

FSIPP NEWSLETTER

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Editor-in-Chief: Deborah H. Tracy, MD

President's Message *Greetings to All* *Harold Cordner, MD*



for the next 2 years.

It is hard to believe that it has already been 2 months since I took over as President of FSIPP. Our immediate Past-President Lora Brown did an incredible job of getting our young organization up and running and we owe her a great deal of gratitude for the hard work and accomplishments. For me FSIPP is much like a ship. We have built it, assembled a crew, started the engines and have departed from port. We have accomplished a lot, but our journey and mission have just begun. As I take the helm of this great ship I am excited about the journey facing us

Fortunately, we have an incredibly dedicated and talented Board of Directors, which will help guide and run the ship to help FSIPP realize its goals: Deborah Tracy, Sandy Silverman, Charles Grudem, Jonathan Daitch, Lora Brown, Rafael Miguel, Jesse Lipnick, Osman Latif, and James Worden for 2008. Unfortunately, we lost Andrea Trescot and Marshall Bedder, two of the most dedicated and tireless advocates of our specialty, as they accepted positions outside of the state of Florida. We wish them well in their endeavors and they will be dearly missed.

We have several goals in this coming year, the most important of which is to increase our membership. It is vital that if we are to stay afloat, we need to increase our membership. Presently we have about 115 members and my goal is to double the membership in 2009. If every member can recruit just *one* physician, we would accomplish that goal and my challenge to all of you is to go out and get your partners, colleagues or even competitors to join FSIPP. They need to understand what is in it for them and how FSIPP has been the only organization that has fought for them to insure patient access to pain management and fair reimbursement. They cannot afford NOT to join us. To help in this regard, we have established regional membership directors who will help in the recruitment effort. We have had great success in hosting regional dinners illustrating to pain physicians what FSIPP has done for them and the immense challenges that we are about to face. With more members we have a stronger presence, voice and financial standing.

Interventional Pain Management as a specialty is under intense scrutiny and we are at serious risk of declining reimbursement. Medicare and other Carriers have determined many of our procedures are "investigational" or are denying authorization for payment. This month CMS, (Medicare) ruled nationally that Thermal Intradiscal Disc Decompression will not be a covered procedure. This is just the beginning. It is our responsibility and resolve to fight through this war, but there will be plenty of battles along the way. We need to stand strong together to fight, but I firmly believe we will prevail.

Two other goals we have made for the upcoming year are to get a prescription drug monitoring bill passed in Florida as well as host an annual FSIPP meeting. The FSIPP Board is in the midst of planning our annual meeting and with the success of last years Best Practices Seminar and lectures, this years will be even better. We have made great progress this year getting a drug monitoring bill recognized with legislative and FMA sponsorship and encouraged contributions to this cause. Hopefully it will pass this year, but I will ask for your financial support and letters when the bill is introduced. As the incidence of drug diversion increases in our country we need this bill for better patient care, enhanced confidentiality and to protect our children.

I welcome anyone who wants to help or needs our help to contact me at anytime. My door (or e-mailbox) is always open. It is truly my honor and privilege to serve as your President and look forward to working with each and every one of you.

Harold Cordner, MD
FSIPP President



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***Update from the Editor-in-Chief
Deborah H. Tracy MD, MBA***



The Florida Society of Interventional Pain Physicians was incorporated as the Florida State Chapter of the American Society of Interventional Pain Physicians (ASIPP) in 2001. Together, ASIPP and FSIPP have tackled pain issues of direct interest to Florida pain doctors. In 2005 FSIPP gained representation on the Medicare Carrier Advisory Committee (CAC) for the State of Florida. Medicare coding, compliance and reimbursement issues are continually reviewed at the CAC and great strides have been achieved by this representation. The goal of FSIPP is to promote and protect interventional pain management in the state of Florida for insure patient access and fair reimbursement policies. Our mission is to promote the development and practice of safe, high quality, cost-effective interventional pain management techniques for the diagnosis and treatment of pain and related disorders, and to ensure patient access to interventional pain medicine (or management) doctors and these treatments in the State of Florida.

***Compliance Billing And Coding
Submitted Questions This Quarter***

Question

1. If a a single median branch nerve is ablated (radiofrequency) more than once in the same procedure can a physician double bill with a modifier 76?

Answer

RF is by nerve; so no matter how many times you burn the same nerve, it's still one RF code.

Question

2. Can we now charge for conscious sedation for Vertebroplasty, Pumps, Stims and other more invasive procedures when we are not using an Anesthesia provider, if yes, what is the code?

Answer

Appendix G of the CPT Code lists the codes for which moderate sedation is bundled. Vertebroplasty is not one of the listed codes, so yes, you can bill moderate sedation. As to which code is applicable, 99144 is the typical code (patient over 5 years or older), and moderate sedation of 30 minutes or less. For each additional 15 minutes of moderate sedation, you bill one additional unit of 99145. This assumes that you, and not a separate physician, provide the moderate sedation.

Question

3. Can I charge for an SI joint Arthrogram prior to an SI Joint Injection if a have a separate procedure note for the Arthrogram?

Answer

An arthrogram is considered diagnostic, for which a separate radiological report is required. So, yes, you can bill it, but let's face it, if you are doing an SI joint, and it's already scheduled, what is the diagnostic purpose? Typically, by the time the SI joint injection is being done, the only radiological service is fluoro. There could be exceptions, where you have a separate diagnostic purpose, even though you know you're doing an SI joint, but you'd better do a really good job on detailing the reason for it, since this will be reviewed carefully to see if there was a separate medically necessary reason.

H.R. 2994: National Pain Care Policy Act of 2007

Introduced 7/11/2007, the House Committee approved this legislation on September 16, 2008. National Pain Care Policy Act of 2007 - Requires the Secretary of Health and Human Services to enter an agreement with the Institute of Medicine to convene a Conference on Pain to: (1) increase the recognition of pain as a significant public health problem; (2) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain; (3)

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identify barriers to appropriate pain care; and (4) establish an agenda for action that will reduce such barriers and improve pain care research, education, and clinical care. Amends the Public Health Service Act to require the Director of the National Institutes of Health (NIH) to establish the Pain Consortium to: (1) establish a national agenda for research on the causes and effective treatments for pain; and (2) convene an annual conference of experts in pain research, treatment, and management to assess and make recommendations on NIH pain research activities and programs. Requires the Director of NIH to establish the National Pain Care Research Advisory Committee. Requires the Director of the Agency for Healthcare Research and Quality to: (1) collect protocols and evidence-based practices regarding pain care at all stages of life; and (2) disseminate such information to regulatory and enforcement agencies, health care programs, payor and providers, health professions schools, hospices, and the general public. Allows the Secretary to provide for the development and implementation of programs to educate and train health care professionals in pain care.

Advice From One Of Our Own, Dr. Lynn Columbus



Disability, overhead and health insurance are a start. Properly structuring your practice and planning for disruptions also are essential

While vacationing in Hawaii with her two daughters in April 2007, pain management specialist Lynne Carr Columbus found herself confronting her own pain. She had her gall bladder out a few weeks earlier, and suddenly was experiencing severe upper thoracic and back pain. "It was so bad I couldn't sleep," she says. Back home in Palm Harbor, Fla., near Tampa, she found out why: a CT scan showed multiple pulmonary nodules and a PET scan revealed lesions on her spine and hip. Biopsy of a tumor at C4 found that the 43-year-old had Langerhans cell histiocytosis, a rare cancer-like immune disorder that primarily affects children. By the end of May, Columbus started chemotherapy. Between the fatigue of chemo and excruciating pain from her lead apron pressing on her tumors when she delivered radio-guided spinal injections she wasn't able to work much. So in June she started filing insurance claims to keep open her 3,000 patient practice and ambulatory therapy center. Columbus had planned ahead. The solo practitioner had disability coverage to replace her income and overhead coverage to pay her 12 employees and office expenses. She had comprehensive health insurance and even a supplemental cancer policy to pay non-medical costs, such as travel expenses. However, when disaster struck, some holes appeared in her plan. She hadn't counted on the three-month income interruption before her long-term disability policy kicked in. In her weakened condition she also found insurance documentation demands burdensome. Her attempt to keep the practice running by hiring locum tenens physician extenders was a disaster. She ended up taking on a temporary physician partner who may eventually take over the practice.

Despite these glitches, the steps Columbus took to protect her practice are paying off. While her income is down by about half, she is able to support her family. And the practice she worked years to build will be there when she's ready to go back.

Below are some steps to take – and some pitfalls to avoid – that will help protect your practice and you if you're unable to work. How will you generate income for your family and yourself? How will you pay practice bills? How will you keep practice running? Who will take control of the practice?"

1. Have a crisis action plan.
2. Investigate income replacement and business expenses insurance coverage.
3. Have legal documents in place that allow successors to take control of the practice.
4. Have disability Insurance and understand the specification of the policy. Exclusions for pre-existing conditions. Definition of total and residual disability. Benefits determined by percent disability v. income loss. Benefits offset by residual income v. percentage of loss. Definition of income. Cancellation and inflation protection.

Proper Disposal of Prescription Drugs Flush it or Crush it? Advising Patients on Disposal of Unused Medications

An **Associated Press probe** reported that trace levels of prescription and OTC drugs are detectable in drinking water nationwide. Waste water contains consumed drugs that are excreted as well as unused drugs that are flushed down the toilet. After treatment, some waste water enters the drinking water supply. The AP investigation detected trace amounts of various drugs - including hormones, antibiotics, anxiolytics, anti-convulsants, cholesterol-lowering drugs, and others - in the drinking water supply of several major metropolitan areas.

In order to avoid misuse, abuse, or diversion of discarded drugs, most unused drugs should be placed into household trash as follows:

- Remove drugs from their original container.
- Mix or crush with an unappetizing substance (coffee grounds, kitty litter, dust) and place into an impermeable container, such as a jar with a lid or a sealable plastic bag.

Place in household trash.

The only drugs that should be flushed down the toilet are those whose label or accompanying patient information explicitly specifies flushing. Patients should refer to printed material accompanying each medication for specific instructions. The FDA advises that the following drugs should be flushed into the toilet rather than thrown into the trash:

Actiq (fentanyl citrate)
Daytrana Transdermal Patch (methylphenidate)
Duragesic Transdermal System (fentanyl)
OxyContin Tablets (oxycodone)
Avinza Capsules (morphine sulfate)
Baraclude Tablets (entecavir)
Reyataz Capsules (atazanavir sulfate)
Tequin Tablets (gatifloxacin)
Zerit for Oral Solution (stavudine)
Meperidine HCl Tablets
Percocet (Oxycodone and Acetaminophen)
Xyrem (Sodium Oxybate)
Fentora (fentanyl buccal tablet)

Some communities host pharmaceutical take-back programs that encourage the public to bring unused drugs to a location for appropriate disposal. Where available, these programs are a good way to dispose of unused drugs.

Source: [Federal Guidelines from the Office of National Drug Control Policy](#), Last Updated: March 20, 2007.

FSIPP Urges Promotion Of Prescription Drug Monitoring Legislation, FLASPER

The Florida Society of Interventional Pain Physicians urges everyone to contact their legislators in support of prescription drug monitoring legislation. This legislation will prevent/decrease drug diversion and abuse, and save countless lives of Floridians. As has been proven in over 30 other States, this type of monitoring system decreases the easy availability of prescription controlled substances on our streets and schools. Drug dealers and abusers from those States now come to Florida to buy their drugs. This has to stop! We strongly emphasize the following in promoting legislation:

Patient privacy is protected

Secure, encrypted, password protected website access for:
 Information on all Schedule II, III, IV medications dispensed within 2 years
 Mandatory data from all dispensing entities of Scheduled drugs
 Fully Licensed Prescribers with DEA licensure for scheduled medicines

The Secure Database:

Does not require patient permission for data entry into or retrieval from database
 Allows Physician and Pharmacist to review database for actual patients or those requesting to become patient
 Should eventually integrate with similar databases nationwide

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Secondary use of the database is restricted:

To Department of Health with active investigation of fraud or medical standard of care

Law Enforcement with active investigation by subpoena

The Department of Health should be the lead agency that:

Begins consultations for design, funding and contracting for program implementation:

Oversees any contracted vendor(s)

Investigates complaints of abuse or misuse of the website and/or refers to criminal justice or professional responsibility board(s).

To learn more about controlled prescription monitoring, go to <http://asipp.org> or <http://nasper.org>.



Coding Epidurography Versus Fluoroscopy

VAUGHN & ASSOCIATES, L.L.C.
Lawyers for Healthcare Providers

When can one code epidurography (72275) as opposed to fluoroscopy (77003)? There has long been confusion as to that issue. Initially, when these two codes were adopted in 2000, many pain physicians quickly ascertained that epidurography was reimbursed at a higher rate than fluoroscopy, and billed the epidurography code. For example, for 2008, the professional component of epidurography is weighted by Medicare at 1.00 RVU's; whereas, fluoroscopy is weighted at .77 RVU's. Thus, Medicare pays the professional component of epidurography at a 23% higher rate than fluoroscopy. Subsequent to the adoption of these codes, information filtered down from various payers, including the AMA, which indicated that epidurography was a diagnostic tool, and should not be billed in lieu of 77003, so, many consultants began to warn physicians against billing epidurography, perhaps too much so.

New guidance from the AMA now clarifies when epidurography can be utilized and what documentation is required. In the July 2008 edition of CPT Assistant, the AMA's coding magazine, the AMA states that epidurography "should be used only when a diagnostic epidurogram is performed. Hardcopy images in multiple planes documenting the flow of contrast must be obtained, and a formal radiologic report must be prepared. * * * The use of code 72275 is for diagnostic purposes and is not indicated or appropriate to use for needle localization in the majority of therapeutic epidural steroid injections or similar procedures in lieu of code 77003. * * * The indications for the use of diagnostic epidurography are limited. The vignette associated with code 72275 for the AMA/Specialty Society Relative Value Scale Update Committee (RUC) describes the use of epidurography to determine whether there are obstructions in the epidural space that would limit the spread of therapeutic substances that may be injected, such as a neurolytic substance for chemical rhizotomy. The data obtained from the diagnostic epidurography should influence and improve patient treatment options and contribute new information to that already obtained from other spinal imaging procedures commonly used, such as magnetic resonance imaging and computed tomography with myelography. Epidurography should not be used routinely for localization with the performance of most therapeutic spinal injection procedures, as this is best addressed by code 77003."

Of course, if one were to legitimately bill epidurography, one could not separately and additionally bill fluoroscopy; the AMA reconfirms that 77003 is bundled into 72275.

Accordingly, if a physician were presented with a case where there were the physician suspected that there were epidural obstructions, and the physician documented why he/she thought there were obstructions, and these obstructions were not previously revealed in other prior MRI's/CT's/myelograms, etc., then the AMA has given the green light to use epidurography, provided that hardcopy images in multiple planes documenting the flow of contrast are obtained, and a formal radiologic report is prepared." However, since the AMA has warned that epidurography should not be used routinely for localization for most therapeutic spinal injection procedures, one should be careful not to include epidurography as part of a template procedure note, since epidurography must be individualized for that patient whose circumstances lead the physician to believe there is an obstruction, and wherein the physician is able to articulate in writing, in the indications section of the procedure note, why the obstruction is suspected.

Coding for Dye Study for Catheter Patency in Implanted Pump

Coding for a dye study to determine catheter patency for an implanted pump is a thorny issue. I have previously seen one consultant recommend billing a myelogram, and Medtronic's website suggests 62318/19. I wasn't comfortable with either of these suggestions.

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On July 16, 2008, the AMA, in a response to my written inquiry regarding how to bill for a dye study, stated the following: "From a CPT coding perspective, code 61070, 'Puncture of shunt tubing or reservoir for aspiration or injection procedure,' should be reported for the injection of contrast material to an implanted intrathecal pump. Code 75809, 'Shuntogram for investigation of previously placed indwelling nonvascular shunt (e.g., LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation,' would be the appropriate CPT code to report for implanted pump catheter dye studies to ascertain catheter patency."

Two words of caution: (1) CPT code 75809 is an "S&I" code, meaning "supervision and interpretation" which requires a formal radiological report be dictated interpreting the shuntogram; and (2) watch out for medical necessity, i.e., is there a medically justifiable reason which you have documented that suggests that a dye study should be done? If there is no suspicion of a problem, you may win the battle and lose the war, i.e., code it correctly but have the entire procedure denied for lack of medical necessity.

Pain Physician Convicted of Improper Incident to Billing

On May 28, 2008, a pain management physician, Dr. Linda Sue Cheek, of Virginia, was sentenced arising out of a federal conviction for billing incident to services when she was out of the office, and at times, out of the country. Improper incident to billing is one of the most prevalent bases upon which physicians are indicted. As you remember, incident to billing involves the physician billing in his/her name, at the physician's 100% rate, for services performed by a non-physician, predicated upon a number of factors, one of which is that the physician must be in the office at the time the non-physician provides the service. If the physician is not in the office, then the service must be billed in the name of the non-physician, such as a NP or PA. Billing in the name of the NP or PA assumes that these providers are credentialed by the payer, and the payer accepts claims submitted in the non-physician's name. If the service is rendered by a non-credentialed provider, such as a RN or LPN, that service cannot be billed if the physician is out of the office, since there is no credentialed provider in whose name the service can be legitimately billed.

22 Modifier Form

The 22 modifier indicates an especially hard or complicated case that is more time intensive than usual for the type of case encountered. The 22 modifier, if accepted by the payer, reimburses an additional sum, the amount of which is carrier determined. Documentation of the increased time and risks is typically required. Recently, one of the Medicare carriers promulgated a 22 Modifier Form which I thought would be helpful in case you are trying to correctly document the extra work in order to capture extra reimbursement. Click here for the form: http://fhsipp.org/22_modifier.pdf

Legal FAQs From



For information specific to your state of practice, contact First Professionals' Risk Management. In what ways do the HIPAA Security Rule and Privacy Rule differ?

Although the Security Rule is closely linked with the Privacy Rule, the Security Rule entails the privacy of electronic protected health information.

What action should be taken when a medical error is suspected or occurs?

Contact First Professionals' Risk Management department for guidance as soon as possible. Make no admissions of liability. Federal and/or state reporting requirements under strict time constraints may apply. Always attempt to discuss the situation with personal counsel or First Professionals before meeting with hospital risk management.

What information must be on a prescription written by a Physician Assistant?

The prescription form must be preprinted with the prescribing physician assistant's name, practice address, phone number, and prescriber number. It must also contain the supervising physician's name, address and phone number if different than that of the prescribing PA. If there is more than one supervising physician, each physician must be identified on the prescription form and the name of the physician under whose supervision the prescription was written must be designated.

Which drugs can a prescribing Physician Assistant write prescriptions for?

Under current Florida law, a PA may not write prescriptions for controlled substances, anti-psychotics, general anesthetics, radiographic contrast materials, and parenteral injectables except for insulin and epinephrine. Only a PA with a current license with approved prescribing privileges can write prescriptions in Florida.

What conditions have the highest claim frequency and severity?

The most prevalent and expensive conditions in malpractice claims are, in descending order: neurological deficit and other birth related injuries; cancer – primarily of the female breast; MI, cardiac arrest and heart disease, and fractures and spinal problems – primarily displacement of intervertebral disc. •

Florida Laws Regarding Disclosure of Licensure Status

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Due to the increasing number of supervised practitioners, such as Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA) involved in patient care, patients may become confused as to the license status of practitioners involved in their care. To decrease consumer confusion and refine patient expectations, Florida regulations encourage clarification of roles among practitioners involved in the delivery of healthcare. Pursuant to Florida Statute 456.072(1)(t) the following may be grounds for discipline: - failure to identify the type of license the practitioner holds in any advertisement naming a practitioner; and - failure to identify the type of license the practitioner holds through written notice, such as the wearing of a name tag, or orally to a patient. The statute does not apply while practitioners are providing services in some facilities, such as hospitals, mental health facilities, community mental health centers or clinics, nursing homes, assisted living facilities, adult day care centers, or adult family care homes and intermediate care facilities.

In situations where a physician supervises other practitioners, Florida Statute 458.348(5) also requires that upon initial patient referral the patient is informed of the type of license the physician receiving the referral holds, as well as that of any other supervised practitioner who will be providing services to the patient. The patient shall be given an opportunity to see the physician or the supervised practitioner and shall sign a form indicating the patient's choice of practitioner prior to the initial examination.

For Medical Doctors, Physician Assistants, and Anesthesiologist Assistants:

Additionally, Florida Administrative Code 74B8-11.003 – Disclosure of Licensure Status requires that practitioners (unless exempt as noted above) disclose their practice license status - Medical Doctor (MD), Physician Assistant (PA) or Anesthesiologist Assistant (AA) - by one of the following methods: - name tag appropriately identifying the licensee as either MD, PA, or an AA, or - wearing an upper body garment which identifies the licensee, or - oral disclosure to the patient upon initial contact, or - providing a business card which identifies the licensee upon initial in-person contact, or - placing a notice in the practice site lobby or reception area which contains a photo of the licensee and



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