

# FSIPP NEWSLETTER

JUNE 15, 2007

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Editor-in-Chief: Deborah H. Tracy, M.D.

## President's Message

### Greetings!

**EVERY INTERVENTIONAL PAIN MANAGEMENT DOCTOR IN FLORIDA** needs to be a dues paying member of FSIPP (Florida Society of Interventional Pain Physicians), the Florida chapter of ASIPP.

These organizations maintain a presence at the state level as well as nationally protecting and preserving your profession. I realize that not everyone is an activist. That is the precise reason you should at least financially support the professional organizations that best represent your interests.

With a seat on the FMA board of specialties, FSIPP is diligently working to support FLASPER legislation to create a Florida controlled prescription database. Such a database has already proven effective in curbing prescription drug abuse in other states. With representation on the Medicare Carrier Advisory Committee, FSIPP is actively involved in reviewing LCDs (local carrier decisions) for codes such as paravertebral/facet blocks and neurolysis procedures.

It is **IMPERATIVE** that you become an active member. The Organization needs your financial support in order to continue Our Mission: 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 these interventions in the State of Florida.

**If you have not yet done so, SEND IN YOUR MEMBER APPLICATION/RENEWAL FORM WITH YOUR DUES PAYMENT TODAY!!!**

Thank you to all who have paid your 2007 FSIPP dues to date. Remember, FSIPP dues are **NO LONGER** collected through ASIPP, but directly through our state component. Applications/Renewal Forms can be found on our website at <http://flsipp.org/membership.htm>. If your name is NOT on the list below, you HAVE NOT paid your 2007 dues. So, please print the Form out, complete it, and send it in with a check for \$200.00. In the future, we will have online capability for payment.

Don't delay! Do it now.....pay your dues, register with the hotel, and send in your conference registration.

See you in Orlando....and thank you again to these paid members!

Lora L. Brown, M.D., FIPP

Gilberto Acosta MD  
Marshall Bedder MD  
Ervin E Bernotus MD  
Carlos Botero MD  
Kenneth Botwin MD  
Lee Ann Brown DO  
Lora Brown MD  
Richard Bundschu MD  
Jennifer Burns MD

Charles Friedman MD  
Russell Gilchrist MD  
Kenneth Giraldo MD  
Dorothea Glass MD  
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Robert Gruber DO  
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John Hunt MD

Raymon Prieve DO  
Stephen Pyles MD  
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Gary Saff MD  
Alan Siegel MD  
Martin Shipman MD  
Sanford Silverman MD  
Michael Solomon MD  
Steve Stein DO



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Nancy Layton MD  
Thanh Le MD  
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Raul Monzon MD  
Joseph Mouhanna MD  
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Yili Zhou MD  
Mark Zimmerman MD  
Frank Zondlo MD  
Keith Zwingelberg MD

### Annual Meeting

FSIPP is meeting with the FL Academy of Pain Medicine, July 27 – 29, at The Gaylord Palms in Orlando. [Please click here](#) for all registration, hotel, and program information. You'll note a discount for FSIPP members – your dues have to be paid to get this discount.

***DEADLINE FOR HOTEL RESERVATIONS AT OUR CONFERENCE RATE, AND DEADLINE FOR EARLY BIRD CONFERENCE REGISTRATION IS JUNE 24!***

### Highlight on Vertebroplasty Workshop

Friday, July 27, 2007, in conjunction with the FAPM/FSIPP Annual Meetings  
The Gaylord Palms, Orlando

The 2007 Florida Academy of Pain Medicine (FAPM) Meeting at the Gaylord Palms in Orlando, Florida, July 27 - 29, in conjunction with the Florida Society of Interventional Pain Physicians (FSIPP) will present a Cadaver Workshop on Vertebroplasty. This course is designed to expose the participant to the diagnostic and technical considerations in providing vertebroplasty with hands on cadaver participation. After completing this intensive 4 hour course the participant will have advanced cognitive skills in recognizing patients who would benefit from vertebroplasty, ordering and interpreting appropriate imaging studies, and recognize complications. For the non-interventionalist the course will enhance the physician's ability to recognize appropriate referrals and understand the challenges and architecture of the procedure. Live proctoring subsequent to this course can be arranged for the interventional physician seeking credentialing. The course will be presented by Dr. Deborah H. Tracy, a Florida Pain Management Interventionalist, who has now accomplished 1000 vertebroplasties. Dr. Tracy is Board Certified and subspecialty certified in Pain Management by the American Board of Anesthesiology, a Fellow of Interventional Pain Practice by the World Institute of Pain, and Certified by American Board of Interventional Pain Physicians.

For Questions regarding this course or the FAPM Meeting please contact Lorry Davis at [lorry4@earthlink.net](mailto:lorry4@earthlink.net).



*Those darn  
hurricanes!  
News from FPIC on  
what to do*

**WE'RE ON THE WEB!**  
**FLSIPP.ORG**

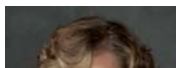
### Shingles and Interventional Pain Treatment

*Andrea Trescot, MD, President ASIPP*

Director, Pain Fellowship Program

University of Florida/VA Medical Center, Gainesville FL

Founding President, Board of Directors, FSIPP



Post herpetic neuralgia, which can develop after

progress to PHN. The interventional approach to the treatment of shingles can be



Post herpetic neuralgia, which can develop after an episode of shingles, is a debilitating pain that may last up to a year in 50% of patients, and may even last up to a lifetime.

The good news is that aggressive interventional pain management is both cost effective and efficacious in treating shingles and preventing PHN. Approximately 1 in 10 individuals who have had chickenpox will develop shingles. Shingles strikes an estimated 200,000 to 800,000 U.S. patients each year, mostly among the elderly or immunosuppressed. The incidence of herpes zoster infection is estimated to be as high as 4.8 cases per 1000 persons each year. Twenty to thirty percent of shingles patients continue to have pain after the shingles lesions have healed, which is called post herpetic neuralgia (PHN). The risk increases with age, approaching 75% of patients over 70 years old. Although the mechanism of pain is not clear, ischemia of the nerve would explain the prelesion pain and the subsequent hypoesthesias. The goal of treatment is to treat the pain of the acute disease and prevent the occurrence of post herpetic neuralgia. The earlier a patient is treated, the less likely the condition will

progress to PHN. The interventional approach to the treatment of shingles can be traced to as early as 1969, when Colding described the use of regional sympathetic blocks for zoster treatment. Sympathetic blocks can be used to prevent the vasoconstriction thought to cause the pain and nerve damage. Patients presenting to our office with supraorbital lesions are offered supraorbital nerve blocks with deposteroid and local anesthetic (1/2cc total volume). Cervical paravertebral nerve blocks and occasionally cervical epidural steroids are used for upper extremity lesions. Thoracic shingles patients are offered a paravertebral nerve block, followed by a thoracic epidural if complete relief is not obtained. Lumbosacral lesions are treated with lumbar or caudal epidural steroids. In addition to the injection, patients are started on a topical ketoprofen-lidocaine compounded salve as well as samples and a prescription for oral gabapentin (Neurontin®) or pregabalin (Lyrica®). Most have already been started on antivirals before they reach our office, but if not, they may be given antivirals as well. It has been extremely gratifying to treat the active shingles patients, especially those in extreme pain. Within moments after the injection the pain is gone, and for most patient's pain never returns or returns at a much decreased level.

*[\(Read More...\)](#)*



### *Check the OIG Sanctions Database*

You must remember to check all new hires on the OIG's Sanctions Database. Hiring an employee listed on the OIG's Sanctions Database is a felony. In a recent case in Florida, an assisted living facility hired an employee who had arrests for prior violence. The Attorney General began an investigation as a result, and ended up finding Medicaid fraud. The Medicaid fraud arrest was the byproduct of an investigation that had nothing to do with fraud, but started with a complaint that the provider had hired someone with prior healthcare offenses. Sometimes, mistakes in one arena can lead to convictions in another arena. Make sure you verify that all potential new hires are not listed on the OIG's Sanctions Database.

The OIG's Sanctions Database can easily be found on the OIG web site. *(May 20, 2007)*

### *Multiple Fluoroscopy Codes on the Same Date of Service*

This is a reminder that in August 2005 the AMA, through its coding newsletter, CPT Assistant, stated that if injections are done at L5 and S1, the provider can code 2 fluoroscopy codes (77003 and 77003-59) because the lumbar region is a different region from the sacral region. Shortly after that, the AMA clarified that comment in December 2005 to state that if only one injection is performed at L5-S1, then only one fluoroscopy code can be billed, the inference being that there must be two separate injections, one in the lumbar region and one in the sacral region to justify two separate fluoroscopy codes.

The upshot of these two comments is that if a facet injection is performed under fluoro at L5-S1, then one fluoroscopy code can be billed. However, if transforaminal epidural injections are performed under fluoro separately at L5 and S1, then two fluoroscopy codes can be billed. *(April 04, 2007)*

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### *Purchasing Drug Supplies from Canada?*

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## *Purchasing Drug Supplies from Canada?*

FSIPP member Eduardo Dieguez, MD, wrote in, inquiring about the legality of buying drugs from Canada. Vaughn & Associates LLC researched this question and unable to come up with a definitive answer, left a message with the DEA to get a more definitive answer. They subsequently followed-up with a written inquiry to the DEA. We are still awaiting that response, but in the meantime, this is what we've got:

"From the research that we do have, the laws regarding this are confusing, as to whether they apply to both controlled and non-controlled substances. The other problem I had was finding information regarding physicians purchasing drugs from Canada. A lot of the research is in regards to pharmacies and consumers purchasing their medication from Canada. However, here are a few issues that I would like to point out from our research:

It is illegal for any person other than the original manufacturer of a drug to import into the United States a prescription drug that was originally manufactured in the United States and sent abroad. This law is in regards to drugs which "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not safe for such except under the supervision of a practitioner licensed by law to administer such drug." {21 U.S.C. 381(d)(1) and 21 U.S.C. 353(b)(1)}

Virtually all drugs imported to the United States from Canada violate the FDCA (The Federal Food, Drug, and Cosmetic Act) because they are unapproved (21 U.S.C. 355), labeled incorrectly (21 U.S.C. 352,353), or dispensed without a valid prescription (21 U.S.C. 353(b)(1)). FDA approvals are manufacturer-specific, product-specific, and include many requirements relating to the product, such as manufacturing location, formulation, source and specifications of active ingredients, processing methods, manufacturing controls, container/closure system, and appearance (21 C.F.R. 314.50) Generally, drugs sold outside of the United States are not manufactured by a firm that has FDA approval for that drug.

The FDA advises against purchasing drugs from foreign countries because of safety concerns. For example, there have been some cases in which consumers bought drugs from a Canadian pharmacy, but the drugs were actually shipped from India.

There is a lot of controversy regarding this issue. However, as soon as we speak to the DEA, we can give you a definite answer as to whether or not it is legal for you to purchase non-controlled drug supplies from Canada."

### *Other Offerings from the Vaughn & Associates Reading Room Regarding Compliance Issues*

#### *DEA official testifies before Senate on Prescription Drug Abuse*



Joseph T. Rannazzisi, Deputy Assistant Administrator for the DOJ Office of Diversion Control Drug Enforcement Administration testified today before the Members of the Judiciary Committee on the alarming rise in prescription drug abuse. Rannazzisi sited illegal Internet sales to be a major contribution in this crisis.

Non-medical use of addictive prescription drugs has been increasing throughout the United States at alarming rates. In 2005, an estimated 6.4 million Americans age 12 and older reported past month use of prescription drugs for non-medical purposes. Of these, 4.7 million used pain relievers non-medically. Nationally, the misuse of prescription drugs was second only to marijuana in CY 2005.

Part of this increase in abuse is fueled by the perception among many that prescription drugs are relatively safe when compared to what some might consider more conventional "street" drugs such as heroin or cocaine. There is relatively little stigma associated with prescription drugs. Because they are manufactured for a legitimate medical purpose, many take these drugs without the anxiety of thinking they will be ostracized for their habit. Perhaps even more alarming is the false sense of security associated with the abuse of these substances. Many feel as though if a doctor can prescribe it, the drug can't be as harmful to your health.

haps even more alarming is the false sense of security associated with the abuse of these substances. Many feel as though if a doctor can prescribe it, the drug can't be as harmful to your health.

## Rannazzisi testimony

### Pay For Performance and Pain Medicine

**Rafael Miguel, M.D.**

Professor and Director  
Pain Medicine Program

Departments of Anesthesiology and Neurosurgery  
University of South Florida, Tampa FL

President, Florida Society of Anesthesiologists



CMS is counting on physicians lining up to cash in on the 1.5% bonus payment offered to those practices that document compliance with a variety of "quality improvement" measures as part of the Physician Quality Reporting Initiative (PRQI), enacted by Congress in December 2006. PRQI identifies 74 different measures, none specifically related to Pain Medicine practices, for data collected from July 1 through December 31, 2007. While the program has

funding for this year, allocation of monies to run the program next year has not been done as of this writing and remember, this was largely a Republican initiative with much Democratic opposition. Although CMS asserts that an electronic health record is not necessary, review of the system identifies that it will require investment into an improved IT system to report compliance with the measures.

[\(Read More\)](#)

## Legal FAQs

Courtesy of **FPIIC**



### Is a specific timeframe set forth when withdrawing professional services to a patient?

No. Although statutes do not specifically set forth the amount of time a patient must be given, managed care contracts and provider agreements may contain language that does. Generally, a 30-day notice period is sufficient; however, depending on the circumstances, a lesser time period may be appropriate. If the patient terminates you, there is no further obligation to treat the patient. Always review the language of applicable managed care plans before terminating the physician-patient relationship.

### Do state or federal laws set forth a specific manner in which obsolete patient records must be destroyed?

No; however, patient records must be destroyed in a manner that protects patient confidentiality. Under HIPAA confidentiality provisions, it is recommended that obsolete patient records be shredded for disposal. If arrangements are made with third parties or entities for the destruction of patient records, a written agreement should be obtained clearly obligating the entity to safeguard confidentiality as well as indemnify and hold harmless you and your practice from any breach of confidentiality for which they are responsible. Clarify the timeframes of the specific record retention laws in the state in which you practice.

### Does the physician-patient relationship end at the time insurance coverage expires or managed care plan terminates?

No. Once established, the physician-patient relationship does not end merely because insurance is no longer available or a change in managed care coverage occurs. A physician's responsibility to the patient continues unless and until the patient severs the relationship or the physician provides proper notification to the patient of the intent to withdraw from providing further care and treatment. Always seek legal or risk management guidance before terminating the physician-patient relationship.

### What action should be taken when a patient discharges a physician?

Document the medical record and send written confirmation to the patient specifically indicating the date that your physician-patient relationship was terminated by the patient. If the patient is in the midst of diagnostic work-up, advise the patient and furnish a copy of all lab or diagnostic reports.

### When a patient leaves the hospital AMA (against medical advice) is the physician-patient relationship automatically severed?

No. The patient can assert that the AMA was purely for some aspect of treatment, such as surgery or physical therapy, but not all care and treatment. Always document the record in the case of an AMA and send a letter to the patient confirming the forfeiture of care and the potential consequences of their actions. Ask the patient to reconsider, but do not deny the patient access to ongoing care. Consider terminating the physician-patient relationship. Depending on the circumstances, seek legal guidance before taking such action.



## CSF Leaks, a Personal Perspective

### Letter from the Editor

As editor of the FSIPP Newsletter I look for good news and educational material every day. I am a former anesthesiologist, fellowship trained in pain management in 1988, but now practice interventional pain management full-time. Through



and antidepressants.

He can not work and has difficulty performing minimal activities of daily living. By this time I have read every article published on Spontaneous Intracranial Hypotension since 1938 and taken Bob as far as Los Angeles, California to see the national guru. Sadly physicians who have limited knowledge about this condition

ologist, fellowship trained in pain management in 1988,



but now practice interventional pain management full time. Through personal experience I have become aware of a clinical entity which is poorly understood by Florida Physicians, but suspect this to be a national challenge of knowledge. This clinical entity is Chronic Spontaneous CSF Leaks (Spontaneous Intracranial Hypotension) and within the domain of the pain management practitioner who often has extensive experience in treating post-dural puncture headaches.

My husband Bob is a 55 year old male who was athletic and in good health until October of 2005, when he developed signs and symptoms of an upper respiratory infection that was accompanied by a severe postural headache and without a sinus drip. MRI of the brain with gadolinium was significant for enhancement of the pachymeninges, obliteration of the supra sellar cisterns, engorgement of the pituitary and cerebral veins and sagging of the brain stem. He underwent work up for rule out meningitis, lumbar puncture revealed an opening pressure of zero. MRA was negative. Test results for infectious etiology were negative. Associated symptoms included severe postural headaches, hypertension, tinnitus, photophobia, phonophobia and cognitive impairment.

Since then Bob has had numerous imaging studies including a Cisternogram, 20 MRI's, and 6 CT Myelograms. He has had 7 Epidural Blood Patches and 4 hospitalizations. Out of desperation he tried alternative medicine including acupuncture, craniosacral therapy, chelation therapy and activator chiropractic treatments. He has been trialed on multiple analgesics, NSAID's, membrane stabilizers, opioids

potension since 1938 and taken Bob as far as Los Angeles, California to see the national guru. Sadly physicians who have limited knowledge about this condition always hint at a psychiatric disturbance.

Chronic spontaneous CSF Leaks can have devastating consequences, but remain a misdiagnosed, poorly understood clinical syndrome. Now known as Spontaneous Intracranial Hypotension, this condition is secondary to a spontaneous rent or tear in the duramater that chronically leaks CSF into surrounding structures of the neuraxis. The consequences of low intrathecal pressure include traction of the brain from the skull leading to meningeal inflammation, engorgement of the cerebral veins and pituitary, hygromas and obliteration of the supra sellar cisterns. In some cases subdural hematoma and or herniation of the brain stem have been reported. Headaches are usually postural but can be constant. Successful treatment is usually accomplished by administration of an empirical epidural blood patch or if the leak is found a directed blood patch. If this approach fails directed fibrin glue or finally a hemi-laminectomy for surgical closure can provide successful results.

So far, in spite of heroic efforts to find Bob's leak, we have been unsuccessful. We now hope that this leak will close spontaneously. Please add this diagnosis to the management of headaches.

Deborah H. Tracy MD, MBA  
Board Certified, Anesthesiology, ABA  
Subspecialty Certified, Pain Management, ABA  
FIPP, Certified ABIPP  
FSIPP, Board of Directors, Secretary  
Editor-In-Chief, FSIPP Newsletter

## **FSIPP NEWSLETTER**

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