

# FSIPP NEWSLETTER

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



**Lora Brown, MD**

## *President's Message Greetings*

In reviewing the list of current FSIPP members, I recognized that there are many Florida Pain Physicians who have not yet joined the Florida Society of Interventional Pain Physicians.

*Now more than ever it is imperative that you get involved if not already.* If you are a member, reach out to your colleagues and bring them into our circle. Encourage every interventional pain physician you know to become an FSIPP member.

We are in the midst of a healthcare crisis. Every day a piece of the healthcare pie is being sliced away. *As an Interventional pain physician you need to have a voice. FSIPP is your voice.* FSIPP represents you and your patients by striving to preserve access to pain management procedures for all patients in the State of Florida. FSIPP represents you on important committees such as the Medicare Carrier Advisory Committee, the Specialty Society Committee at the FMA, and as a member of the Florida Pain Coalition.

This year alone, FSIPP and its members have fought to preserve payment for paravertebral (facet) injections, won an appeal for nonpayment of sacroplasty procedures, as well as, proposed and passed a FMA resolution to amend legislation to create mandatory reporting to a scheduled II drug registry within the state of Florida.

This year FSIPP has tripled its members, started an informative newsletter, and created a website. *All in a year... not too bad.*

Our goals for the coming year include:

- *FSIPP will continue our fight to preserve reimbursement by assisting carriers in the development of practice protocols. We will do this through our continued presence on the CAC. In addition, a reimbursement committee has been formed to build alliances with managed care carriers. Our goal is to participate in the creation of their practice algorithms.*
- *In an attempt to protect its members from "drug diversion and doctor shoppers" FSIPP will continue to spearhead the fight for FLASPER, a bill that requires mandatory reporting of all controlled drugs by pharmacists to a scheduled drug registry within the state of Florida accessible only to pharmacists, healthcare providers, and law enforcement.*

*(Continued on Page 2)*



### *Inside this issue:*

***ASIPP Annual Meeting,  
Washington DC***

***Level II Office Surgery***

***2007 Annual Meeting  
At The Gaylord Palms***

***Sacral Vertebroplasty  
Denial Reversed by  
ALJ***

***CMS Starts Auditing  
99233***

***CMS Agrees to Pay for  
Moderate Sedation***

***FLASPER Update***

***Minimally Invasive  
Spinal Surgery***

***Risk Management  
Guidelines***

***Legal FAQs***

***Do You Share Space  
and Equipment — Not  
For Long?***

*(Continued From Page 1)*

- *FSIPP is in the process of developing a regional network of leaders who will serve as regional representatives. This grassroots network will be used to build our organization. In addition, it will provide a mechanism to disseminate information and mobilize our colleagues quickly when needed.*
- *We hope to build an alliance with federal, state and local law enforcement. FSIPP's intent is to provide an opportunity to create a venue for ongoing dialogue between legitimate pain physicians and law enforcement, whether anonymous or not, through our newsletter.*
- *FSIPP plans to create a patient membership category with website and newsletter. This will allow interventional pain physicians to educate patients on a large scale about relevant issues whether clinical or political. In doing so, we hope to develop a large patient email database that we can activate during important political events and elections.*
- *FSIPP has agreed to work closely with FAPM in order to improve the 2008 annual meeting. We hope to partner with FAPM in hosting the annual meeting beginning 2009.*

So, as you can see there is much to be done. We need you to join us in our efforts. Please get involved at whatever level you like. Not everyone is an activist. Not everyone can afford the time. I know, however, that you can afford the simple annual membership dues of \$200. **It will be the best investment you make all year.**



### *ASIPP Annual Meeting, Washington DC*

Lora L. Brown, M.D., FIPP

We have returned from the 9<sup>th</sup> Annual ASIPP Meeting and Capitol Hill Legislative visits in Washington DC. *I am proud to say that Florida made a strong showing!*

Florida Society of Interventional Pain Physicians (FSIPP) was one of four states to be awarded the *Outstanding State Chapter Award*. Drs. Harold Cordner, Marshall Bedder and I were there to accept the award on behalf of

FSIPP.

### *Congratulations to all FSIPP members!!!*

Thanks to the following physicians who took time out of their busy schedules to participate in the Washington lobby process:

Robert Ycaza, MD, Danya Godoy, MD, Sanford Silverman, MD, Ruben Gonzalez, MD, Harold Cordner, MD, Joseph Mouhanna, MD, Marshall Bedder, MD, Andrea Trescott, MD, and Lora Brown, MD

Visits were made to the offices of Sen. Martinez, Sen. Nelson, Rep. Stearns, Rep. Brown, Rep. Mack, Rep. Young, Rep. Hastings, Rep. Buchanan. We had the opportunity to discuss Physician Payment Reform, ASC Payment Issues, as well as NASPER Funding.

I feel that the entire experience was richly rewarding and look forward to returning in 2008. I encourage all FSIPP members to mark your calendars now for the 10<sup>th</sup> Annual ASIPP Meeting and Legislative Days in Washington DC June 21-25, 2008. Remember, you are welcome to bring spouses, friends, and age appropriate children. Make this a family vacation next summer!

...[JOIN FSIPP TODAY!!](#) [Renew your FSIPP membership](#) TODAY!!

*Level II Office Surgery***MOST FREQUENTLY ASKED QUESTION  
FROM THE MEMBERSHIP THIS QUARTER****LEVEL II OFFICE PROCEDURES****What are the State Requirements for Level II Office Procedures?**

Believe it or not answering this question has been an arduous and time consuming task. The Florida State Department of Health Website (<http://www.doh.state.fl.us/mqa/index.html>), which provides information and addresses these types of questions does not take the reader to a simple answer. The following is what I have gathered from the State, Professional Consultants, Rule 64B8-9.009 Standard of Care for Office Surgery and the "2006 Guidelines for Design and Construction of Health Care Facilities."

Rule 64B8-9.009 Standard of Care for Office Surgery (see link below) contains ~360 lines. At line 211 Standards for Level II Office Surgery are addressed, however on previous lines requirements for both Level II and Level III are mixed together. The "2006 Guidelines for Design and Construction of Health Care Facilities" co-authored by the FGI, AIA and the U.S. Department of Health and Human Services addresses Plant Requirements.

If you are pursuing Level II Certification, FSIPP advises that you hire a consultant to check your plant before you proceed to avoid unnecessary expense or implausibility. The following Outline is only a template for the feasibility of your thought process.

**OFFICE SURGERY LEVEL II**

1. Maintain Complete Records
2. Written Informed consent
3. Maintain a Log
  - Patient identifier
  - Type of procedure
  - Type of anesthesia
  - Duration of procedure
  - Post op care
  - Adverse incidents
4. One monitor to 2 patients in post op
5. Crash Cart (full and current)
 

<ul style="list-style-type: none"> <li>Adenosine 6mg/ 2ml x 3</li> <li>Aibuterol Inhaler</li> <li>Amiodarone 150 nag x 2</li> <li>Atropine 0.4 mg/mi; 3 ml</li> <li>Calcium chloride 10%; 10 ml</li> <li>Dextrose 50%; 50 ml</li> <li>Diphenhydramine 50 mg</li> <li>Doparnine 200 mg minimum</li> <li>Epinephrine 1:10,000 dilution; 10 ml</li> <li>Epiriephrine 1:1000 dilution; 1 mix 3</li> <li>Flumazenil 0.1 mg/ml; 5 ml x 2</li> <li>Emergency intubation equipment, suction devices, ETT, laryngoscopes</li> <li>Positive pressure ventilation device</li> </ul>	<ul style="list-style-type: none"> <li>Furosemide 40 mg</li> <li>Hydrocortisone or Methylprednisolone or Dexamethasone</li> <li>Lidocaine 100 mg</li> <li>Magnesium sulfate 1 gm x 2</li> <li>Naloxone 0.4 mg/mi; 3 ml</li> <li>Propranolol 1 mg x 1</li> <li>Sodium bicarbonate 50 mEq/50 ml</li> <li>Succinylcholine 1 vial</li> <li>Vasopressin 20 units x 2</li> <li>Verapamil 5mg x 2</li> </ul>
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6. Benzodiazepine must be stocked, but not on crash cart
7. Oxygen supply

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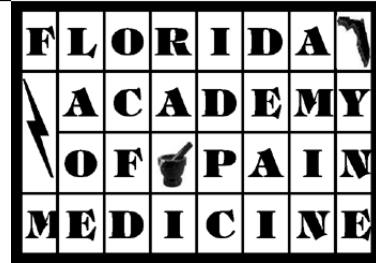
8. IV Solutions and equipment
9. Double tourniquet for Bier block
10. Monitors BP/EKG/O2 Sat
11. Adequate procedure room light
12. Emergency power source, to run required equipment and lighting for a minimum of 2 hours, must be run every 30 days, take less than 8 sec to engage, with a 'Transfer Switch'
13. Sterilization Equipment
14. Sedation Monitor must be at least an RN and cannot function in any other capacity during procedure
15. RN credentialed in ACLS must be available to monitor in Recovery Room
16. Surgeon must be "readily available," able to return in 15 minutes, if he/she leaves
17. Policy and Procedure Manual
  - Updated annually and implemented
  - Duties, responsibilities of personnel
  - Quality assessment and improvement systems
  - Cleaning, sterilization
  - Infection control
  - Emergency procedures
  - Risk Management Program
  - Identification, investigation of frequency and causes of adverse incidents
  - Identify trends of incidents
  - Measures to correct, reduce and minimize risk
  - Documentation of these functions and periodic review (quarterly)
18. Adverse incidents shall be reported within 15 days of occurrence to Department of Health
19. Signs posted prominently that the Office is regulated by the Rules of the Board of Medicine (64B8 and appear on the informed consent) and posted "Patients Rights"
20. Pre-operative medication and sedation if used IV, IM, or rectally and require intra and post op monitoring
21. Sedation, intra op, allows pt to tolerate unpleasant procedures but respond purposefully to verbal command or tactile stimulation
22. Transfer Agreement with a licensed hospital if he/she does not have privileges to do the procedure at a hospital within a 30 minute transport time
23. Physician must have satisfactory training, BC or BE, in the procedure and have current ACLS
24. Procedure Room
  1. No less than 250 sq ft
  2. Sink located in or outside the room
  3. Smooth and cleanable wall surfaces (seamless)
  4. Semi-gloss paint
  5. Gurney must be able to pass in and out of room
  6. No carpet
  7. Positive pressure ventilation
    - 90% filtration
    - 10 – 15 air exchanges per hour
    - Supply and return of AC in the room
    - Hepa-filter
  8. Fire retardant window treatments
25. Recovery Area
  - 50 sq ft, per patient recovered, at one time

*64B8-9.009 Standard of Care for Office Surgery*

**FAPM/FSIPP 2007 Annual Meeting**



Our most esteemed Executive Director, Lorry Davis



Dr Cordner, FSIPP President-Elect, plays the tambourine



Gaylord Palms Lobby



Dr Brown, FSIPP President, plays drums while Dr Linetsky, FAPM Board of Directors, dances

**FSIPP Board Supports Sacroplasty  
Sacral Vertebroplasty Denial Reversed by ALJ**



Vertebroplasty of the sacrum has no CPT code. The current vertebroplasty codes only relate to the thoracic and lumbar levels. As such, Medicare has been denying the 22899 code for sacral vertebroplasty, a/k/a sacroplasty. However, recently, one of my clients in Florida, Dr. Deborah Tracy, took on Medicare and appealed the denial of sacral vertebroplasty and won.

Attached is the opinion from the Administrative Law Judge ("ALJ") which is titled, "Notice of Fully Favorable Decision," and in which the ALJ reversed the QIC decision (i.e., the second level of appeals by an independent Medicare contractor). The QIC had determined that sacroplasty was investigational, and therefore, not covered. Subsequent to the QIC decision, Dr. Tracy obtained and submitted to the ALJ a whole host of articles regarding the efficacy of sacroplasty. Dr. Tracy also obtained letters from colleagues, her state society, the patient, and the patient's primary treating physician. I then helped her craft the letter to the ALJ informing him that vertebroplasty was already an approved procedure at the thoracic and lumbar levels, and thus, the procedure itself was not investigational, and indeed, should be paid because the same supplies, equipment, cement, kit, and methodology are used to perform the vertebroplasty in the sacrum as are used in the lumbar region.

In this case it helped that the patient, who had been bedridden for months, was able to walk within hours of the procedure – a dramatic result. Dr. Tracy's submissions to the ALJ were so persuasive that the ALJ rendered a decision solely from Dr. Tracy's written submissions, and she didn't have to appear at a hearing and provide testimony, as is the usual course in an ALJ hearing.

This decision is important for a couple of reasons. First, it shows that if you appeal to the ALJ level, you stand a much better chance of success than at the first two levels of appeal, which are decided by Medicare's trained dogs. Second, just because those dogs are trained to bark "Investigational!" – "don't make it so." If you believe you're right, appeal it to the ALJ – just make sure the medical literature supports your position.

To view the attachment referenced in this article please visit the Reading Room area of our website.

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

## CMS Starts Auditing 99233

Friday, August 17, 2007

CMS is now targeting CPT code 99233 (the highest level subsequent hospital care code) – at least in Louisiana. So, this is an advance warning. Not too many of you bill 99233 of which I am aware, other than the intensivists that work in critical care departments.

It is not surprising that CMS has targeted 99233, as they have previously targeted the highest code in the new patient, established patient, and consult code sets. Now, CMS has made the logical progression to audit the highest paying code in the subsequent hospital care code set.

I learned of this in a somewhat unusual way. A psychiatrist whom I had represented several years ago requested an appointment to discuss an audit letter he had received from CMS. When I reviewed the audit letter, it had a color graph showing the number of times each of the top 5 physicians had billed 99233 to Medicare in Louisiana. None of the physicians were named on the graph, but the letter explained that my client was #2 on that graph. In trying to console him, I offered, "Well, you can rest assured that you're not the only one going to be audited. I'll bet that Medicare is going to audit all 5 of the physicians in this top 5 list." He responded, "You're right. My son is number 1 on that list, so I'll be sending him to see you tomorrow." <http://www.lalawfirm.net> or [Click here to go](#) to the Client Log-in area.

## CMS Agrees to Pay for Moderate Sedation



On August 27, 2007, CMS issued Transmittal 1324 relating to moderate sedation, and contains the conditions under which CMS will, and will not, pay for moderate sedation. The implementation date is October 1, 2007. I am aware that some states, such as Florida, have adopted rules on the payment of moderate sedation, but this Transmittal will supersede those rules and provide broader opportunities for payment. I have attached the CMS Transmittal in case you need to submit it to appeal the improper denial of moderate sedation codes when billed to Medicare (see the last 2 pages of the 14-page Transmittal). [Click here for highlights](#)

## FLASPER Update

FLASPER Florida All Schedule Prescription Electronic Reporting did NOT pass the legislature this year (again). A House Bill 1155 was passed during the 2007 Legislative Session, creating an information-only website at AHCA on e-prescribing and more. In Aug., 2007, FSIPP led the charge at the FMA Annual Meeting and got the FMA to support a TRUE "FLASPER Amendment" to what was passed. We intensify our efforts.



## Minimally Invasive Spinal Surgery

James Joseph Ronzo, DO  
GOLFCOAST SPINE INSTITUTE  
Inverness, Florida

Surgeons have traditionally used an open approach to perform spinal fusion procedures, which involves making an incision along the middle of the back, stripping large bands of back muscles free from the spine, and retracting the muscles to each side of the opening so that the surgeons can view the spine and easily access the vertebrae for instrument implantation. Minimally invasive surgery involves muscle dilation rather than muscle stripping. Spinal fusion can now be performed using less invasive techniques, making highly invasive posterior fusion unnecessary in many cases. Muscle dilation is achieved by using a series of sequential dilators to separate the fibers of the muscles in a spine, making a small tunnel, giving the surgeon a view of the spine through a very small incision.

*(Continued on Page 7)*

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By using these tubes, the surgeon can access the spine where the problem is, without having to make a long incision along those spinal levels. By allowing surgeons to operate through incisions less than an inch in length and to spare muscle by leaving it virtually intact, minimally invasive techniques can significantly reduce the pain, blood loss, and recovery time associated with traditional open surgery.

James J. Ronzo, D.O., is recognized as a leader in minimal access spine surgery. He has lectured on the subject nationally and internationally. For several years, Dr. Ronzo has been sharing his expertise in the operating room with visiting spine surgeons from around the country. Running the cadaver laboratory in Tampa, Florida, he has mentored spine and neurosurgeons in the art of minimal access spine techniques in spinal fusions. Dr. Ronzo has studied the outcomes of 600 patients of which he has performed 1 to 4 level, lumbar fusions using this minimally invasive technique. This group had a median age of 64.4 years. The results were as follows:

	Minimally Invasive Technique	Traditional
Average hospital stay was	1.5 days	3.9 days
Average surgery time	117 minutes	240 minutes
Average blood loss	109 cc	255 cc

Of this same study group, the success fusion rate was 99% (2 patients were non-compliant with the doctor's orders; they were re-operated on and were successfully fused). Infection rate was zero. Average pain levels went from an 8 pre-op, to a 3 at six months post operative. Based on these outcomes, there is no doubt that the Minimally Invasive Spine Surgery in the use of lumbar fusions *is* the future of spine surgery.

**Dr. Ronzo** is a long time resident of Citrus County, Florida. He graduated from Crystal River High School and attended University of Central Florida. Medical school in Nova Southeastern University College of Osteopathic Medicine, Ft. Lauderdale was followed by a five year Orthopedic Residency in Grand Blanc, Michigan. Dr. Ronzo then completed his fellowship with Florida Orthopedic Institute at Tampa General Hospital. He has been practicing in Citrus County since 2000 and in Hernando for the past 3 years.

***Risk Management Guidelines:  
Low Health Literacy***



Low health literacy is a frequent source of malpractice claims. A basic understanding of one's health care improves diagnostic accuracy, enhances patient decision-making and increases the likelihood of adherence to therapeutic regimens, thereby reducing claims exposure.

[Read More . . . .](#)

***Legal FAQs From***



***What action should be taken when a patient is noncompliant or refuses to undergo diagnostic studies, care, or treatment?***

Document your recommendations and the patient's noncompliance. Advise the patient of the potential consequences of noncompliance or refusal, and document your discussion. Confirm the patient's non-compliance, your subsequent discussion and the potential consequences in a letter to the patient sent certified mail, return receipt requested and send a copy of the letter by regular mail as well.

*(Continued on Page 8)*

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Consider withdrawing from the patient's care, but first review the language of any managed care contracts that may apply to the situation and seek guidance from First Professionals' Risk Management Department or personal counsel. If you practice in a group setting, it may be necessary to withdraw on behalf of others in the group and the practice itself.

### ***Does the ADA (Americans with Disabilities Act) require that a translator be provided for non-English speaking patients?***

No; however, Title VI of the Civil Rights Act does. Title VI of the Civil Rights Act forbids discrimination by any program **that receives money from the federal government** and requires that health and social service providers give their limited-English-proficient patients meaningful access to their services, which may entail offering translation services. These services must be provided to the patients free of charge.

### ***How does the ADA affect a solo medical practice?***

The ADA labor provisions do not affect employment practices for businesses with less than 15 employees; however, a medical practice is considered a public accommodation and is generally required to be accessible to disabled patients. Barriers to access must be removed if alterations are "readily available," which is determined by considering factors such as the nature and cost of the action, the owner's and tenant's financial resources and the impact of the action on the operation of the business. Such accommodations might include installing a ramp, making curb cuts, widening doorways, and modifying restrooms. Generally these accommodations are made at the expense of the building owner. In most cases, local commercial building codes require such accommodations and may preempt ADA requirements.

### ***Must a sign language interpreter be certified under ADA requirements?***

No. The factor in determining whether effective communication will result is whether the interpreter is qualified, not actually certified by an official licensing body. A qualified interpreter is one who is able to interpret effectively, accurately and impartially, both receptively and expressively.

### ***Must a physician supply an interpreter at the request of the patient?***

Yes, in compliance with the ADA the expense incurred in providing interpreter services may be used as a write-off for tax purposes. •

## ***Health Care Providers:***

### ***Do You Share Space and Equipment — Not For Long?***

***by Robert S. Stroud, Esq.***

***June 2007***



*Blalock, Walters, Held & Johnson, P.A.*

Earlier this year, the Centers for Medicare & Medicaid Services ("CMS") issued regulations which prohibited many Independent Diagnostic Testing Facilities ("IDTFs") (i.e., imaging centers) and physician arrangements (specifically block leasing and shared ancillary models, both of which are common in the health care industry). Thankfully, CMS rescinded this law and apologized for "any inconvenience this may have caused". What does this mean for the future? We predict that changes are still coming.

#### **Current law permits the following:**

1. Physicians who perform and read imaging studies in their office can bill globally for both the technical and professional portions of the scans;

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(Continued From Page 8)

2. Physicians who perform imaging studies in their office and use an off-site independent contractor radiologist can bill only for the technical portion of the scans, with the teleradiologist billing directly for the professional portion of the scans; and

3. Physicians who perform imaging studies in their office and use an independent contractor radiologist to read the scans in the physician's office can bill globally for both the technical and professional portions of the scans.

Other proposed regulatory changes will continue to allow options 1 and 2, but will prohibit option 3. If these changes become final, physicians that bill for the technical component of the imaging studies would have two choices: (1) perform the professional interpretations directly through employed physicians; or (2) permit an independent radiologist to perform and bill separately for the professional component of the service.

Bottom line, the current climate in CMS places all diagnostic imaging arrangements under attack. Combined with the reimbursement cuts under the Deficit Reduction Act, the environment is historically tough.

**What can be done today?**

1. Before entering into new arrangements or renewing current ones, providers should carefully review and negotiate unwinding provisions in the event that future rules impact current arrangements.

2. Analyze how these potential changes could change your practice if implemented and begin to develop a response strategy.

3. Stay in touch with us! We will strive to keep you informed and prepared.

4. Remember that many regulatory changes bring future opportunities, yet to be identified.

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**WE'RE ON THE WEB!**

**FLSIPP.ORG**

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**FSIPP NEWSLETTER**

To Contact Us: [info@flsipp.org](mailto:info@flsipp.org)