Florida Society of Interventional Pain Physicians

FSIPP Newsletter

WINTER 2017

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

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President's Message

By Orlando Florete, MD

The New Year is upon us and never before has our specialty been under assault from multiple fronts. First and foremost, the problem associated with opioid prescribing is mounting. Patients are either denied their medications or there is a significant delay in drug access. Private payers are making it more difficult for patients to obtain either by requiring pre-authorization, increasing the co-pay, removing the opioids from their formulary, or compelling patients to use alternative analgesic medications. The Center for Disease Control and Prevention (CDC) developed a guideline for prescribing opioids for chronic pain in primary care settings in 2016, but insurance companies took the guideline as gospel and are applying it to pain management physicians. The unintended consequence is that chronic pain patients are being forced to reduce their dosage or there is outright denial of their medications. Recently, the Drug Enforcement Agency (DEA) ordered drug manufacturers to reduce the production of hydrocodone and oxycodone by 25% starting in 2017. More recently, the Agency suspended a major distributor from selling hydromorphone in Florida. These sanctions have a major impact in medication access for legitimate patients with chronic painful conditions and can potentially be an emerging health threat to patients as recently expressed by the Florida Department of Health (DOH).

Another major issue is decreasing reimbursement associated with direct patient care. Payment for interventional pain procedures are either reduced or totally denied. Accepted treatment modalities are suddenly labeled as experimental or unproven in spite of the evidence to the contrary. In Oregon, there is a drive to eliminate coverage for all spinal interventional techniques. This position may cascade and may delegitimize the practice of Interventional Pain Management in the United States.

On the political front, initiatives to change the landscape of pain management practice in this state of Florida are evolving. For example, nurse anesthetists want to expand their scope of practice to include the ability provide pain management services, fluoroscopic injections and manage opioids in spite of their lack of training. The legislature passed a law allowing health extenders (ARNPs and PAs) to have the ability to write prescription for schedule II and III drugs except when they are working under a pain practitioner. These are examples of the battles that we continue face. We must be vigilant in opposing efforts that may be harmful to patients, threaten access to coverage by trained providers and oppose efforts that undermine our specialty. It needs YOUR involvement and participation, either actively or financially.

However, there are silver linings in the horizon that may have a positive impact in our clinical practice. Telehealth (Telemedicine) is being introduced into the state and may change the routine of following up patients. Medical cannabis is now legal in Florida. Medical marijuana has been shown to reduce opioid related deaths by 25% in states where medical marijuana is legal. There is as much as over 60% reduction in opioid utilization in those states with no reported medical marijuana related deaths. This may become a viable option to use in lieu of chronic opioid therapy in some patients. Regenerative medicine with the use of stem cells is getting more popular. This treatment modality may change the way we practice Medicine in the future.

We now established the organization's research and educational foundation. This will become our arm in educating our physicians, raise funds that may be able to support our financial need to sustain our future educational and research programs. FSIPP is becoming more active politically, developing closer ties with the Florida Medical Association (FMA), and actively engaging members of the State Legislature. In this regard, I am calling all of our members to be more active in our organization. Your vigorous participation is important. As one voice we can be strongly heard.

FSIPP Update from the Executive Director

Michelle Byers-Robson, FSIPP Executive Director

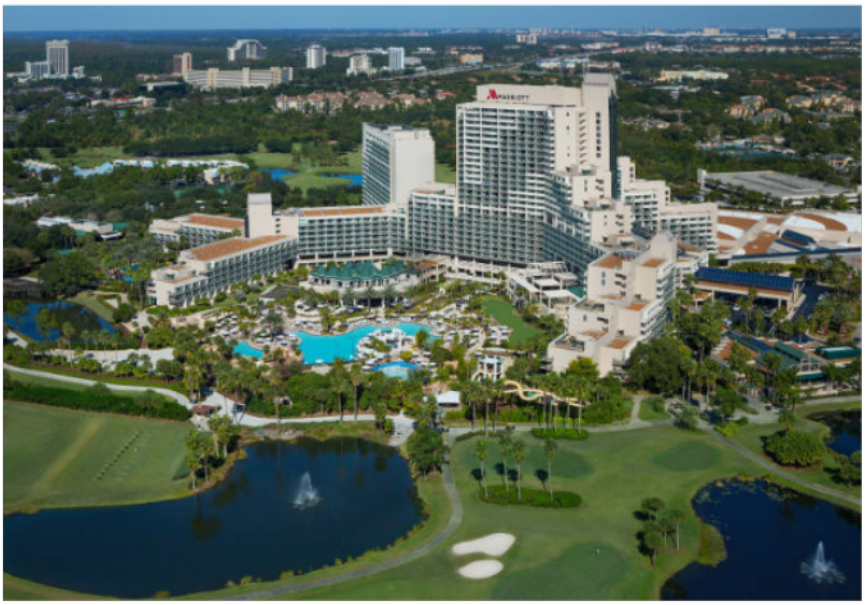
It's amazing that it is already 2017 and that I have started my second year as the Executive Director of FSIPP. My goals in taking over the Executive Directorship were to: Improve the Financial Health of FSIPP and the FSIPP PAC, Maintain and Grow FSIPP Membership, Produce the best FSIPP Annual Meeting yet and Increase and Improve Communication and Collaboration between the FSIPP membership. Below is a snapshot of where we currently stand with respect to these goals.

FSIPP Financial Health

FSIPP has continued the FSIPP regional meetings in 2017 and we continue to be supported by multiple corporate sponsors. Additionally, by continuing to monitor our financial spend FSIPP, the FSIPP PAC and the FSIPP Educational Foundation all demostrate significant financial strength and growth. In 2016, the FSIPP PAC was able to contribute substantially to multiple political campaigns both directly and through the FMA. We increased our political voice significantly through the efforts of both our financial contributions and Board Member presence at both political campaign events and hearings.

FSIPP Membership

FSIPP closed the 2015 year with 203 total members, we closed 2016 with 226. We are growing, but we have a long way to go to our goal of 350! As you know, all FSIPP membership renewals are due January, 2017 – so if you haven't renewed yet, please be sure to go online to http://www.FSIPP.org under "Memberships" and renew!! Also, fellows and residents can be members at no charge while PA's, Nurses and Nurse Practioners can be associate members at only $150 per year. Be sure to encourage all of your friends and co-workers to be a member today!



FSIPP Annual Meeting

FSIPP Annual Meeting – REGISTER NOW!! As you know, the FSIPP Annual Meeting will take place Thursday, April 27-Sunday, April 30, 2017 at the Orlando World Resort in Orlando, Florida. For the 2017 annual meeting, the FSIPP educational planning committee is committed to bringing in local and national experts on Interventional Pain Management. The FSIPP meeting has historically been one of the largest and best state society meetings for ASIPP. We are committed to making this year one of the best FSIPP has ever offered! Be sure to register early to take advantage of both our reduced registration rates for our members AS WELL AS our early registration rates! Registration is ALWAYS open at: http://www.FSIPP-conference.com.

Have a wonderful 2017 and I am looking forward to seeing EVERYONE at our upcoming meeting at the Orlando World Resort, April 27-30!

FSIPP 2017
Annual Meeting, Conference and Trade Show

INTERVENTIONAL PAIN MANAGEMENT 2017

April 27 - 30, 2017

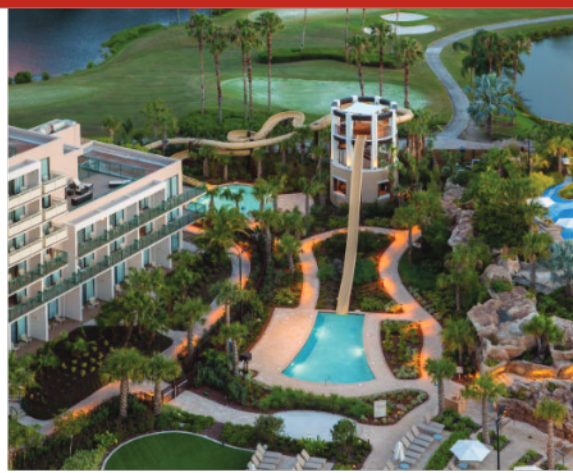
FSIPP ANNUAL 2017 MEETING

The membership, exhibitor and speakers for our 2017 meeting are of the ultimate quality. With the addition of product theaters providing hot breakfast and entertainment for your families we hope to make this the best ever State meeting. We have increased Exhibitor opportunities to greater than 60 Exhibit Booths. As a result of your suggestions, with emphasis on family friendly concordant activities, we have succeeded in engaging Orlando World Resort in Orlando Florida for this upcoming event. Additionally we have increased the event days from three to four.

SEE YOU APRIL 27 – 30 FOR THE FSIPP ANNUAL MEETING AT THE ORLANDO WORLD RESORT!!!

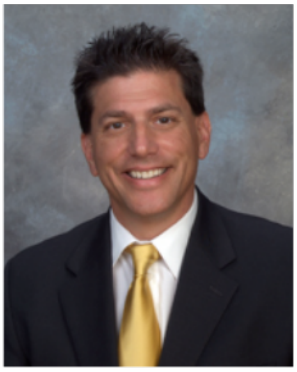
Orlando World Center Marriott
8701 World Center Drive
Orlando, FL 32821

Register Now & Save



Medical Cannabis Update

By Sanford Silverman, MD



The Florida Compassionate Medical Cannabis Act was signed into law in 2014. The department of health established the Office of Compassionate Use which coordinates patient and physician registration. Physicians licensed under Chapter 458 and 459 of the Florida Statutes are authorized to prescribe non-smoked cannabis low in tetrahydrocannabinol (THC) content, or ***low-THC cannabis*** (contain 0.8 percent or less of THC and more than 10 percent of cannabidiol (CBD) weight for weight), to qualified patients. Floridians must the following requirements to be prescribed ***low-THC cannabis*** under the act:

- The patient must be a permanent Florida resident.
- If a patient is under the age of 18, a second physician must agree with the determination of need for the patient.
- Other treatments must have been tried without success.
- The ordering physician must determine the risks of using low-THC cannabis are reasonable considering the benefit to the patient.
- The ordering physician must register the patient in the Compassionate Use Registry.
- The ordering physician must maintain a patient treatment plan which outlines the dose, route of administration, planned duration, monitoring of the patient's illness, and tolerance of the low- THC cannabis, and submit the plan to the University of Florida, College of Pharmacy, on a quarterly basis for research purposes

Florida law also states that prior to registering a patient for medical cannabis, they must be treated by the ordering physician for three (3) months, and have tried and failed standard treatments for the underlying condition, including but not limited to medications, injections, and physical therapy.

The only medical conditions authorized for medical marijuana prior to January 2, 2017 are:

- seizures
- severe and persistent muscle spasm
- cancer
- terminal Illness (can use medical marijuana that is NOT low dose THC)

Florida law specifically **PROHIBITS THE SMOKING OF MEDICAL MARIJUANA**.
For a physician to be able to order medical cannabis they must take an 8 hour online CME course administered by the FMA/FOMA, which costs $995. The physician must document the treatment failures that would allow the ordering of medical cannabis and submit reports to the University Of Florida Department Of Pharmacy on a quarterly basis.

Amendment 2

Amendment 2 was initially defeated in 2014. On November 7, 2016 amendment 2 passed which substantially changed the medical cannabis law. Specifically, amendment 2 states:

- "Debilitating Medical Condition" means cancer, epilepsy, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), post-traumatic stress disorder (PTSD), amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis, or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.
- "Identification card" means a document issued by the Department that identifies a qualifying patient or a caregiver.
- "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2014), and, in addition, "Low-THC cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2014), shall also be included in the meaning of the term "marijuana."

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Medical Cannabis Update

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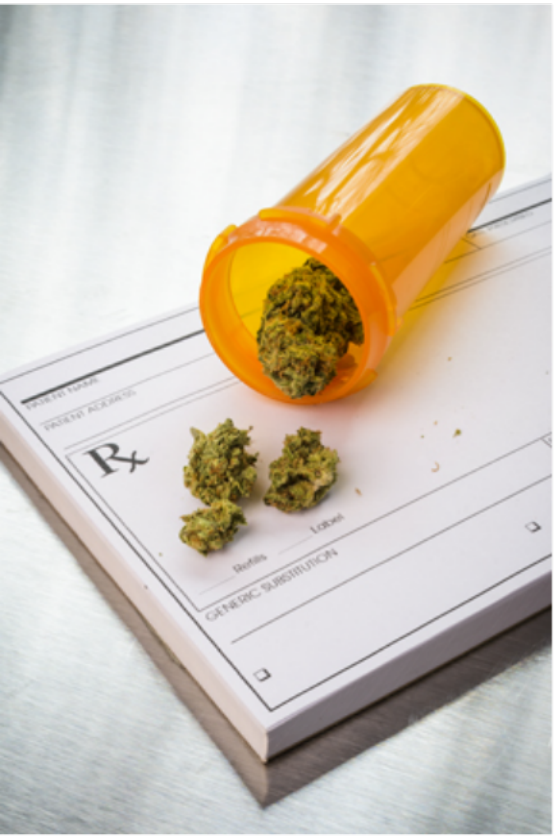
The passage of amendment 2 means that more patients have access to medical cannabis, which includes ***higher THC content***. The ban on smoking medical cannabis remains in effect.

Medical evidence

There have been a few studies which have looked at the effects on pain from medical cannabis. Most of these have used cannabis with higher THC content. A commercially available product in Canada and the European Union (Sativex® spray, GW pharmaceuticals) is indicated for breakthrough cancer pain and uses a THC: CBD ratio of approximately 1:1. CBD (cannabidiol) is non-euphorigenic and has no reward enhancing properties while THC (tetrahydrocannabinol) is the active reward enhancing agent, which puts cannabis in the schedule 1 category (highly abusable with no medical usefulness).



Regulatory issues

Physicians commonly ask "can I be prosecuted for prescribing medical cannabis?" The answer is yes, it is *possible* since this is a schedule 1 drug and is considered illegal by the federal government. However, there have been several memoranda from the DOJ as well as congressional actions which essentially have make this unlikely…. provided the physician follows state law. We do not *prescribe* cannabis but *order* it, which also is a difference.

The 2002 9th circuit court decision on medical cannabis upheld a permanent injunction enjoining the government from revoking a physician's license to prescribe controlled substances based solely on the physician's professional recommendation of the use of medical marijuana, and from investigating a physician based on the same impermissible motive.

The court recognized *"physician speech is entitled to first amendment protection because of the doctor-patient relationship…"- "…only that the government may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship, unless the government in good faith believes it has substantial evidence of criminal conduct."* The court found that the Physician's recommendation itself was not illegal conduct, but noted that *"if, in making the recommendation, the Physician intends for the patient to use it as the means for obtaining marijuana, as a prescription is used as a means for a patient to obtain a controlled substance, then a Physician would be guilty of aiding and abetting the violation of Federal law."*

Both California's and Florida's compassionate use acts require the involvement of the Physician before a patient can legally (under state) law procure cannabis (three months doctor-patient relationship prior to the procurement or ordering of medical cannabis.

The ninth circuit court opinion affords California Physicians a measure of protection from federal prosecution and investigation because the California statute only requires a *"recommendation"* from a Physician, not a prescription. Florida's act requires a Physician *"order"* for the patient to obtain low-THC cannabis. The DEA's position on medical cannabis has not changed: *"while some people have interpreted these guidelines to mean that the Federal government has relaxed its policy on "medical" marijuana that is not the case. Investigations and prosecutions of violations our state and Federal law will continue." Furthermore, the DEA has targeted physicians linked to medical cannabis: US Drug Enforcement Administration investigators have visited the homes and offices of Massachusetts physicians involved with medical marijuana dispensaries and delivered an ultimatum: sever all ties to marijuana companies, or relinquish federal licenses to prescribe certain medications, according to several physicians and their attorneys* ***(source: DEA targets doctors linked to medical marijuana;*** *By Kay Lazar and Shelley Murphy GLOBE STAFF JUNE 06, 2014)*

In summary, ordering medical cannabis in the state of Florida is legal, but you must follow the law to the letter.

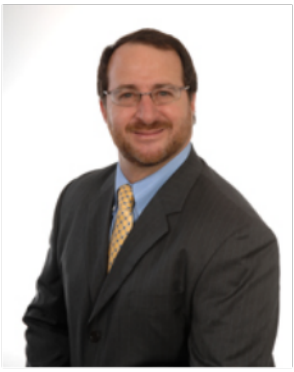
The New CMS Quality Payment Program MACRA-MIPs/APMs

By Deborah H. Tracy, MD

The Final Rule of the CMS Merit-Based Incentive Payment System, MIPS, and Alternative Payment Models, APMs, was published on 10/14/16, and is ~ 2,300 pages. Now identified as the Quality Payment Program, QPP, it is extensive in scope to reward or penalize providers for performing certain activities in four performance categories. The four categories are: (1) Quality, which will replaces PQRS, (2) Cost, attributed to Medicare providers by a complex set of statistical formulas replacing the Value Modifier (3) Improvement Activities, a new category of 90+ undertakings and (4) Advancing Care Information, which replaces Meaningful Use. The four categories result in a final score of between 0 to 100 points. Depending on the provider's final score, a penalty/reward is assessed, or the provider remains neutral. For 2017 the penalty is 4%, but the bonus could be 3 to 4 times that amount. Physicians must educate themselves and their practice managers on how to understand and potentially achieve high scores in the new Quality Payment Program and avoid costly penalties in their Medicare Part B claims. The FSIPP Annual meeting will provide several hours of education on understanding and achieving performance scores.

Thoughts on the Infraforaminal Approach to the Transforaminal Epidural Steroid Injection

By Jonathan Daitch, MD



Over the past 5 years, there has been a fair amount of information disseminated on the potential pitfalls of injecting the infrapedicular zone of the neural foramen to access the epidural space. Formerly it was called "the safe zone." However, scientific papers indicate that the Artery of Adamkewicz may be situated in this upper zone, leading to potential cases of paraplegia. Like many of you I have done transforaminal injections into the superior zone under the pedicle for my entire career, and I continue to do them. However, recently on select cases, I have been using (and gaining experience) with the infraforaminal approach, since I feel there are significant anatomic benefits in several types of cases.

To do the infraforaminal approach you simply line up similar to a discogram. Hug the superior articular process with your needle at the level of the disc. Place your needle into the posterior aspect of the foramen. Placing it too anteriorly increases the risk of an intradiscal injection.

I have been using the infraforaminal approach for:

1) pure discogenic pain
2) lateral recess stenosis
3) discogenic pain above the fusion level
4) cases where there is blockage or scar preventing superior spread into the epidural space above the nerve root.

In discogenic pain, there are posterior tears into the outer annulus. These often spread laterally. Pain is caused by leakage of the inflammatory nuclear chemicals into the spinal canal. Since steroids are potent neutralizers of PG2alpha, they might exert a more local inhibition of the inflammatory response. My thinking is that with the infraforaminal approach, the steroid anti-inflammatory medication is being placed at the level of the affected disc, as close as possible to the pathology. Hence, a more enhanced analgesic effect.

Lateral recess stenosis is underdiagnosed by radiologists, and is a frequent cause of lumbar radicular pain. For this reason, I like to view all of my patient's spine MRI films. Any time one notices a triangular shaped canal (from posterior bulging of the disc), think lateral recess stenosis and compression of the descending nerve root. For lateral recess stenosis, say at L4-5, the neural compression is not in the L4 foramen, but is affecting the descending nerve root of L5 as it is compressed between the disc and the facet joint. If the medication is placed infraforaminally, many times it will pass medially and inferior to the disc, very close to the area of compression of the descending nerve root. However, medication traditionally placed along the exiting L5 nerve root below may not travel superomedially enough to reach this area of compression. Certainly injections above this along the L4 nerve root will not reach this area of neural compression in the lateral recess.

For discogenic pain or stenosis above the level of a fusion, the infraforaminal approach may provide easier access to the disc and possible lateral recess stenosis. Comparatively, injecting below at the level of the fusion may be difficult due to hardware or fusion mass. The infraforamenal approach at the disc level above the fusion avoids the hardware and fusion mass.

Finally, there may be instances of scarring or neural compression superior in the foramen, not allowing spread of contrast dye into the epidural space. In these cases, it may be worth trying the alternative approach inferiorly under the exiting nerve root to try to achieve better epidural spread. I have been attempting to incorporate more infraforaminal approaches into my epidural armamentarium, and these types of cases are the ones which appear to make the most anatomic sense. I anticipate that my use of this infraforaminal approach will increase significantly over the next several years.

The Long Fight for Coverage for the Mild® Procedure

By Jesse Lipnick, MD

Mild® is a safe, outpatient, minimally invasive, fluoroscopically guided therapeutic treatment that can help LSS patients stand longer and walk farther with less pain. Mild® is performed through a 5.1 mm treatment portal that requires no general anesthesia, no implants, and no stitches. Mild® safely decompresses the spinal canal by removing small portions of lamina and hypertrophic ligamentum flavum leaving the structural stability of the spine intact.

Once the hypertrophic ligamentum flavum has been debulked, the space is restored in the spinal canal and clinical studies have demonstrated that around 80% of patients experience a significant reduction in pain and improvement in standing time and walking distance even in the presence of other LSS causal factors. Here is a link to a video presentation of the procedure:
http://www.vertosmed.com/physician/mild_procedure_anim.php

Mild® has been studied in over 11 clinical studies and positive outcomes have been published in more than 16 peer-reviewed journal articles. The procedure has been performed on over 15,000 patients. No major device-related complications have been reported in any clinical trial. The most current data on the MiDAS ENCORE study was recently published in PAIN PHYSICIAN: https://goo.gl/QFCxWZ

On September 8th 2016, CMS issued a "Proposed Decision Memo for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433R)." (CMS uses the acronym PILD -percutaneous image guided lumbar decompression - because Mild® is a trademark name of Vertos Medical). This proposal continued to restrict the utilization of the Mild® procedure and limit the procedure to the vast majority of Medicare beneficiaries here in Florida and across the country. October 6th, 2016 FSIPP joined the efforts led by ASIPP, Drs. Manchikanti and Calodney, and submitted public comment strongly urging CMS to alter their proposal and allow for broader coverage of this thoroughly studied and proven procedure. The following link will take you to the Vertos' comment:
https://goo.gl/KnKqE2

In the effort to advance MILD coverage, a coalition of organizations including other ASIPP State Chapters, AAPM, ASRA, ASA, The Cleveland Clinic, The Mayo Clinic, Baylor Medical Center, Members of the US Congress, the Medical Device Industry and countless other Interventional Pain Physicians, Societies and Healthcare Centers across the country formed to support MILD advancement with CMS coverage.

These efforts did not go unnoticed and our voices were herd! On December 7th, 2016 CMS issued a Final "Decision Memo for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433R)" and announced plans for broader patient access. Details still need to be worked out and we hope to have those to you in the next issue.

WCI 2017
Workers' Compensation Educational Conference
and 29th Annual Safety & Health Conference
August 6 – 9, 2017

The 72st Annual Workers' Compensation Educational Conference and 29th Annual Safety & Health Conference
August 6 - 9, 2017
The Orlando World Center Marriott

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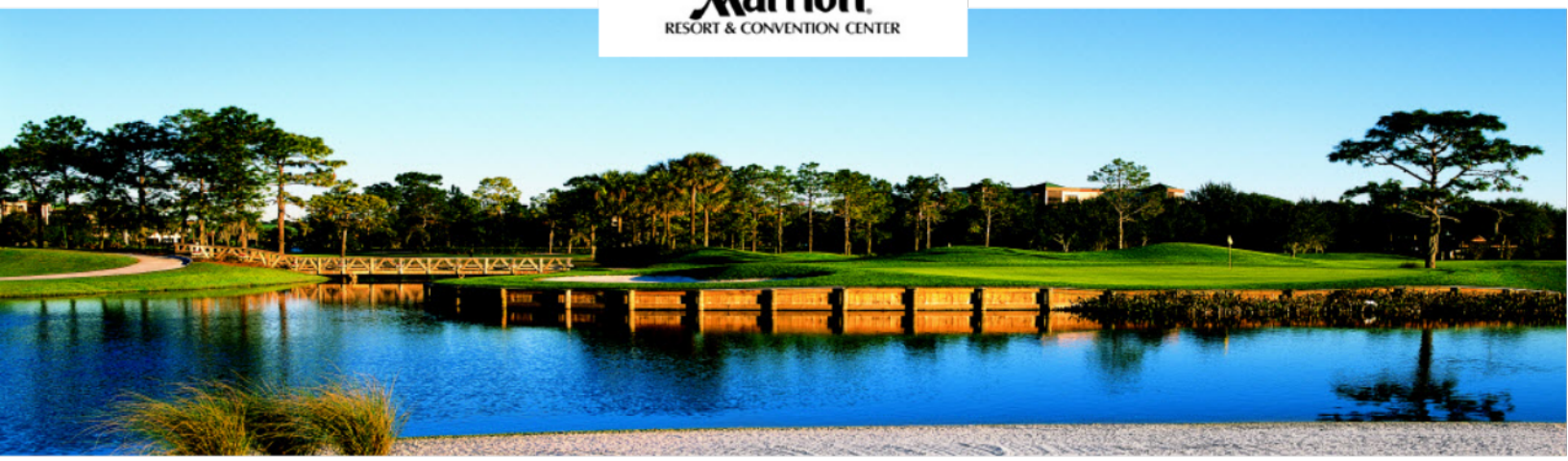
ORLANDO WORLD CENTER Marriott RESORT & CONVENTION CENTER



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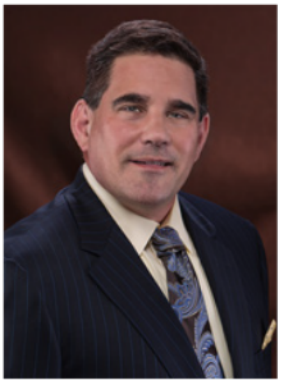
New Developments in Sacroiliac Joint Ablation

By George J. Arcos D.O., FAOCA



The past five years have witnessed much confusion as to the most effective option for sacroiliac joint radiofrequency denervation. The largest axial joint in the body, the sacroiliac joint is estimated to account for 15-26% of low back pain cases. Unfortunately, there is wide anatomical variability of sacroiliac joint innervation. The lateral branches of the S1-3 dorsal rami comprise the primary innervation, with cadaveric studies revealing that S1-2 always contributes, S3, L5, and S4 contribute 88%, 8%, and 4% to the innervation, respectively. The posterior lateral branch nerves are inconsistent in their anatomic locations, varying in number and location, from patient to patient, side to side, and each level. This variability often results in prolonged procedural times, and unpredictable outcomes. In addition, the lateral branch nerves turn their anatomic courses at variable depths, with some situated on periosteum and others embedded in soft tissue or ligamentous structures. One can see, given these wide and unpredictable anatomical variations, that single plane lesions are unlikely to interrupt all afferent nociceptive information.

Two approaches have been developed to overcome these obstacles. Single strip lesioning with a multi-electrode RF probe (Simplicity III) utilizes a single percutaneous entry point, with the probe placed lateral to the sacral foramina and medial to the SIJ. A series of overlapping RF lesions (five total) is created over 8 minutes (80 degrees C) using the preprogrammed RF sequence. The design parameters are thought to overcome variability in anatomic location, as well as depth. Bellini and colleagues studied 60 patients with dual positive diagnostic SIJ blocks, who underwent single strip lesioning. Their results revealed greater than 50% pain relief in 91.8% of treatments, persisting at 1 year. Of note, the authors also reported clear improvement in ODI (Oswestry Disability Index) scores six months after treatment, reflecting clear functional improvement.

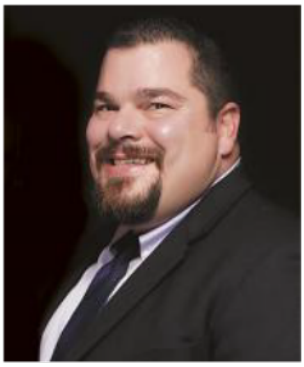
Similarly, Hegarty reported 12 month outcome data on patients treated with the single strip probe, as noted above. He reported a 61% reduction in pain intensity, and a mean reduction of 4.7 points in the VAS score. The VAS score declined steadily over the 12 month study period, with daily pain intensity, pain at rest, and pain with movement, all significantly improved following treatment. In addition, Roland-Morris Functional Scores (RMF) continued to show significant improvement at 12 months compared to pre-procedural scores. Quality of life improvement, as measured by Global Patient Improvement Assessment (SF-12), ranged from 70% to 85% improvement at 12 months.

A similar approach was described by Cheng J and colleagues at the Cleveland Clinic, as reported in Pain Physician (2016; 19;603-615).A guide block was developed to facilitate placement of 7-9 needle electrodes to simultaneously ablate the L5 dorsal ramus and lateral branches of the S1, S2 and S3 dorsal rami. Outcomes were compared directly to cooled RFA. The guide block technique reduced operating time more than 50%, decreased radiation exposure more than 80%, and decreased cost by more than $1000 per case. Strip lesions were performed at 85 degrees C for 150 seconds via four electrodes. Two controlled lesions were made at a time, with sequential lesions by combinations of needle connections. In both types of strip lesioning, clinical outcomes exceeded both traditional RFA, as well as cooled RFA. In the guide block study, patients experiencing greater than 50% pain relief were 5 times higher in the strip lesioning group, compared to cooled RFA group. The cohort reported by Hegarty was comprised of patients known to be refractory to all other treatments, yet displayed continued improvement over time.

The results of these studies are significant, given the challenge of effectively treating SIJ mediated low back pain. This is especially true, given the mixed results and unsatisfactory outcomes of pharmacotherapy, prolotherapy, viscosupplementation, chiropractic manipulation, intraarticular injections, surgical fusion. Randomized controlled clinical trials are necessary to establish clear superiority over existing RFA therapies.

FSIPP Political Action Committee Update

By Miguel de la Garza, MD



It has been a busy year for the FSIPP Political Action Committee (PAC). The FSIPP PAC had the privilege to coordinate political fundraising efforts with the Florida Medical Association PAC. Of note, FSIPP PAC and FMA PAC endorsed candidates won 94% of election races. FSIPP PAC board members hand carried checks to many of the most powerful candidates, ensuring face to face dialogue at important junctures in many races.

- **Of the Florida Senate races we were involved in, 22 of 24 of our candidates won – 92%**
- **Of the Florida House races we endorsed, 70 of 74 won – 95%**
- **Only one incumbent House member lost their re-election – Amanda Murphy in Pasco County**
- **Of the heavily contested Dade County Senate races, Anitere Flores and Frank Artiles won, Miguel Diaz de la Portilla lost (he was the only incumbent Senator to lose)**
- **FMA and FSIPP good friend Dana Young won a very contentious race in Senate District 18 in the Tampa area**
- **The Republicans hold the majority in the House with 79 Republicans to 41 Democrats**
- **The Republicans also still hold the majority in the Senate with 25 Republicans and 15 Democrats**
- **There will be 20 brand new Senators – half of the entire body of the Senate will be new this year**

Finally, in December, FSIPP PAC committee members supported and attended fundraiser with House Republican Speaker Richard Corcoran, Speaker Designate Jose Oliva and the freshman Republican leadership.

Special thanks to the ongoing efforts of Jon Johnson, Melanie Brown, FMA PAC leadership, and the FSIPP PAC committee members. Job well done!

What's New In Chronic Pain In 2017

By David Vaughn, Esq., CPC

This article was revised to correct the descriptions of the new interlaminar epidural codes that were incorrectly defined in the original article.

1. **Conversion Factor.** The non-anesthesia conversion factor is $35.8887 vs. $35.8043 last year.

2. **UDT.**

a. Increased Reimbursement for Confirmation Codes. The Final 2017 Clinical Laboratory Fee Schedule (CLFS) adopts the increased reimbursement recommended in the Proposed Rule for the 4 Medicare UDT confirmation codes as follows (unadjusted for geographic location):

- G0480: from $79.95 to $116.85 = $36.90
- G0481: from $123.00 to $159.90 = $36.90
- G0482: from $166.05 to $202.95 = $36.90
- G0483: from $215.25 to $252.15 = $36.90

b. Added Requirement to Each Confirmation Code. CMS is adding the following verbiage to each of the 4 confirmation codes. A confirmation test must utilize "(2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)." Check with your lab director to make sure that your confirmation testing can accommodate these 2 new requirements; if not, you cannot bill these 4 confirmation codes.

c. Deleted Medicare Screening Codes. The current 3 Medicare G codes for screening (G0477, G0478, and G0479) have been deleted.

d. Deleted CPT Screening Codes. The 5 current CPT codes for screening (80300, 80301, 80302, 80303, 80304) have also been deleted.

e. Replacement Screening Codes. The deleted Medicare and CPT Code screening codes have been replaced in 2017 by 3 new screening codes, found in the CPT Code, which will be applicable to all payers:

- 80305 (direct optical observation; dipsticks, cups, cards, per DOS, bundles validation testing);
- 80306 (instrument assisted direct optical observation; per DOS, bundles validation testing); and
- 80307 (instrument chemistry analyzers, i.e., IA, per DOS).

f. Effect of Screening Changes. Last year, 2 of the 5 screening codes in the CPT Code allowed providers to bill one unit for each drug tested (80302 and 80304). The new codes only allow one unit of service regardless of the number of drugs or drug classes tested.

g. Drug Lists A& B Deleted. Additionally, last year, the CPT Code differentiated between drugs listed in Drug List A versus Drug List B. This year Drug Lists A and B are gone.

h. New Medicare Confirmation Code for Less Sophisticated Testing. G0659 is a new Medicare code for definitive tests being done at labs that "are performing a less sophisticated version" of confirmations." In essence, this new G code is designed to be billed if your high complexity lab does is not capturing the 2 new criteria, discussed in 2. b. above, that are now incorporated into the Medicare confirmation codes. The new G code is defined below.

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Definition. G0659: "Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of a stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes."

Pricing. Per CMS, "the work performed in this test approximates the work performed in G0479 (IA screening). Therefore, CMS proposes to price this new code at the same amount as G0479 (G0479 has been renumbered as 80307).

3. **Moderate Sedation.**

a. Deleted Codes. CPT codes 99143-45 and 99148-50 have been deleted.

b. Replacement Codes. The new moderate sedation codes mimic the old moderate sedation codes except that the time frame of 30 minutes has been reduced to 15 minutes, and the threshold to bill the primary code has been reduced from 16 minutes to 10 minutes.

c. Same MD/NPP providing sedation as doing the procedure:

- 99151 - 15 minutes, less than 5 years old
- 99152 - 15 minutes, 5 years or older
- 99153 - Each add'l 15 minutes of intraservice time

d. Different MD/NPP providing the sedation:

- 99155 - 15 minutes, less than 5 years old
- 99156 - 15 minutes, 5 years or older
- 99157 - Each add'l 15 minutes of intraservice time

e. Lower Time Threshold. The new CPT codes reduce the amount of time required to bill moderate sedation.

- Total Minutes Reduced in Half. 0-30 minutes for the initial/primary code is reduced to 0-15 minutes.
- Billing Threshold is Atypical. 10 minutes of intraservice time is required to bill the first code (reduced from 16 minutes previously). Note, this is different from the typical rule that more than half of a time-based code is required to bill (which would be 8 minutes in this case).
- Add-on Code Time is Typical. However, beginning with the 2nd code, which is an add-on code (billable after the first 15 minutes), the 8-minute rule does apply to that second code (the add-on code).
- Example. For example, while 10 minutes is required to bill 99152 by itself (10 minutes is the billing threshold for this 15-minute code), 23 minutes is required to bill 99152 and 99153 (the full 15 minutes for 99152 and 8 minutes (1 minute past the midway point) for 99153).

f. Deletion of Appendix G from CPT Code. Appendix G, which lists all the codes that bundle moderate sedation, has been removed from the CPT Code, meaning that moderate sedation isn't bundled with any CPT code. Medicare agrees with the AMA on this issue. For Medicare, any bundled procedure listed in Appendix G of CPT 2016 will have its wRVU reduced by .25 since no codes are bundled any longer with moderation sedation (and Medicare had factored into the reimbursement of those procedures the use of moderate sedation at a work value of .25 wRVU). So, if you are billing a code that was on Appendix G in 2016, you are going to have to bill 99152 (moderate sedation 5 years or older) just to say even with 2016 reimbursement, for Medicare.

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4. **Interlaminar Epidural Codes.**

a. Deleted Codes. CPT 2017 deletes the 4 epidural codes 62310, 62311, 62318, and 62319, and replaces them with 8 new epidural codes.

b. Replacement Codes. The replacement codes are:

- 62320 - C/T; no fluoro; no indwelling catheter
- 62321 - C/T; w/ fluoro; no indwelling catheter
- 62322 - L/S; no fluoro; no indwelling catheter
- 62323 - L/S; w/ fluoro; no indwelling catheter
- 62324 - C/T; no fluoro; w/indwelling catheter
- 62325 - C/T; w/ fluoro; w/indwelling catheter
- 62326 - L/S; no fluoro; w/indwelling catheter
- 62327 - L/S; w/ fluoro; w/indwelling catheter

c. Purpose. The purpose of exchanging the 4 old codes with the 8 new codes is to distinguish between interlaminar epidurals done with, versus without, fluoroscopy.

d. Physician Reimbursement w/ and w/o Fluoro.

Code Description	Office RVU/Payment	Facility RVU/Payment
62320 - CT w/o imaging	4.75/$171	2.94/$105.84
62321 - CT w/ imaging	7.06/$254.16	3.17/$114.12
Extra if Fluoro Used	**$83** - Office	**$9** - Facility
62322 - LS w/o imaging	4.43/$159.48	2.53/$91.08
62323 - LS w/ imaging	6.93/$249.48	2.89/$104.04
Extra if Fluoro Used	**$90** - Office	**$13** - Facility
62324 - CT indwelling cath w/o imaging	4.15/$149.40	2.68/$96.48
62325 - CT indwelling cath w/ imaging	6.26/$225.36	3.08/$110.88
Extra if Fluoro Used	**$76** - Office	**$14** - Facility
62326 - LS indwelling cath w/o imaging	4.36/$156.96	2.63/$94.68
62327 - LS indwelling cath w/ imaging	6.38/$229.68	2.80/$100.80
Extra if Fluoro Used	**$73** - Office	**$6** - Facility

5. **Fluoroscopy.**

a. Add-on Codes. 77002 and 77003 are newly designated as add-on codes. The "+" designation beside 77002 and 77003 means these codes can only be billed with another code (this doesn't really change anything for pain management since that is how we've always billed these codes).

b. Procedures for 77003. 77003 is limited to the following 9 codes:

- 61050/61055 - C1-C2 puncture
- 62267 - percutaneous aspiration of disc for dx purpose
- 62270/62272 - lumbar spinal puncture, dx/therapeutic
- 62280-82 - neurolytic injection into spinal canal or epidural space
- 62284 - lumbar myelography injection
- 64510 - injection stellate ganglion
- 64517 - injection superior hypogastric plexus
- 64520 - injection paravertebral sympathetic, lumbar/thoracic
- 64610 destruction trigeminal nerve, 2nd and 3rd branches

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c. Interlaminar Epidurals Cannot be Billed with 77003. Last year, the CPT Code allowed 77003 to be billed with interlaminar epidurals (Medicare did not). This year, 77003 will not be billed with any epidural codes, because the use of fluoro with interlaminar epidurals is built into the new epidural codes.

d. Procedures for 77002. There are approximately 50 procedures which the CPT Code authorizes as "parent" codes with which 77002 may be billed. Notable ones are:

- 20550, 20551, 20552, 20553 (tendon, ligament, and TPI);
- 20600, 20605, 20610 (small, intermediate, large joints);
- 64505 - sphenopalatine ganglion; and
- 64600 - destruction of trigeminal nerve.

6. **JW Modifier for Wastage.** Pursuant to MLN Article MM9603, effective 1/1/17, providers are required to use the JW modifier to bill for discarded Part B drugs in single use vials. The discarded amount must be documented in the medical record. The rule applies to all Medicare carriers. If you do not use JW, on audit the unused portion will be disallowed. Bill as two separate line items, as follows:

- Bill the amount used on the first line (with no JW), i.e., J1030 - 5 units
- Bill the amount wasted on the second line item, i.e., J1030 JW - 5 units

7. **Prolonged Non-Face-to-Face E/M Services.**

a. Medicare Payment Initiated. CMS will now pay for these services, as represented by 99358 (first hour) and 99359 (each additional 30 minutes). Medicare also adopts the CPT Code descriptors and introductory comments for these codes.

- 99358 - Prolonged E/M service before and/or after direct patient care, first hour;
- 99359 - each additional 30 minutes (add-on code).

b. Limited to Physicians and NPPs. The services must be performed by the physician or NPP, not clinical staff, and cannot be items that are typical clinical staff scope of services.

c. Reimbursement Amount. 99358 pays 3.16 RVUs ($114), and 99359 pays 1.52 RVUs ($54).

d. Date and Time Issues. Time can be discontinuous; 99358 is only reportable at the 30-minute threshold; 99359 is reportable at the 15-minute threshold. The date of service can be a different date from the underlying E/M service to which the non-face-to-face service is related, such as review of medical records. These codes can be billed as follow up to or preparation for any other face-to-face E&M code at any level.

8. **Definitions of Percutaneous, Endoscopic, and Open; Visualization.** Immediately prior to CPT code 63001, the CPT Code provides new definitions of "percutaneous," "endoscopic," and "open" as they pertain to spinal procedures, clarifying that if a procedure isn't classified as endoscopic or percutaneous, the assumption is that the code is designed to apply to an open procedure.

- Percutaneous: Image-guided procedures (e.g., CT or fluoro) performed with indirect visualization of the spine without the use of any device that allows visualization through a surgical incision.
- Endoscopic: Spinal procedures performed with continuous direct visualization (e.g., eye, microscope or endoscope) of the spine through a surgical opening.
- Open: Spinal procedures performed with continuous direct visualization of the spine through a surgical opening.
- Indirect Visualization: Image guided (eg. CT or fluoroscopy), not light-based visualization.
- Direct Visualization: Light-based visualization; can be performed by eye, or with surgical loupes, microscope, or endoscope.

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9. **Endoscopic Decompression of Nerve Roots.** New code 62380 provides for the endoscopic decompression of the spinal cord or nerve roots, but requires laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated disc, 1 interspace, lumbar.

10. **Incident to Billing.**

a. Exceptions to Direct Supervision. There are two new exceptions to incident to billing where the MD does not have to be in the office to bill incident to, i.e., only "general supervision" is required. Those two exceptions are transitional care management (99495-96) and chronic care management (99490).

b. Definition of General Supervision. "General Supervision" is defined now at 42 CFR 410.26 as "the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service."

c. Bill Under the Supervising Physician. Additionally, CMS now states that the supervising practitioner for billing purposes "need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services." So, if the regular physician is out of the office, the physician who is in-house and supervising that day must bill the mid-level's service if incident to billing is utilized. The mid-level should document who the supervising physician is and that he/she is in the office and immediately available.

11. **99024 for Bundled Visits.**

a. Visits During Global. This is the code for an E/M visit performed during the global period.

b. Required Billing. Effective 7/1/17, practitioners in a group of 10 or more "practitioners" in the following 9 states must bill 99024 for visits during the global period: FL, KY, LA, NV, NJ, ND, OH, OR, and RI.

c. Which Codes. CMS will publish a list of procedures to which the 99024 code must be billed. Check out the CMS website.

d. Penalty for Failure to Report. If you don't report, CMS may impose a 5% penalty in the future to "encourage" this reporting.

e. Possible Pain Codes. RF.

12. **PT/OT.**

a. Deleted Codes. PT codes 97001-04 were deleted (PT/OT eval codes).

b. Replacement Codes. These 4 codes were replaced by 8 new codes, 97161-68.

c. Assessment Codes are Based on Complexity. Essentially, these new codes turn the single PT assessment code into multiple codes, depending on complexity (typically 20/30/45 minutes), and do the same for OT assessments.

d. Always Therapy Codes. New PT eval codes 97161-64 are "always therapy codes," meaning that they are always considered PT codes and require the GP modifier (services delivered under an outpatient PT plan of care).

e. 2017 Medicare Therapy Caps. The 2017 therapy cap for Medicare is $1,980.

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13. **Cryoablation of Nerves Have Temporary Codes.**
    - 0440T - upper extremity, including imaging
    - 0441T - lower extremity, including imaging
    - 0442T - "truncal" nerve (i.e., brachial plexus or pudendal), including imaging

14. **Telehealth.**

a. New Modifier 95. Append modifier 95 to any of the codes listed in Appendix P of the CPT Code (approximately 75 codes, most of which are E&M and psych codes).

b. New Place of Service (POS). Both the facility where the patient is and the location where the practitioner is bill POS 02.

c. Requirements To Bill Telehealth. (1) service furnished must be on the list of telehealth services; (2) service must be furnished via an interactive telecommunication system; (3) furnished by an authorized practitioner; (4) the patient must be in a telehealth originating site; and (5) the patient must be an eligible telehealth patient.

d. Payment. Medicare pays both a facility fee to the originating site and a physician fee to the practitioner furnishing the service.

e. Telephones and Emails. Telephone, fax, and stand-alone email are not interactive telecommunication systems.

f. New Critical Care G Codes. New codes G0508 and G0509 are designed for critical care rendered via telehealth and are effective 1/1/17.

15. **Recoupment.** Medicare can now recoup overpayments against a provider who shares a TIN with an "obligated provider" that owes Medicare money, regardless of whether that provider is assigned a different Medicare billing number or NPI from the obligated provider.

16. **New Code for Assessment of Cognitive Impairment.** Medicare adopts a new G code for the assessment of cognitive impairment, such as Alzheimer's or dementia. The AMA is supposed to adopt a similar code in 2018. G0505 cannot be billed on the same DOS as new patient and established patient E/M codes (99201-99215), or various other psych codes.

17. **Placement/Replacement of Stimulator/Leads for Sleep Apnea - T Codes.** Placement, revision, removal, and other related codes pertaining to a generator and stimulator leads for sleep apnea are contained in the temporary codes (a/k/a emerging technology codes) 0424T-0436T.

18. **OIG 2017 Work Plan.** The OIG has announced that it is going to investigate the following items during 2017 in regard to chronic pain.
    - Orthotics. Review the reasonableness of pricing on back and knee braces.
    - Orthotics. Review orthotic claims for compliance with LCDs.
    - Transitional Care Management. Review the accuracy of billing for transitions from inpatient to LTAC or rehab or nursing home or home.
    - Chronic Care Management. Review the billing where non-face-to-face care is billed for patients with 2 or more significant chronic conditions that place the patient at risk of death and which are expected to last 12 months or until death.
    - DME. Must be enrolled in Medicare to order DME.
    - Prolonged Services. Review medical necessity.
    - Drug Wastage in Single Use Vials. Determine whether requiring manufacturers to lower the volume in single use vials can reduce cost.