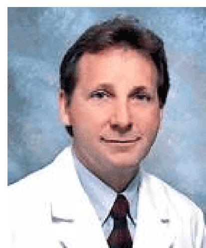
FSIPP NEWSLETTER

FALL, 2009

VOLUME 3, ISSUE 3
EDITOR-IN-CHIEF: DEBORAH H. TRACY, MD



President's Message
Holiday Greetings!

Harold J. Cordner, MD

Although hurricane season is over, the winds of change have already begun in Florida. As a result of the passage of SB462, the prescription drug monitoring bill, the Florida Board of Medicine must draft rules to regulate pain clinics per that legislation. The Board of Medicine has already had several meetings to discuss these new regulations. FSIPP leadership fully supports the need for these regulations and the need to shut down "pill mills" and unscrupulous, non-qualified "pain physicians." Statistics this year show nearly 12 prescription drug deaths *per day* in Florida. The Board of Medicine is very serious about these regulations and protecting the citizens of Florida.

While The Board of Medicine and FSIPP agree with the need for these regulations, there are others who are strongly opposed to them and are quite vocal in their objections. The FSIPP Board has been hard at work attending the meetings and helping to draft these regulations. Drs. Rafael Miguel, Sanford Silverman, and I attended the last Board of Medicine meeting to testify and present meaningful proposals to the original draft of the proposed regulations. I can give you a glimpse into what most likely will be part of these regulations.

There will be mandatory registration and annual inspections of all pain clinics, including risk management, safety, infection control, quality assurance plans, and medical records. Mandatory urine drug screening will be required for first time prescriptions and twice a year afterwards. Medical records will have to document patient history, physical exam, appropriate testing, treatment plan, informed consent, consultations, and periodic review of the treatment plan and goals. Each pain clinic will have a medical director, who will be responsible for all the reporting and compliance of these regulations.

The topic that has drawn the most controversy has been training requirements for "Pain Physicians." We heard testimony from non-physician pain clinic owners, primary care physicians turned pain management providers, as well as Board certified, fellowship trained Pain Management physicians. FSIPP believes that Pain Management is a recognized medical subspecialty that is defined by the diagnosis and comprehensive multimodal treatment of patients who suffer with chronic pain. Given the complexity of chronic pain, a pain medicine specialist is one who is adept in the evaluation, diagnosis and treatment of patients who suffer with chronic pain utilizing treatment that is comprehensive, multimodal, concurrent, coherent, patient-specific, and structured.

FSIPP believes the specialty of Pain Management needs to be preserved and respected. FSIPP also recognizes the need for access to qualified, competent physicians and will propose language that maintains the integrity of our specialty by requiring those who hold themselves out as pain management practitioners to have proper training. We have recommended that grandfathering under certain conditions be considered. We can no longer watch some physicians continue to endanger our specialty. FSIPP leadership will continue to fight for you and help provide constructive, meaningful change. The time to act and stand strong is now, and I welcome all of you to participate and provide feedback.

The Boards of Medicine and Osteopathic Medicine Pain Management Clinic Standards of Practice Committee will be holding their next meeting on December 19, 2009. The meeting begins at 10:00 am and will be held at the Marriott Tampa Airport, 4200 George J. Bean Parkway, Tampa, FL, (813) 879-5151.

FSIPP Corporate Diamond Sponsor

Interested in Corporate Sponsorhip?

Inside this issue:

1. **PRESIDENT'S MESSAGE** ***Harold J. Cordner, MD***
2. **FSIPP ANNUAL MEETING ANNOUNCEMENT**
3. **Vertebroblasty Challenge, Letter from the Editor,** ***Deborah H. Tracy, MD, MBA***
4. **Florida Local Coverage Determinations**
   Urine Drug Testing ***Sanford M. Silverman, MD***
   Monitored Anesthesia Care ***Lora L. Brown, MD***
5. **Pain Management Procedures under Scrutiny for Non-Coverage**
6. **Florida Board of Medicine**
   Legislative Updates
   Practitioners' Profile
   Economic Impact
7. ***David Vaughn, Atty***
   CPT 2010 Changes Coding for Stimulator Leads
   Medicare Stops Paying for Consults 1/1/10
   CPT 2010 Changes Facet Block Codes

FSIPP 2010 Annual Meeting & Trade Show

Mark Your Calendar!
May 21 - 23, 2010
Gaylord Palms Resort

FSIPP'S INNOVATIIVE ANNUAL MEETING 2010

KEYNOTE SPEAKER

Mary Lee Jensen, MD - 'Vertebroplasty, the History, Evolution of Evidence, and Present Day Position.'
Gabor Racz, MD 'Epidural Lysis'
Gabor Racz, MD - 'Facet Radiofrequency Ablation'
Stan Golovac, MD – 'Internal Disc Disruption'
Rafael Miguel, MD – 'New Rules and Regulations from the Florida Board of Medicine Regarding Pain Clinics'
Lora Brown, MD - 'Spinal Stenosis, Recent Research Advances'
Deborah H. Tracy, MD, MBA - 'Legislative Update, Healthcare Reform'

'Minimally Invasive Spine Surgery' Fusion vs. Non-fusion
'Discography'
'Intradiscal Therapies'
'The Development of Stem Cells for Pain Management Procedures'

Vertebroplasty Challenge, NEJM
By Deborah H. Tracy, MD, MBA

As representatives of the Medicare CAC in J9 we have spent considerable time addressing nationwide concerns regarding the recent publications in the New England Journal of Medicine (NEJM) challenging the efficacy of vertebroplasty and the necessity to reevaluate our local coverage determination in Florida and other jurisdictions. The Florida Society of Interventional Pain Physicians (FSIPP) finds these recent publications seriously flawed and fears that patients in some jurisdictions may loose access to this long standing effective treatment for vertebral compression fractures. FSIPP has prepared statements addressing these concerns.

The two studies cited were:

1. A Randomized Trial of Vertebroplasty for Painful Osteoporotic Vertebral Fractures, *Rachelle Buchbinder, Ph.D.,* et al, volume 361:557-568, August 6, 2009. *Conclusions:*

(Continued on page 3)

(Continued from page 2)

We found no beneficial effect of vertebroplasty as compared with a sham procedure in patients with painful osteoporotic vertebral fractures, at 1 week or at 1, 3, or 6 months after treatment. (Australian, New Zealand Clinical Trials Registry number, ACTRN012605000079640).

2. A Randomized Trial of Vertebroplasty for Osteoporotic Spinal Fractures, *David F. Kallmes, M.D.*, et al, volume 361:569-579, August 6, 2009. *Conclusions:* Improvements in pain and pain-related disability associated with osteoporotic compression fractures in patients treated with vertebroplasty were similar to the improvements in a control group. (Clinical Trials.gov number, NCT00068822 [Clinical Trials.gov]).

The Buchbinder study is flawed from the following perspective. Over 67% of the patients came from a single site. If this paper was being submitted to the FDA it would not qualify as a multi-center trial. The influence of the single site is likely to be dramatic and if the primary investigator at the site was in favor of conservative management, there exists reason to question the results. Additionally, it appears that the primary variable was the difference in mean pain, not the difference in a clinically relevant response rate (responder analysis). To achieve a difference of 1 (one) point in the mean, would have required over 120 patient participants in each group, not the 35 and 38 that were actually followed. Thus it is a negative trial because the size was likely too small to begin with.
The FDA would have required a responder analysis, but this was not accomplished in this study. Because all of the statistical output is in terms of means and confidence intervals it is woefully inadequate to determine the distribution roperties.The NEJM should have done a better job of scrutinizing these results. The New York Times media outlet has now dispersed to the public that a valuable procedure performed in the United States for 15 years is no better than a sugar pill. Additionally, the interventionalists' who provided the procedure starting in 2005 had no experience in cement augmentation of the vertebral bodies.

With respect to the Kallmes paper, the study was also sized on the difference in mean changes in the outcomes, which were analyzed by methods that were based on a normal distribution. The distinction between the differences in means and the differences in responders give reason to believe that the data were also badly asymmetric. If one were to design a study to detect a difference in responders between 64% and 48%, the sample size should be 133 per group for 80% power, not 68 and 63 patient participants as provided by these authors. Thus this study is underpowered leading to a type 2 statistical error (falsely concluding no difference, when one exists). Obviously, the size of the Kallmes trial was very much smaller than that necessary to achieve relevant statistical data. One extra person with a clinically significant change would have produced a P-value less than 0.05. The problem with this observation is that it was probably a secondary endpoint. That being the case, there would have had to be a multiplicity adjustment and the P-value would have to be less than 0.025. If a single additional patient had a favorable response to vertebroplasty or an unfavorable response to the sham procedure, the resultant conclusion of the paper would change.

There are several other perplexing concerns with Kallmes study. Only patients who had fractures of uncertain age were required to have imaging with MRI or bone scan. The need for imaging with MRI prior to vertebroplasty is well documented in the literature. The increased sensitivity of MRI over plain film allows for detection of unsuspected fractures at other levels. It also allows for characterization of fractures as acute or chronic/healed. Furthermore, 36% of fractures in the vertebroplasty group were treated between 27 and 52 weeks after the onset of symptoms, a loosely controlled time frame that questions the varying degrees of fracture age in the groups. The natural history of osteoporotic compression fractures is that they generally heal over a 6-8 week period. In reality, two out of approximately three vertebral compression fractures are non-painful and discovered as incidental findings on radiographs. This publication leaves this phenomenon completely unexplained and provides no correlation to the myriad of literature available supporting vertebroplasty.

Another confounding factor is that 13% (9/68) of patients in the vertebroplasty group were receiving workers compensation. This could provide incentive for these patients to describe continued pain and disability. Would the data change if patients receiving workers compensation were excluded from the study? Moreover, many patients with osteoporosis have co-existing spine disease, spinal stenosis, facet arthropathy and or sacroiliac joint dysfunction that can be contributing sources of pain. Patients who undergo vertebroplasty and complain of persistent spine pain that is different from the original fracture pain require additional intervention or medical management. The authors fail to address any investigation as to subsequent spine pain in the vertebroplasty group.

Some of the data in Kallmes study seems to support the efficacy of vertebroplasty. It is interesting to note that the crossover rate from sham to vertebroplasty was 43% after "adequate pain relief was not achieved." The crossover rate from vertebroplasty to sham at one month was only 12%. Was there some factor not captured in pain and disability scales to account for this significant difference? Additionally, we question whether any attempts were made

(Continued on page 4)

(continued from page 3)

to investigate the causes of failed vertebroplasties. Specifically, were any other refractures noted? In, *A Prospective Analysis of Clinical Outcomes after Percutaneous Vertebroplasty for Painful Osteoporotic Vertebral Body Fractures,* Do, et al, reported a 17 % (29/167) rate of refracture in vertebroplasty patients. Likewise, Trout, et al, reported subsequent fractures in 19.9% (86/432) of patients.

Our Society is concerned as to whether the very nature of an invasive study with a sham procedure and a high patient refusal rate, creates a skewed population. The sham procedure, in essence, resulted in a facet block. Consequently, the patients did indeed get therapy, with no untreated control for comparison. Thus the study design is flawed, misinterpreting facet injection as a "sham" procedure. The facet block and marcaine infiltration will provide short term pain relief. Furthermore, it does not require a sophisticated understanding of statistics to realize that the target populations of patients, those with incapacitating pain, are very unlikely to agree to a study with a placebo treatment arm when they have the option of treatment that is likely to help them immediately. The slow accrual of patients and ultimate abandonment of target enrollment despite the high volume of institutions involved argues strongly that there was overwhelming selection bias in patient enrollment.

Finally, The Florida Society of Interventional Pain Physicians stands firm that the results of these studies are not conclusive and that vertebral cement augmentation remains an effective treatment for vertebral compression fractures. I forwarded the *Position statement on percutaneous vertebral augmentation: a consensus statement developed by the American Society of Interventional and Therapeutic Neuroradiology, Society of Interventional Radiology, American Association of Neurological Surgeons, Congress of Neurological Surgeons and American Society of Spine Radiology,* Jensen, et al, American Journal Neuroradiology, 28:1439–43, Sept., 2007. This position statement in no uncertain terms maintains that the mortality and morbidity associated with untreated vertebral compression fractures outweighs the risks of not providing the procedure as well as the risks of the procedure itself. FSIPP continues to support this position statement until such time that the foundation of our knowledge is changed by well conducted studies with accurate and reproducible statistics and methodologies. There are hundreds of published papers documenting the dramatic improvement in pain and function in patients who undergo vertebral cement augmentation. Physicians, Societies and Associations in the United States, are left to wonder why the vertebroplasty patients in these studies did not do as well as those that are published in multiple prospective and retrospective case series. There is no thoughtful commentary within these studies on their inherent limitations.

In summary, spine pain is a complex medical condition that requires detailed clinical evaluation by experienced practitioners. Patient selection is principal in considering treatment with vertebral cement augmentation. Randomized controlled studies will often disagree. These studies have relatively small cohorts of patients and should raise red flags in drawing conclusions as I have outlined above.

Deborah H. Tracy, MD, MBA, Editor-in-Chief
Medicare, FCSO, CAC, Representative
FSIPP, President-Elect

Local Coverage Determination For Urine Drug Screening
By Sandford M. Silverman, MD

The Florida Society of Interventional Physicians supports urine drug screening of chronic pain patients at the initiation of care and up to two times per year, both at the point of service and or a qualified lab.

The state of Florida is ground zero for prescription drug abuse in the United States. Approximately 11 people die daily in FL from this epidemic. This has prompted the State of Florida to enact legislation to control diversion and abuse through the creation of database to monitor controlled substances and mandate the Florida Board of Medicine (BOM) to regulate and set forth rules governing pain clinics in the state.

Recent meetings of the BOM have prompted the real likelihood of requiring pain practitioners who prescribe controlled for pain management to perform urine drug testing (UDT) on their patients. This is a valuable risk management tool and should be utilized by all physicians who prescribe controlled substances for the management of pain or the treatment of chemical dependency. UDT in pain management has been validated by several studies and has been shown, as part of a comprehensive risk management program to reduce doctor shopping, diversion and prescription abuse by over 50% (Pain Physician. 2006, 9: 57-60).

Eliminating payment for UDT, in particular point of service (POS) testing which yields immediate qualitative results would create an unfunded mandate on physicians. This will result in the discharge of thousands of patients from pain practices and create a serious treatment deficit in the management of chronic pain.

FSIPP had urged carriers to continue the reimbursement of POS testing for physicians who utilize controlled substances for the treatment of chronic pain.

Medicare Reimbursement For Monitored Anesthesia Care (Mac) For Pain Management Spinal Interventions

By: Lora L. Brown, MD

The LCD, Monitored Anesthesia Care (MAC) for Interventional Pain Management – (DL30570) is under revision by First Coast Service Options and the comment period ended 11/7/2009. We hope and encourage you to participate in our FSIPP alerts and receive all opinions.

The carrier has identified provider fraud and abuse in this area and seeks to tighten coverage by further defining medical indications. FCSO has proposed in this LCD the elimination of coverage of MAC for procedure codes, 20550, 20551, 20552, 20553, 27096, 62310, 62311, 64470, 64472, 74475, 64476, 64479, 64480, 64483, 64484, unless medical indications listed in the LCD warrant the need for MAC. In summary, the draft considers MAC anesthesia unnecessary for the simpler procedures like epidurals and facets unless there is documentation of medical necessity. The general consensus of the FSIPP representatives is that the determination for the necessity of MAC anesthesia should be left to the discretion of the patient and provider. The option for MAC anesthesia should be preserved due to the inherent risk associated with spinal interventional procedures, despite medical condition.

The specialty of pain management includes the utilization of many spinal interventional procedures including intralaminar and transforaminal epidural injections, facet joint and medical branch nerve blocks, radiofrequency neruolysis of nerves, sympathetic nerve blocks, implantation of spinal cord stimulators and intrathecal pumps, as well as intradiscal procedures. Although considered minimally invasive these procedures possess inherent potential danger. Pain management procedures involve manipulation of needles and devices very near spinal neural structures including the spinal cord, nerve roots and their blood supply. As a result, there is intrinsic danger involved in these procedures that can be induced by patient movement during critical points of the procedure. In addition, cardiac abnormalities such as local anesthetic induced hypotension, local anesthetic toxicity due to vascular absorption, vasovagal reactions, cardiac arrhythmias, and ST wave depression due to cardiac ischemia may occur during these procedures. The latter potential cardiac events many times are induced by fear and anxiety felt by patients presenting for these procedures.

Many patients who suffer from chronic pain and present for these therapies happen to be elderly and often times are Medicare patients. The advanced age of these patients is associated with co-morbid medical conditions such as hypertension, coronary artery disease, diabetes, obesity, sleep apnea, pulmonary, renal, and liver disease. Medical co-morbidities are associated with increased peri-operative complications and thus warrant additional anesthetic attention.

In addition to medical conditions supporting anesthesia monitoring during spinal procedures, one must take into account the overall patient experience. In fact, in my current practice a survey was conducted among patients who had their spinal procedures delivered to them with and without MAC anesthesia. The results were overwhelming in support (98%) of MAC. Anecdotally, in my practice, I see fewer complications including cardiac arrhythmia and ST changes warranting hospital admission since I have utilized MAC anesthesia services as a standard of care.

There are also endoscopists who perform colonoscopies and EGDs without MAC anesthesia. These patients are at risk for overdosed Versed and Demerol and suffer for hours and sometimes days after their procedures with sedation, nausea and vomiting. Just because something can be done does not mean it is the best way or the most appropriate way to do it. Without skilled anesthesia providers, many pain practitioners are administering IV conscious sedation medications themselves without the same level of patient monitoring or management. These IV drugs have longer half-lives and are associated with post-procedure side effects like nausea, vomiting and sedation, especially in the elderly who often have delayed renal and liver clearance. As you know propofol, when titrated appropriately is an excellent alternative, as it is rapidly metabolized and eliminated completely from the body within fifteen to twenty minutes.

Utilizing MAC anesthesia does not equate to deep sedation. I am very aware of the anesthesia closed claims data regarding sedation during pain management spinal procedures. In my opinion, this further supports having an anesthesia professional experienced in administering light to moderate conscious sedation to patients undergoing spinal procedures. A skilled professional may relax the patient while maintaining responsiveness from the patient. I strongly support maintaining the opportunity to utilize MAC anesthesia for pain management spinal interventions. I believe that it is safer as well as more acceptable by the patients. Consequently, I believe it to be a better standard of care to which Medicare patients should have access. I realize that, in the era of cost containment, all medical services are being evaluated. I agree that there are certainly incidences where a patient may not have co-morbid medical conditions, may not possess procedural anxiety and be relatively healthy. As a result, may not require MAC anesthesia

(continued on page 6)

(Continued from page 5)
on the basis of medical indication. I believe that the decision to or not to utilize MAC anesthesia should be left to the physician and should be an integral part of the patient-physician relationship.

If FCSO decides to implement policies regarding clinical guidelines for Monitored Anesthesia Care (MAC) I suggest the following:

Medical indications for MAC anesthesia should be documented within the patient's medical record and listed again as an indication within the procedure note. Medical indications should include the presence of medical co-morbidities such as hypertension, coronary artery disease, diabetes, obesity, sleep apnea, pulmonary disease, renal disease, liver disease, anxiety disorder, or severe procedural fear/anxiety. Any other condition that would prevent the complete cooperation from the patient would warrant anesthesia care as well.

Pain Management Procedures Under Scrutiny For Non-Coverage

By Deborah H. Tracy, MD, MBA

The Florida Society of Interventional Pain Physicians has responded to potential non-coverage determinations that place facet joint interventions on the non-covered code list by the Medicare Administrator, Noridian, in the Northwest United States (Alaska, Oregon, Washington, Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming). As representatives of the Medicare Carrier Advisory Committee for the State of Florida we understand waste, abuse, and fraud as an escalating problem in health care in the United States. As a sub chapter of the American Society of Interventional Pain Physicians, we have reviewed the extensive letter sent to Noridian by Dr. Lax Manchikanti, CEO. We stand firm with the ASIPPs recommendation that removing facet injection from coverage will be detrimental to patients with facet joint syndrome and support the evidence that diagnostic and ablative facet joint procedures provide patients with significant pain relief. However, we also stand firm that these procedures must be provided by physicians trained in pain management, since patient selection criteria is key in achieving positive results

As you are aware the 2007 OIG Report on Facet Joint Injections identified significant fraud and abuse, but may we also point out the 88% of the surveyed injections were provided by physicians who were not credential nor trained in pain management. The diagnostic information and documentation reported was extremely poor, except for the physicians who were designated as interventional pain management specialists. There is no doubt there is waste, abuse, and fraud in performing facet joint interventions by physicians who are untrained and merely seeking to capture procedure based revenues. We maintain that facet joints are one of the common structures responsible for spinal pain. Deleterious effects of elimination of facet joints include an exponential overall increase in emergency room visits, physician visits and a further increase in waste as the identified etiology of pain will not be covered and therefore not provided. Additionally, the consequences of a decision like this will hamper patient access and increase the cost to the beneficiary fund in the long run. Penny wise pound foolish seems to be an appropriate cliché that has permeated the payer medical industry. In Florida, Medicaid underpays physicians and consequently does not pay for the cost of care incurred. Therefore, Medicaid patients unable to get primary care, wind up receiving their care from Emergency Departments. Healthcare economists have evaluated this approach to be more costly than reimbursing the physicians and providers fairly. Well, here we go again.

Strict regulations must be implemented without sacrificing the care of the patient. The OIG has recommended strengthening program efforts to prevent improper payments, not eradication the treatments. Manchikanti has also recommended tighter regulations on medical necessity, indications, limitation on levels and time intervals.

Florida's MAC, J9, First Coast Service Options recently revised the Local Coverage Determination for paravertebral facet injections and ablation in an effort to accomplish this task. We believe as does our carrier that waste, abuse, and fraud can be substantially reduced or even eliminated while still maintaining access to the patients and also provide appropriate care consistent with the mission of Medicare.

In summary, spine pain is a complex medical condition that requires detailed clinical evaluation by experienced practitioners. Patient selection is principal in considering treatment of the facet joint. We respectfully request reconsideration of this proposed decision.

For questions, please feel free to contact us.

Deborah H. Tracy, MD, MBA
Florida Medicare CAC
Florida Society of Interventional Pain Physicians, President-Elect

The Florida Board Of Medicine
2009 Legislative Session Highlights

Below is a summary of bills signed by the Governor following the 2009 Legislative Session that may affect your Florida license. Be sure to go to http://www.leg.state.fl.us/statutes/index.cfm and read more details concerning these new laws.

- **SB 462** - This bill requires the Department of Health, when funds are available, to develop a comprehensive electronic database system for the purpose of controlled substance prescription drug monitoring. This bill also requires registration of certain clinics that perform pain management. The Board plans to conduct rule workshops in the near future. Be sure to go to the Board of Medicine's web page at: www.FLHealthSource.com to stay abreast of the law and future workshops. This bill was signed by the Governor on June 18, 2009.
- **SB 720** - This bill requires the Board of Medicine to review entities previously approved by the Board to grant board certification in Dermatology every three years. This bill also lifts the requirement for physicians to co-sign charts written and prepared by physician assistants. In addition, this bill lifts certain limitations on ARNP's and PA's solely performing hair removal with lasers. The Council on Physician Assistants will be meeting in August to repeal rules relating to co-signature of medical records. This bill was signed by the Governor on June 16, 2009.
- **HB 387** - This bill provides for an increase in the number of medical faculty certificates permitted at institutions. This bill was signed by the Governor on June 1, 2009.
- **SB 1986** - This bill primarily deals with reducing Medicaid fraud. It also requires the Board to deny licensure or to revoke licensure of an individual, with certain felony health care fraud convictions. The bill also outlines four new disciplinary violations and requires the Department of Health to work with the Agency for Health Care Administration to prosecute physicians who have not remitted amounts owed to the state for overpayments. This bill also exempts sleep related testing facilities from the patient self referral act. This bill was signed by the Governor on June 24, 2009.
- **SB 2188** – This bill concerns Administrative Procedures. New procedures include a requirement that Boards with electronic agendas place copies of the public agenda materials on their web site at least 7 days prior to the meeting. It also requires the Boards to place a copy of their meeting notices on the web site. This bill was signed by the Governor on June 16, 2009.

As you can see, there are significant changes this year. Also, please understand there are other laws enacted that are not highlighted in this letter. It is important that you take a few minutes to go to the web site listed above and read these new laws as well as any others that might pertain to your specific practice type to ensure you are practicing in compliance and that your patient's continue to receive quality health care.

Where do you find the laws and rules?
Florida Statutes (laws): http://www.leg.state.fl.us/statutes/index.cfm
Florida Administrative Code (Rules): http://www.leg.state.fl.us/statutes/index.cfm
You can subscribe and unsubscribe for a no-cost, automatic e-mail of every new item put on the Board website by going to this web site:

http://flems.doh.state.fl.us/mailman/listinfo/boardofmedicine

Crystal A. Sanford, CPM
Program Operations Administrator, Florida Board of Medicine

The Florida Board Of Medicine
Practitioner's Profile

So, let's talk Practitioner Profiles. When was the last time you really sat down and reviewed your profile?

The Florida Legislature passed a law in 1997 requiring the Department of Health to maintain profiles for medical doctors, osteopathic physicians, chiropractic physicians, podiatric physicians and advanced registered nurse practitioners [s. 456.041 – 046, Florida Statutes]. The law also outlined the type of data to be collected. Practitioner Profiles allow Floridians to have access to practitioner information that enables the patients to make sound health care decisions.

(Continued on page 8)

(Continued From Page 7)

When a physician becomes licensed in Florida, he/she will be given a practitioner profile to review for accuracy. The profile goes live on our web site 30 days later. Thereafter, practitioners **are required** to update their profile within **15 days** of any change. The Board of Medicine has supported legislative changes that would increase that reporting time period to 30 days; however, at this time, it remains 15 days.

So right now, you might be asking yourself, when *was* the last time you updated your profile. Take a moment, access the Internet and go to www.doh-mqaservices.com. Once there, click on *Licensees*.

The Florida Board Of Medicine
Economic Impact of Florida Physicians

Key Findings

Economic Impact of Florida's Private Practice Physicians in 2009
In 2009, private practice physicians' offices in Florida create or support approximately:
451,500 jobs – which represents 5 percent of total employment in the state;
$22 billion in real disposable personal income ("Income");
$56 billion in Total Economic Activity; and
$3 billion in government revenues.
Each individual private practice physician in Florida today supports, on average:
19 additional jobs;
$913,000 in Income for those jobs; and
$2.3 million in Total Economic Activity.

Economic Impact Projections for 2020
By 2020, the annual impact of private practice physicians' offices will include:
almost 650,000 jobs;
over $41 billion in Income for those jobs;
$93 billion in Total Economic Activity; and
around $6 billion in government revenues.

The Economic Impact of Florida's Physician Shortage
Creating an additional 2,700 Graduate Medical Education (GME) residency positions, to meet the average national ratio of GME residents per state population, will create or maintain an additional:
34,000 jobs in 2012 to 44,000 jobs in 2020;
$2.4 billion in Income for those jobs in 2012 to $4.1 billion in 2020; and
$4.3 billion in Total Economic Activity in 2012 to $6.3 billion in 2020.

Expanding Florida's ratio of physicians per 100,000 population by 10 percent, to meet the national average of physicians per state population, will create an additional:
50,000 jobs in 2012 to 65,000 jobs in 2020;
$3.6 billion in Income for those jobs in 2012 to $6.1 billion in 2020; and
$6.5 billion in Total Economic Activity in 2012 to $9.3 billion in 2020.

Reading Room

CPT 2010 Changes Coding for Stimulator Leads

CPT 2010 deletes the existing stimulator electrode removal code, 63660, and replaces it with 4 new codes, 63661-63664. Practices will need to change their charge tickets accordingly. More importantly, the AMA, in the introductory comments, resolves the issue of whether one can charge the lead removal code when that procedure consists of a 2-minute snip and pull of the trial leads, as some practices have been doing in the past.

The four new codes, 63661-63664, are now divided into: (1) removal only versus revision and/or replacement, and (2)

(Continued on page 9)

(Continued from page 8)
percutaneously placed leads versus open surgeries via laminotomy or laminectomy. So, 63661 is for removal only of percutaneously placed leads; whereas, 63662 is for removal of leads placed via laminotomy or laminectomy. 63663 is for revision (including replacement), as opposed to just removal, and is limited to percutaneously placed leads; whereas, 63663 is for the same revision, but applies to leads placed via laminotomy or laminectomy.

As to the issue of whether one can bill for the removal of trial leads placed percutaneously and attached to an external generator, the AMA says do NOT bill a removal code for that service. See the introductory comments to the stimulator section. Fluoroscopy, regardless of the code used, is bundled for all four codes. Additionally, one cannot bill the revision and replacement codes when one has billed the removal codes. So, if the provider removes and replaces, then the provider bills the revision and replacement code; whereas, if one only removes, one bills the removal only code. Finally, unlike the lead placement code (63650), which allows a separate code for each lead placed (because the code description uses the singular "array" to describe the service), the removal and replacement codes use the plural "array (s)" in the descriptor, indicating that only one removal or replacement code would be billed even if two leads were removed, revised, or replaced.

There are still some unanswered questions. What happens if you remove two percutaneously placed trial leads, and then replace them with two permanent leads attached to an implanted generator? Are you limited to billing 1 instance of 63663 ("revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed"); or, can you still bill 2 instances of 63650 for the placement of the 2 permanent leads, as is the current practice? We may have to write the AMA for an answer to that question.

Medicare Stops Paying for Consults 1/1/10

In the 2010 Medicare Fee Schedule Final Rule ("Final Rule"), CMS states that due to physician inability to code consults correctly, CMS is just going to take its toys and go home and not pay for consults, inpatient or outpatient.

Get ready for a mess. The consult codes are still in the 2010 CPT Code, but if you bill them to Medicare, they will be denied. So, what happens when you bill the primary insurer a consult code, but Medicare is secondary? Medicare says the secondary payment will be denied. What happens when Medicare is primary, a consult was performed, but you have to bill a non-consult code to Medicare, yet you want to bill the higher paying consult code to the secondary payer? Medicare has no solution for you. We will discuss how to handle this at our seminar in December.

CMS says it will take the money that it would have paid for consults and increase payments for inpatient and outpatient E&M codes, allegedly 6% for outpatient codes and less than 1% for inpatient codes.

Offices are going to have to figure out how to block consults from being billed to Medicare, or just stop billing consult codes at all to stop the different billing scenarios between commercial payers and Medicare.

CPT 2010 Changes Facet Block Codes

Change your charge sheets for facet blocks. The existing codes, 64470-64476, have been deleted and replaced by codes 64490-64495. There are now 6 facet codes, not four. Moreover, fluoro is now bundled, so change the charge sheets to reflect that 77003 is no longer billable (to any payer) with facet blocks. Interestingly, the RF codes have not changed. So, presumably, fluoro can still be billed with the facet RF codes, and the number of levels of RF has not been restricted, as is the case with the new 2010 facet block codes.

Specifically, for the facet blocks, instead of just one add-on code for each additional level, the new structure contains two add-on codes. The first add-on code is for the first additional level, but the second add-on code is for all additional levels after the second level, no matter how many additional levels are performed. Effectively, this limits the number of billed levels to 3, since the second add-on level is defined as "third and any additional level(s)." To further illustrate the point, additional instructions state that you can only bill one unit of the second add-on code, again meaning that once you reach your third level, you are doing the fourth and fifth levels for free.

To resolve the debate over whether the T12-L1 interspace is lumbar or thoracic, the CPT Code now instructs one to use the lumbar codes.

Copyright © 2004 All Rights Reserved
Application Design and Development By teknarus, llc

WE'RE ON THE WEB!
FLSIPP.ORG

FSIPP NEWSLETTER

To Contact Us: *info@flsipp.org* Ph. 904 270 8886