

PAIN MEDICINE NETWORK

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Come to New Orleans in February

This coming February 7-10, 2007, marks the 23rd Annual Meeting of the American Academy of Pain Medicine. AAPM will be returning to the city of New Orleans, a location known for its unique charm, outstanding restaurants, and southern hospitality. Despite the terrible blow inflicted by Hurricane Katrina in 2005, the city's downtown area has undergone an incredible rebirth and is once again open and thriving. AAPM's Annual Meeting Site Selection Committee made an onsite inspection of the Ernest N. Morial Convention Center, the host hotel Hilton New Orleans Riverside, and surrounding community, and assures us that New Orleans is open for business and ready for company.

Please make plans to join your colleagues for a series of exceptional educational and social events. Tourism is the lifeblood of the New Orleans economy, and your attendance will mean much to the citizens who have endeav-

ored to rebuild this historic city. Let's help them rejuvenate and restore New Orleans by providing the needed income to support job development, show appreciation for their outstanding efforts, and celebrate the Crescent City's continuing recovery.

As always, the AAPM Annual Meeting will showcase a wide range of educational opportunities and new products, and provide you with many chances to network with your Pain Medicine colleagues. Don't miss this excellent opportunity for quality continuing medical education that also celebrates the resilience of the Crescent City and its people! See you there!



Frederick W. Burgess, MD PhD
President, AAPM



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Decade of Pain Control and Research, 2001-2010





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Understanding Consultation Codes

Emily Hill, PA



Many of the services provided in a Pain Medicine practice involve the taking of a history, physical examinations, and subsequent decisions regarding the plan of care. In Current Procedural Terminology (CPT) coding, these services are described as Evaluation and Management (E/M) services. The various E/M codes reflect the necessary physician work required for the type of service, place of service, and the patient's status.

New Patient Services and Consultations

One of the designations posing difficulty for many physicians is the one that defines new patient services and consultations. According to CPT guidelines, a new patient is one who has not received any professional services within the past 3 years from you or your colleague of the same specialty in your group practice. The new patient definition applies only to the categories of E/M services titled "Office or Other Outpatient Services" and "Preventive Medicine Services." New patients are typically self-referred or have been sent by another healthcare provider for treatment.

By contrast, consultations are unique services in the sense that a physician has been asked for, and delivers, an opinion on the evaluation or management of a specific problem. Patients you see in consultation may be either new patients or established patients to your practice. The criteria for the use of consultation codes are met if

- A physician is asked for his or her opinion or advice regarding the evaluation and/or management of a specific problem. This verbal or written request may come from another physician or other appropriate source.
- Both the request and need for the consultation are documented in the patient's medical record.
- A written report is prepared by the consulting physician that describes his or her findings and any services ordered or performed. This report must be sent to the requesting healthcare provider.

Additional Services with a Consultation

CPT states that at the same or subsequent visit, the consultant may initiate diagnostic or therapeutic services. The specifically identifiable procedures performed (i.e., identified with a CPT code) may be reported separately. The modifier 25 is added to the consultation code.

At some point, a consultant may cease to be a consultant and become the treating or attending physician. CPT states that, "If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate E/M services code for the site of service should be reported."

In the hospital setting, E/M services following the initial consultation are reported using subsequent hospital care codes (99231-99233). In the office setting, subsequent services are reported using established patient E/M codes (99211-99215).

Types of Consultation Codes

Based on current usage, CPT 2006 deleted the codes for follow-up inpatient consultations and confirmatory consultations. These codes were found to be redundant and other more specific E/M codes are available. There are now just two subcategories of consultation codes: Initial Inpatient Consultations and Office or Other Outpatient Consultations.

The Initial Inpatient Consultation codes are used for services provided to hospital inpatients, nursing facility residents, or patients in a partial hospital setting. They are reported the first time you are asked for your opinion during that facility stay. You may only report one Initial Inpatient Consultation code during the patient's admission for you or your group partner in the same specialty.

Consultation codes do not have time restrictions like the new patient E/M codes. Therefore, if you are requested to reevaluate the patient's condition and treatment plan in an outpatient setting,

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What Your Colleagues are Reading

Frederick W. Burgess, MD PhD, AAPM President

Increasing Deaths from Opioid Analgesics in the United States

L. J. Paulozzi, D. S. Budnitz, & Y. J. Xi
Pharmacoepidemiology and Drug Safety, 2006 (e-published ahead of print).

The authors performed a trend analysis on data relating to opioid analgesic deaths reported to the Centers for Disease Control and Prevention, and on prescription opioid sales provided by the Drug Enforcement Administration. Unintentional drug-related mortality rates increased an average of 5% per year from 1979 to 1990 and 18% per year from 1990 to 2002. This rapid increase during the 1990s reflects the rising number of deaths attributed to narcotics and unspecified drugs. Between 1999 and 2002, the number of opioid analgesic poisonings on death certificates increased 91%, while heroin and cocaine overdose reports increased only 12% and 23%, respectively. By 2002, opioid analgesics were listed in 5,528 deaths, exceeding deaths from heroin and cocaine. The increase in deaths correlated with the increase in sales for each type of opioid. The increase in deaths involving methadone did not appear to be linked to methadone maintenance programs, but instead appeared to be linked to the greater availability of tablet formulations employed for pain treatment.

Commentary: Drug diversion and misuse has long been associated with the prescription of opioid medication. Recent trends toward more aggressive pain treatment appear to be contributing to an increase in drug diversion, and increased availability of potent opioids

in the population. Physicians prescribing opioids must recognize this danger, and take steps to educate their patients on the risks of allowing others access to their opioid medication, the need for safeguarding their prescriptions, and on the potential toxicity of opioids when prescribed directions are not followed.

Methadone has a unique pharmacokinetic profile; its delayed onset and prolonged half-life can lead to unintentional overdose. Sustained-release opioids, if misused, may behave as a rapid-release preparation and cause a massive overdose. Careful education on the risks and benefits is essential. Failure to keep our own house in order may contribute to a backlash of restrictions and reduced availability of potent opioids.

Predictors of Opioid Misuse in Patients with Chronic Pain: A Prospective Cohort Study

T. J. Ives, P. R. Chelminski, C. A. Hammett-Stabler, R. M. Malone, J. S. Perhac, N. M. Potisek, et al.

BMC Health Services Research, April 4, 2006, 6, 46.

A 1-year prospective cohort study was conducted to assess the incidence and predictors of opioid misuse in patients enrolled in an internal-medicine, chronic-pain, disease-management program within an academic medical center. One hundred sixty nine patients receiving opioids for chronic noncancer pain were monitored for opioid misuse. Opioid misuse included a negative urine screen for the prescribed opioid, a positive urine screen for nonprescribed controlled and illicit substances,

evidence of procurement from multiple prescribers, diversion of opioids, and prescription forgery.

Thirty-two percent (62 patients) of the monitored cohort were found to misuse their medication or violate the guidelines of treatment. Forty percent of the patients who were found to misuse tested positive for cocaine and amphetamines. Twenty-four percent of misusers did not have detectable levels of the prescribed opioid in their urine. Another 9% were found to have detectable levels of medications not prescribed by the clinic. Only 3 patients were found to have diverted or forged prescriptions. Risk factors predictive of opioid misuse included: a history of alcohol abuse (relative risk 1.95), history of cocaine abuse (RR 3.3), positive urine for cannabinoids (RR 2.7), multiple drug convictions (RR 15.1), and prior drug or driving-under-the-influence convictions (RR 3.6).

Commentary: Risk factors, such as a history of substance abuse, are not absolute contraindications to pain treatment with opioid medications. However, the wise practitioner will take steps to monitor all patients for appropriate patterns of drug use. Establishing clear expectations on the part of the patient for the proper use of their medication, and conducting random, routine urine toxicology testing is essential to avoid improper use, and will allow for early recognition of patterns of inappropriate drug use or diversion. Failure to guard against diversion and drug misuse represents a public health threat, and is regarded as inappropriate prescribing by law enforcement in the present legal environment.



Methadone: A Novel and Potentially Hazardous Opioid Analgesic

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Clinical Pharmacologist, Rush University Medical Center, Rush Pain Center, NorthShore Pain Center, Skokie, IL

Managed-care pharmacy-benefit programs and multiple state Medicaid pharmacy formularies are electing to promote the prescribing of methadone as an opioid of choice due to this drug's low acquisition cost for pain management (eudynia, maldynia, neuropathic pain). Some programs advise the analgesic use of methadone in lieu of long-acting and long-term opioid prescribing. This recommendation poses efficacy and effectiveness challenges to wellness; furthermore, neither of these two areas has been exposed to rigorous double-blind placebo controlled trials. Efficacy reflects controlled clinical variables as opposed to effectiveness, which reflects a real-world experience devoid of controls.

The pharmacologic and pharmacodynamic profiles of methadone are well described elsewhere. Refer to **Table 1** for pharmacologic, pharmacokinetic, and pharmacodynamic information regarding methadone.

Methadone has been used for decades in the management of substance abuse disorders in patients with a chemical dependency/addiction to opioids. The reasons for methadone selection include: excellent oral bioavailability (F), prolonged duration of action, a lack of active analgesic metabolites, low acquisition costs, the uniqueness of the drug's NMDA receptor antagonism, and serotonin (5-HT) reuptake inhibition. Methadone utilization in the management of eudynia, maldynia, neuropathic pain, and cancer pain has long been appreciated.

Clinical concern has arisen recently concerning methadone-associated QTc interval prolongation/dispersion, potentially contributing to morbidity and/or mortality with cavalier prescribing. Several clinical reports describe adverse patient outcomes in individuals who have exceeded the normal therapeutic dose range, or have utilized other pharmacotherapeutic agents with QTc prolongation effects (see **Table 2**) or have pharmacokinetic, pharmacodynamic, or pathophysiologic comorbidities.

Patients with risk factors or QTc prolongation, whether these risk factors are pharmacokinetic, pharmacodynamic, or pathophysiologically mediated, may benefit from a cardiac evaluation, or at least a baseline EKG, prior to initiation

TABLE 1 Methadone

<p>A racemic mixture (diphenylheptane). Mu agonist, non-opioid NMDA antagonism (d-isomer) blocks Ca²⁺ channel, lesser kappa agonist, possibly strong delta receptor activity; chronic exposure desensitizes mu and delta receptors-1-isomer, 5-HT/NE RUB (reuptake blocker)-d-isomer.</p>
<p>Duration 4–6 hr (up to 48 hr following chronic dosing) for analgesia; analgesic oral onset 30–60 min, analgesic peak 30 min–1 hr following repeat dosing. The drug accumulates with repeated dosing, necessitating frequent monitoring and dosage reductions, particularly during the first several days after starting the medication, as analgesic effects peak in 3–5 days.</p>
<p>Protein binding 80%–89%, 1AGP acid glycoprotein</p>
<p>Fraction absorbed 80% (oral), range: 40%–99% (bioavailability)</p>
<p>T_{1/2} 15–25 hr/single dose, range 13–47 hr, 48–72 (average 7–59 hr) with multiple dosing; prolonged with alkaline pH</p>
<p>V_{dss} 3.8 L/kg (1b–8L range)—wide tissue distribution, highly lipophilic</p>
<p>S/E LE, edema (antidiuretic effect), sedation, dizziness, hypotension, bradycardia, peripheral vasodilation, palpitations, histamine release, libido decrements (less euphoria), dysphoria; see text for others</p>
<p>Metabolism (hepatic and intestinal) CYP 2B6, 2C8/9, 2C19, 2D6, 3A4 (Major), substrate N-demethylation; metabolite: inactive N-demethyl-3, 3-diphenylpyrrolidene (EDDP), accumulation: due to long T_{1/2}</p>
<p>Elimination 52% urine (≤ 10% unchanged); feces; some renal glomerular reabsorption[†]</p>
<p>Absorption PO rapid, incomplete</p>
<p>C_{ss} 3–5 days</p>
<p>C1cr ≤ 10ml/min utilize 50%–75% or less of the dose</p>
<p>PG C, crosses placenta</p>
<p>C4P450 Drug interaction inhibits 2B6/3A4</p>

[†] Note: Avoid use in hepatic disease; may cause dose-related, inter-patient variation (torsades de pointes, which is dose related, particularly at high doses); see text. Chronic dosing may produce auto-induction.

of therapy. If the patient's evaluation reveals normal sinus rhythm without cardiac conduction abnormalities, treatment may proceed. Patients with documented risk factors may periodically receive serial EKG studies, prior to subsequent doses or dose escalations.

Prescribing of methadone generally requires a highly compliant patient who is without propensity to auto-manipulate the methadone doses or use other pharmacotherapeutic agents—prescribed or non-prescribed, over-the-counter medications, phytopharmaceuticals, or illicit controlled substances—without the awareness of the

methadone prescriber. Patients treated with methadone should be instructed and counseled in a manner to prohibit auto-manipulation of the methadone doses or their frequency. Therapeutic drug monitoring may be engaged with systems to manage the methadone utilization, including urine drug testing by gas chromatography/mass spectrometry (GC/MS). Continued clinical vigilance for misuse, diversion, and the combination of methadone with other pharmacologic agents is essential.

Using caution in patients at risk for QTc prolongation also includes patients

TABLE 2
Selected Noncardiac Pharmacotherapies with Potential of Producing Arrhythmia and/or QTc Prolongation

Bronchodilator	Clarithromycin	Chlorpromazine	Alpha Agonist/Vasoconstrictor
Albuterol	Erythromycin	Clozapine	Epinephrine
Ephedrine	Gatifloxacin	Fluphenazine	Norepinephrine
Isoproterenol	Gemifloxacin	Haloperidol	Phenylephrine
Levalbuterol	Levofloxacin	Loxapine	Phenylpropanolamine
Salmeterol	Lomefloxacin	Mesoridazine	Pseudoephedrine
Terbutaline	Moxifloxacin	Molindone	Anorexiant
Alpha 1 Adrenergic Receptor Blockade (BPH)	Norfloxacin	Olanzapine	Benzphetamine
Alfuzosin	Ofloxacin	Perphenazine	Diethylpropion
Anti Parkinson's	Telithromycin	Pimozide	Fenfluramine
Amantadine	Sparfloxacin	Prochlorperazine	Phendimetrazine
Apomorphine	Trimethoprim – Sulfamethoxazole (TMP/SMX)	Quetiapine	Phentermine
Tricyclic and Tetracyclic Antidepressant (TCAs)	Trovafloracin	Risperidone	Sibutramine
Amitriptyline	Oncology	Trifluoperazine	Alzheimer Cholinesterase Inhibitor
Amoxapine (tetracyclic)	Abarelix	Thioridazine	Donepezil
Clomipramine	Arsenic trioxide	Thiothixene	Galantamine
Desipramine	Daunorubicin	Typical antipsychotic	Rivastigmine
Doxepin	Idarubicin	Ziprasidone	Memantine
Imipramine	Tamoxifen	Antiviral	Tacrine
Maprotiline	Toremifene	Foscarnet	Endocrine
Mirtazapine	Sedative–Hypnotic	Rimantadine	Levothyroxine
Nortriptyline	Choral hydrate	GI Stimulant	Liothyronine
Protriptyline	Central Muscle Relaxant	Cisapride	Octreotide
Trimipramine	Cyclobenzaprine	Anticonvulsant	Thyroid (desiccated)
SSRI Antidepressant	Tizanidine	Fosphenytoin	Anti-infective
Citalopram	Antiemetic	Felbamate	Pentamidine
Escitalopram	Alosetron	Gabapentin	Uterine Relaxant
Fluoxetine	Dolasetron	Phenytoin	Ritodrine
Fluvoxamine	Domperidone	Pregabalin	NSAIDs
Paroxetine	Droperidol	Antimanic	(All COX I and COX II have MI risk factors)
Sertraline	Granisetron	Lithium	Celecoxib
CNS Stimulant/ADHD	Ondansetron	Phosphodiesterase Inhibitor	Diclofenac
Amphetamine	Antifungal	Sildenafil	Etodolac
Atomoxetine	Fluconazole	Tadalafil	Fenoprofen
Dextroamphetamine	Itraconazole	Vardenafil	Flurbiprofen
Methamphetamine	Ketoconazole	Immunosuppressant	Ibuprofen
Methylphenidate	Voriconazole	Tacrolimus (FK506)	Indomethacin
Antidepressants (other)	Antimalarial	Opioids	Ketoprofen
Bupropion	Chloroquine	Alfentanil	Mefenamic
Trazodone	Halofantrine	Fentanyl	Meloxicam
Nefazodone	Diuretic	Ketamine	Nabumetone
Venlafaxine	Indapamide	Hydromorphone	Rofecoxib
Antibiotics	Anesthetic	Levomethadyl	Sulindac
Alatrofloxacin	Cocaine	Levorphanol	Valdecoxib
Ampicillin	Antipsychotic	Methadone	
Ciprofloxacin	Aripiprazole	Propoxyphene (dextropropoxyphene)	
	Atypical antipsychotics	Sufentanil	

with medications that additionally produce QTc interval prolongations, or in those patients with a premorbid history of conduction abnormalities. The conduction abnormality of QTc interval-prolongation and the development of torsades de pointes is associated with doses that are equal to or higher than 200 mg per day, although this has been observed in some patients with lower doses who may possess associated risk factors. Caution is also necessary in patients with volume depletion or with genetic polymorphism. Genetic polymor-

phism usually involves a deficiency in CYP450 enzymes, 2C (2C9, 2C19), and 2D6. Both of these cytochrome enzymes (CYP) are involved in the disposition of methadone. A deficiency of these enzymes will produce an increase in area under the curve (AUC) of the parent compound, due to impaired methadone metabolism. Cardiovascular events reported with methadone include bradycardia, peripheral vasodilation, cardiac arrest, syncope, hypotension, arrhythmia, edema, extrasystoles, bigeminal rhythms, tachycardia, torsade de pointes, ventricular

fibrillation/tachycardia, ECG changes, cardiac output QT interval prolongation, T-wave inversion, cardiomyopathy, heart failure and hypertension.

In reviewing **Table 2**, a number of agents prescribed in the management of pain may contribute to prolonged QTc intervals, including tricyclic antidepressants, gabapentin, pregabalin, cyclobenzaprine, and propoxyphene. Recall that methadone is metabolized by CYP3A4 in the liver (hepatic first pass) and the small intestines (gut first pass). It is

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Frequently Asked Questions About New Orleans: Post Katrina

What areas of the city have returned to normal?

The hospitality and tourism destinations of New Orleans were not flooded and are storm-and-debris-free, open, and thriving. These sites include: the French Quarter, Faubourg Marigny, Warehouse Arts District, Garden District/Uptown, Audubon and University section, Carrollton and Riverbend, and historic Algiers on the city's west bank. Hotels, restaurants, and retail businesses in these areas are eager for your patronage. Also, Jefferson Parish and the North Shore of Lake Ponchartrain are home to more than a dozen bustling neighborhoods.

What's the status of the Convention Center?

The Ernest N. Morial Convention Center partially reopened in February 2006, and the majority reopened in June 2006, with more than 740,000+ square feet of exhibit space, 99 meeting rooms, a 4,000-seat auditorium, and a 36,000-square foot ballroom. More than \$60 million in renovations and upgrades are being made to the facility. The remaining four halls, 41 meeting rooms, and 32,000-square foot ballroom will reopen in November 2006.

How many hotels are open?

Of the metropolitan area's 140 hotels, 103 are open, 90 of which are located in downtown New Orleans. Among the metro area's 38,000 hotel rooms, 27,300 are back in service. Notable properties returning to service soon are the Ritz-Carlton Hotel (December 2006), the Fairmont Hotel (Spring 2007), and the Hyatt Regency New Orleans (Fall 2007).

Will I see evidence of hurricane damage at the Convention Center or nearby areas?

No. After remediation work was completed, the clearance process included visual inspection and sampling for airborne fungal spores and ongoing monitoring. Water sampling was also completed to ensure that no contamination had occurred. All areas in the tourism corridor of the city are storm-and-debris-free, open, and thriving.

Are there enough police?

The Vieux Carre Police Station is fully functional in the heart of the French Quarter. The pre-Katrina police force

numbered 1,680 officers serving 485,000 citizens, with a ratio of one police officer for every 289 citizens. The post-Katrina police force is 1,469 officers who serve 190,000 citizens, with a ratio of one police officer for every 130 citizens. The National Guard has been assigned to patrol the outlying damaged and sparsely populated neighborhoods of the city to keep them safe as they rebuild. This will allow the New Orleans Police Department to increase their patrols in the tourism areas and historic parts of the city, enhancing the already strong safety record these districts enjoy.

What's the status of the airport?

Louis Armstrong International Airport reports that 111 flights depart daily (67% of pre-Katrina departures), with 33 destination cities served (77% of pre-Katrina numbers), and 13,185 seats daily (59% of pre-Katrina levels). Airlines in operation are: Air Canada, Air Tran, America West, American Airlines, Delta Airlines, Frontier Air, Jet Blue, Midwest, Northwest Air, Southwest Airlines, TACA (pending), United Airlines, and U.S. Airways. New Orleans Lakefront Airport is open 24 hours a day for VFR (Visual Flight Rules) and VOR (VHF Omni-directional Range) GPS. Full-service fuel, line service, flight training, and aircraft rescue crews operate from this facility and are available.

Are there taxis?

Taxis are available on New Orleans streets and at major hotels. The Taxicab Bureau reports over 50% of their cabs are back on the street. Rates are fixed at \$28 from the Louis Armstrong International Airport to downtown (for one or two people). For parties of more than two, the fare is \$12 each. Regular rates are \$2.50 upon entry, plus \$1.60 per mile thereafter, and an extra \$1 for each additional passenger.

Are there still plenty of restaurants in New Orleans?

The Louisiana Restaurant Association reports that there are over 700 restaurants open (this figure does not include fast-food or national-chain restaurants), including restaurants in the French Quarter, downtown, and in the Warehouse District. Eighteen major new restaurants have opened in the metro area and are enjoying success.

Is there shopping in New Orleans?

There are many major urban shopping destinations in the city, and they include shopping complexes such as The Shops at Canal Place, The Riverwalk Marketplace, and Jax Brewery. New Orleans prides itself on its distinctive boutiques and art galleries found along Royal Street in the French Quarter, and miles of eclectic shops on Magazine Street and Uptown.

What cultural institutions are open?

All major museums have reopened including the New Orleans Museum of Art, Bestoff Sculpture Garden, Ogden Museum of Southern Art, National World War II Museum, Contemporary Arts Center, Louisiana Children's Museum, Louisiana Philharmonic Orchestra, and the New Orleans Ballet.

Is New Orleans environmentally safe?

The New Orleans Department of Health, along with the EPA, Department of Environmental Quality, and CDC released statements that the land, sea, and air in the New Orleans area had been tested and retested and that the test results show the city is safe for citizens and visitors.

What conventions have decided to return to New Orleans?

The following are a few of the large meetings scheduled for New Orleans in fall 2006:

- Society of Exploration Geophysicists, October 2006; 8,000 attendees
- American Society for Human Genetics, October 2006; 6,000 attendees
- American College of Emergency Physicians, October 2006; 6,000 attendees
- American Society for Reproductive Medicine, October 2006; 6,000 attendees
- Federation of Societies for Coatings Technology, November 2006; 6,500 attendees
- National Association of Realtors, November 2006; 25,000 attendees

Are there opportunities to help the New Orleans recovery when I'm there?

Yes! AAPM is organizing a volunteer effort during the meeting. Please visit www.aapm.org for more details.

AAPM Welcomes Positive Press on New DEA Policy Statement

The media reacted favorably to the recent DEA announcement proposing to allow physicians to prescribe up to a 90-day supply of Schedule II controlled substances during a single office visit, where medically appropriate.

AAPM issued a media statement supporting the DEA's Sept. 6, 2006, Notice of Proposed Rulemaking in the Federal Register and policy statement, "Dispensing Controlled Substances for the Treatment of Pain."

More than 175 positive news pieces on the proposed change to the "Do Not Fill Until..." provision have appeared through a variety of media outlets, including newspapers, magazines, online news sources, television, and wires services. AAPM President Frederick Burgess was interviewed for an in-depth article in *USA Today*. The *Washington Post* also published a positive article citing Academy member Howard Heit. Three Associated Press wire stories and a United Press International wire story have received extensive play in newspapers and television station Web sites around the globe. Related articles have appeared in prestigious media outlets including the *Wall Street Journal*, *Los Angeles Times*, ABC News, CBS.com, *San Francisco Chronicle*, and the *Houston Chronicle*.

While the DEA announcement of a proposed rule today does not ensure this balance, the Academy is pleased that it appears to

be a step toward opening lines of formal communication on the issue and that the move was seemingly embraced by the media.

- The AAPM media statement is on the AAPM Web site under "Academy News" www.painmed.org/about/academy/.
- The full version of the DEA Practitioner's Manual that includes the policy statement can be found at www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html.
- A brief audio update on the proposed DEA changes is available on the Legal Side of Pain Web site, www.legalsideofpain.com. The audio podcast will be available under the AAPM section of the Legal Side of Pain Web site to all AAPM preferred members. Preferred membership in the Legal Side of Pain is free to all AAPM members and can be obtained by visiting www.legalsideofpain.com or sending an e-mail to jbolen@legalsideofpain.com.
- Frederick Burgess, MD PhD, quoted in *USA Today* and Join Together: www.usatoday.com/news/health/2006-09-06-painkiller-limits_x.htm
www.jointogether.org/news/headlines/inthenews/2006/90-days-painkiller-supplies.html
- Howard Heit, MD, quoted in the *Washington Post*: www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090601756.html

Court Ruling a Victory for Pain Physicians

Positive results from the ongoing AAPM advocacy work were apparent in the recent ruling of the United States Court of Appeals for the Fourth Circuit vacating the conviction of a Virginia physician convicted of drug trafficking.

On August 22, 2006, the Court of Appeals ruled that jury instructions that did not instruct the jury to consider whether the defendant physician had acted in good faith were defective. Consequently, the physician, William E. Hurwitz, MD, will be granted a new trial. The decision adopted the arguments that were advanced by AAPM in an amicus curiae brief. The AAPM argued that a physician charged with violating the Controlled Substances Act for allegedly prescribing excessive narcotics was entitled to a jury instruction telling the jury that it should not convict if it found that the physician acted in good faith and within the bounds of sound medical practice. AAPM also pointed out that failure to give such an instruction could result in undertreatment of legitimate pain patients by conscientious practitioners due to fears of criminal conviction.

Although the AAPM brief did not take a stand on the guilt or innocence of Dr. Hurwitz, AAPM believes that

the appellate court acted correctly by removing a dangerous precedent that could have negatively impacted physicians who legitimately prescribe controlled substances to treat patients with pain. "This decision significantly lowers future risk for legitimate physicians who offer appropriate care to patients in pain," says Frederick Burgess, MD PhD, AAPM President.

Dr. Hurwitz's defense was based on the premise that a high-dose protocol is proper for patients with intractable pain and stopping high-dose therapy could be problematic for the patient.

"As now supported by the court's decision, AAPM believes that the judge's instructions confused the previously well-established line between medical malpractice and criminal activity," concludes Dr. Burgess.

AAPM's legal counsel, Jack R. Bierig, JD, of Sidley Austin LLP, states: "The decision in *United States v. Hurwitz* does not go as far as some might like because it defines 'good faith' in terms of generally accepted medical practice rather than the physician's personal belief regarding such practice. Nevertheless, in reversing the conviction of Dr. Hurwitz based on the failure of the trial judge to give a good faith

instruction, the decision represents a significant victory for pain physicians. It provides a strong precedent for the position that physicians who reasonably believe that they are acting in accord with proper medical practice when they prescribe high doses of pain relief medication should not be convicted of criminal conduct. Moreover, the decision confirms the importance and effectiveness of advocacy by the Academy for positions that serve the interests of its members and their patients."



CORPORATE MEMBER PROFILE

Dominion Diagnostics is a national CAP- and CLIA-certified medical laboratory that was founded in February 1997. Dominion strives to provide clinical diagnostic laboratory services that place the patient at the center of the process. Dominion understands that pharmacological management of the pain patient is multidisciplinary, and includes both clinical aspects of the pain itself and issues including addiction, pseudo-addiction, tolerance, undertreatment of pain, drug diversion misuse and abuse, and drug-drug interactions. These issues can range from clinical to forensic to legal, and laboratories are being tasked to develop and perform procedures that will satisfy all of these criteria. This is a new phenomenon for the clinical diagnostic laboratory as historically these issues have been divided into forensic/workplace (nonclinical) testing and therapeutic (clinical) drug monitoring. The underlying science and performance of these two divergent tasks can be very different.

Dominion has assembled a team of professionals, including PhD-level pharmacologists and toxicologists, registered pharmacists, clinical laboratory scientists,



regional ASPM members, a medical review officer, and IS professionals. This team is dedicated to advancing the fields of pharmacology and toxicology as they pertain to pain management, addiction medicine, and primary care physicians.

AAPM Involvement

Dominion is a corporate member of AAPM and has been a participant in AAPM's Annual Meetings since 2005. Dominion will celebrate its 10th anniversary coincident with the 23rd AAPM Annual Meeting in New Orleans (February 7–10, 2007).

Our Product

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To further their education goals, Dominion employs a professional training staff that provides ongoing pharmacokinetic support for its clients across the country. The training assists clients with understanding and developing quantitative urine drug testing and monitoring programs. In addition, Dominion develops scientific-based curricula for educational programs. The staff participates in periodic seminars and conferences on current trends in pharmacology, pathopharmacology, and molecular pharmacogenomics. In pursuit of these educational goals, some of the programs Dominion has worked with include the American Society for Clinical Laboratory Science of Central New England (CLS/CNE), the North Carolina Foundation for Alcohol and Drug Studies, and the South Carolina School of Alcohol and Other Drug Studies.

For additional information, please visit www.dominiondiagnostics.com.



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2008

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Understanding Consultation Codes *continued from page 2*

an outpatient consultation code can be reported for the subsequent request. Likewise, another Initial Inpatient Consultation can be reported if a consult is requested during a different hospital stay. The service must meet all the requirements of a consultation and cannot be for ongoing management of the patient's condition.

As part of the changes, CPT 2006 states, "A 'consultation' initiated by a patient and/or family, and not requested by a physician, is not reported using the consultation codes but may be reported using the office visit codes, as appropriate." It further states that if a consultation is mandated, e.g., by a third-party payer, then modifier 32 (mandated services) should be appended to the consultation code.

When to Use Consultation Codes

Suppose you are asked by another healthcare provider to evaluate a patient's chronic pain and to recommend management options. The patient has been on a series of oral medications but continues to have significant pain. Because of your expertise in the area, you are asked to see the patient in your office and provide advice regarding management options. At this visit, you evaluate the patient and possibly recommend changes in medication or other aspects

of the patient's treatment plan. As a consultant, you may initiate the medication change and/or order diagnostic studies at this visit. If you also asked the patient to return for follow-up, then the next visit with the patient would be reported using established outpatient codes.

Let's assume the requesting physician asked you to take over the management of the patient's pain-related issues, and does not expect to continue treating the patient's pain. In this case you are not a consultant, as the care of the patient has been transferred to you. You would report this initial service using either a new or established patient E/M code.

Documentation Requirements for Consultations

Like all E/M services, the level of service must be supported by the documentation in the medical record. In the case of consultations, the request and need for the consultation and a written report of the findings must be documented in the patient's medical record. On December 20, 2005, CMS released Transmittal 788, which clarified documentation and other consultation requirements. It continued to support the use of consultation codes when there is a verbal or written request from the requesting provider, and the request and need are documented by the consultant.

The Transmittal included revised language that indicated the consultation request also must be included in the requesting provider's plan of care. While the consultant cannot always verify that this directive has been followed, it emphasized the need to ensure that the requirements for a consultation are met before reporting a consultation code.

Why Use Consultation Codes?

Both CPT and CMS instruct the coder to select the most specific code for the service performed. Choosing consultation codes, when appropriate, meets that directive. Equally important for the average practice is the fact that consultation codes typically reimburse better than most other categories of services. The difference in reimbursement obviously depends on the type and level of service provided as well as the payer.

Pain Medicine practitioners may want to create request forms for their primary referral sources to assist in the differentiation between consultation requests and transfers of care, and to help meet any payer requirements. Working as a team, physicians and their staffs can ensure that coding is done properly, thereby improving reimbursement and avoiding allegations of false claims.

Emily Hill serves as counsel on Coding and Reimbursement issues to AAPM.

Methadone: A Novel and Potentially Hazardous Opioid Analgesic *continued from page 5*

important to avoid the concurrent dietary consumption of grapefruit juice, which will decrease the clearance of the methadone enantiomers.

A recent article describes methadone as modestly increasing the QTc interval and QT dispersion. The increase in QT dispersion reflects heterogeneous cardiac repolarization and occurs with nonantiarrhythmic agents such as many synthetic opioids (methadone, propoxyphene, hydromorphone, etc.). However, the magnitude of this effect with methadone appears to be substantially less than with antiarrhythmic drugs. Most nonantiarrhythmic drugs (antibacterials, antidepressants, anti-seizure drugs, antifungals, antivirals, gastrointestinal medications) may exhibit conduction effects similar to methadone on cardiac repolarization via blockade of the human ether-a-go-go (HERG) potassium channel.

Patients who might be at risk for the development of prolonged QTc syndrome include those with cardiac hypertrophy,

hypokalemia, hypomagnesemia, and other agents that prolong the QT interval, and inhibitors of the cytochrome enzymes responsible for methadone metabolism. Methadone metabolism is primarily mediated by CYP3A4 and includes lesser pathways, including 2D6, 2B6, 1A2, 2C9, 2C19. Induction of these CYP450 isoenzymes results in enhanced metabolism of methadone and a decrease in plasma concentrations. Concomitant use of cytochrome enzyme inhibitors affects methadone metabolism, leading to increased plasma concentrations and AUC of methadone. Prudence dictates a careful evaluation of the concurrent pharmacotherapies and any phytopharmaceutical medications, along with an assessment of the patient's predisposition to genetic polymorphism prior to prescribing methadone, due to the potentially life-threatening pharmacokinetic and pharmacodynamic challenges imposed. Lifestyle attributes in patient selection should produce awareness in patients who consume alcohol. Acute

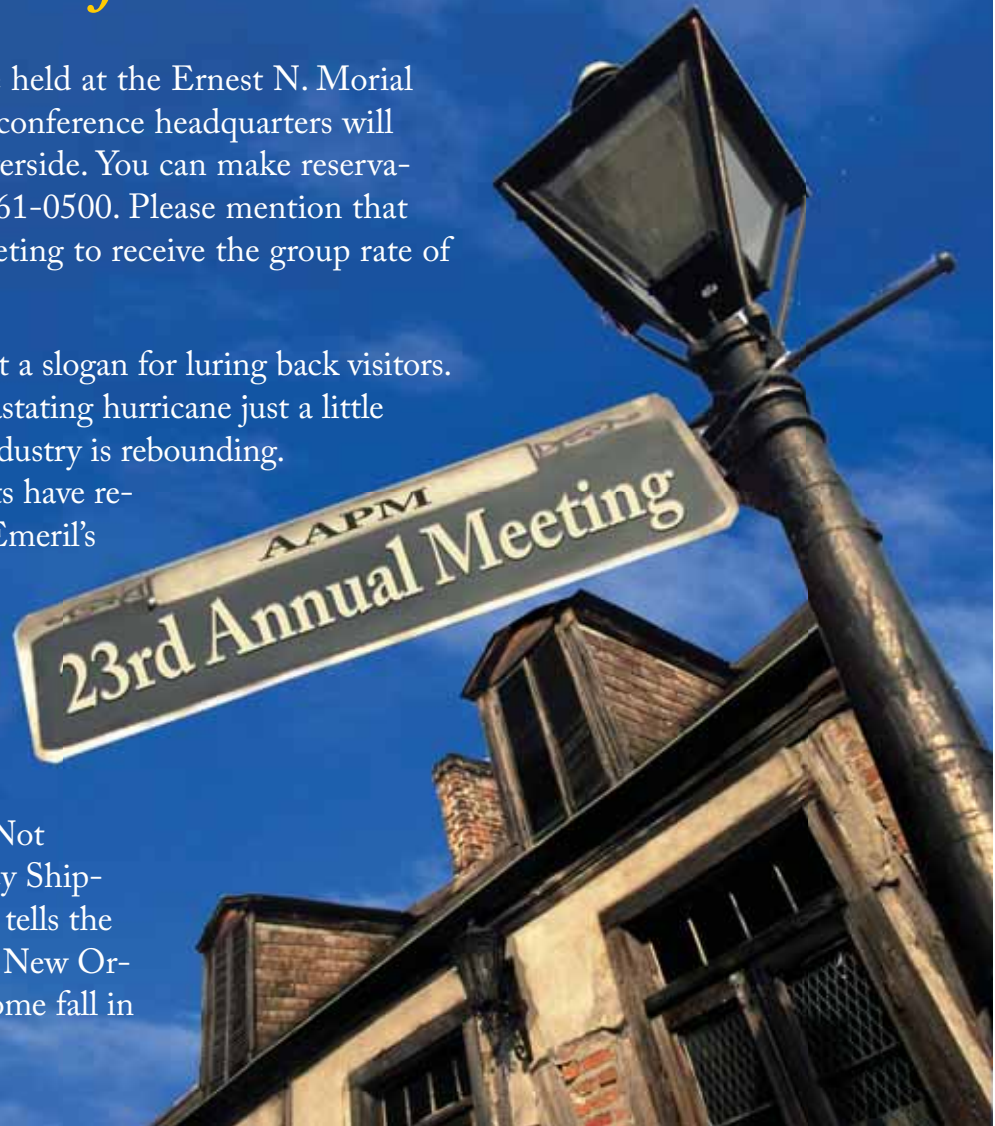
consumption may increase the AUC of methadone, therefore producing an enhanced potential for toxic synergy from both central nervous system depressants. Unintended accidental overdose deaths associated with methadone involve the combination of alcohol and other controlled substances. Acquiring a baseline, complete metabolic profile prior to prescribing any medication would indicate electrolyte abnormalities as well as volume status; and impaired renal or hepatic function will aid in identifying adverse influences on the pharmacokinetics and pharmacodynamics of any drug utilized in the management of pain. High inter-patient variability in pharmacokinetic and pharmacodynamic properties of methadone requires a patient-specific, individualized approach to prescribing.

Resource: Visit the AAPM Web site (www.painmed.org) to read the full bibliography for this article.

Next Annual Meeting Set for New Orleans in 2007

The AAPM 23rd Annual Meeting will be held at the Ernest N. Morial Convention Center in New Orleans. The conference headquarters will be located in the Hilton New Orleans Riverside. You can make reservations by calling the hotel directly at 504/561-0500. Please mention that you are attending the AAPM Annual Meeting to receive the group rate of \$225 single/double.

“Welcome Back to New Orleans” is not just a slogan for luring back visitors. Although this U.S. region was hit by a devastating hurricane just a little over one year ago, New Orleans’ tourism industry is rebounding. During the past 8 months, 1,333 restaurants have re-opened, such as Gordon Biersch Brewery, Emeril’s Nola, and The Polo Lunch Club. Many clubs operate nightly, featuring jazz and other music styles that are unique to this cultural city. New Orleans has also re-opened attractions, such as Longue Vue Gardens, Audubon Nature Institute, the shops at Canal Park, Ripley’s Believe It or Not Museum, The Museum of Art, and Odyssey Shipwreck and Treasure Adventure (which now tells the tale of two hurricanes). In the words of the New Orleans’ Convention and Visitor’s Bureau, “Come fall in love with New Orleans all over again.”



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