Pain Physician, Volume 4, Number 4, pp 296-304
2001, American Society of Interventional Pain Physicians®
ISSN 1533-3159

From the President's Desk

Interventional Pain Medicine: A Specialty in the New Millenium

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I have not written this letter in some time, and I wanted to take this chance to reflect on the issues of the past year or so before the October annual meeting.

I am honored to serve as the president of the American Society of Interventional Pain Physicians (ASIPP) and assist to move the interventional pain medicine community into the 21st century. ASIPP, formerly known as AOPMA, started with humble beginnings and evolved into the present society representing over 1100 interventional pain practitioners, (a great majority of the interventional pain physicians) from multiple specialties. The achievements of the organization have been beyond my greatest expectations.

- Who could have imagined that interventional pain management would have its own specialty? Interventional pain medicine was not even conceived as a group until three years ago.
- Who would have known that ASIPP would be able to achieve so much for interventional pain medicine and also positively influence the policy makers in Washington in such a short period of time?
- Who would have conceived that a toddler organization, only two and a half years old, with members numbering 850, would visit the Secretary of Health and Human Resources?
- Who would have thought that a 300 member organization in existence for barely a year would convince the Healthcare Financing Administration (HCFA), now the Centers for Medicare and Medicaid (CMS) into adding nine interventional pain medicine codes to the Ambulatory Surgery Center (ASC) approved list, which are not only the bread and butter practice of interventional pain medicine but have also improved access to these services to thousands of patients in need of these services?
- Who could have dreamed that the Ambulatory Payment Classification (APC) Panel would take an entirely new classification proposed by ASIPP and act on it for reimbursement for hospital outpatient departments (HOPD)?
- Who could have predicted that ASIPP would have a peer-reviewed journal, an enlightening newsletter, and comprehensive texts on the interventional pain management approach to managing low back pain and an extensive guide for documentation billing and coding in interventional pain medicine?

Honestly, none of us dreamed that we could achieve so many things in such a short period of time. Despite these accomplishments, we are faced with even more challenges in the millennium. We always used to worry about regulations for Medicare and Medicaid. Now it appears that we should worry more about new regulations from private insurers. But, if we continue to be persistent, innovative, and creative, (not in billing of course), should realize even greater accomplishments for interventional pain medicine.

It appears that we will have specialty recognition for interventional pain management. Now the question is, when will it be implemented? Once the implementation is carried out (expected to be April or June of next year), we will have the further tasks of enrollment and proving to Medicare that our practice expenses are different from anesthesiology practice expenses (no offense to anyone). That can only be accomplished by the collection of appropriate and reliable data.

The new classification of various interventional techniques presented to the APC Commission is a great start for interventional pain medicine. This classification has already been helpful in increasing reimbursement for hospital outpatient departments. However, it is not simply the reimbursement, but also the recognition by CMS of the complexity of these procedures. It is my hope that CMS will continue to utilize this classification beyond hospital outpatient departments and apply it to ambula-

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tory surgical center, as well as physician payments. However, we need to provide proper data for CMS to base their classifications and improve reimbursements rather than reduce them. On the surface, it may appear that the present classification may reduce reimbursement for ASCs if they follow the same system as HOPD. However, we should realize that this was based on poor quality data. In addition, ASCs function under district rules for themselves, and also distinctly different from HOPDs and physician offices. I would like this classification to be adapted only for purposes of complexity. We also should realize that some of the simple procedures that carry higher reimbursements may lose that. We should, though, always be fair rather than only to advocate for more money. The following is the classification presented by ASIPP, along with the comparison of the proposed classification by CMS which shows some of the changes, and also the proposals not accepted by CMS.

ASIPP PROPOSAL	CMS PROPOSAL AND MODIFICATIONS
Level I ♦ Trigger Point, Joint, and Other Injections and Lower Complexity Nerve Blocks ♦ CPT 20550 (APC 040—$104.65), 20600 (040), 20605 (040), 20610 (040), 64612 (211—$164.66), 64613 (211), 64614 (971—$76.88), 64400-64418 (211), 64425 (211), 64430 (211), 64435 (211), 64445 (211), 64450 (211), 64505 (211), 64508 (211) ♦ *Why clinically homogenous:* All single injections on the basis of anatomical landmarks with relatively low incidences of technical complications ♦ *Why resources homogeneous*: No fluoroscopy, iv access or fluids, or operating room needed (when only procedure performed); service largely a function of simple alcohol preparation, needle and syringe, local anesthetic and/or steroid; minimal recovery time (5 to 10 minutes) ♦ Recommendation: Move from APC 211 (and other APCs) to APC 971	***Level VI nerve injections (proposed as level I interventional techniques)*** These codes include: 20550 – trigger point injection 20600 – small joint injection 20605 –intermediate joint injection 20610 – large joint injection 64400 – trigeminal nerve block 64402 – facial nerve block 64405 – greater occipital nerve block 64408 – vagus nerve block 64410 – phrenic nerve block 64412 – spinal accessory nerve block 64413– cervical plexus nerve block 64415 – brachial plexus nerve block 64417 – axillary nerve block 64418 –suprascapular nerve block 64425 –ilioinguinal nerve block 64430 – pudendal nerve block 64435 –paracervical (uterine) nerve block 64445 – sciatic nerve block 64450 – other peripheral nerve or branch block 64505– injection, anesthetic agent; sphenopalatine ganglion 64508 – carotid sinus (separate procedure)
Level II ♦ Moderate Complexity Nerve Blocks and Epidurals ♦ CPT 27096 (not specified), 62270 (APC 210 - $148.79), 62272 (210), 62273 (212-$180.53), 62310- 62319 (212) ♦ *Why clinically homogenous*: mostly single injections, performed in spinal area, with somewhat higher technical complication risk ♦ *Why resources homogeneous*: single tray; requires sterile preparation; may or may not need fluoroscopy (based on patient needs or provider approach); may be performed in the operating room, recovery room, or other HOPD locations; local anesthetic and/or steroids; may or may not require sedation; intensity of monitoring and recovery all similar; may or may not require iv (based on patient needs or provider approach); moderate recovery time (20-30 minutes) ♦ Recommendation: Move Services from APC 210 to APC 212	***Level III nerve injections (proposed as Level II interventional techniques)*** These codes include: 62270 – spinal puncture, lumbar, diagnostic 62272 – spinal puncture, therapeutic, for drainage of spinal fluid (by needle or catheter) 62273 – injection, epidural, of blood or clot patch 62310 – cervical/thoracic epidural 62311 – lumbar/caudal epidural 62318 – continuous epidural – cervical/thoracic 62319 – continuous epidural – lumbar/sacral 64614 – chemodenervation extremity(s) and/or trunk muscle(s) (it may be a misprint. We will comment on this, should be in Level VI) The reimbursement ranged for these procedures from $148.79 to $180.53. The new reimbursement would be $197.27 with net increase.

ASIPP PROPOSAL	CMS PROPOSAL AND MODIFICATIONS
Level III ♦ Moderate High Complexity: Epidurals, Facet Blocks, and Disk Injections ♦ 62280-62282 (APC 212), 62290 (No APC), 62291 (No APC), 64420 (211), 64421 (211), 64470 (211), 64472 (211), 64475 (211), 64476 (211), 64479 (211), 64480 (211), 64483 (211), 64484 (211), 64510 (211), 64520 (211), 64530 (211), 64630 (211), 64640 (211) ♦ Clinically homogenous: precision interventional techniques performed for diagnosis or treatment of conditions involving persistent pain; greater Technical complication risk; more difficult to access relevant sites than Level II procedures ♦ Resource homogenous: requires fluoroscopy, contrast, sterile environment, sterile preparation, and special spinal or Chiba needles, drugs, local anesthetics, and/or steroids; iv access and fluids; most require iv sedation; tray [sometimes]; moderate to significant recovery time (20 to 45 minutes) ♦ Recommendation: keep or move to 211 and recalculate with a smaller number of services that bear a tighter resource and clinical relationship to one another	***Level IV nerve injections (proposed as Level III interventional techniques)*** These were moderately high complexity procedures including epidurals, facet blocks and disk injections. These codes include: 62280 – neurolytic subarachnoid 62281 – cervical/thoracic epidural - neurolytic 62282 – lumbar/sacral epidural - neurolytic 64420 – intercostal nerve block - single 64421 – intercostal nerve block - multiple 64470 – facet injection – cervical/thoracic - single 64472 - facet injection – cervical/thoracic - additional 64475 – facet injection – lumbar/sacral- single 64476 - facet injection – lumbar/sacral- additional 64479 – transforaminal cervical/thoracic - single 64480 - transforaminal cervical/thoracic - additional 64483 - transforaminal lumbar/sacral - single 64484 - transforaminal lumbar/sacral - additional 64510 – stellate ganglion block 64520 – lumbar or thoracic sympathetic block 64530 – celiac plexus block 64630 – pudendal nerve neurolysis 64640 – peripheral neurolysis The reimbursement for these procedures ranged from $164.66 to $180.53. The reimbursement now will be $209.98.
Level IV ♦ High Complexity: Lysis of Adhesions, Neurolytic Procedures or Removal of Implantable Pumps and Stimulators ♦ CPT 62263 (APC 212—$180.53), 64600 (211), 664605 (211), 64610 (211), 64620 (211), 64622 (211), 64623 (211), 64626 (211), 64627 (211), 64680 (211), 62355 (105-$746.92), 62365 (105) ♦ Clinically homogenous: patients have failed other interventional techniques and are invasive in nature, with significant potential complications ♦ Resource homogenous: requires operating room or procedure room with sterile environment, significant sterile preparation, fluoroscopy, significant special supplies (e.g., (1) for lysis of adhesions, RK needle, Racz catheter, contrast, 10% sodium chloride solution, local anesthetic and/or steroids, iv antibiotic, special dressing with antibiotic cream and multiple injections; and, (2) for radiofrequency neurolysis, lesion generator, multiple radiofrequency needles, and grounding pad); local anesthetic; significant recovery period (30 to 60 minutes); almost all require iv sedation ♦ Recommendation: move these to APC 105 to reflect their high complexity and demanding resources	***Level V nerve injections (proposed as Level IV interventional techniques)*** These codes include: 62263 – percutaneous epidural adhesiolysis 64600 – neurolytic – trigeminal – small branches 64605 – neurolytic – trigeminal – 2/3 division 64610 – neurolytic – trigeminal – at foramen ovale 64620 – intercostal neurolysis 64622 – facet neurolysis – lumbar/sacral - single 64623 - facet neurolysis – lumbar/sacral - additional 64626 - facet neurolysis – cervical/thoracic - single 64627 - facet neurolysis – cervical/thoracic - additional 64680 – celiac plexus neurolysis These were reimbursed from $164.66 to $180.53, which is proposed to be reimbursed at $387.42 which is a significant increase. This should facilitate many of the procedures which physicians were unable to offer in hospital settings.

Thus, CMS has accepted most of the recommendations and adjusted the payments mostly in the direction of higher payments for these procedures. CMS also has accepted the request for higher payment for implantables, which

Table 1. *Frequency of utilization of lumbar epidural injections (CPT 62311) by various specialties for 1999 and 1998, in Medicare recipients*

Specialty Name	Non-facility	Facility	Total 1999	Total 1998	% change
Allergy/Immunology	0	468	468	121	286%
Anesthesiology	75,761	428,313	504,074	496,611	2%
Cardiology		65	65	37	76%
Diagnostic radiology	5,656	7,256	12,912	11,053	17%
Emergency medicine	226	755	981	646	52%
Family practice	1,185	1,600	2,785	2,761	1%
Gastroenterology	36	0	36	30	20%
General Practice	1,422	2,178	3,600	3,175	13%
General surgery	289	868	1,157	1518	-24%
Internal medicine	2,331	1,932	4,263	4,073	5%
Interventional radiology	370	1341	1,711	1,299	32%
Nephrology	21	0	21	84	-75%
Neurology	2,278	8,659	10,937	6,708	63%
Neurosurgery	1,796	5,471	7,267	7,259	0%
Nuclear medicine	0	94	94	51	84%
Obstetrics/Gynecology	16	0	16	28	-43%
Ophthalmology	0	18	18	0	-
Orthopedic surgery	14,769	12,431	27,200	26,919	1%
Osteopathic manipulative therapy	71	291	362	487	-26%
Pathology	93	10	103	43	139%
Pediatric medicine	23	0	23	0	-
Physical medicine rehabilitation	9,298	21,636	30,934	23,573	31%
Preventive medicine		75	75	74	1%
Psychiatry	300	567	867	533	62%
Radiation oncology	0	41	41	15	173%
Rheumatology	1,353	222	1,575	1,532	2%
Thoracic surgery	145	0	145	164	-12%
Urology	0	21	21	15	40%
Others	4,476	3,316	7,792	9,233	-16%
Total	121,915	497,628	619,543	608,453	1.8%

increased morphine implantation from $554 to $4824 even though it reduced stimulator implantation payment to $5,719 from $6171. These payments are in addition to the equipment, hence, this should improve access. It is clear that ASIPP is not only looking out for physicians, but also looking out for facilities to maintain access even though few of the ASIPP members have any interest in hospitals.

Table 2. *Utilization data by with and without Modifier for all services for Medicare recipients for year 1998 and 1999*

Modifier	1998	1999	% change
	583037541	587275312	0.7%
22	-	143829	-
26	94356277	96499595	2.3%
50		1678057	-
51	6468755	6566134	1.5%
52	-	540530	-
53	-	13077	-
54	323525	337272	4.2%
55	329994	340894	3.3%
56	6798	5716	-16%
62	59029	57908	-2%
66	-	160	-
80	1129727	846195	-25%
QK	2434410	2346950	-3.6%
QX	2420641	984	-96%
QZ	844756	2734	-68%
TC	5031781	5413700	7.6%
Total	696,443,234	702,069,047	0.8%

The next issue is the practice of interventional pain medicine. Once again, I would like to show the statistics of frequency of utilization of various types of interventional procedures for 1999 (the latest year for which statistics are available) and compare them to 1998 statistics which have been published in the past (1). Once again, for purpose of this review, I considered anesthesiologists, physical medicine/rehabilitation physicians, and neurologists who are practicing pain management as interventional pain practitioners. The remaining groups were considered as non-pain practitioners, even though orthopedic surgeons, neurosurgeons, interventional radiologists, and diagnostic radiologists performed a number of interventional pain procedures. One of the drawbacks of these results is that the new interventional pain management codes went into effect starting 1/1/2000, however, CMS has converted this data into 2000 codes for 1998 and 1999.

Table 1 shows the frequency of utilization of lumbar epidural injections utilizing CPT 62311 by various specialties for 1999 and 1998 in only Medicare recipients. This table is designed to show the interventional pain medicine community how lumbar epidural injection is utilized by various specialties. Fortunately, there was only 1.8% increase in the total procedures with 2% increase claimed by anesthesiologists, 31% increase by physical medicine and rehabilitation specialists, and 63% increase by neurologists. Major decreases were seen in general surgery, nephrology, obstetrics and gynecology, osteopathic manipulative therapy, thoracic surgery and various others. However, there has been an increase also by cardiologists, emergency medicine, physicians, gastroenterologists, psychiatrists, radiation oncologists, and urologists among non-interventional pain practices. The increases of procedures by interventional radiologists was only 32% compared to 173% by radiation oncologists and 62% by psychiatrists and 84% by nuclear medicine specialists and a whopping 139% by pathologists. However, in most cases numbers were small.

Table 2 shows utilization data with or without modifier for all services for Medicare recipients for the year 1998

Table 3. *Comparison of frequency of utilization of various types epidural, spinal and disc injection procedures in Medicare recipients for 1999 and 1998, by pain management and other specialties*

CPT	Anesthesiology		Neurology and Physiatry		Others		Total		Total 1999	Total 1998	Percent change
	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility			
62263 Epidural lysis of adhesions	227	1005	0	0	78	248	305	1253	1558	1001	56%
62280 Subarachnoid neurolysis	59	130	0	0	16	28	75	158	233	226	3%
62281 Cervical epidural neurolysis	315	1001	62	17	66	108	443	1126	1569	1719	-9%
62282 Lumbar epidural neurolysis	2665	4251	218	54	2484	1211	5367	5516	10883	9543	14%
62290 Lumbar discography	433	3516	53	66	1372	5982	1858	9564	11422	8784	30%
62291 Cervical discography	129	391	0	46	151	505	280	942	1222	1372	-11%
62310 Cervical/ Thoracic epidural	9493	51305	637	296	2939	4711	13069	56312	69381	64563	8%
62311 Lumbar/ Sacral epidural	75761	428313	4759	3883	41395	65432	121915	497628	619543	608453	2%
62318 Cervical continuous epidural	752	3519	19	17	167	311	938	3847	4785	4382	9%
62319 Lumbar continuous epidural	6054	97314	20	93	381	4658	6455	102065	108520	117440	-8%
Total	95888	590745	5768	4472	49049	83194	150705	678411	829116	817483	2%

Table 4. *Comparison of frequency of utilization of facet joint injections and neurolytic blocks in Medicare recipients for 1999 and 1998, by pain management and other specialties*

CPT	Anesthesiology		Neurology and Physiatry		Others		Total		Total 1999	Total 1998	Percent change
	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility			
64470 C/T facet joint block - single	730	3108	152	72	1356	1020	2238	4200	6438	6286	2%
64472 C/T facet joint block - additional	86	395	0	0	20	73	106	468	574	349	64%
64475 Lumbar/Sacral facet joint block - single	9827	41298	2190	1054	18855	14171	30872	56523	87395	84854	3%
64476 Lumbar/Sacral facet joint block additional	20737	90546	2271	1894	21645	26077	44653	118517	163170	145267	12%
64622 L/S facet neurolysis - single	1342	8743	148	102	1071	1673	2561	10518	13079	10371	26%
64623 L/S facet neurolysis - additional	2663	22486	282	218	1584	3785	4529	26489	31018	24255	28%
64626 C/T facet neurolysis - single	0	35	0	0	0	0	0	35	35	25	40%
64627 C/T facet neurolysis - additional	86	395	0	0	20	73	106	468	574	349	64%
Total	35471	167006	5043	3340	44551	46872	85065	217218	302283	271756	11%

Table 5. *Comparison of frequency of utilization of various types of nerve blocks excluding epidurals, disc injections, and facet joint blocks in Medicare recipients for 1999 and 1998, by pain management and other specialists*

CPT	Anesthesiology		Neurology and Physiatry		Others		Total		Total 1999	Total 1998	Percent change
	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility			
64400 Trigeminal N.B.	800	1425	491	10	4204	472	5495	1907	7402	9363	-21%
64402 Facial N.B.	234	359	38	0	726	683	998	1042	2040	2523	-19%
64405 Greater occipital N.B.	4322	6972	5848	329	6579	776	16749	8077	24826	25305	-2%
64408 Vagus N.B.	0	0	77	0	256	15	333	15	348	258	35%
64410 Phrenic N.B.	13	54	0	0	0	0	13	54	67	35	91%
64412 Spinal accessory N.B.	687	208	87	0	454	0	1228	208	1436	1170	23%
64413 Cervical plexus block	564	1713	1039	23	3137	487	4740	2223	6963	10014	-30%
64415 Brachial plexus block	1177	11614	833	0	1100	337	3110	11951	15061	9037	67%
64417 Axillary N.B.	175	1256	41	0	278	84	494	1340	1834	1750	5%
64418 Suprascapular N.B.	2162	1904	973	0	4529	137	7664	2041	9705	9961	-3%
64420 Intercostal	831	2414	120	29	3387	357	4338	2800	7138	7936	-10%
64421 Intercostal N. Blocks	2868	9291	408	15	4316	1413	7592	10719	18311	19485	-6%
64425 Ilio-Inguinal N.B.	1080	2495	77	0	1517	386	2674	2881	5555	5557	-.04%
64430 Pudendal N.B.	88	93	0	0	272	79	360	172	532	757	-30%
64435 Paracervical N.B.	16	10	0	0	1339	72	1355	82	1437	1,926	-25%
64445 Sciatic N.B.	3096	2839	1255	23	11971	304	16322	3166	19488	22513	-13%
64450 Peripheral N.B.	12423	14633	2410	89	86417	6175	101250	20897	122147	127904	-5%
64479 C/T Transforaminal epidural - single	279	691	361	0	1559	323	2199	1014	3213	3292	-2%
64480 C/T Transforaminal epidural - each additional	2027	2505	1046	75	6447	831	9520	3411	12931	17066	-24%
64483 L/S Transforaminal - single	3797	9185	5059	187	21593	4930	30449	14302	44751	45385	-1%
64484 L/S Transforaminal - each additional	6095	7514	3137	238	19427	2605	28659	10357	39016	51487	-24%
64505 Sphenopalatine ganglion block	247	308	14	0	5271	54	5532	362	5894	6532	-10%
64510 Stellate ganglion block	1723	9079	165	38	215	406	2103	9523	11626	12968	-10%
64520 Lumbar/Thoracic sympathetic block	1974	7571	665	68	2073	552	4712	8191	12903	14637	-12%
64530 Celiac plexus block	126	1019	0	0	11	173	137	1192	1329	1538	-14%
64600 Trigeminal neurolysis	64	277	42	10	273	106	379	393	772	735	5%
64605 Trigeminal neurolysis	42	72	0	0	34	43	76	115	191	209	-9%
64610 Trigeminal neurolysis	0	264	0	24	0	410	0	698	698	561	24%
64613 Chemodenervation cervical spinal muscle	133	313	7553	2033	1343	613	9029	2959	11988	16606	-28%
64620 Intercostal neurolysis	212	1262	0	0	43	238	255	1500	1755	1752	.17%
64630 Pudendal nerve neurolysis	0	16	0	0	0	0	0	16	16	16	0%
64640 Peripheral neurolysis	1075	2590	2319	839	10962	3148	14356	6577	20933	17375	20%
64680 Celiac plexus neurolysis	107	702	0	0	0	211	107	913	1020	1129	-10%
Total	48437	100648	34058	4030	199733	26420	282228	131098	413326	446782	8%

and 1999 with a very slight increase in total services provided to Medicare recipients over a period of one year.

Table 3 shows a comparison of frequency of utilization of various types of epidural, spinal, and disc injection procedures for Medicare recipients for 1998 and 1999 by pain management and other specialists. This showed a 56% increase in epidural lysis of adhesions with CPT 62263 followed by 30% increase in lumbar discography and 14% increase in neurolytic lumbar epidural blocks. There was an 11% reduction in cervical discography, 9% reduction in cervical epidural neurolysis, and 8% reduction in continuous lumbar epidural infusions. Overall, there was a 2% increase of these procedures in Medicare recipients.

Table 6. *Summary of frequency of utilizations of various categories interventions in Medicare population for 1999 and 1998, by pain management and other specialists*

	Anesthesiology		Neurology and Physiatry		Others		Total		Total 1999	Total 1998	Percent change
	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility			
Epidural, spinal, and disk injections	95888	590745	5768	4472	49049	83194	150705	678411	829116	817483	2%
Facet joint blocks	35471	167006	5043	3340	44551	46872	85065	217218	302283	271756	11.1%
Other types of nerve blocks	48437	100648	34058	4030	199733	26420	282228	131098	413326	446782	-8%
Total	179796	858399	44869	11842	293333	156486	517998	1026727	1544725	1536021	1%

Table 4 illustrates the frequency of utilization of facet joint injections and neurolytic blocks. Overall, there was 11% increase of all facet joint procedures with 64% increase seen with cervical joint blocks at additional levels, as well as cervical facet joint neurolysis at additional levels, followed by 40% increase in cervical facet neurolysis for subsequent levels and over 25% increase for lumbar facet neurolysis.

Table 5 shows statistics of various types of nerve blocks for 1998 and 1999. This table describes many of the somatic and sympathetic and peripheral nerve blocks. Overall, there was an 8% decrease in the total utilization even though there was a 91% increase seen with phrenic nerve blocks, 67% increase was seen with brachial plexus blocks. Table 6 shows the summary of frequency of utilization of various categories of interventions in the Medicare population with an overall increase of 1%.

Table 7 shows the frequency of utilization of procedures which are performed only to a minor extent by interventional pain specialists and includes trigger point injections, joint injections and sacroiliac joint injections. For these procedures, there was an overall decrease of 1% whereas there was a 2% increase for large joint injections, an 11% decrease for small joint injections, 6% for intermediate joint injections and, finally a 3% decrease for trigger point injections.

Well, so much for statistics. Now let us discuss the future of our society. Interventional pain specialists have been the first ones to fall through the cracks of various traditional medical societies including the AMA. It has been repeatedly stated that it is impossible to prove or disprove when and how much? We had these societies to protect us all these years. However, practices are becoming more specified and fractionated, thus, our efforts also should be

Table 7. *Comparison of frequency of utilization of trigger point injections and intraarticular injections by pain management and other specialties for year 1999 and 1998, in Medicare recipients*

CPT	Anesthesiology		Neurology & Physiatry		Others		Total		Total 1999	Total 1998	Percent change
	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility	Non-facility	Facility			
20550 Trigger point injection	105479	93073	35747	731	897306	26027	1038532	119831	1158363	1188776	- 3%
20600 Small joint injection	785	1556	377	0	359125	7859	360287	9415	369702	414799	-11%
20605 Intermediate joint injection	2210	3360	901	28	419868	16353	422979	19741	442720	468642	-6%
20610 Large joint injection	20026	32810	4370	258	2357131	101707	2381527	134775	2516302	2471012	2%
27096 Sacro-iliac joint injection	58	315		0	365	1543	423	1858	2281	2374	-4%
Total	128558	131114	41395	1,017	4033795	153489	4203748	285620	4489368	4545603	-1%

specific, focused and fractionated. Many of us belong to various traditional societies such as the American Society of Anesthesiology, the American Academy of Physical Medicine and Rehabilitation, and the American Society of Neurology. In addition, we also belong to various societies representing pain practitioners, if not physicians, including the International Association for the Study of Pain, the American Academy of Pain Medicine, the American Pain Society, and the American Academy of Pain Management. Some of us also belong to the International Spinal Injection Society, the North American Spine Society, the American Academy of Minimally Invasive Surgery, and other traditional societies such as the American Academy of Orthopedic Surgeons and the American Association of Neurological Surgery, etc. While we all agree that we all need to belong to AMA, we are not quite sure what the AMA does for interventional pain physicians. Similarly, we are not sure of specific contributions of any of the above mentioned organizations for interventional pain physicians. Thus, the only way we can survive in the new millennium is with efforts which are focused (even though fractionated), but fulfilling.

Let us look at not only evidence based medicine, but also the evidence of what our parent or traditional societies have done for interventional pain physicians. While I hate not to answer the question, I would like to answer the question of what ASIPP has done for interventional pain medicine. As we prepare to attend our third annual meeting, I would like to say that we are participating in the most prestigious, the most practical and the most well attended interventional pain program anywhere in the United States. However, we should not stop here. We need to form alliances, not only with federal agencies, but with various organizations which are critical in providing and managing patient access to care. We should not become bureaucratic. Our focus must be on the preservation of interventional pain medicine and maintaining access to patient care.

Finally, I would truly like to thank everyone: my family, the staff of the Pain Management Center of Paducah, the executive and other committees, the board of directors, legislators and their staff, and their family. Arent Fox and its staff for helping the interventional pain medicine community realize many of the goals set last September at our annual meeting. Without the hard work and commitment of Bert Fellows, Vidyasagar Pampati; Vijay Singh, MD; David Kloth, MD; Bhupinder Saini, MD; the board; entire membership; and the staff of Arent Fox and the Pain Management Center of Paducah, we never would have been able to accomplish this much in a year. Once again, to every one of the members, non-members, legislators and administrative staff who have put forth an effort to help the American Society of Interventional Pain Physicians to exceed even our own expectations, I thank you wholeheartedly.

I also would like to thank various physicians from the American Society of Anesthesiologists, starting with Neil Swissman, MD, the current president; also Barry Glazer, MD, president elect; James Cottrell, MD, first vice president; Elmer Dunbar, MD, president of the Kentucky Society of Anesthesiologists; Linda Lucas, MD, delegate from Kentucky; Ann Still, MD, pain committee member; Douglas Merrill, MD, chairman of the pain committee; and Alexander Heineberger, MD, member of economics committee. In addition, I would like to thank Samuel Hassenbusch, MD, president of the American Neuromodulation Society; John Oakley, MD, past present of the American Neuromodulation Society; and so many others who have supported us in our endeavors.

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