“The Pharmacist won’t fill my prescription!”

This is a complaint that our membership has heard far too often over the past two years. After the Pill Mill Crisis led to the implementation of HB 7095 and the Prescription Drug Monitoring Program; it has become increasingly difficult for our patients to fill their legitimate prescriptions for controlled substances. The pendulum has swung too far and now there is a patient access problem.

To address this issue FSIPP has worked with the FMA to find the cause as well as a solution for our patients. We are all well aware of the undue pain and suffering that the denial of these medications can cause.

The Board of Pharmacy (BOP) has asked the leadership of FSIPP to help determine a solution. We now have two members who sit on the BOP Controlled Substance Standards Committee. At our first meeting the committee heard testimony from the public, pharmacists, and physicians on this patient access issue. Three of the four physicians who provided testimony were FSIPP board members. The information provided in this testimony is crucial to give pharmacists information regarding the consequences of telling a legitimate pain patient, “No, I won’t fill your prescription.”

I would like to thank the following FSIPP members for their leadership on this issue.

Mark Rubenstein, MD, is our liaison to the FMA. Mark has been extremely instrumental in spearheading this issue, and sits on the committee with me.

Harold Cordner, MD, Miguel De La Garza, MD and Sandy Silverman, MD. Who closed their practices and traveled to Orlando to give testimony to the committee.

At this time I can tell you that the solution to this issue is not clear; but the process has begun to ensure that our patients have access to the medications that they need.
INTRODUCING FSIPP’S NEW EXECUTIVE DIRECTOR

Please welcome Michelle Byers as the new Executive Director of FSIPP. Michelle has over 17 years of experience working, training and managing in pharmaceuticals, medical devices and biotechnology. She was the Associate Director of Training for Elan Pharmaceuticals and has worked as a Consultant and Territory Manager for Flowonix.

She has extensive experience working with and planning educational programs for multiple professional societies including: West Virginia Society of Interventional Pain Physicians (WVSIPP), the New York and New Jersey Societies of Interventional Pain Physicians combined program (NY/NJSIPP), and the National Spine and Pain Educational Symposia – “The Business of Pain”, to name a few. She developed and successfully launched “The Napa Pain Conference” for Dr. Eric Grigsby, the “Cancer Pain Conference” for Dr. Lisa Stearns and the annual “PAIN” meeting and charitable fun run for Dr. Timothy Deer. She was also instrumental in having the WVSIPP recognized by the ACCME in 2014 by gaining Certification with Commendation as a national CME provider.

She has a passion for providing education for clinicians and caregivers working with patients in pain. She has proudly served as a committee member for the National Pain Foundation, a National Board Member for the Huntington's Disease Society of America and as President of the Pain Education Society. Michelle’s career focus is to develop societies and continuing medical education programs that are relevant and impactful to clinicians treating patients in pain.

We are proud to have her as the face of our society!

Michelle can be reached at:
Director@fsipp.org,
or via phone 415-518-5391.

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2015 ASIPP/FSIPP ANNUAL MEETING

A HUGE SUCCESS!

The membership, exhibitors and speakers were awesome and the evaluation scores were high and of the ultimate quality. The meeting was held in Orlando at the Lowe’s Royal Pacific Resort, Universal, on April 9, 10, 11, 12 of 2015. We had eight hundred physician participants and the educational agenda did blow our minds.

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MEDICAL MEDIA

St. Jude Medical
MORE CONTROL. LESS RISK.

AIS™ Leading the Way in Intrathecal PainCare™
“To Be Or Not To Be”: A Hospital Employed Pain Physician?

Maulik Bhalani, MD
FSIPP, Board of Directors
Florida Pain Medicine, CEO

Welcome to the world of change. As pain physicians, we learn about Neuroplasticity throughout our medical school, residency, fellowship and CME education; but no one ever taught us about the possibility of “career-plasticity” which we will all cross paths with in these dynamic times within our healthcare system. As more and more pain physicians come to a crossroads, many of us will become hospital employed, join large single or multi-specialty groups, or just abandon our practice to retire. Some of us may even give up on our dream and entrepreneurial vision of having a thriving single physician pain practice. By the end of the day and within the next few years, we will all choose a variety of different paths, but the primary and ultimate goal should stay focused around what is best for our pain patients and making the ultimate choice which keeps us happy as pain physicians. In case you do decide to pursue a hospital-based employment/venture, here is some information, which will help guide you through the process.

For many who have been around the healthcare industry, physician/hospital integration is nothing new. Almost every article you will read and person you talk to will remind you that mass hospital employment of physicians has been tried, and unsuccessful in the 1990’s and the reasons for this demise were countless. Practices were bought out by hospitals for large sums of money, often multiples of the annual income and additionally physicians were guaranteed their annual income for three to five years and received hospital benefits after the acquisition. The weak link with regards to the sustainability of the relationship proved to be the minimal involvement of physicians in the organizational makeup and decision-making within the practice after the merger. Physicians took on the burden of higher overheads by moving into hospital owned real estate coupled with more costly regulations and minimal, if any, productivity incentives. With the combination of a physician having a little voice in their own practice and little incentives to work hard, the innate human nature took over, physician productivity sank, and the partnerships imploded from within the core. In the 2000’s increasing stark regulations limited the hospital support of physician practices, and physicians and hospitals became independent while still depending on each other.

Now, times are changing once again for the reciprocal, even though physicians and hospital administrators are very different. Physicians are more so doers, reactive, independents, solo decision makers, and business owners. While on the other hand hospital administrators tend to more planners, proactive, participative, collaborative problem solvers and business stewards. Simply put, physicians tend to focus more on the individual or the patients and the administrators tend to focus more on the organization consisting of the patient, doctor, staff and hospital administration and revenue stream. In the era of the ACA Hospitals, physicians are becoming increasingly dependent of each other for survival and more importantly for success, but the partnership structure has to make sense for both sides and there can be win-win situations. Pain control throughout the hospitals will be looked at for “core measures,” quality metrics, and reimbursements, and thus pain physicians will become increasing important and more valuable for the guidance they can provide to these massive healthcare systems.

Advantages of being hospital employed include a sustained salary, a built-in referral system, and the advantage of a large organizational support system. Other advantages include a chance to refine your skills and allowing a long time to grow the practice and learn the trade, especially for those who are just starting their careers. Partnership models include a variety of structures from straight salaried positions, to salaried with incentive benefits, to payment models with work RVU based structures. Do your homework, and base this on the MGMA datadive (or AMGA), as this is what hospitals will use for all benchmarks for contracts. According to the MGMA in 2012, the mean salary for Anesthesia: Pain Management is $562,140 by hospital ownership with a wRVU or work-RVU conversion factor mean of $68.88; but does this mean anything to you and should these be baseline values when negotiating contracts? Do these numbers even mean anything when the physician cannot govern efficiency and the flow of processes? Does the model allow for optimum, and just as importantly, affordable care for our patients?

(continued next page)
“To Be Or Not To Be”: A Hospital Employed Pain Physician?

(continued from page 4)

Other models like contractual agreements such as PSA or professional services agreement, which can include medical director agreements, coverage agreements, hospital based services agreements, co-management agreements, PSA conversion agreements, or leased employee agreements. An explanation of a PSA alone would take up an entire article itself. The advantage of PSAs is that they allow for the opportunity to integrate and align in order to improve quality and efficiency. It allows for population and health management, while allowing physicians to be comfortable with their aversion to the word “employment” and operate within or maintain their independence. This also can promote the building of centers of excellence within the hospital-based systems.

Disadvantages include limited financial growth, the insecurity of being replaceable, no long term equity, partnership, or ownership of assets. Other disadvantages include high overhead and higher cost of medical care, which is ultimately passed onto the patients. Hospital based care is generally the most expensive care within a community for the same or similar services provided as they will often bill CMS for part A and part B to cover for hospital facility fees and medical professional fees respectively. When the total value of these parts are added, the higher number, the “facility” fee, is often not counted as part of the physicians productivity. Unfortunately, that is where most of the profit lies and if the contractual agreement does not account for such, then the long-term partnership will likely fail. Other major obstacles include the hierarchy of organization. As physicians we are used to ruling-the-roost, but when you become hospital employed this is not often the case and you have business administrators/MBAs or nurses in charge of the physician lines of service which usually does not bode well for the physicians personalities. Couple this with the “red-tape” in combination with little decision making power and voice, and it is easy to see why this is a tough model for pain physicians.

Conflicts are inevitable between partnerships of physicians and hospitals, but the best way to solve these is by keeping continued open dialogue, keeping conversations transparent and honesty with open book policies on both ends. You need to stay active and participate in your “career-plasticity” in these continually changing times. The alliance of the pain physician and hospital must allow each party to utilize their relations, knowledge and compassion to better serve the ones whom we all work for, our patients. Finally, you should evaluate four things per Becker review prior to initiating a hospital-physician partnership which include understanding the core value proposition and making sure the core values match, finding ways in which both parties benefit, capturing created value, and anticipating market response.
COLLECTIONS, CONNECTIONS AND CORRECTIONS

Jonathan Daitch, MD
FSIPP Treasurer

I have been in private pain practice for 14 years. I started in an office setting and then moved into a combined office and ASC setting. Until recently, we have always done our own billing and collecting. I have lectured many times on monitoring your practice financially. Like many of you, we too have battled collection department turnovers. Just when we were on stable footing, turnovers would upset the collection cart. In addition, when we reviewed our denials, we were frequently disheartened by missed deadline losses when our staff failed to respond to denials in a timely fashion. We reached the final straw when we could not recruit an adequate collection manager and had to come up with an alternate solution.

We have used NextGen EHR since 2006 with significant success. We own our own on-site system and maintain all of our own patient data. We knew of several practices utilizing NextGen Revenue Cycle Management (RCM) Company for their collections. We had the RCM Company do a free analysis for us. They basically showed us that they could improve our collection efficiency and EVEN PAY FOR THEMSELVES THROUGH IMPROVED COLLECTIONS!!

We did our homework, interviewed their clients, and began negotiating a contract with them. After several months we arrived at a fair contract. Now, we bill and submit the claims. They do all insurance collections. We collect our self-pay portions, including deductibles co-pays, and co-insurances. Additionally, we collect our Work Comp and PI cases. Overall they collect 80% of monies. We collect the other 20%.

We are now 9 months into this endeavor. We are happy!! We have monthly meetings with the NextGen RCM Company with detailed computerized reports. Total AR and Days in AR are decreasing, and collections are increasing. Write offs are even getting done in a timely fashion! We are rapidly achieving our preset goals. We have several less employees. Plus the EHR Revenue Cycle Management Company can utilize all the financial and practice management information to analyze other areas of practice efficiency.

I am glad we waited until this juncture to implement this outside collection strategy. Fortunately, it has been a positive experience in more ways than one!
MEDICAL MARIJUANA

Sanford Silverman, MD
FSIPP Immediate Past President

As most of you are aware, the legalization of medical marijuana continues to be debated in our state. This is a highly controversial issue because of the lack of evidence using marijuana for certain medical conditions, and the adverse effects and consequences of marijuana, particularly on youth. In addition, we are just now recovering from the prescription drug epidemic with significant drops in mortality from opioid use. The introduction of another addictive substance creates some concern.

To understand what “medical marijuana” is you really have to focus NOT on the herb, but the substances contained in that herb; cannabinoids. Specifically, marijuana contains several psychoactive ingredients. Marijuana is like a salad; there are some things in it that are beneficial and some that are not. THC (tetrahydrocannabinol) is the major psychoactive compound, which creates the euphoria and “high”, while cannabidiol and cannabinol are also psychoactive, but tend to reduce the excitatory effects of THC.

The biggest problem with medical marijuana is inhaling the products of combustion. Like tobacco, marijuana contains carbon monoxide, ammonia, hydrogen cyanide, acetaldehyde, acetone, benzene, toluene, phenol, napthalene, benzantracene, and benzpyrene. In fact, compared to tobacco smoke, each inhalation of marijuana is typically 2/3 larger, inhaled 1/3 deeper, held 4 times longer, and 50% higher in tar. Therefore, 2-4 marijuana cigarettes are roughly equivalent to 20+ tobacco cigarettes. As physicians, we cannot condone the smoking of ANYTHING. However, as seen in Colorado, food products and oils are widely utilized for both medicinal and recreational use.

There is a disproportionate negative effect of marijuana on youth. Specifically, the rate of marijuana dependence or addiction is roughly about 10% for anyone over 18 who experiments (which is the same rate of addiction to anything in the general population), 27% for age < 18, and 9% for age > 18. This is because the human brain does not fully develop until about age 21, and the parts that develops last are the prefrontal and frontal areas, which are responsible for decision making. Anyone who has teenagers knows that this population often makes poor decisions; because their brains have not matured.

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MEDICAL MARIJUANA
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Endogenous cannabinoids are responsible for development of the central nervous system. If exogenous cannabinoids are introduced to a developing brain, they can alter brain development. Studies have shown a relationship between early cannabis use and a host of psychological conditions, including psychosis, bipolar disorder, schizophrenia and addiction. Also, the marijuana consumed today contains much higher concentrations of THC than that consumed in the 1960’s-1990. High THC cannabis can cause psychosis, paranoia, and extreme stimulation.

Marijuana disrupts short term memory, increases appetite, and reduces spontaneous motor activity. Competitive athletes know this because being off a second in your response time can mean the difference between victory and defeat. THC (Marinol) is prescribed by physicians (I prescribe it) to treat protracted nausea and loss of appetite frequently seen in cancer patients and the chronically ill. Non-cancer pain can manifest the same suffering and many of my non-cancer pain patients utilize Marinol.

Marijuana has been used to treat spasticity as seen in multiple sclerosis. High cannabidiol marijuana, (low in THC) has been used to treat intractable epilepsy in children, the so called “Charlotte’s Web” strain, which has been legalized in Florida, but cannot be smoked and is only approved for epilepsy and myospastic disorders. Sativex spray which is made from marijuana (GW pharmaceuticals) is available in Canada and the EU to treat cancer pain (currently undergoing trials in the US).

In November of 2014 a constitutional amendment was narrowly defeated, not reaching the 60% threshold (only 57%). There is movement however to resubmit such an amendment and or introduce legislative changes to make more types of marijuana (higher THC content) available for more types of diseases.

Clearly there is potential for the medical use of cannabinoids, not necessarily marijuana. Cannabinoids bind to 2 types of receptors, one in the brain (CB1) responsible for the psychoactive effects, and the other (CB2) in blood, spleen, and intestines. The CB2 receptor has been shown to modulate pain and there is research being conducted to develop CB2 receptor drugs to manage chronic pain (without the euphoria).

As pain physicians, we will be significantly impacted by any legislation or constitutional amendment that allows the medical use of marijuana. FSIPP closely monitors all legislative activities that potentially impact our specialty. Ultimately, we may be practicing in a legalized marijuana environment which will complicate our already challenging job of prescribing controlled substances for chronic pain.
Andrea Trescot, MD
FSIPP Immediate Past President

Superficial radial nerve (SRN) entrapment is an often overlooked cause of forearm and thumb pain, mimicking de Quervain’s tendonitis, DJD of the thumb, carpal tunnel syndrome, and CRPS. It is also called “Wartenberg’s syndrome” and “handcuff or wristwatch neuropathy”.

Entrapment of the SRN was first described by Stopford in 1922. Ten years later, Wartenberg described an isolated entrapment of the SRN in 5 patients who complained of radial wrist and thumb pain. Because it seemed similar to the entrapment of the lateral femoral cutaneous nerve (known as meralgia paresthetica), he named the entrapment cheiralgia paresthetica. According to Dang, SRN entrapment is a rare entrapment, with an annual incidence of 0.003%.

Patients with superficial radial neuralgia usually have pain and/or abnormal sensation (numbness, hyperalgesia, and hyperesthesia) over the back of the hand, thumb and index fingers. This pain may lead to weakness of the thumb and decreased grip strength. Wrist movements, especially ulnar volar flexion and forearm hyperpronation, increase the pain. The pain of SRN entrapment is usually not a problem at night, though patients frequently have pain at rest. SRN entrapment can cause or mimic Chronic Regional Pain Syndrome (CRPS), resulting in swelling, hyperesthesia, allodynia and pain on movement. These symptoms are seen initially at the thumb or radial aspect of the dorsum of the hand, but can spread to the whole hand and forearm. Patients often try to protect the hand from stimulation with gloves or bandages.

Entrapment of this nerve can occur in one of several ways. The first is the result of activity that causes spasm or hypertrophy of the brachioradialis muscle, such as hammering or using a computer mouse. SRN entrapment can occur where it becomes superficial between the BR and ECRL, about 9 cm proximal to the styloid process of the radius. When the forearm is supinated, the BR and ECRL tendons are parallel; pronation twists them such that the lateral ECRL crosses deep to the BR tendon, thereby decreasing the area through which the nerve passes. This compression is aggravated by ulnar flexion of the wrist, hyperpronation and other movements that stretch the nerve. These patients may also have pain at the lateral epicondyle. A second group has had trauma to the radial aspect of the forearm (such as infiltration of an IV in the “intern’s vein”, banging the forearm on the edge of a table, steroid injections for de Quervain’s tenosynovitis or a distal radius (e.g. Colles’ fracture).

<table>
<thead>
<tr>
<th>Occupation/trauma history relevant to superficial radial nerve entrapment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brachioradialis entrapment</strong></td>
</tr>
<tr>
<td>Hammering</td>
</tr>
<tr>
<td>Computer mouse use</td>
</tr>
<tr>
<td>Repetitive pronation/supination (as in throwing sports)</td>
</tr>
<tr>
<td><strong>Forearm trauma</strong></td>
</tr>
<tr>
<td>IV infiltration</td>
</tr>
<tr>
<td>Steroid injection for wrist tendonitis</td>
</tr>
<tr>
<td>Distal radius (e.g. Colles’) fracture</td>
</tr>
<tr>
<td>Forearm lacerations</td>
</tr>
<tr>
<td>Handcuffs</td>
</tr>
<tr>
<td>Digital fracture</td>
</tr>
<tr>
<td><strong>Surgical</strong></td>
</tr>
<tr>
<td>Post trapeziectomy</td>
</tr>
<tr>
<td>Treatment with an external fixation device or Kirchner wires</td>
</tr>
<tr>
<td><strong>Inflammation</strong></td>
</tr>
<tr>
<td>De Quervain’s tenosynovitis with or without surgical release</td>
</tr>
<tr>
<td><strong>Compression</strong></td>
</tr>
<tr>
<td>Watchband</td>
</tr>
<tr>
<td><strong>Stretch</strong></td>
</tr>
<tr>
<td>Closed reduction of a forearm fracture</td>
</tr>
</tbody>
</table>

Distribution of pain with superficial radial nerve entrapment

(continued next page)
SUPERFICIAL RADIAL NERVE (SRN) ENTRAPMENT

(continued from previous page)

Table 2. Differential diagnosis of dorsoradial wrist pain

<table>
<thead>
<tr>
<th>Potential distinguishing features</th>
</tr>
</thead>
<tbody>
<tr>
<td>de Quervain’s tenosynovitis of the first extensor compartment (abductor pollicis longus and brevis tendons)</td>
</tr>
<tr>
<td>No Tinel over SRN, have pain with resisted thumb motion. Pain and tenderness over the radial styloid. No paresthesias or increased pain with hyperpronation. Associated with collagen vascular diseases, e.g. rheumatoid arthritis</td>
</tr>
<tr>
<td>Lateral antebrachial cutaneous nerve (LABC) neuroma or neuritis</td>
</tr>
<tr>
<td>Pain is more lateral</td>
</tr>
<tr>
<td>More proximal radial nerve, brachial plexus or cervical spine pathology</td>
</tr>
<tr>
<td>Weakness in the PIN-innervated or radial nerve-innervated muscles</td>
</tr>
<tr>
<td>Thumb joint pathology</td>
</tr>
<tr>
<td>Xray changes of MCP joint, crepitus and tenderness over the MCP/PIP joints</td>
</tr>
</tbody>
</table>

The diagnostic studies for the superficial radial nerve are listed in Table 3.

Table 3. Diagnostic tests for Superficial Radial Nerve entrapment

<table>
<thead>
<tr>
<th>Potential distinguishing features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical exam</td>
</tr>
<tr>
<td>Tenderness to palpation over the SRN</td>
</tr>
<tr>
<td>Provocative test</td>
</tr>
<tr>
<td>Forced forearm pronation reproduces symptoms within a minute</td>
</tr>
<tr>
<td>Diagnostic injection</td>
</tr>
<tr>
<td>Should improve pinch and grip limited by pain</td>
</tr>
<tr>
<td>Ultrasound</td>
</tr>
<tr>
<td>SRN is small at this level; easiest if tracked proximal to distal</td>
</tr>
<tr>
<td>MRI</td>
</tr>
<tr>
<td>Not useful</td>
</tr>
<tr>
<td>Arteriography</td>
</tr>
<tr>
<td>Not useful</td>
</tr>
<tr>
<td>X-ray</td>
</tr>
<tr>
<td>Not useful</td>
</tr>
<tr>
<td>Electrodiagnostic studies</td>
</tr>
<tr>
<td>Helpful if positive</td>
</tr>
</tbody>
</table>

Identification and Treatment of Contributing Factors

Removing tight watches or jewelry, splinting, changing work ergonomics and administration of anti-inflammatory medications are all first-line approaches to treatment. In one series, 71% of 29 patients had excellent or good pain relief (3 of these also had a steroid injection) after non-operative interventions.

Injection Technique

Landmark-Guided Technique

The superficial radial nerve is very superficial in the forearm, hence the name. It is readily palpated and amenable to blind techniques. The index and middle fingers of the non-injecting hand straddle the nerve, similar to starting a wrist IV. A 27g needle is then advanced (like an IV) toward the nerve at an acute angle. A peripheral nerve stimulator (PNS) may help aid localization. Deposteroid and a small volume of local anesthetic (less than 2cc) should be injected deeply enough in the tissues to avoid steroid atrophy of the skin, at the same time taking care not to injure the nerve.
SUPERFICIAL RADIAL NERVE (SRN) ENTRAPMENT
(continued from previous page)

Ultrasound-Guided Technique
The superficial nerve is small at this level, and difficult to visualize under ultrasound unless the exam is started proximally at the elbow and the radial nerve followed distally. However, if the nerve itself is not visualized, the radial artery, adductor pollicis longus, and extensor pollicis brevis are easily seen, and a peripheral nerve stimulator can aid in the identification of the nerve. The nerve can be injected using in-plane or out-of-plane techniques.

Neurolytic/Surgical Technique

Cryoneuroablation
When it is available, cryoneuroablation is the treatment of choice for patients who have not responded to the non-operative interventions above. This is most easily done with a closed technique. The area of maximal tenderness is identified, usually between the brachioradialis and extensor carpi radialis muscles. If possible, the 12 gauge intravenous catheter is used, advanced proximally parallel to the nerve. The 2.0 mm probe is then placed through the catheter. Sometimes the tissues are too thin to accept the larger probe; then a 14-gauge catheter and 1.4 mm probe must be used. Smaller gauge, hand-held cryo devices such as thelovera™ may be useful in these situations.

Davies et al. described 6 patients treated with cryoneuroablation via open visualization of the nerve or neuroma. Patients were followed for a mean of 11 months; all returned to work and reported good to excellent relief.

Radiofrequency Lesioning
Although RF lesioning (or pulsed RF lesioning) of the SRN has not been described in the literature, similar nerves have been successfully treated with pulsed radiofrequency.

Surgery
Surgical exploration and release should be reserved for intractable cases. If this is required, the diagnosis of SRN entrapment should be clear and the procedures should include neurolysis from all compressive structures and microsurgical internal neurolysis if necessary.

Braidwood described 12 cases of SRN entrapment; 7 cases had a history of trauma (ORIF of the forearm, IV cut-down, radial fracture, surgical de Quervain’s release), but the remaining 5 cases did not have a clear-cut cause of entrapment. Two patients improved with steroid injections; the rest underwent excision of the nerve at the brachioradialis muscle. All of the patients were left with an area of hypoesthesia but “felt this was a small price to pay”.

Complications
Because the nerve is superficial, steroid injections in this area have the potential to cause skin atrophy. Chodoroff described skin atrophy and SRN injury after an injection for de Quervain’s.

Summary
Superficial radial neuralgia can mimic a variety of conditions, including CRPS, carpal tunnel syndrome, and de Quervain’s tendonitis. Appropriate diagnosis will lead to appropriate treatment.
What's New in Chronic Pain 2015
By David Vaughn, Esq., CPC

I wrote this article at the beginning of the year, but some of you may not have received it due to problems we were having with the old website.

Scope of this Article. The purpose of this Article is to review some of the new changes in chronic pain for 2015. This article does not cover the changes to the urine drug tests ("UDT") codes, as that will be covered in a separate article.

1. Coding.

A. Vertebroplasty. The 2014 vertebroplasty codes 22520-22522 have been deleted. The new codes adopted to take their place are 22510–22512. 22510 is cervical/thoracic; 22511 is lumbar/sacral; and 22512 is for each additional level, whether cervical/thoracic or lumbar/sacral. All codes include bone biopsy and imaging.

B. Kyphoplasty. Like vertebroplasty, the 2014 CPT codes for kyphoplasty (22523-22525) have been deleted. The new codes are 22513 (thoracic), 22514 (lumbar, but not sacral), and 22515 (each additional level, whether thoracic or lumbar, but not sacral). All codes include bone biopsy and imaging. For 2015, moderate sedation is bundled for both kyphoplasty and vertebroplasty, per Appendix G of CPT 2015; for 2014, it was only bundled for vertebroplasty.

C. Sacroplasty. The 2014 current codes on Sacroplasty (0200T, 0210T) are amended in 2015 to bundle image guidance. Therefore, you cannot bill image guidance separately for these services.

D. Epidurals. The 2015 Medicare Physicians Fee Schedule Final Rule ("Final Rule"), page 112, states that for 2015, Medicare (not the AMA) will bundle fluoroscopy for all epidurals, including CPT codes 62310, 62311, 62318, & 62319. The AMA is not bundling fluoroscopy with translaminar epidurals in the CPT Code; therefore, you can continue to bill these 4 codes with fluoroscopy (77003) to commercial payers, unless a specific payer adopts the Medicare bundling rule.

E. Myelography with Lumbar Injection. There are new codes for myelography with lumbar injections. I doubt many of you will be using these codes, so I am just going to refer you to the code descriptors for these new codes, i.e., 62302, 62303, 62304, and 62305.

F. Joint Injections. The CPT Code now distinguishes between joint injections with and without ultrasound. New codes are added when joint injections are done under ultrasound. They are 20604 (small joint), 20606 (intermediate joint), and 20611 (large joint). The existing joint injection codes are all amended to add "without ultrasound" (20600, 20605, and 20610). So, effectively, there are 2 codes for small joints, 2 codes for intermediate joints, and 2 codes for large joints, one with ultrasound and one without ultrasound.

G. Ultrasound Interpretation. The new ultrasound codes for joint injections require a written interpretation. The AMA’s 2015 Changes, An Insider’s View gives an example of the verbiage contemplated to be in the report, as follows: “I performed a focused ultrasound evaluation, including reviewing the specific area to be injected, and the best approach for the injection. The joint was noted to be of [normal] [abnormal] anatomic structure. The pathological findings included ____________. Using ultrasound guidance, I inserted the needle into the joint. Permanent images were recorded and placed in the chart.”

H. Obesity Group Counseling. A new G code was created for group obesity counseling, G0473, for groups of 2-10, 30 minutes.

I. 59 Modifier Substitutes. In Transmittal 1422 dated August 14, 2014, effective January 1, 2015, CMS is adding substitute modifiers for Modifier 59. These modifiers are to be used in lieu of, not in addition to, Modifier 59. CMS is not requiring these modifiers at the current time, although CMS will allow the modifiers now in lieu of 59. At some point CMS will identify either the code sets to which the modifiers will apply or the providers who must use them. Until then, I recommend you not use the new modifiers unless you are required by Medicare. The modifiers are: XE (separate encounter); XS (separate structure); XP (separate practitioner); and XU (unusual non-overlapping service that isn’t part of usual component of main service).

(continued next page)
What's New in Chronic Pain 2015
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2. **E&M Social History.** CPT 2015 changes the requirements for a Social History documentation for level 4 and 5 codes such that the social history now requires the following 8 items to be in the social history: (1) Marital status or living arrangements; (2) Current employment, (3) Occupational history; (4) Military history; (5) Use of drugs, alcohol, and tobacco; (6) Level of education; (7) Sexual history, and (8) Other relevant social factors.

3. **New POS Code.** The Final Rule, page 93, states "For professional claims, instead of finalizing a HCPCS modifier, we are deleting current POS code 22 and establishing two new POS codes - one to identify outpatient services furnished in on-campus, remote, or satellite locations of a hospital, and another to identify services furnished in an off-campus hospital PBD [provider based department] that is not a remote location of a hospital, a satellite location or hospital emergency room."

4. **Global Periods Being Deleted.** The Global Periods will be deleted over the next 3 years. The 10-day global will disappear in 2017, and the 90-day global will disappear in 2018. Thereafter, services that were in the global periods will be billed separately. Currently, there are 3 global periods, 0, 10, and 90 days. The codes for which the global periods were applicable will be revalued to remove that value.

5. **PT Therapy Caps.** According to the Final Rule for 2015, the physical therapy cap is $1,940.

6. **2015 Conversion Factors.** The 2015 non-anesthesia conversion factor, assuming Congress steps in again and enacts the Physician "Fix" will be $35.8013, which will begin April 1. If no Physician Fix bill, the conversion factor is $28.2239.

7. **Stark Code List.** The updated code list can be found at

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New CMS Audits of Spinal Cord Stimulators
By David Vaughn, Esq., CPC

**Recent SCS Audits.** During the past month, two of my chronic pain clients have received audit letters from a special CMS contractor, Strategic Health Solutions, regarding audits of spinal cord stimulators ("SCS").

**Supplemental Medical Review Contractor.** Strategic Health Solutions is a Supplemental Medical Review Contractor; it is not your MAC, or a RAC, or ZPIC. Strategic Health Solutions will conduct nationwide audits of special target areas primarily identified by the CERT contractor or the OIG. CMS selects the specific procedures the Supplemental Medical Review Contractor audits. SCS's have been identified as a procedure having a high nationwide error rate, not because providers are not implanting the stimulators, but because providers are not documenting each of the elements of medical necessity.

**SCS Issues.** An SCS is a big ticket item for CMS; as such, most Medicare carriers have an LCD setting forth the documentation requirements for implanting an SCS. Typically, there must be a multidisciplinary approach, such as a referral from or to an orthopedist or neurologist, documentation of intractable pain, previous failure of other modalities such that the SCS is a measure of last resort, a psych eval, etc.

**Check Your LCD.** In light of this new, nationwide audit, check your carrier’s LCD to ensure that you are documenting each of the required LCD elements.
SPONSOR LAUNCHES NEW PRODUCT

Medtronic just launched a new Kyphon V premium vertebroplasty 13ga system which offers physicians the opportunity to maximize precision and minimize radiation exposure during vertebroplasty. The new system combines small gauge bone access with the Kyphon Cement Delivery System that lets you stand up to 4 feet away from the radiation source - which has been measured to reduce hand radiation by over 70%.