest Earned	Expenses	Cash on hand at the end of year
1999	\$35,000.00	\$0.00	\$0.00	\$0.00	\$35,000.00
2000	\$78,200.00	\$105,000.00	\$156.46	\$0.00	\$8,356.46
2001	\$107,550.00	\$60,500.00	\$1,287.86	\$358.00	\$56,336.32
2002	\$107,300.00	\$133,300.00	\$378.08	\$208.00	\$30,506.40
2003	\$214,850.00	\$111,000.00	\$603.02	\$3,187.94	\$131,771.48

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Table 3. Significant achievements of ASIPP since its inception

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1. Preservation of interventional pain management
  2. Specialty designation for interventional pain management
  3. Specialty designation for pain management
  4. Membership in AMA Specialty and Service Society
  5. Introduction of National All Schedules Electronic Prescription (NASPER) Reporting Act
  6. Membership on Carrier Advisory Committees in multiple states
  7. Education:
    - ◆ Semiannual and Annual Meetings
    - ◆ Cadaver Workshops,
    - ◆ Board Review Course
    - ◆ Journal
    - ◆ Newsletter
  8. Inclusion of nine (9) new or replacement codes on the ASC approved list
  9. CPT coding for Interventional Pain Management:
    - ◆ Level III CPT code for Spinal Endoscopy
    - ◆ A new code for one day Percutaneous Adhesiolysis
  10. Campaign for Interventional Pain Management (Administrative and Legislative)
    - ◆ Letter campaign on multiple issues - ASIPP has sent over 18,000 letters to HCFA, as well as to legislators
    - ◆ Almost 40 letters of congressional support on various issues
    - ◆ Meeting with Secretary of HHS, Hon. Tommy Thompson on several occasions
    - ◆ ASIPP members have made over 500 legislative visits meeting congressional members
    - ◆ Multiple meetings with KEY Congressional contacts
    - ◆ Multiple meetings with CMS with presentations
  11. ASIPP Publishing:
    - ◆ Pain Physician Journal – listed on EMBASE
    - ◆ Pain Physician Newsletter
    - ◆ Interventional Pain Management: Low Back Pain – Diagnosis and Treatment
    - ◆ Interventional Pain Medicine: Documentation, Billing, and Coding
  12. Evidence-Based Practice Guidelines for Interventional Techniques in the Management of Chronic Spinal Pain
  13. Controlled Substance Guidelines
  14. MedPAC study on access to Interventional Pain Management
    - ◆ Multiple presentations revealing barriers to coverage and payment for interventional pain procedures to MedPAC
    - ◆ MedPAC Report:
      - The Secretary should evaluate payments for services provided in hospital outpatient departments, ambulatory surgical centers, and physicians' offices to ensure that financial incentives do not inappropriately affect decisions regarding where care is provided.
      - The Secretary should evaluate payment rates for ambulatory surgical centers (ASCs) using recent charge and cost data from a sample of ASCs. He also should update the list of procedures that are covered when performed in ASCs.
      - The Secretary should recalculate the practice expense payments for interventional pain procedures when data become available on the practice expenses of physicians specializing in pain management.
      - The Secretary should sponsor additional research about the effectiveness of interventional pain services to strengthen the evidence basis for Medicare's coverage decisions.
  15. Passage of the Bill delaying the implementation of the Prospective Payment System (PPS) until January 1, 2002, and extending the phase-in period to 4 years with 25% increments, in conjunction with FASA
  16. Instrumental in the passage of the MedPAC Study Bill which examines barriers to coverage and payments for outpatient interventional pain procedures
  17. Forty-nine state societies and affiliation with the Texas Pain Society
  18. Approval of new classification for interventional techniques, with higher reimbursement in Hospital Out Patient Settings, including Intrathecal Pumps
  19. ASIPP website, which is a resource center with up to date information and also various articles published in *Pain Physician*
  20. Compliance Manual - This compliance manual was developed by Arent Fox, the premier healthcare law firm in Washington.
  21. Policy and Procedure Manuals - Policy and Procedure Manuals are available for Ambulatory Surgery Centers, as well as interventional pain practices
  22. Affiliation and assistance to state organizations in all 50 states.
  23. Link - ASIPP provides links with Corporate Sponsors, Members, and other Organizations.
  24. Restoration of reimbursement at a higher level for lumbar facet joint neurolytic procedures, discography, and for multiple radiology codes in 2001
  25. Approval of lysis of adhesions by Medicare in multiple states
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# NASPER Introduced (HR. 3015)



**Rep. Ed Whitfield  
(R-KY)**



**Rep. Frank Pallone  
(D-NJ)**

The National All Schedules Prescription Electronic Reporting Act (NASPER) of 2003 was introduced in the Energy and Commerce Committee of the House of Representatives on September 4, 2003, by **Representative Ed Whitfield (R-KY)**, and **Representative Frank Pallone (D-NJ)**.

Since it's introduction, the following have joined as co-sponsors:

## **Alabama**

Spencer Bachus (R)

## **Arkansas**

John Boozman (R)

## **California**

Grace Napolitano (D)

Mary Bono (R)

## **Colorado**

Marilyn Musgrave (R)

## **Connecticut**

Rosa DeLauro (D)

Christopher Shays (R)

## **Florida**

Dave Weldon (R)

Robert Wexler (D)

## **Illinois**

Judy Biggert (R)

Danny Davis (D)

Rahm Emanuel (D)

Lane Evans (D)

John M. Shimkus (R)

## **Indiana**

Mark Souder (R)

## **Kentucky**

Ernie Fletcher (R)

Ken Lucas (D)

Anne Northup (R)

Ed Whitfield (R)

## **Louisiana**

William Jefferson (D)

David Vitter (R)

## **Michigan**

Dale Kildee (D)

Bart Stupak (D)

## **Minnesota**

Jim Ramstad (R)

## **Mississippi**

Charles Pickering (R)

## **Missouri**

Roy Blunt (R)

## **New Jersey**

Frank Pallone (D)

Bill Pascrell (D)

## **New York**

Carolyn Maloney (D)

## **Ohio**

Sherrod Brown (D)

## **South Carolina**

Jim DeMint (R)

## **Texas**

Gene Green (D)

Ralph Hall (R)

Max Sandlin (D)

Pete Sessions (R)

## **Washington**

George Nethercutt (R)

Norman Dicks (D)

## **Wisconsin**

Jerry Kleczka (D)

Updates on the Status of H.R. 3015 can be found at :  
[www.capwiz.com/asipp/issues/bills/](http://www.capwiz.com/asipp/issues/bills/)

NASPER is a Bill to amend the Public Health Service Act by establishing an electronic system for practitioner monitoring of the dispensing of any Schedule II, III, or IV controlled substance. The importance of this proposed legislation and its necessity and feasibility have been provided in the past. Our conviction has strengthened with recent statistics from 2002 National Survey on Drug Use and Health performed in 2003 by Substance Abuse and Mental Health Services Administration. The findings of overall illicit drug use, along with controlled substance diversion and abuse are concerning to not only the providers, but also the public in general. This survey showed the following facts:

- ♦ In 2002, an estimated 19.5 million Americans, or 8.3% of the population aged 12 or older, were current illicit drug users. Current drug use means use of an illicit drug during the month prior to the survey

interview. The same survey of 1999 showed current users as 14.8 million Americans.

- ♦ An estimated 6.2 million persons, or 2.6% of the population aged 12 or older, were current users of prescription-controlled drugs taken non-medically.
  - An estimated 4.4 million used pain relievers
  - An estimated 1.8 million used tranquilizers
  - An estimated 1.2 million used stimulants
  - An estimated 0.4 million used sedatives

This is in contrast to the 2001 survey, with 3.5 million using pain relievers, 1.5 million using tranquilizers, 1 million using stimulants, and 0.3 million using sedatives.

In 2002, approximately 1.9 million persons aged 12 or older had used

OxyContin non-medically at least once in their lifetime. This is a significant increase as OxyContin use was less than a million in 2001.

- ♦ In 2002, an estimated 11.0 million persons reported driving under the influence of an illicit drug during the past year.
- ♦ Among pregnant women aged 15 to 44 years, 3.3% reported using illicit drugs in the month prior to their interview.
- ♦ In 2002, among adults who used an illicit drug in the past year, 17.1% had serious mental illness in that year, while the rate was 6.9% among adults who did not use an illicit drug.

Soon this Bill will be introduced in the Senate. Hearings are scheduled during the 1<sup>st</sup> week of March 2004, in congress Purdue Pharma is also introducing a competing bill.

108TH CONGRESS  
1ST SESSION

# H. R. 3015

To amend the Public Health Service Act to establish an electronic system for practitioner monitoring of the dispensing of any schedule II, III, or IV controlled substance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 4, 2003

Mr. WHITFIELD (for himself and Mr. PALLONE) introduced the following bill; which was referred to the Committee on Energy and Commerce

## A BILL

To amend the Public Health Service Act to establish an electronic system for practitioner monitoring of the dispensing of any schedule II, III, or IV controlled substance, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

### SECTION 1. SHORT TITLE.

This Act may be cited as the “National All Schedules Prescription Electronic Reporting Act of 2003”.

## **SEC. 2. FINDINGS.**

The Congress finds as follows:

- (1) The Harold Rogers Prescription Monitoring Program has supplied and will continue to supply critically important information and experience regarding effective prescription drug monitoring practices.
- (2) Schedule II, III, and IV controlled substances have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.
- (3) Schedule II, III, and IV controlled substances have a moderate to high potential for misuse when the prescribing practitioner is unaware of all such prescriptions that a patient is receiving, including abuse, improper use, and illegal distribution.
- (4) Such misuse imposes substantial and detrimental effects on the health and welfare of the American people.
- (5) Currently there is no national databank that health care practitioners and pharmacists who, respectively, prescribe and dispense schedule II, III, and IV controlled substances can access to determine whether a particular prescription is medically unnecessary.
- (6) A national electronic databank, supported by State databanks where they are established under State law, would allow providers to access the information necessary to ascertain that a particular prescription may be unnecessary or the subject of misuse.
- (7) A major portion of the use and misuse of schedule II, III, and IV controlled substances involves interstate and foreign commerce.
- (8) Schedule II, III, and IV controlled substances dispensed intrastate cannot be differentiated from schedule II, III, and IV controlled substances that are dispensed interstate, and have significant interstate effects.

## **SEC. 3. ELECTRONIC MONITORING SYSTEM FOR DISPENSING CONTROLLED SUBSTANCES.**

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding after section 399N the following:

### **“SEC. 399O. ELECTRONIC MONITORING SYSTEM FOR DISPENSING CONTROLLED SUBSTANCES.**

“(a) ESTABLISHMENT.—The Secretary shall establish an electronic system for practitioner monitoring of the dispensing of any schedule II, III, or IV controlled substance involving patients under their care.

“(b) NO FEE OR TAX.—A practitioner shall not be required to pay a fee or tax in connection with the system established under subsection (a).

“(c) REPORTING REQUIREMENT.—Every dispenser shall report to the Secretary the information required by this section in a timely manner as prescribed by the Secretary, except that reporting shall not be required for “(1) a drug administered directly to a patient; or “(2) a drug dispensed in a quantity limited to an amount adequate to treat the patient for 48 hours or less.

“(d) INFORMATION TO BE REPORTED.—The Secretary shall determine by regulation the information to be reported under subsection (a) for each schedule II, III, or IV controlled substance. Such information shall include the following:

- “(1) Patient identifier.
- “(2) Drug dispensed.
- “(3) Date of dispensing.
- “(4) Quantity dispensed.
- “(5) Number of refills ordered.

“(6) Practitioner who signed the prescription.

“(7) Dispenser.

“(e) ELECTRONIC FORMAT.—The Secretary shall specify the electronic format for the reporting of information under subsection (a), and may waive the requirement of such format with respect to an individual dispenser.

“(f) PROVISION OF INFORMATION.—The Secretary may provide information from the system established under subsection (a) and, in the case of a request under paragraph (2), compilations of such information, in response to a request by—

“(1) a practitioner who certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment or evaluating the need for such treatment to a bona fide current patient; or

“(2) any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, who certifies that—

“(A) the requested information is related to an investigation or proceeding involving the unlawful diversion or misuse of a schedule II, III, or IV substance, and the authority has reasonable cause to conclude that such information will further the purpose of the investigation or assist in the proceeding; or

“(B) the requested information is necessary for research purposes, but only in the case of research to be conducted by the Department of Health and Human Services, a State medicaid program, or the Drug Enforcement Administration, and the intended purpose of the research is related to a function committed to such agency by law that is not investigative in nature.

“(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to restrict the ability of any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to secure information as otherwise authorized by law.

“(h) LIMITATION.—The Secretary shall make reasonable efforts to limit the information provided pursuant to a valid request under subsection (f) to the minimum necessary to accomplish the intended purpose of the request. The Secretary shall also make reasonable efforts to implement a real-time electronic system, as consistent with any available appropriated funds. Reports or communications made under subsections (c), (f)(1), or (f)(2)(A) shall not, in any event, be made to or by the Secretary more than 1 week after the antecedent or triggering request or event.

“(i) SUBSEQUENT TRANSFER OF INFORMATION.—A person who, pursuant to subsection (f), receives data or any report of the system from the Secretary shall not provide the information to any other person or entity except by order of a court of competent jurisdiction or other legal authority, by written patient authorization as authorized under section 164.508(b) of title 45, Code of Federal Regulations, or any successor regulations, or as otherwise authorized or permitted by the Health Insurance Portability and Accountability Act of 1996. The provisions of subsections (f), (g), and (h) are deemed to comply with the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder. This section shall not prevent the disclosure of information by a local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority to district attorneys, attorneys general, and others, in furtherance of criminal investigations or prosecutions, or licensure, disciplinary, or other judicial or administrative proceedings within their respective jurisdictions.

“(j) PENALTIES.—

“(1) Any dispenser who knowingly fails to transmit information to the Secretary as required by this section shall be subject to a civil monetary penalty of \$100 for each such failure, and a maximum civil monetary penalty of \$25,000 for such failures concerning any particular patient.

“(2) Any person who seeks or makes a knowing disclosure of transmitted information by or to a person not authorized by subsection (f) or the Health Insurance Portability and Accountability Act of 1996, or who knowingly obtains information under this section not relating to a bona fide specific current patient, shall be subject to a civil monetary penalty of not more than \$25,000 for each such violation.

“(k) STATE MONITORING SYSTEM.—A State may elect to have its own prescription monitoring system, subject to its own rules and regulations, operating in its jurisdiction to the exclusion of the Federal program created by this section, so long as the State system provides the information required by this provision to the Federal program in a fashion consistent with any requirements issued by the Secretary. The Harold Rogers Prescription Monitoring

Program and the funding it provides may be accessed by a State electing to proceed under this provision. This mechanism is intended to encourage States to develop systems that may operate to provide additional information and experience that will assist in the refinement of both the Federal and State programs.

“(l) DEFINITIONS.—For purposes of this section:

“(1) The term ‘administered directly to a patient’ means the direct application of a schedule II, III, or IV controlled substance to the body of a patient by a practitioner or by the practitioner’s agent in the practitioner’s presence, whether such application is by injection, inhalation, ingestion, or any other means.

“(2) The term ‘agent’ means an authorized person who acts on behalf of or at the direction of a practitioner.

“(3) The term ‘dispense’ means to deliver a schedule II, III, or IV controlled substance to an ultimate user pursuant to the lawful order of a practitioner.

“(4) The term ‘dispenser’ means a practitioner who so delivers a schedule II, III, or IV controlled substance to an ultimate user.

“(5) The term ‘local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority’ means—

“(A) any State or local officer authorized under State or local law who is employed as an investigative agent of a State or local narcotics control agency;

“(B) the Drug Enforcement Administration;

“(C) the executive director or chief investigator, as designated by each board, of the State boards of podiatry, dentistry, pharmacy, medical licensure, osteopathic examiners, veterinary medical examiners, nursing, or other boards representing appropriate health care-related disciplines, but only with respect to information relevant to licensees of the respective boards;

“(D) the Department of Health and Human Services;

“(E) a State medicaid program;

“(F) a properly convened Federal or State grand jury or other judicial authority pursuant to an appropriately and properly issued subpoena; or

“(G) any contractor selected by the Secretary to establish or maintain the prescription database if the Secretary imposes appropriate restrictions on such contractor and its personnel.

“(6) The term ‘patient identifier’ means the patient’s—

“(A) full name;

“(B) address, including zip code;

“(C) date of birth; and

“(D) social security number or alternative identification number.

“(7) The term ‘practitioner’ means a physician, nurse practitioner, clinical nurse specialist, physician assistant, dentist, veterinarian, pharmacist, hospital, or other person licensed, registered, or otherwise permitted under Federal or State law to distribute, dispense, or administer a controlled substance in the course of professional practice.

“(8) The term ‘schedule II, III, or IV controlled substance’ means a controlled substance (as that term is defined in section 102 of the Controlled Substances Act) included in schedule II, III, or IV of section 202 of such Act.”

# Continuing Advocacy in Washington



In September 2003, just after ASIPP's legislative session from May 6-8, 2003 in Washington DC, a second legislative session followed the annual meeting in Washington DC, and was even better and larger than all the previous ones. One hundred twenty members of the American Society of Interventional Pain Physicians (ASIPP) visited 201 House and Senate members, explaining the issues facing interventional pain physicians and issues related to patient access. This was in addition to the 78 members of the American Society of Interventional Pain Physicians who visited in May of 2003 in the continuing effort to educate legislators

with regards to multiple issues being faced by interventional pain physicians on a daily basis. Apparently repeat visits do get recognition.

Members of ASIPP were pleased by the interest shown by the legislature and administration on issues related to interventional pain management and its access to patients. By repeated visits, legislators are becoming aware of the many issues, including membership on the Carrier Advisory Committees (CACs), the addition of multiple procedures to the ASC approved list, and the need for NASPER.

The ASIPP Board of Directors and over 100 members visited 201 legisla-

tive offices, 54 in the Senate, and 147 in the House.

The legislative delegation presented at 3-point agenda addressing the issues facing interventional pain physicians, which continue to limit access to patients and issues making interventional pain management practices complicated on a daily basis. Once again, ASIPP presented a clear message based on patient access, safety, and quality of care. The three issues ASIPP focused on were:

1. The proposed National All Schedules Electronic Reporting Act (NASPER)
2. Addition of interventional procedures to the ASC list

3. Representation of interventional pain physicians on Carrier Advisory Committees in all states

On Monday's session, September 8, 2003, our governmental affairs representative, former Senator Tim Hutchinson, emphasized the importance of grassroots involvements in lobbying. He also emphasized that effective advocacy is not going to be achieved from a yearly visit by a society's president or by members of the Board. It can only be achieved by visits by each and every member of the society. He added that it is extremely important for each member to visit their Congressman or woman and

Senator in their local offices and educate the local staff, along with Washington staff, with regards to the multiple issues of interventional pain management and of interest to you. Mike Pape, District Director of Representative Ed Whifield (1st District R-KY) echoed the same issues and also described the means by which members can approach their offices not only in Washington but locally in their districts to develop personal relationships.

Representative Ed Whitfield (R-KY) also spoke on several issues facing interventional pain management, along with issues facing medicine in general. He spoke extensively on the

three issues facing interventional pain management, along with the Medicare Bill which will avert the proposed cuts of 4.4% in physician fee and result in 1.5% increase rather than decrease. As always, he extended his support in resolving multiple issues facing interventional pain physicians.

Tom Scully, Administrator of CMS, was the luncheon speaker on Monday, September 8, 2003. He described the inner workings of the program and difficulties with staff in enacting changes. He focused his discussion mainly on representation on the Carrier Advisory Committees.

The Senators and Representatives visited are listed on next page.

**ALABAMA** (ASIPP Members Attending - Dr. Kenneth Varley)  
 Representative Robert Aderholt (R-AL)  
 Representative Spencer Bachus (R-AL)  
 Representative Joe Bonner (R-AL)  
 Representative Robert E. "Bud" Cramer (D-AL)  
 Representative Artur Davis (D-AL)  
 Representative Terry Everett (R-AL)  
 Representative Michael D. Rogers (R-AL)  
 Senator Richard C. Shelby (R-AL)  
 Senator Jeff Sessions (R-AL)

**CALIFORNIA** (ASIPP Members Attending - Dr. Standiford Helm II, Dr. Charles Williams, and Dr. Miguel Dominguez)  
 Representative Joe Baca (D-CA)  
 Representative Xavier Becerra (D-CA)  
 Representative Howard Berman (D-CA)  
 Representative Mary Bono (R-CA)  
 Representative Ken Calvert (R-CA)  
 Representative Lois Capps (D-CA)  
 Representative Dennis Cardoza (D-CA)  
 Representative Christopher Cox (R-CA)  
 Representative Randy "Duke" Cunningham (R-CA)  
 Representative Susan Davis (D-CA)  
 Representative Calvin Dooley (D-CA)  
 Representative John Doolittle (R-CA)  
 Representative David Dreier (R-CA)  
 Representative Anna Eshoo (D-CA)  
 Representative Sam Farr (D-CA)  
 Representative Bob Filner (D-CA)  
 Representative Elton Gallegly (R-CA)  
 Representative Jane Harman (D-CA)  
 Representative Wally Herger (R-CA)  
 Representative Michael Honda (D-CA)  
 Representative Duncan Hunter (R-CA)  
 Representative Darrell Issa (R-CA)  
 Representative Tom Lantos (D-CA)  
 Representative Barbara Lee (D-CA)  
 Representative Jerry Lewis (R-CA)  
 Representative Zoe Lofgren (D-CA)  
 Representative Robert Matsui (D-CA)  
 Representative Howard "Buck" McKeon (R-CA)  
 Representative Juanita Millender-McDonald (D-CA)  
 Representative Gary Miller (R-CA)  
 Representative George Miller (D-CA)  
 Representative Grace Napolitano (D-CA)  
 Representative Devin Nunes (R-CA)  
 Representative Doug Ose (R-CA)  
 Representative Nancy Pelosi (D-CA)  
 Representative Richard Pombo (R-CA)  
 Representative George Radanovich (R-CA)  
 Representative Dana Rohrabacher (R-CA)  
 Representative Lucille Roybal-Allard (D-CA)  
 Representative Edward Royce (R-CA)  
 Representative Linda Sánchez (D-CA)  
 Representative Loretta Sanchez (D-CA)  
 Representative Adam Schiff (D-CA)  
 Representative Brad Sherman (D-CA)  
 Representative Hilda Solis (D-CA)  
 Representative Fortney "Pete" Stark (D-CA)  
 Representative Ellen Tauscher (D-CA)  
 Representative William Thomas (R-CA)  
 Representative Mike Thompson (D-CA)  
 Representative Maxine Waters (D-CA)  
 Representative Diane Watson (D-CA)  
 Representative Henry Waxman (D-CA)  
 Representative Lynn Woolsey (D-CA)  
 Senator Barbara Boxer (D-CA)  
 Senator Dianne Feinstein (D-CA)

**COLORADO** (ASIPP Members Attending - Dr. James Thacker and Judith Holmes, JD)  
 Representative Bob Beauprez (R-CO)  
 Representative Diane DeGette (D-CO)  
 Representative Joel Hefley (R-CO)  
 Representative Scott McInnis (R-CO)  
 Representative Marilyn Musgrave (R-CO)  
 Representative Thomas Tancredo (R-CO)  
 Representative Mark Udall (D-CO)  
 Representative Ben Nighthorse Campbell (R-CO)  
 Senator Wayne Allard (R-CO)

**CONNECTICUT** (ASIPP Members Attending - Dr. David Kloth and Dr. David Levi)  
 Representative Rosa DeLauro (D-CT)  
 Representative Nancy Johnson (R-CT)  
 Representative John E. Larson (D-CT)  
 Representative Christopher Shays (R-CT)  
 Representative Robert Simmons (R-CT)  
 Senator Christopher Dodd (D-CT)  
 Senator Joseph Lieberman (D-CT)

**DELAWARE** (ASIPP Members Attending - Dr. Pain Physician News  
 Winter 2004

Ganesh Balu and Dr. Frank Falco)  
 Representative Michael Castle (R-DE)  
 Senator Joseph R. Biden, Jr. (D-DE)  
 Senator Thomas Carper (D-DE)

**FLORIDA** (ASIPP Members Attending - Dr. Manjul Derasari, Dr. Luis Escobar, Dr. Shyam Swaine, and Dr. Andrea Trescot)  
 Representative Michael Bilirakis (R-FL)  
 Representative Allen Boyd (D-FL)  
 Representative Corrine Brown (D-FL)  
 Representative Ginny Brown-Waite (R-FL)  
 Representative Ander Crenshaw (R-FL)  
 Representative Jim Davis (R-FL)  
 Representative Peter Deutsch (D-FL)  
 Representative Mario Diaz-Balart (R-FL)  
 Representative Tom Feeny (R-FL)  
 Representative Mark Foley (R-FL)  
 Representative Porter Goss (R-FL)  
 Representative Katherine Harris (R-FL)  
 Representative Alcee Hastings (D-FL)  
 Representative Ric Keller (R-FL)  
 Representative Kendrick Meek (D-FL)  
 Representative John Mica (R-FL)  
 Representative Jeff Miller (R-FL)  
 Representative Adam Putnam (R-FL)  
 Representative Ileana Ros-Lehtinen (R-FL)  
 Representative Clay Shaw, Jr. (R-FL)  
 Representative Cliff Stearns (R-FL)  
 Representative Dave Weldon (R-FL)  
 Representative Robert Wexler (D-FL)  
 Representative Bill Young (R-FL)  
 Senator Bill Nelson (D-FL)  
 Senator Bob Graham (D-FL)

**GEORGIA** (ASIPP Members Attending - Dr. David Gale, Dr. Carlos Giron, and Dr. Robert Windsor)  
 Representative Sanford Bishop, Jr. (D-GA)  
 Representative Max Burns (R-GA)  
 Representative Mac Collins (R-GA)  
 Representative Nathan Deal (R-GA)  
 Representative Phil Gingrey (R-GA)  
 Representative Johnny Isakson (R-GA)  
 Representative Jack Kingston (R-GA)  
 Representative John Linder (R-GA)  
 Representative John Linder (R-GA)  
 Representative Denise Majette (D-GA)  
 Representative Jim Marshall (D-GA)  
 Representative Charlie Norwood (R-GA)  
 Senator Saxby Chambliss (R-GA)  
 Senator Zell Miller (D-GA)

**ILLINOIS** (ASIPP Members Attending - Dr. Scott Glaser and Dr. Stephen Minore)  
 Representative Judy Biggert (R-IL)  
 Representative Jerry Costello (D-IL)  
 Representative Philip Crane (R-IL)  
 Representative Edward Davis (D-IL)  
 Representative Rham Emanuel (D-IL)  
 Representative Lane Evans (D-IL)  
 Representative Luis Guterrez (D-IL)  
 Representative Dennis Hastert (R-IL)  
 Representative Henry Hyde (R-IL)  
 Representative Jesse Jackson, Jr. (D-IL)  
 Representative Timothy Johnson (R-IL)  
 Representative Mark Steven Kirk (R-IL)  
 Representative Ray LaHood (R-IL)  
 Representative William Lipinski (D-IL)  
 Representative Donald Manzullo (R-IL)  
 Representative Bobby Rush (D-IL)  
 Representative Janice Schakowsky (D-IL)  
 Representative John Shimkus (R-IL)  
 Representative Jerry Weller (R-IL)  
 Senator Richard Durbin (R-IL)  
 Senator Peter Fitzgerald (R-IL)

**INDIANA** (ASIPP Members Attending - Dr. Gavin Chartier, Dr. Joseph Fortin, Dr. Shaun Kondamuri, and Dr. Steven Rupert)  
 Representative Dan Burton (R-IN)  
 Representative Steve Buyer (R-IN)  
 Representative Julia Carson (D-IN)  
 Representative Chris Chocola (R-IN)  
 Representative Baron Hill (D-IN)  
 Representative John N. Hostettler (R-IN)  
 Representative Mike Pence (R-IN)  
 Representative Mark Souder (D-IN)  
 Representative Peter Visclosky (D-IN)  
 Senator Evan Bayh (D-IN)  
 Senator Richard Lugar (R-IN)

**KANSAS** (ASIPP Members Attending - Dr. Rodney Jones)  
 Representative Dennis Moore (D-KS)  
 Representative Jerry Moran (R-KS)  
 Representative Jim Ryun (R-KS)  
 Representative Todd Tiahrt (R-KS)  
 Senator Sam Brownback (R-KS)

**Senator Pat Roberts (R-KS)**

**KENTUCKY** (ASIPP Members Attending - Mr. Bert Fellows, Dr. Laxmaiah Manchikanti, Dr. ElMBER Dunbar, Dr. Michael Cassaro, Dr. Peter Wright, and Ms. Lois Downing)  
 Representative Ed Whitfield (R-KY)  
 Representative Ernie Fletcher (R-KY)  
 Representative Ken Lucas (D-KY)  
 Representative Jim Bunning (R-KY)  
 Representative Sherrrod Brown (D-OH)  
 Representative Roy Blunt (R-MO)  
 Representative Frank Pallone (D-NJ)  
 Representative Anne Northup (R-KY)

**LOUISIANA** (ASIPP Members Attending - Dr. Melanie Firmin, Dr. Kevin Gorin, Dr. Luis Hernandez, Dr. Edwin Hyde, Tammy Lessing, Dr. John McCain, Dr. Allan Parr, Dr. Jimmy Ponder, and Dr. Clifton Sheperd)  
 Representative Rodney Alexander (D-LA)  
 Representative Richard Baker (R-LA)  
 Representative William Jefferson (D-LA)  
 Representative Chris John (D-LA)  
 Representative Jim McCrery (R-LA)  
 Representative WJ "Billy" Tauzin (R-LA)  
 Representative David Vitter (R-LA)  
 Senator John B. Breaux (D-LA)  
 Senator Mary L. Landrieu (D-LA)

**MARYLAND** (ASIPP Members Attending - Dr. Kenneth Carle, Dr. P. Bobby Dey, Dr. Ruijin Yao)  
 Representative Roscoe Bartlett (R-MD)  
 Representative Benjamin Cardin (D-MD)  
 Representative Elijah Cummings (D-MD)  
 Representative Wayne Gilchrest (R-MD)  
 Representative Chris Van Hollen (D-MD)  
 Representative Steny Hoyer (D-MD)  
 Representative Dutch Ruppersberger (D-MD)  
 Representative Albert Russell Wynn (D-MD)  
 Senator Barbara Mikulski (D-MD)  
 Senator Paul Sarbanes (D-MD)

**MASSACHUSETTS** (ASIPP Members Attending - Dr. Cameron Govonlu, Sharon Jarmolowicz, PA, and Dr. Bentley Ogoke)  
 Representative Michael Capuano (D-MA)  
 Representative William Delahunt (D-MA)  
 Representative Barney Frank (D-MA)  
 Representative Stephen Lynch (D-MA)  
 Representative Edward Markey (D-MA)  
 Representative James McGovern (D-MA)  
 Representative Martin Meehan (D-MA)  
 Representative Richard Neal (D-MA)  
 Representative John Olver (D-MA)  
 Representative John Tierney (D-MA)  
 Senator Edward Kennedy (D-MA)  
 Senator John Kerry (D-MA)

**MICHIGAN** (ASIPP Members Attending - Dr. Francoise Singh, Halema Addu, Susan Khoury, Jessica Labre, Dr. Chancur Piryani, Dr. Vijay Singh, Kelly Van Oss, Amit Verma, Robert Whitens, and Andrea Wickman)  
 Representative Dave Camp (R-MI)  
 Representative John Dingell (D-MI)  
 Representative Sander Levin (D-MI)  
 Representative Michael Rogers (R-MI)  
 Representative Bart Stupak (D-MI)  
 Representative Fred Upton (R-MI)  
 Senator Debbie Stabenow (D-MI)  
 Senator Carl Levin (D-MI)

**MINNESOTA** (ASIPP Members Attending - Georgann Gillund, Dr. David Schultz, Marsha Thiel, Dr. Thomas Kowalkowski)  
 Representative Jim Ramstad (R-MN)  
 Representative Olav Sabo (D-MN)  
 Senator Norm Coleman (R-MN)  
 Senator Mark Dayton (D-MN)

**MISSISSIPPI** (ASIPP Members Attending - Dr. Arnold Feldman)  
 Representative Chip Pickering (R-MN)  
 Senator Thad Cochran (R-MS)  
 Senator Trent Lott (R-MS)

**NEW JERSEY** (ASIPP Members Attending - Dr. Kenneth Zahl)  
 Representative Mike Ferguson (R-NJ)  
 Representative Frank Pallone (D-NJ)  
 Representative Rodney Frelinghuysen (R-NJ)  
 Senator Jon Corzine (D-NJ)  
 Senator Frank Lautenberg (D-NJ)

**NEW YORK** (ASIPP Members Attending - Dr. Isaiah Florence and Dr. Benjamin Hirsch)  
 Representative Vito Fossella (R-NY)

Representative Edolphus Towns (D-NY)  
 Representative Eliot Engel (D-NY)  
 Representative Amo Houghton (R-NY)  
 Representative Charlie Rangel (D-NY)  
 Representative Michael McNulty (D-NY)  
 Senator Charles Schumer (D-NY)  
 Representative Hilary Clinton (D-NY)

**NORTH CAROLINA** (ASIPP Members Attending - Dr. Mark Goodson, Dr. Hans Hansen, Dr. Mark Hines, Dr. James M. Chimaik, and Dr. Ronald VanDerNoord)  
 Representative Cass Ballenger (R-NC)  
 Representative Richard Burr (R-NC)  
 Representative Sue Myrick (R-NC)  
 Senator Elizabeth Dole (R-NC)  
 Senator John Edwards (D-NC)

**OHIO** (ASIPP Members Attending - Dr. David Chow and Dr. Jeffrey Janata)  
 Representative Sherrod Brown (D-OH)  
 Representative Earl Gillmor (R-OH)  
 Representative Rob Portman (R-OH)  
 Representative Ted Strickland (D-OH)  
 Representative Stephanie Tubbs-Jones (D-OH)  
 Senator Mike DeWine (R-OH)  
 Senator George V. Voinovich (R-OH)

**OREGON** (ASIPP Members Attending - Dr. Timothy Kelly and Dr. Edward McCluskey)  
 Representative Greg Walden (R-OR)  
 Representative Earl Blumenauer (D-OR)  
 Senator Gordon H. Smith (R-OR)  
 Senator Ron Wyden (D-OR)

**PENNSYLVANIA** (ASIPP Members Attending - Dr. Dajie Wang, Dr. John Lee, Dr. David Leff, Dr. Jagadeesha Shetty)  
 Representative Mike Doyle (D-PA)  
 Representative Philip English (R-PA)  
 Representative Joseph Pitts (R-PA)  
 Senator Rick Santorum (R-PA)  
 Senator Arlen Specter (R-PA)

**SOUTH CAROLINA** (ASIPP Members Attending - Dr. Arthur Jordan and Dr. Andrew Geer)  
 Senator Lindsey Graham (R-SC)  
 Senator Ernest Hollings (D-SC)

**TENNESSEE** (ASIPP Members Attending - Jennifer Bolen, JD and Dr. Claudio Feler)  
 Representative Bart Gordon (D-TN)  
 Representative John Tanner (D-TN)  
 Senator Bill Frist (R-TN)  
 Senator Lamar Alexander (R-TN)

**TEXAS** (ASIPP Members Attending - Dr. Jon Harmer, Dr. Samuel Hassenbusch III, Dr. Liesel Leedy, Dr. Gabor Racz, Dr. Allan Kay, and Dr. Prithvi Raj)  
 Representative Joe Barton (R-TX)  
 Representative Kevin Brady (R-TX)  
 Representative Lloyd Doggett (D-TX)  
 Representative Ralph M. Hall (D-TX)  
 Representative Gene Green (D-TX)  
 Representative Sam Johnson (R-TX)  
 Representative Max Sandlin (D-TX)  
 Senator Kay Bailey Hutchison (R-TX)  
 Senator John Cornyn (R-TX)

**VERMONT** (ASIPP Members Attending - Dr. Evan Musman)  
 Senator James Jeffords (I-VT)  
 Senator Patrick Leahy (D-VT)

**VIRGINIA** (ASIPP Members Attending - Dr. Cyrus Bakht, Dr. JM Manuela de Klaver, Dr. Lisa Barr, and Dr. George VanOsten)  
 Representative Rick Boucher (D-VA)  
 Representative Eric Cantor (R-VA)  
 Representative Robert Goodlatte (R-VA)  
 Representative Frank R. Wolf (R-VA)  
 Senator George Allen (R-VA)  
 Senator John Warner (R-VA)

**WASHINGTON** (ASIPP Members Attending - Dr. Joseph Jasper and Dr. Solomon Kamson)  
 Representative Norman D. Dicks (D-WA)  
 Representative Jennifer Dunn (R-WA)  
 Representative Jim McDermott (D-WA)  
 Senator Maria Cantwell (D-WA)

**WEST VIRGINIA** (ASIPP Members Attending - Dr. Richard Bowman and Dr. Ahmet Ozturk)  
 Representative Paul Ryan (R-WI)  
 Representative Jerry Kleczka (D-WI)  
 Senator Herbert Kohl (D-WI)  
 Senator Russ Feingold (D-WI)

# Highlights of 5<sup>th</sup> Annual Meeting

SEPTEMBER 6-8, 2003 IN WASHINGTON, DC

The 5th Annual Meeting of the American Society of Interventional Pain Physicians was held at Hilton Alexandria Mark Center in Alexandria, Virginia. The highlights of this annual meeting, apart from a busy didactic schedule and workshops, were the legislative visits, political speakings, and collaboration with other organizations, including the American Society of Anesthesiologists and the American Academy of Pain Medicine. Multiple distinguished speakers included Representative Ed Whitfield (R-KY), Mike Pape, District Director of Ed Whitfield, former Senator Tim Hutchinson, Tom Scully, Administrator of CMS, Samuel Hassenbusch, MD, President Elect of the American Academy of Pain Medicine, James E. Cottrell, MD, President of the American Society of Anesthesiologists, and Peter Staats, MD, President of the Neuromodulation Society.

The meeting was well attended by over 350 participants.

The next annual meeting will be held in Washington DC from September 11-13, 2004 followed by legislative visits on Tuesday & Wednesday, September 14-15, 2004.

The extensive topics of discussion included the following:

Complex Regional Pain Syndrome  
Psychology in Chronic Pain  
Radiology  
Practice Management  
Compliance, Fraud, and Abuse  
Liability Issues  
Managing State Organizations  
Chronic Low Back Pain

The faculty:

<b>Sairam Atluri, MD</b>	<b>Laxmaiah Manchikanti, MD</b>
<b>Jennifer Bolen, JD</b>	<b>Erin B. McMahon, JD</b>
<b>Mark V. Boswell, MD, PhD</b>	<b>Joanne Mehmert, CPC</b>
<b>JoAnne Burkhardt</b>	<b>W. Stephen Minore, MD</b>
<b>R. Allen Button, Esq.</b>	<b>Mike Pape</b>
<b>David W. Chow, MD</b>	<b>John Pier, MD</b>
<b>James E. Cotrell, MD</b>	<b>Gabor B. Racz, MD</b>
<b>Elmer E. Dunbar, MD</b>	<b>Marcy T. Rogers, MEd</b>
<b>Frank J. Falco, MD</b>	<b>William Sarraille, JD</b>
<b>Claudio A. Feler, MD</b>	<b>David Schultz, MD</b>
<b>Joseph Fortin, DO</b>	<b>Thomas A. Scully</b>
<b>Frank Grant</b>	<b>Jeff Segal, MD</b>
<b>Hans C. Hansen, MD</b>	<b>Nalini Sehgal, MD</b>
<b>Samuel Hassenbusch III, MD, PhD</b>	<b>Vijay Singh, MD</b>
<b>Senator Tim Hutchinson</b>	<b>Anna Spencer, JD</b>
<b>Melissa Hawkins, CPA</b>	<b>Peter S. Staats, MD</b>
<b>Standiford Helm II, MD</b>	<b>Andrea M. Trescot, MD</b>
<b>Benjamin Hirsch, PhD</b>	<b>Kenneth Varley, MD</b>
<b>Joshua A. Hirsch, MD</b>	<b>Sridhar V. Vasudevan, MD</b>
<b>Judith H. Holmes, JD</b>	<b>Bradley Vilims, MD</b>
<b>Jeffery W. Janata, PhD</b>	<b>Rep. Ed Whitfield</b>
<b>Arthur E. Jordan, MD</b>	<b>Wade Wong, DO</b>
<b>David S. Kloth, MD</b>	<b>Peter D. Wright, MD</b>

## Tom Scully, Administrator of CMS, Addresses ASIPP Annual Meeting



Tom Scully, Administrator of the Centers for Medicare and Medicaid Services, addressed the Annual Meeting of the American Society of Interventional Pain Physicians on September 8, 2003. During the lunch, Mr. Scully provided his insights into the Medicare program, its operation, inner workings of

Medicare, and other issues related to interventional pain physicians.

Mr. Scully spoke extensively about the Carrier Advisory Committee, his meetings with staff, and his impressions. Following this, he stated he would be able to answer our concerns on that issue within one week. Subsequently, we received the following information from Mr. Scully, described in the letter below, which was sent to the membership, as well as Medicare Directors.

Mr. Scully also spoke about drug reimbursement of physician-administered drugs. He stated that there were multiple options under consideration and he was not able to provide us with any further details.

At the time of writing this newsletter, Mr. Scully had resigned his position as Administrator of CMS.

FDA Chief Mark McClellan, a physician and economist, has been nominated by President Bush to be the new Administrator of the Centers for Medicare and Medicaid Services, a part of the Department of Health and Human Services. If confirmed by the Senate, Dr. McClellan will become administrator of the CMS, which spends more than \$480 billion a year and regulates nearly every sector of the nation's health care system.

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### American Society of Interventional Pain Physicians

"The Voice of Interventional Pain Management"

2831 Lone Oak Road, Paducah, KY 42003

Tel.: (270) 554-9412; Fax : (270) 554-8987

E-mail: [drm@asipp.org](mailto:drm@asipp.org)

Dear Friends,

On the issue of representation on the Carrier Advisory Committees (CACs), our legislative counsel in Washington, Senator Tim Hutchinson, based on a call from CMS Administrator, Tom Scully, has informed us that Mr. Scully has decided "to inform the medical directors that they should include representation from ASIPP (interventional pain management) and that he presumes that they will unless they affirmatively object and provide their justification for excluding an ASIPP representative from CAC representation.

Mr. Scully believes that this presumption will bring a rapid expansion to the number of states (17) in which we currently have representation. He further added that should this action not achieve the desired results (uniform representation on all CACs), he is prepared to review the issue again and perhaps take the fully mandated approach."

This is an enormous step forward in ASIPP's efforts to have a fair and equitable opportunity to participate in the decision making process for establishing Local Medical Review Policies (LMRPs) which is the task of the Carrier Advisory Committees. We are grateful to CMS Administrator Scully and the CMS staff for their cooperation. We also thank all of the Medical Directors and look forward to working together with them.

Sincerely,

*Laxmaiah Manchikanti, M.D.*

*President & Executive Director*

# Medicare Prescription Drug Bill: Medical World Benefits

## Physicians to Receive 1.5% Positive Reimbursement Updates in 2004 and 2005

## Big ASC Payment Change May Be in the Pipeline

## Restrictions on Specialty Hospitals

Medicare Prescription Drug and Modernization Act of 2003 passed the House of Representatives on November 22. The Senate passed the same bill on November 25. President George W. Bush signed this Bill into law on December 8, 2003.

This Bill is a mixed bag for interventionalists with substantial improvement in payment rates for physician services, however, with risk for ASC services and specialty hospital services.

### **GOOD NEWS FOR PHYSICIANS**

The Medicare bill prevents a proposed 4.5% cut and replaces it with a 1.5% increase which overall represents a 6% favorable swing in the Medicare conversion factor for interventional pain physicians, along with all other physicians. Further, the Bill also prevents cuts in 2005. However, passage of this legislation hardly means that physicians are out of the woods in terms of Medicare reimbursement. Unfortunately, due to postponing the present cut, and to the impact of the statutory Medicare update formula, there could be steep cuts unless Congress acts further to prevent such cuts and takes long-term steps. Thus far, CMS has not provided an updated formula, however, expect-

ed calculated rates are posted on our website at [www.asipp.org](http://www.asipp.org).

### **BAD NEWS FOR AMBULATORY SURGERY CENTERS**

ASCs will lose their cost-of-living adjustments. The new Medicare Act replaces the cost-of-living adjustment with adjustment of the CPI (-3%) for the period of April 1, 2004 through September 30, 2004. Effective October 1, 2004, ASCs will have no rate adjustments through September 30, 2009.

Further, the legislation deletes the requirement for CMS to base future ASC rates on a cost survey. Instead, the Bill calls for a General Accounting Office (GAO) study of ASC costs, comparing them to services for issue in hospitals. The Bill asks GAO to recommend to Congress by January 1, 2005 whether the hospital outpatient prospective payment system is appropriate for determining ASC rates.

CMS must implement a new ASC payment system by January 1, 2008, best rate least in part on the GAO's recommendations. The new payment system must be budget neutral.

### **SPECIALTY HOSPITALS IN LIMBO**

A provision in the Bill will erase for 18 months the Stark exception that

allowed physicians to refer patients to specialty hospitals they own. While physician investors may still refer Medicare beneficiaries to existing specialty hospitals and those under development before November 18, 2003, they are barred from referring patients to specialty hospitals for which architectural plans are incomplete or funding has not been received. According to the General Accounting Office in an October 20, 2000 report, there are 100 specialty hospitals already existing, and 26 are under development.

### **REGULATORY RELIEF PROVISIONS**

Due process protections for Medicare Carrier audits include:

- ♦ Deferring any financial penalties until physician appealed rights are exhausted
- ♦ No penalties when a physician relies on guidance from Medicare officials
- ♦ An opportunity to correct errors before repayment demands are made
- ♦ Limits on extrapolation or small-scale audits to generate large overpayment demands
- ♦ Physicians in rural areas benefit
- ♦ Geographic payment disparities would be reduced with a \$1 billion increase in the work component to the fee schedule
- ♦ An additional \$700 million in incentives to maintain and enhance the physician supply in rural and underserved areas

# Correct Coding Initiative Update

## Reversal of Multiple Edits for Interventional Procedures

Many of the interventional pain management codes are subject to CCI edits. On the following page is a letter written to ASIPP from the AdminaStar Medical Director Niles Rosen, MD, with regards to multiple inappropriate codes in response to a letter of request from ASIPP. The interventional pain management community is grateful to AdminaStar Federal and Dr. Niles Rosen, who have gracefully agreed with the changes we requested. Dr. Manchikanti, on behalf of ASIPP sent a letter to Dr. Niles Rosen at AdminaStar Federal on the issue of Correct Coding Initiative and Interventional Pain Management, explaining multiple instances of unfair bundling, and expressed concern about this issue. This letter stated that multiple component codes with comprehensive codes are erroneous or cause significant difficulty for providers in filing for claims with modifiers to override these codes. ASIPP expressed that our understanding of CCI to be accurate in order to prevent abuses in the system. ASIPP only described the commonly performed interventional pain management procedures, and their comprehensive and compo-

nent codes. Multiple codes at issue included the following:

1. CPT 0027T : Endoscopic lysis of epidural adhesions with direct visualization using mechanical means or solution injection including radiological localization and epidurography
2. CPT 27093: Injection procedure for hip arthrography – without anesthesia
3. CPT 27096: Injection procedure for sacroiliac joint, arthrography
4. CPT 62263 : Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
5. CPT 62264: Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
6. Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with

or without other therapeutic substance; epidural, cervical or thoracic

7. CPT 62282 : Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
8. CPT 62290 : Injection procedure for discography, each level; lumbar
9. CPT 62310: Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
10. CPT 62311: Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)



**AdminaStar Federal**  
A CMS Contracted Carrier and Intermediary  
<http://www.adminastar.com>

October 24, 2003

Laxmaiah Manchikanti, MD  
American Society of Interventional Pain Physicians  
2831 Lone Oak Road  
Paducah, KY 42003

Dear Dr. Manchikanti:

I thank you for your letter dated August 27, 2003 in which you comment about numerous National Correct Coding Initiative (NCCI) edits. Apparently, we never received your earlier letter dated June 25, 2003 until it came as an attachment to your August letter. We have discussed both letters with CMS which owns NCCI and makes all decisions about its contents.

CMS will delete all the edits that you listed for deletion except four edits which were previously deleted in NCCI version 9.3 implemented on October 1, 2003. (A list is attached.) The deletions will appear in NCCI version 10.0 scheduled for January 1, 2004 and will be retroactive to the implementation dates of the edits. Since the edits have allowed use of NCCI associated modifiers such as modifier -59 for different anatomic sites, the edits should not have resulted in any inappropriate denial of payments.

Edits are often added to NCCI which bundle a range of codes with another code. For example, NCCI bundles a number of codes for postoperative pain management into virtually all surgical procedures since under global surgery rules a provider performing an operative procedure cannot separately report postoperative pain management for that procedure. Most of the edits that you wrote about were entered into NCCI because of similar types of edits using ranges of codes although not necessarily related to postoperative pain management. Since these types of edits allow use of NCCI associated modifiers, they do not cause inappropriate denials of payment because providers can use the modifiers if appropriate. However, such edits may result in additional administrative work. When providers or societies identify these types of edits where a provider would always use a modifier to bypass the edit, CMS deletes the edit.

P.O. Box 50469  
8115 Knue Road • Indianapolis, IN 46250-0469  
National Correct Coding Initiative  
Fax: (317) 841-4600

We appreciate your assistance with the NCCI. If you have additional comments about NCCI edits, please do not hesitate to write.

Sincerely,



Niles R. Rosen, M.D.  
Medical Director  
National Correct Coding Initiative

Cc: Marsha Mason-Wonsley, CMS CPT Coding Specialist

Attachment (one page)

**ATTACHMENT – NCCI EDITS TO BE DELETED ON JANUARY 1, 2004 IN  
VERSION 10.0 RETROACTIVE TO ORIGINAL EFFECTIVE DATES OF THE  
EDITS**

<u>Column 1 Code</u>	<u>Column 2 Code</u>
0027T	64470
0027T	64479
27093	64470
27093	62318
27093	64475
27096	62318
27096	64470
27096	64475
62263	62281
62263	62310
62263	62318
62263	64470
62263	64479
62263	64475
62264	62281
62264	62310
62264	62318
62264	64470
62264	64479
62264	64475
62281	62319
62281	64475
62282	62318
62282	64470
62290	62311
62290	64470
62290	64475
62290	64483
62310	62319
62310	64470 PREVIOUSLY DELETED ON 10/1/2003
62310	64475 PREVIOUSLY DELETED ON 10/1/2003
62311	62318
62311	64470 PREVIOUSLY DELETED ON 10/1/2003
62311	64475 PREVIOUSLY DELETED ON 10/1/2003

**AN UPDATE ON THE CORRECT CODING INITIATIVE IN INTERVENTIONAL PAIN MANAGEMENT**

CMS inserted **7,904 changes** into the National Correct Coding Initiative (CCI) Version 10.0, effective January 1, 2004, including **7,263 new comprehensive - component code edits** and **244 new mutually exclusive edits**. The majority of code pair additions occur in the 00000-09999 (Anesthesia), 30000-39999 (Respiratory, cardiovascular, hemic and lymphatic system) and HCPCS code ranges. This is a dynamic process which changes every 3 months.

Updates on Correct Coding Initiative can be found at [www.asipp.org/news.htm](http://www.asipp.org/news.htm)

# ASIPP'S Evidence Based Guidelines for Interventional Techniques is on National Guideline Clearing House Website ([www.guidelines.gov](http://www.guidelines.gov))



## MAJOR RECOMMENDATIONS

*These recommendations are presented in abbreviated form. Readers should refer to the text of the guideline document for a detailed discussion of each of the following topics.*

Definitions for the designations of levels of evidence (level I [conclusive], level II [strong], level III [moderate], level IV [limited], and level V [indeterminate]) are given at the end of the Major Recommendations.

## Diagnostic Interventional Techniques

### *Facet Joint Diagnostic Blocks*

Based on multiple evaluations, the validity, specificity and sensitivity of facet joint nerve blocks are considered strong in the diagnosis of facet joint pain. Based on multiple evaluations, facet or zygapophysial joints have been implicated as the source of chronic spinal pain in 15% to 45% of the heterogeneous groups of patients with chronic low back pain, 48% of the patients with thoracic pain, and 54% to 67% of the patients with chronic neck pain. Reported false-positive rates varied from 27% to 63% in cervical spine, 58% in thoracic spine, and 22% to 47% in lumbar spine.

### *Provocative Discography*

Extensive evidence of provocative discography was reviewed on normal volunteers, comparison of discography findings on post mortem specimens, comparison with computed tomography and magnetic resonance imaging, high-intensity zone identification, evidence of discogenic pain or internal disc disruption and false-positives in patients with low back pain or with psychological abnormalities. Based on the cumulative analysis of the literature, the evidence for cervical and thoracic discography is limited. However, the evidence for lumbar discography is strong for discogenic pain provided that lumbar discography is performed based on the history, physical examination, imaging data, and analysis of other precision diagnostic techniques. There is no evidence to support discography without other non-invasive or less invasive modalities of treatments or other precision diagnostic injections.

### *Transforaminal Epidural Injections*

The current evidence provides moderate evidence of transforaminal epidural injections in the preoperative evaluation of patients with negative or inconclusive imaging studies and clinical findings of nerve root irritation. The present review of the available literature provides limited evidence as to the role of transforaminal epidural injections in the diagnosis of segmental dural-nerve root pain in the absence of disc herniation and negative provocative discography.

### *Sacroiliac Joint Blocks*

Based on the results of controlled diagnostic local anesthetic blocks, prevalence of sacroiliac joint pain has been shown to be present in 10% to 18.5% of patients with low back pain with a false-positive rate of 20%. The evidence for specificity and validity of sacroiliac joint diagnostic injections is moderate.

## **Therapeutic Interventional Techniques**

### *Facet Joint Pain*

- *Intraarticular Injections.* The evidence of intraarticular injections of local anesthetics and steroids from randomized trials, complemented with that of non-randomized trials (prospective and retrospective evaluations) provided moderate evidence of short-term relief and limited evidence of long-term relief of chronic neck and low back pain.
- *Medial Branch Blocks.* Combined evidence of the medial branch blocks from one randomized trial, complimented with two non-randomized trials (one prospective and one retrospective evaluation) provided strong evidence of short-term relief and moderate evidence of long-term relief of pain of facet joint origin.
- *Medial Branch Neurotomy.* Considering the one systematic review, two randomized trials, four prospective evaluations, and three retrospective evaluations, combined evidence of radiofrequency neurotomy of medial branches provided strong evidence of short-term relief and moderate evidence of long-term relief of chronic spinal pain of facet joint origin.

### *Epidural Injections*

- *Caudal Epidural Injections.* The combined evidence of caudal epidural steroid injections with randomized trials and non-randomized trials (prospective and retrospective trials) is strong for short-term relief and moderate for long-term relief.
- *Interlaminar Epidural Injections.* Evidence for the overall effectiveness of interlaminar epidural steroid injections in managing chronic low back pain is moderate for short-term relief and limited for long-term relief.
- *Transforaminal Epidural Injections.* Based on the evaluation of multiple randomized and non-randomized trials, transforaminal epidural injections provided strong evidence for short-term and long-term relief. Their effectiveness in post lumbar laminectomy syndrome and disc extrusions is inconclusive.

### *Epidural Adhesiolysis*

- Evidence of effectiveness of percutaneous adhesiolysis, based on randomized and non-randomized evaluations is moderate for short-term and long-term relief with repeat interventions.
- Evidence synthesis for spinal endoscopy with prospective evaluations and retrospective evaluations showed moderate evidence for short-term relief and limited evidence for long-term relief.

### *Intradiscal Therapies*

- *Intradiscal Electrothermal Therapy.* Based on this evidence analysis, it appears that intradiscal electrothermal therapy meets the criteria for moderate evidence for short-term relief and limited evidence for long-term relief.
- *Nucleoplasty.* Evidence is limited showing the effectiveness of percutaneous disc decompression (PDD) with nucleoplasty.

### *Implantable Therapies*

- *Spinal Cord Stimulation.* The evidence for spinal cord stimulation in properly selected population with neuropathic pain is moderate for long-term relief.
- *Implantable Intrathecal Drug Administration System.* Based on the available literature, there is moderate evidence indicating the long-term effectiveness of intrathecal infusion systems.

## Evaluation

Appropriate history, physical examination, and medical decision making from the initial evaluation of a patient's presenting symptoms are essential. There are numerous acceptable medical methods to evaluate a chronic spinal pain patient. These methods vary from physician to physician and textbook to textbook. Following the guidelines established by the Centers for Medicare and Medicaid Services (CMS) not only would assist a physician in performing a comprehensive and complete evaluation, but also assist them to be in compliance with regulations. The guidelines of CMS provide various criteria for five levels of services. The three crucial components of evaluation and management services are: history, physical examination, and medical decision-making.

## Evaluation and Management Algorithm

A suggested algorithm for the Comprehensive Evaluation and Management of Chronic Pain is available in the original guideline document (page 55).

## Criteria for Performing Interventional Techniques

The following criteria should be considered carefully in performing interventional techniques:

- Complete initial evaluation, including history and physical examination.
- Physiological and functional assessment, as necessary and feasible.
- Definition of indications and medical necessity:
  - Suspected organic problem
  - Nonresponsiveness to less invasive modalities of treatments except in acute situations such as acute disc herniation, herpes zoster and postherpetic neuralgia, reflex sympathetic dystrophy, and intractable pain secondary to carcinoma.
  - Pain and disability of moderate-to-severe degree.
  - No evidence of contraindications such as severe spinal stenosis resulting in intraspinal obstruction, infection, or predominantly psychogenic pain.
  - Responsiveness to prior interventions with improvement in physical and functional status to proceed with repeat blocks or other interventions.
  - Repeating interventions only upon return of pain and deterioration in functional status.

## Delivery of Interventional Technology

Following is the description of frequency of various types of interventional techniques. Safety and effectiveness of multiple types of interventional techniques have been established. These are based on available evidence and consensus to the safety, clinical effectiveness, and cost effectiveness. However, these are not based on evidence synthesis methodology. Descriptions are provided only for some commonly used procedures.

### *Facet Joint Injections*

- In the diagnostic phase, a patient may receive injections at intervals of no sooner than 1 week or, preferably, 2 weeks.
- In the therapeutic phase (after the stabilization is completed), the suggested frequency would be 2 months or longer between each injection, provided that at least  $\geq 50\%$  relief is obtained for 6 weeks.
- If the neural blockade is applied for different regions, it can be performed at intervals of no sooner than 1 week or preferably 2 weeks for most types of blocks. It is suggested therapeutic frequency remain at 2 months for each region. It is further suggested that all regions be treated at the same time, provided all procedures are performed safely.
- In the diagnostic or stabilization phase, the suggested number of injections would be limited to no more than 4 times per year.
- In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and it is suggested that these be limited to a maximum of six times for local anesthetic and steroid blocks for a period of 1 year.
- Under unusual circumstances with a recurrent injury or cervicogenic headache, blocks may be repeated at intervals of 6 weeks after stabilization in the treatment phase.

### *Medial Branch Neurolysis*

- The suggested frequency would be 3 months or longer between each neurolytic procedure, provided that at least  $\geq 50\%$  relief is obtained for 10 to 12 weeks.
- If the neural blockade is applied for different regions, it may be performed at intervals of no sooner than 1 week or, preferably, 2 weeks for most types of blocks. The therapeutic frequency for neurolytic blocks would preferably remain at intervals of at least 3 months for each region. It is further suggested that all regions be treated at the same time, provided all procedures are performed safely.

### *Epidural Injections*

- Epidural injections include caudal, interlaminar, and transforaminal.
- In the diagnostic phase, a patient may receive injections at intervals of no sooner than 1 week or preferably, 2 weeks, except for blockade in cancer pain or when a continuous administration of local anesthetic is employed for reflex sympathetic dystrophy.
- In the therapeutic phase (after the diagnostic phase is completed), the suggested frequency of interventional techniques would be 2 months or longer between each injection, provided that at least  $\geq 50\%$  relief is obtained for 6 to 8 weeks.
- If the neural blockade is applied for different regions, it may be performed at intervals of no sooner than 1 week and preferably 2 weeks for most type of blocks. The therapeutic frequency may remain at intervals at least 2 months for each region. It is further suggested that all regions be treated at the same time, provided all procedures are performed safely.
- In the diagnostic phase, it is suggested number of injections would be limited to no more than 2 times except for reflex sympathetic dystrophy, in which case 3 times is reasonable.
- In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and it is suggested that these be limited to a maximum of 6 times per year.
- Under unusual circumstances with a recurrent injury current injury, carcinoma, or reflex sympathetic dystrophy, blocks may be repeated at intervals of 6 weeks after diagnosis/stabilization in the treatment phase.

### *Percutaneous Lysis of Adhesions*

- The number of procedures are preferably limited to:
  - With a 3-day protocol, 2 interventions per year,
  - With a 1-day protocol, 4 interventions per year.

### *Spinal Endoscopy*

- The procedures are preferably limited to a maximum of 2 per year provided the relief was  $\geq 50\%$  for  $\geq 4$  months.

### *Sacroiliac Joint Injections*

- In the diagnostic or stabilization phase, a patient may receive injections at intervals of no sooner than 1 week or, preferably, 2 weeks.
- In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency would be 2 months or longer between each injection, provided that at least  $\geq 50\%$  relief is obtained for 6 weeks.
- If the neural blockade is applied for different regions, it may be performed at intervals of no sooner than 1 week or, preferably, 2 weeks for most types of blocks. The therapeutic frequency may remain at 2 months for each region. It is further suggested that all regions be treated at the same time, provided all procedures are performed safely.
- In the diagnostic or stabilization phase, the suggested number of injections would be limited to no more than 4 times per year.
- In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 6 times for local anesthetic and steroid blocks for a period of 1 year.

## **Definitions:**

### **Designation of Levels of Evidence**

#### Level I

*Conclusive:* Research-based evidence with multiple relevant and high quality scientific studies or consistent reviews or consistent reviews of meta-analyses.

#### Level II

*Strong:* Research-based evidence from at least one properly designed randomized, controlled trial of appropriate size (with at least 60 patients in the smallest group); or research-based evidence from multiple properly designed studies of smaller size; or at least one randomized trial, supplemented by predominantly positive prospective and/or retrospective evidence.

#### Level III

*Moderate:* Evidence from a well-designed small randomized trial or evidence from well-designed trials without randomization, or quasi-randomized studies, single group, pre-post cohort, time series, or matched case-controlled studies or positive evidence from at least one meta-analysis.

#### Level IV

*Limited:* Evidence from well-designed nonexperimental studies from more than one center or research group.

#### Level V

*Indeterminate:* Opinions of respected authorities, based on clinical evidence, descriptive studies, or reports of expert committees.

### **CLINICAL ALGORITHM(S)**

The original guideline contains algorithms for 1) the Comprehensive Evaluation and Management of Chronic Pain; 2) the Approach to Diagnosis of Chronic Back Pain without Disc Herniation; 3) the Application of Therapeutic Interventional Techniques in Management of Chronic Low Back Pain; and 4) the Approach to Diagnosis of Chronic Neck Pain without Disc Herniation.

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence supporting the recommendation is identified in the "Major Recommendations" field.

## IDENTIFYING INFORMATION AND AVAILABILITY

### **BIBLIOGRAPHIC SOURCE(S)**

- Manchikanti L, Staats PS, Singh V, Schultz DM, Vilims BD, Jasper JF, Kloth DS, Trescot AM, Hansen HC, Falasca TD, Racz GB, Deer TR, Burton AW, Helm S, Lou L, Bakhit CE, Dunbar EE, Atluri SL, Calodney AK, et al. Evidence-based practice guidelines for interventional techniques in the management of chronic spinal pain. *Pain Phys* 2003;6:3-81. [1175 references]

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

### **DATE RELEASED**

2003

### **GUIDELINE DEVELOPER(S)**

American Society of Interventional Pain Physicians - Medical Specialty Society

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American Society of Interventional Pain Physicians

**GUIDELINE COMMITTEE**

Research and Guideline Committee

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

The Research and Guideline Committee was responsible for developing the guideline. It consisted of the Executive Committee of the Board and all the authors.

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**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

There were no conflicts of financial interest. No funding was provided by any external agency.

**GUIDELINE STATUS**

This is the current release of the guideline.

**GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [American Society of Interventional Pain Physicians Web site](#).

Print copies: Available from the American Society of Interventional Pain Physicians, 2831 Lone Oak Road, Paducah, KY 42003; Phone: (270) 554-9412; Fax: (270) 554-8987; email: [asipp@asipp.org](mailto:asipp@asipp.org).

**AVAILABILITY OF COMPANION DOCUMENTS**

None available

**PATIENT RESOURCES**

None available

**NGC STATUS**

This NGC summary was completed by ECRI on July 21, 2003. The information was verified by the guideline developer on July 31, 2003.

**COPYRIGHT STATEMENT**

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions. This guideline is available for download from the [American Society of Interventional Pain Physicians \(ASIPP\) Web site](#).

# Cadaver Workshops

ASIPP continued its Cadaver Workshops in 2003, all being conducted at the Medical Education and Research Institute (MERI) in Memphis, TN. The following workshops were conducted.

May 17-18, 2003      Cervical/Thoracic/Lumbar Workshop  
August 2-3, 2003      Lumbar Workshop  
October 25-27, 2003      Cervical/Thoracic Workshop

The faculty were as follows:

John K. Brendel, MD	Joshua A. Hirsch, MD	Gabor B. Racz, MD
Mark V. Boswell, MD	Standiford Helm II, MD	David M. Schultz, MD
Aaron K. Calodney, MD	Joseph F. Jasper, MD	Rinoo V. Shah, MD
Gilbert S. Chandler III, MD	Yasin Khan, MD	Vijay Singh, MD
Thomas Cohn, MD	David S. Kloth, MD	Michael J. Sorensen, MD
Claudio A. Feler, MD	Michael McKenna, MD	Andrea M. Trescot, MD
Stephen Gipson, MD	Dermot J. More-O'Ferrall, MD	Kenneth G. Varley MD
Hans C. Hansen, MD	Gurpreet S. Padda, MD	Bradley D. Vilims, MD

All of these workshops have been well attended. We would like to thank all the members for their time in providing instruction at these cadaver workshops.

In 2004 there will again be three Cadaver Workshops held at the Medical Education and Research Institute (MERI) in Memphis, TN.

However the hotel has been changed to the famous Peabody in Memphis, TN. There will be some changes in coaching and organization of these meetings to be more efficient and instructive.

The first meeting will be held March 20-21, 2004 in combination with the World Institute of Pain

with FIPP Board Preparation and the 3rd Interventional Examination for Certification for Fellow of Interventional Pain Practice (FIPP).

The second meeting will be held June 26-27, 2004, Lumbar Workshop.

The third meeting will be held November 6-7, 2004, Cervical/Thoracic Workshop.

The following have graciously accepted to be instructors in 2004.

Rajive Adlaka, M.D.	Hans C. Hansen, M.D.	Gurpreet Singh Padda, M.D.
Sairam L. Atluri, M.D.	Standiford Helm II, M.D.	Gabor B Racz, M.D.
Mark V. Boswell, M.D.	Joshua A. Hirsch, M.D.	Anthony Sabatino, M.D.
John K. Brendel, M.D.	Joseph F. Jasper, M.D.	David M. Schultz, M.D.
Ricardo Buenaventura, M.D.	Yasin N. Khan, M.D.	Nalini Sehgal, M.D.
Allen W Burton, M.D.	David S. Kloth, M.D.	Rinoo V. Shah, M.D.
Aaron K. Calodney, M.D.	Peter S. Kosek, M.D.	Vijay Singh, M.D.
Philip M. Cantu, M.D.	Ronald Laub, M.D.	Michael J. Sorensen, M.D.
Thomas G. Cohn, M.D.	William David Leak, M.D.	Praveen Suchdev, M.D.
Elmer E. Dunbar, M.D.	Edward Lubin, M.D.	Andrea M. Trescot, M.D.
Claudio A. Feler, M.D.	Robert J. Masone, M.D.	Kenneth G. Varley, M.D.
Stephen L. Gipson, M.D.	Michael J. McKenna, M.D.	Bradley D. Vilims, M.D.
Scott E. Glaser, M.D.	Dermot J. More-O'Ferrall, M.D.	Lynn R. Webster, M.D.

# Specialty Designation:

## It is important to be in your own specialty of Interventional Pain Management

### What is Specialty Designation ?

Physician specialty codes are self-designated codes that describe the kind of medicine physicians practice. The appropriate use of specialty codes prevents inappropriate suspicion and improves the quality of your utilization data. All physicians that have an UPIN must have a specialty code other than 70, multi-specialty "Clinic" or "Group Practice."

### What about the "Interventional Pain Management" Designation?

Due to the hard work of the American Society of Interventional Pain Physicians, the specialty designation for "pain management" was awarded. Through continued efforts, ASIPP was also able to obtain specialty designation for Interventional Pain Management.

Centers for Medicare and Medicaid awarded the "Interventional Pain Management" specialty designation on November 1, 2002. The new code is "09".

### Why a separate designation?

A separate designation for Interventional Pain Management will assist in various ways as follows:

- This will enable Medicare to track utilization data.
- This will enable physicians to represent themselves better with regards to utilization for interventional pain procedures, At the present time,

they are compared with a primary specialty, which in many cases is anesthesiology. Thus, when a pain physician is compared to peers (primarily other anesthesiologists), a pain physician will be performing many more services which are not performed by anesthesiologists leading to or triggering an audit.

- The same can apply to physiatrists and neurologists.
- A specialty designation will also assist in serving a member of the state society on the Carrier Advisory Committee, thus, having influence in the formation of Local Medicare Review Policies.
- The final issue is with regards to practice expense. At this time, most interventional pain procedures are included under anesthesiology practice expense which is the lowest. Thus, in the future, after 3 to 4 years, this will assist in establishing practice expenses for interventional pain procedures at a much higher level than anesthesiology levels. This increase can be expected to be 200% to 250% higher. Physiatrists and neurologists will not have this same benefit of practice expense in the future, but it would assist them in the audit process. Physiatrists, neurologists and others practicing mainly interventional pain management could be the target of an audit based on their specialty distribution as most physiatrists do not perform facet joint injections and one phys-

iatrist performing facet joint injections can be at risk for audit.

### Who can join?

Any physician who is performing pain management can join the new specialty designation, but we recommend only physicians who are performing pain management at least 50% of the time to join. However, there is no restriction imposed by assignment of a specialty designation for what a physician can perform or cannot perform. Physician practice limitations are based on each state licensure provisions.

### Can a physician have two designations?

Yes. A physician can designate himself/herself into two specialties, one primary and one secondary.

### The Importance of Changing Your Specialty Designation

ASIPP fought successfully for recognition of the specialty designation for "Interventional Pain Management - 09." This newly created specialty designation enhances awareness of the profession within the Centers for Medicaid and Medicare Services ("CMS") and the health care industry. However, this continuing effort for greater recognition of the interventional pain profession is impeded by individual physicians' failure to apply for redesignation.

ASIPP has also been seeking the representation of interventional pain physicians as a required specialty on the Carrier Advisory Committees (CACs). Medicare carriers use such committees to assist in developing policies for coverage and reimbursement issues. We have argued that with 6,000 interventional pain physicians currently in this greatly expanding area of practice that has been the subject of Local Review Policy's recent focus, interventional pain physicians should be a required specialty for participation in CAC. Unfortunately, the low numbers of members who are designated as practicing Interventional Pain Management undermine our argument and, more importantly, our efforts to ensure that medical policies of the Medicare program accurately reflect and consider our practice of medicine.

As you are probably aware, anesthesiologists and other physicians engaged in interventional pain management are audited with disproportionate frequency. Interventional pain physicians provide evaluation and management services appropriately with greater frequency than some other physicians since our practice requires more extensive interaction with and evaluation of patients. However, this higher level of reporting of office visits by

interventional pain physicians, especially anesthesiologists, has triggered concerns within CMS and resulted in recurrent audits in the past because the designation of "anesthesiologist" is not consistent with an office-based practice. Using the new specialty designation ensures that your billing practices will be reviewed under the appropriate standards.

It is also important to provide the most accurate information available to CMS for its record-keeping and reimbursement rate setting purposes. By redesignating as an interventional pain physician, members can facilitate the collection of the correct practice expense information and calculation of reimbursement rates. We believe that the performance of interventional pain management under other designations is, in aggregate, seriously depressing practice expense for our services. Changing your specialty designation will NOT preclude you from providing and billing for general anesthesia services.

#### **The Process of Changing Specialty Designation**

In order to change their specialty designation, members should submit an abbreviated Form 855I. Members do not need to complete the entire Form 855I since the rea-

son for submission is a "Change of Information." The relevant sections to be completed are the General Application Information, Practitioner Identification, and Certification Statement (signature page).

Under the "Practitioner Identification" section, subsection E (Medical Specialties), part 1 (Physician specialty), members must write "Interventional Pain Management – 09" in the blank space provided under "undefined physician type." CMS is aware of the need to update Form 855I to reflect the recognition of the Interventional Pain Management – 09 specialty. Our contacts at CMS do not anticipate Form 855I to be revised before 2004, however, because the forms are being updated through a lengthy notice and comment rule-making procedure. Until subsection E, part 1 is revised, members will need to write in the newly recognized specialty designation.

The Form 855I can also be found at <http://cms.hhs.gov/providers/enrollment/forms/> on Centers for Medicare and Medicaid Services' website.

ASIPP will continue in its efforts to promote interventional pain physicians as a profession and hopes that you will take the first step toward that goal by seeking redesignation.

## **Email Alert!**

Over the past few months, we have had increasing difficulty with our e-mail communications to our members due to the ever increasing issues of Spam and viruses. Apparently, AOL has blocked us from sending bulk mail to our members with AOL accounts and we have been unsuccessful in negotiating with them to correct this problem.

As a result of the unreliability of our communication by e-mail, the overburdening expense of communicating by regular mail, and the time delays of reporting by newsletter, we will, in the future, post all the latest communications on our web-site at [www.asipp.org/news.htm](http://www.asipp.org/news.htm) Please visit this site on a daily basis to keep abreast of the latest ASSIP communications. If there is urgent news, we will still try to reach you by e-mail, but the most reliable way to keep abreast of things will be to check our web-site daily.

# Pain Physician Moving Forward

With the publication of the January 2004 issue of *Pain Physician* journal, former Editor-in-Chief Curtis W. Slipman, MD passes the baton to the new Editor-in-Chief Mark V. Boswell whose goal is to continue to maintain the high standards of publication set by Dr. Slipman and to carry the journal to even higher levels of quality. Please help him in that effort by contributing manuscripts for publication.

The *Pain Physician* journal, ASIPP's official publication depends upon its membership for high quality interventional pain management articles to communicate information about evolving knowledge in the field, practice management, and legal/ethical issues. Due to the large volume of patient services you provide, many of you are in an ideal position to formulate important research of an original nature. Much useful data goes to waste for the simple reason that physicians avoid research and publication fearing that it is too difficult or time-consuming. To be sure, time and effort are required, but it is not as difficult or burdensome as you might believe, and the personal rewards of such efforts are many, as are the medical/societal benefits. As with everything else in life, the more often you do it, the easier and better it becomes.

Therefore we would like to encourage all of you to get involved in this most important educational effort and opportunity. Please consider submitting original contributions, current opinions, case reports, technical notes, and/or topical or historical reviews regarding any aspect of interventional pain medi-

cine. Put it on your list of resolutions for 2004 and get started. *Pain Physician* journal has a speedy turn around time, so you won't have to wait several months to see your work in print. Give it a try! Information for authors may be found in the back of every issue of the journal or you may go to the ASIPP website at [www.asipp.org](http://www.asipp.org) and click on Journal.

Here is a sampling of recently published manuscripts to inspire you:

Is Fluoroscopy Necessary for Sacroiliac Joint Injections?

*Original Contribution*

Hans C Hansen, MD

Accuracy of Precision Diagnostic Blocks in the Diagnosis of Chronic Spinal Pain of Facet or Zygapophysial Joint Origin

*A Systematic Review*

Mark V. Boswell, MD, Vijay Singh, MD, Peter S. Staats, MD, and Joshua A. Hirsch, MD

Supraclavicular Approach to Brachial Plexus Block Using Fluoroscopic Anatomic Landmarks and Nerve Stimulation

*Technical Notes*

Bradley D. Vilims, MD, & Robert Wright, MD

Bleeding Risk in Interventional Pain Practice: Assessment, Management, and Review of the Literature

*Current Opinion*

P. Prithvi Raj, MD, Rinoov V. Shah, MD, Alan D. Kaye, MD Ph D, Stephen Denaro, BS, and Jason M. Hoover, BS

Evaluation of Variables in Illicit Drug Use: Does a Controlled Substance Abuse Screening Tool Identify Illicit Drug Use?

*An original Contribution*

Laxmaiah Manchikanti, MD, Vidyasagar Pampati, MSc, Kim S. Damron, RN, and Carla D. McManus, RN, BSN

Comparison of Intradiscal Restorative Injections and Intradiscal Electrothermal Treatment (IDET) in the Treatment of

Low Back Pain

*An original Contribution*

Richard Derby, MD, Björn Eek, MD, Sang-Heon Lee, MD, PhD, Kwan Sik Seo, MD, and Byung-Jo Kim, MD, PhD

Evaluation of Percutaneous Disc Decompression Using Coblation in Chronic Back Pain With or Without Leg Pain

*An original Contribution*

Vijay Singh, MD, Chandur Piriyani, MD, and Katherine Liao, MD

Epidural Steroids in the Management of Chronic Spinal Pain and Radiculopathy

*A Systematic Review*

Mark V. Boswell, MD, PhD, Hans C. Hansen, MD, Andrea M. Trescot, MD, and Joshua A. Hirsch, MD

Spinal Endoscopic Adhesiolysis in the Management of Chronic Low Back Pain: A Preliminary Report of A Randomized, Double-Blind Trial

*An original Contribution*

Laxmaiah Manchikanti, MD, Jose J. Rivera, MD, Vidyasagar Pampati, MSc, Kim S. Damron, RN, Carla D. Beyer, RN, BSN, Doris E. Brandon, CST, and Sue R. Wilson, ORT

Submit your manuscripts to the new *Pain Physician* Editor-in-Chief:

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Together, we can make 2004 the most productive and enlightening year yet for the *Pain Physician* journal. Thank you.

# Comprehensive Pain Medicine Board Review

American Society of Interventional Pain Physicians with assistance of P. Prithvi Raj, MD, founder of the World Institute of Pain, conducted its first comprehensive Board Review Course in Washington DC, from September 10-14, 2003, following ASIPP's Annual Meeting.

This course was in high demand with registration closed one month prior to the course, yet we were over-

booked. The course had 54 lectures with 17 instructors, with several pre- and post-tests and appropriate discussions.

The course followed the format of the American Board of Anesthesiology pain medicine subspecialty examination. The course also provided 51 continuing hours for the attendees.

The results of the subspecialty examination arrived at the end of November. Thus far, the results show that 80% of the members attending this course have passed the examination.

The Second Comprehensive Board Review Course will be held August 7-11, 2004 in St. Louis at Chase Park Plaza, 212-232 N. Kingshighway Blvd., St. Louis, MO 63801. The format has been changed to accommodate a larger number of participants and also to provide less distraction with smaller groups. The course will be conducted in two sessions with 75 members attending each one.

Pre-test and post-test questions also have been revised.

There have been significant additions and deletions to the speakers, as well as the presentations.

**Please see Registration form on next page**