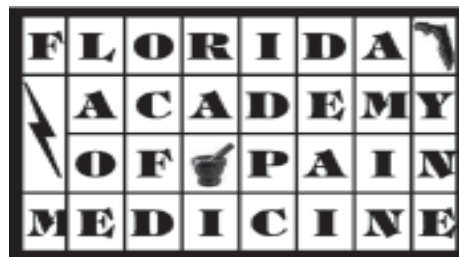


# PAINInfo



NEWS FROM THE FLORIDA ACADEMY OF PAIN MEDICINE ♦ VOL 10, NO. 1 ♦ Spring, 2005

## PRESIDENT'S MESSAGE

By Sanford Z. Pollak, D.O.

We had a successful conference at the Ritz Carlton in Coconut Grove last summer and now we are looking forward to **FAPM's 2005 meeting** which will be held July 29-31, at The Gaylord Palms Resort and Convention Center in Orlando. Inside this issue of PainInfo, you will find the program ***Schedule-at-a-Glance***. Registration materials should be mailed out in late April. You can go to our website, <http://fapm.med.new.net>, and gather information about the meeting, including hotel registration. As the registration materials are developed, they will also be put on the website for you.

I will look forward to seeing you at the meeting in July. But in the meantime, let's take a look at what has been happening with FAPM and its members.

Since we last met, the national and state elections occurred. How have Florida Amendments 3, 7, and 8 affected your practices? Remember, Gary W. Jay, M.D., is FAPM's new Medical Director. This position was created to give our organization continuity during the year between meetings with organizations such as the FMA. Dr. Jay can be reached at [drgwjay@aol.com](mailto:drgwjay@aol.com). Catch his comments inside this issue regarding the ***DEA's Interim Policy on Prescription Fill Dates***.

Fred A. Furgang, M.D., FAPM Board Member-at-Large, has contributed an article inside entitled "***Dangerous Drugs and the Decade of Pain***." This is an expansion on his response to the DEA's Interim Policy referenced above.

Sanford M. Silverman, M.D., and Michael A. Weitzner, M.D., two FAPM members, are on the Board of the newly formed ***Florida Pain Initiative***. The FPI, as an avenue to redress our grievances with the DEA, is mentioned in Dr Furgang's article. The FPI is meeting for the first time this month in Orlando. More information about the FPI is inside.

Andrea M. Trescot, M.D. is FAPM's Legislative Chair. She, like Dr. Jay, represents pain medicine with organizations such as the FMA. Dr. Trescot is also active on the national level. You can read her comments on ***State and National Legislative Issues*** inside this issue, including references to "Empire Medical Training," Medicare guidelines for facet blocks, and NASPER (National All Schedule Electronic Reporting).

Thank you to Francisco X. Vilasuso, M.D., an FAPM member who represented us at a State Medicaid meeting on the issue of ***Neurontin***. The issue is that Neurontin is not FDA-approved for pain. Medicaid has recently changed its formulary so that only morphine products are available. Dr. Vilasuso's reflections on the Medicaid meeting are inside.

Rafael Miguel, M.D., wrote the article inside entitled "***Interventional Pain Clinics and the Florida Board of Medicine Office Surgery Rule***." This answers questions raised at his presentation at our last meeting, "Proper Use of Opioids in the Pain Management Setting."

## Inside

***FSPMR & FSIPP to Meet again in Conjunction with FAPM Annual Meeting***

***Bolded and italicized titles in the President's Message to the left indicate articles inside.***

(Continued Page 2)

## President's Message (Continued)

Three FAPM members, Felix S. Linetsky, M.D., Rafael Miguel, M.D., and Francisco Torres, M.D., have written an article entitled "Treatment of Cervicothoracic Pain and Cervicogenic Headaches with Regenerative Injection Therapy," which was published by Elsevier in Anesthetic Techniques in Pain Management. And in continuing to argue the case for prolotherapy, Dr. Linetsky, with Laxmaiah Manchikanti, M.D., has written an article, "Regenerative Injection Therapy for Axial Pain." This article has been copyrighted this year by Elsevier for future publication in Techniques in Regional Anesthesia and Pain Management. Dr. Linetsky's and Dr. Manchikanti's position is that despite continued controversy, multiple published studies show RIT's effectiveness.

And finally, congratulations to Winston C.V. Parris, M.D., FAPM Board Member-at-Large, who received the CMG (Companion of the Most Distinguished Order of St. Michael and St. George) insignia at Buckingham Palace in London. The award was bestowed on Dr. Parris by His Royal Highness Prince Charles. Details are inside.

*Dr. Pollak practices in Jacksonville.*

## DEA Interim Policy and Prescription Fill Dates

By Gary W. Jay, M.D.

Writing a prescription with a fill date is a very definite no-no, unless you want a visit from the DEA. This means that all pain patients who need medications must be seen every 28-30 days. It also means that much more care must be given to even considering prescribing Schedule IIs to a patient with a history of drug abuse.

At a California meeting in December, about half of the pain specialists attending indicated that now would be a good time to leave pain medicine. Things are becoming too draconian. The DEA's 180 degree turn does not bode well. Information in the Federal Register indicated that in the past, the number of pain patients, the number of prescriptions and the amount of pain meds written did not in themselves (something else had to be going on) represent a potential problem to the DEA. BUT THEY DO NOW!

*Dr. Jay practices in Tamarac. He is a former President of FAPM and currently serves on the Board as Medical Director.*

**Further Comments**

*By Fred A. Furgang, M.D. Please read his article, "Dangerous Drugs and the Decade of Pain," in this issue, for his thoughts on this DEA problem.*

*Dr. Furgang is Assistant Professor of Anesthesiology, Director of Pain Management at the University of Miami School of Medicine. He serves on FAPM's Board as a Member-at-Large.*

By Andrea M. Trescot, M.D.

ASIPP, the American Society of Interventional Pain Physicians, in conjunction with the European company Grunenthal, is creating a "certification" for opioid prescribing for PCPs. ASIPP will be giving this exam for the first time this March in New Orleans, and hopefully it will protect FPs from DEA scrutiny.

*Dr. Trescot practices in Orange Park and she is the President of the Florida Chapter of ASIPP. A former FAPM President, she currently serves on the Board as the Legislative Chair.*

**FAPM OFFICE**

FL Academy of Pain Medicine  
P.O. Box 330298  
Atlantic Beach, FL 32233-0298

**Phone:** 904-270-8886

**Fax:** 904-246-9233

**Email:** Lorry4@earthlink.net

**URL:** <http://fapm.med.or>  
<http://fapm.med.new.net>

Lorry S. Davis, M.Ed.,  
Executive Director

## Florida Pain Initiative

Sanford M. Silverman, M.D., and Michael A. Weitzner, M.D., two FAPM members, are on the Board of the newly formed Florida Pain Initiative. According to its website ([www.floridapain.org](http://www.floridapain.org)) FPI is a member of the American Alliance of Cancer Pain Initiatives. The organizational meeting was on March 7 of this year in Orlando. FPI's goals:

- a. making pain management a healthcare priority in our state
- b. increasing legislative awareness of the magnitude of the social and economic impact of pain
- c. establishing a statewide presence in advocating improved access to pain management
- d. developing educational programs for professionals and the general public related to effective pain management strategies
- e. re-establishing the Florida Pain Commission that existed from 1995-1996.

Dr. Silverman practices in Pompano Beach. He can be reached at [silvpain1@bellsouth.net](mailto:silvpain1@bellsouth.net). Dr. Weitzner practices in Tampa, and he can be reached at [mweitzner@helioscenter.net](mailto:mweitzner@helioscenter.net).

### State and National Legislative Issues

By Andrea M. Trescot, M.D.

On the state level, several pain issues have come to the forefront. For those of you not yet aware, a Florida-based pain training program called "Empire Medical Training" has been advertising that they will train family physicians to do "high paying pain procedures" in their office. The literature states that they can teach procedures like "facet 62664 which Medicare pays \$350 per level" without pointing out that these are neurolytic codes. The pro forma they send to prospective applicants suggest \$10,000 per month extra income, without any apparent outlay for fluoroscopic equipment, suggesting that they are proposing that these procedures be done without xray guidance. They also offer to train family practitioners in their own offices (which obviously do not have fluoroscopic equipment).

In response, the proposed new Medicare guidelines for facet blocks, which are available at [www.flmedicare.com](http://www.flmedicare.com), recommend the use of fluoroscopy for facet blocks. New local carrier determinations (the old LMRP term has been changed) for epidurals and peripheral nerve blocks are also available at this site.

On the national level, the National All Schedule Electronic Reporting (NASPER) bill has passed the House and has moved to the Senate. This bill would provide a clearinghouse that would archive controlled prescription records. When a patient comes to your office, you would be able to query the databank to determine if this patient has filled a controlled substance from any other physician in your city, any other city, or any other state. Please contact our senators (and any other senator if possible) to let them know how important this bill is. Sample letters are available at <http://www.asipp.org>.

### "Dangerous Drugs" and the Decade of Pain

By Fred. A. Furgang, M.D.

Before it was called the Drug Enforcement Agency (DEA), it was the Bureau of Narcotics and Dangerous Drugs (BNDD). The implication that all narcotics, including prescription opioids, were "dangerous drugs" was accepted as fact. Before pain management became the area of intense interest that it is today, the use of prescription opioids was essentially limited to the management of short-term post-operative pain, and severe cancer pain. Since opioids were "dangerous," it was not unreasonable to place them in a separate category (II) which prohibited the issuance of refills.

The BNDD evolved into the DEA, "pain medicine" evolved, if not into a recognized specialty, at least a medical discipline, and the U.S. Congress established this period as the "Decade of Pain." In addition, JCAHO, with input from the American Pain Society, established pain control standards to be applied to our certified institutions. Pain management fellowships spread throughout the land, and pain doctors and clinics spread like wildflowers. Pain medicine attracted not only some of medicine's best and brightest, but also, unfortunately, some of its most unscrupulous elements as well.

*(Continued Page 6)*

## Medicaid and Neurontin

By Francisco X. Vilasuso, M.D.

Neurontin is no longer on the Medicaid formulary for pain. Only morphine products are available. On June 30, 2004, Neurontin was abruptly cut off the formulary without any warning to the Medicaid recipients who were prescribed it.

Last fall, at a Medicaid Community Relations meeting, the FMA was successful in getting me on the agenda to represent FAPM regarding the Neurontin issue. The Medicaid representatives made their case for the fact that much of their limited resources goes to medication and priorities for these diminishing resources had to be reconfigured. I realized that if I politely waited for my place on the agenda, I would never be heard. I had to be assertive and outspoken to get FAPM's message across. The President of the Florida Psychiatric Association was present and chimed in vociferously in agreement with me.

I learned that three physicians on Medicaid's pharmacy committee were an oncologist, a neonatologist, and a family practitioner. It would seem that two of the three would have had an active knowledge of the uses of Neurontin for neuropathic pain. At the meeting, I was given permission to distribute copies of "Advances in Neuropathic Pain, Diagnosis, Mechanisms and Treatment Recommendations," reprinted from Archives in Neurology 2003; 60(11): 1524-1534, copyright 2003 American Medical Association.

On the positive side, I did have a chance to meet with some of the Medicaid hierarchy, specifically Emily Fritz, Director of Medicaid Community Relations. I also met afterwards with FMA Medical Economics Specialist, Glenda Henderson. Participating in these state meetings can be very frustrating, but I am hopeful that my participation will be at least a drop in the bucket towards modifying Medicaid policy regarding Neurontin.

*Dr. Vilasuso practices in Miami.*

## Interventional Pain Clinics and the Florida Board of Medicine Office Surgery Rule

By Rafael Miguel, M.D.

At the 2004 FAPM meeting in Coconut Grove, statements were made on pain clinics and the Board of Medicine (BOM) Office Surgery Rule that have generated some discussion. At its March, 2002, meeting, the Florida BOM identified invasive pain procedures as surgery for the purpose of the Office Surgery Rule. This required office-based interventional pain clinics to be in compliance with all aspects of the Rule. (64B8-9.009 located at <http://fac.dos.state.fl.us/faonline/chapter64.pdf>).

Differences in the sedation and analgesia utilized are the primary defining characteristics of a Level I, II or III procedure. Minimal preoperative oral sedation/tranquilization is typical of Level I and requires **compliance with the Rule but not registration with the State**. Level II (conscious sedation, be it IV, IM or rectally) and Level III (deep sedation/major conduction blockade/general anesthesia), require **compliance with the Rule and registration with the State**.

There is an exclusion caveat for IIA, where procedures are expected to last 5 minutes or less and are associated with complications where the need for hospitalization would be remote. While some procedures performed in office-based interventional pain clinics may fall under this definition, many do not and the pain physician needs to assess his/her entire practice to make that determination.

*Dr. Miguel practices in Tampa. He is Professor and Chairman, Dept. of Anesthesiology; Director, Pain Medicine Program, University of South Florida.*

## Continuing Education Schedule-at-a-Glance

**Friday, July 29, 2005**

7 - 8 am - Continental Breakfast/Registration

Coffee will be available throughout the morning

8 am - 12 pm WORKSHOPS

1. **Update of Spinal Cord Stimulators and Intrathecal Pumps** -  
*Douglas M Hershkowitz MD, Port Charlotte, FL*
2. **Examination of the Neuromusculoskeletal System** -  
*Ronald B Tolchin DO, Miami Beach, FL*

12 pm LUNCH on your own

Coffee/Beverages will be available throughout the afternoon

1 - 5 pm WORKSHOPS

1. **RIT/ Prolotherapy** - *Felix S Linetsky MD, Palm Harbor, FL*
2. **Cryoablation** - *Andrea M Trescot MD, Orange Park, FL*

DINNER on your own

**Saturday, July 30**

7 - 8 am Hot Breakfast in Exhibit Hall/Registration

8 - 8:05 Welcome from Lorry Davis, FAPM Executive Director

8:05 - 8:15 am - Opening Comments/FAPM President

- 1) 8:15 - 9:00 am, **Addiction Treatment** - *Sanford M Silverman, MD, Pompano Beach, FL*
- 2) 9:00 - 9:45 am, **Rise and Fall of Vioxx** - *Fred A Furgang MD, Miami, FL*

9:45 - 10:15 am - Coffee Break in Exhibit Hall

- 3) 10:15 - 11:00 am, **RIT/Prolotherapy Principles & Practice in Light of Recent Publications**  
*Felix S Linetsky MD, Palm Harbor, FL*
- 4) 11:00 am - 12:00 pm - **KEYNOTE ADDRESS, Interventional Spinal Injection Procedures**  
*Richard Derby MD, Dale City, CA*

12:00 - 2:00 pm - Luncheon and FAPM Annual Meeting

- 5) 2:00 - 2:45 pm, **Impairment Rating** - *Anthony J Dorto MD, Miami, FL*
- 6) 2:45 - 3:30 pm, **Interventional Disc Therapies** - *Yili Zhou MD PhD, Miami, FL*

3:30 - 4 pm, Beverage Break in the Exhibit Hall

- 7) 4:00 - 4:45 pm, **EMG in Pain Management** - *Erick A Grana MD, Tampa, FL*
- 8) 4:45 - 5:30 pm, **Peripheral Joint Pain, New Developments in Management**  
*Francisco Torres MD, Clearwater, FL*

5:30 - 7:00 pm, President's Cocktail Reception -

Open Bar and Hors D'oeuvres in Exhibit Hall

7:00 - 9:00 pm, FSPMR & FSIPP Dinner Meetings

**Sunday, July 31**

7:30 - 8 am - Continental Breakfast in Exhibit Hall/Registration

- 9) 8:00-8:45, **Challenges in the Management of Chronic Pain Patients with Psychiatric Comorbidities & Addictions**

*Mitchell JM Cohen MD, Philadelphia, PA*

- 10) 8:45 9:30 am **Central Sensitization** - *Albert L Ray MD, Miami, FL*
- 11) 9:30 - 10:15 **Fibromyalgia and Myofascial Pain** - *Gary W Jay MD, Tamarac, FL*

10:15 -10:45 am, Coffee Break in the Exhibit Hall (Exhibitors, Then Depart)

- 12) 10:45 - 11:30 am - **Intra-Articular Injections of Phenol** -  
*Tim J Lamer MD, Jacksonville, FL*

- 13) 11:30 am - 12:15 pm - **Ergonomics** - *James D McCluskey MD, MPH, PhD (C), Tampa, FL*

12:15 - 1:00 pm - **Working Lunch with FREE PAPER PRESENTATIONS**

1:00 pm Meeting Closure - Next President-Elect

## **Dr. Winston C. V. Parris Receives CMG Award**

On Thursday, November 25<sup>th</sup> 2004, Dr. Winston C.V. Parris received the CMG (Companion of the Most Distinguished Order of St. Michael and St. George) insignia at an investiture ceremony at Buckingham Palace in London. This award was made by



Queen Elizabeth II and was bestowed on Dr. Parris by His Royal Highness Prince Charles, the Prince of Wales. The palace reports that this award was given to Dr. Parris for his contributions to pain medicine in the United States, in particular, and worldwide. The report states that Dr. Parris is recognized for his work in introducing pain medicine to the Caribbean and more recently for the formation of the St. Lucia Pain Institute based in his homeland, St. Lucia, The West Indies. Dr. Parris is further recognized for his work in treating underprivileged chronic pain patients in St. Lucia.

In addition to other achievements, Dr. Parris is a founding member of the American Academy of Pain Medicine, past Secretary of the American Academy of Pain Medicine, past President of the American Board of Pain Medicine, past President of the World Society of Pain Clinicians, Clinical Professor of Anesthesiology at University of South Florida in Tampa, Adjunct Professor of Anesthesiology at Vanderbilt University in Nashville TN and is the President and Medical

Director of the St Lucia Pain Institute.

Dr. Parris is the author of 3 chronic pain textbooks, 34 book chapters, 83 abstracts, 91 Scientific publications and 154 abstracts. His most recent publication is entitled "Cancer Pain Management: Principles and Practice."

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## **"Dangerous Drugs" and the Decade of Pain**

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Over the years we have readily accepted patients from all referral sources; in many cases, these patients became our patients "for life." The indications for opioid therapy have greatly expanded to include not only severe pain, but intractable chronic non-malignant pain of moderate intensity. We have greatly expanded our pharmacologic and therapeutic arsenal in pain management, but now realize that many of the drugs formerly believed to be "safe," are in fact now considered potentially "dangerous;" for example, the cardiovascular effects of Vioxx and liver failure with Tylenol. To be sure, the current brouhaha of the NSAID's and COX-2 inhibitors is a mix of science, politics, and economics, nevertheless the possibility of harm resulting from what many have believed were relatively innocuous drugs, is very real.

On the other hand, we have come to appreciate opioids as having many beneficial properties. They do not have target organ toxicity, there is no ceiling effects to their analgesia, are generally well tolerated, and in many ways are "safe and effective." Although, some pain specialist have developed along the lines of interventional therapy or behavioral modification, in general, the full-service pain clinic will rely heavily on opioid therapy for many of its patients. Indeed, many patient referrals actually come to the clinic with pain well controlled but on opioids for "adjustment" or maintenance of therapy. Patients often state that the referring physician is not willing to write the prescriptions for their opioid medication, for whatever reason, but probably out of fear of potential recrimination from a state regulatory agency or the DEA.

The problem for the full-service pain clinic, which includes most of our academic centers, is that we become saturated with patients whose pain is reasonably well controlled on chronic opioid medication. This severely limits our ability to see new patients. It is not unusual for academic clinics to have a waiting list several months long for new consults. Since we cannot provide refills on Class II drugs, what we have done in the past, at least in Florida, is to provide the patient with multiple prescriptions, usually to cover the next ninety days. Of course, to be legal each script must be dated with the date it is actually written; however, the

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## **“Dangerous Drugs” and the Decade of Pain**

follow up scripts indicated a “do not fill before” date. Although, it took time to write these extra scripts, it saved the patient from monthly office visits, and saved someone the cost of those visits. This “win-win” situation for all parties concerned has come to an abrupt halt.

Last November (2004), the DEA issued a statement that it considered the writing of “sequential” scripts the same as refills on Class II’s. I agree with this position: we were getting “around the law” by providing sequential prescriptions; essentially we were providing refills on narcotics. So, where do we go from here?

Legitimate pain clinics should not become the depository for all those stable patients who are on chronic opioid therapy! In the past, we readily accepted the long-term management of such patients; we can no longer afford to do so; it precludes us from fulfilling our mandated purpose of finding ways to relieve pain in those still suffering. We must have time on our schedule to see new patients, and to give them the time they deserve for a thorough evaluation, and to continue working with those patients still in intractable pain.

If we do not send the well-controlled patient back to the original referral source, our practices will expand exponentially with the “refill-patient.” We must no longer accept the argument from our colleagues that they are “not comfortable prescribing.....” We must educate them, support them with written documentation that affirms the beneficial effects of the current therapy, and certainly be available to provide whatever assistance they may need in the future with the patient. We must speak to the referring physician, or PCP, and explain the necessity for this change in policy; if they are to have a place to refer their difficult “pain patients” in the future, we must be able to “recycle” patients back to them.

In general, a patient with a chronic, stable, disorder can see their physician once or twice a year. Prescriptions for chronic medication are commonly written for, and covered by third party payers, for ninety days with three refills. This covers a whole year of therapy! A full-service pain clinic may have 50% or more of its patients on chronic opioid therapy, now requiring monthly refill visits.

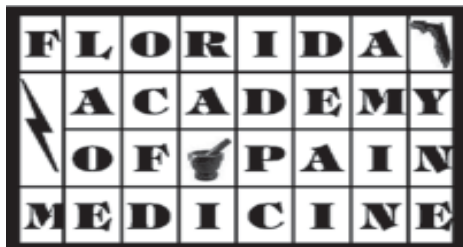
As an analogy consider the use of PCA (patient controlled analgesia). Originally, the anesthesiologist wrote the orders, at the surgeon’s request, for post-op pain management. Then the payers took the position that the surgeon’s global fee included payment for post-op pain management. It took time, effort, and education of our surgical colleagues, but now the vast majority of them are perfectly content to write their own PCA orders.

Besides re-cycling patients back to PCP’s, what else can we do? If you don’t like the law, seek to change it! The existing law negatively impacts the legitimate pain physician, whereas an unscrupulous cash-only “pain clinic” actually thrives on repeat prescription writing. Change will have to occur at the Federal level; lawmakers will have to be convinced that they must do more than “lip-service” to make the Decade of Pain a reality. We must eliminate the stigma surrounding the legitimate use of opioids for patients in chronic pain. Prescription drug abuse, addiction, and diversion are indeed problems that must be dealt with, but should not inhibit us from doing what is right for our patients in intractable pain.

We must also work at the state level to gain a consensus of support. All organizations that have an interest in pain management should band together in a statewide pain initiative (e.g. the Florida Pain Initiative). The force brought to bear on the U.S. Congress by such unity of statewide initiatives should be sufficient to effect change in DEA policy.

Broadening the scope of opioid treatment has precedent elsewhere. At one time, methadone was only used in heroin treatment centers, and only by specially licensed physicians certified in addiction medicine. Now, methadone is used in pain centers for pain therapy as long as we certify that fact. I propose that we establish a new certification for pain centers/physicians that will allow us to issue refills on opioid prescriptions, similar to the certification that is provided for addiction therapy with methadone, or now with buprenorphine.

Certification for “opioid refill privileges” would follow an application to DEA, educational training program, and investigation if warranted. This should be sufficient to limit certification to those physicians who have a legitimate need for the privilege. Chronic pain is now recognized as a disease entity. When this disease is treatable by opioid administration, these patients should be entitled to the same unimpeded access to necessary therapeutic agents as patients with any other chronic illness. When we arrive at that point, we will have truly arrived in the “Decade of Pain.”



P.O. Box 330298

Atlantic Beach, FL 32233-0298

The Florida Academy of Pain Medicine is proud to present

# **THE 2005 ANNUAL**

# **CONFERENCE**

July 29-31, 2005

# **The Gaylord Palms Resort & Convention Center**

## **Kissimmee (Orlando)**

*Florida Society of Physical Medicine & Rehabilitation Summer Meeting  
Florida Society of Interventional Pain Physicians Summer Meeting*