



# SPS NEWS

The Official Publication of The Southern Pain Society

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## One Thing You Can Do This Month to Improve Your Legal/ Regulatory Compliance Self-Audit Lesson #1 – History and Physical Evaluation

Jennifer Bolen, JD

Have you ever taken the time to sit down and do a self-audit of one chart? Would you know where to start? You probably have had some billing and coding expert come in and take a look at your performance and give you advice on how to document better so you can maximize your billing. Right? Makes perfect sense to me. I would do it if I stood in your shoes. Ask yourself, however, what those billing and coding experts did to help you feel better about the controlled substance prescriptions you write. Did they understand your state requirements on prescribing controlled substances to treat pain? Are they legal/regulatory experts? Can you talk about that stuff with them? Probably not. Now, think about this:

What would happen if a licensing board investigator walked into your practice tomorrow and asked you to produce 20 files? Are you certain that your controlled substance documentation would stand up to licensing board scrutiny?

If I have your attention, good. If not, humor me and read on. You handle patient records all the time, but when is the last time you really sat down and took a hard look at how you document your clinical rationale for the treatments you order? I do not mean in preparation for a deposition or malpractice lawsuit – it's usually too late by then. When is the last time you sat down to do some proactive work on your practice – specifically as it relates to controlled substance prescribing and legal/regulatory issues? If you have done something like this in the last thirty days, this article is not for you right now. Save it for a rainy day. If you have not, however, set some time aside in the next week and work through Self-Audit Lesson #1 on History and Physical Evaluations – A Legal/Regulatory Perspective.

### Preparation for Self-Audit Lesson #1

Get a notebook (three-ring binder is preferable). Cutout and three-hole punch the checklist accompanying this article and put it in your notebook behind tab number one.

Select a patient chart. You will use this patient chart throughout this series on self-audit, so once you select the chart enter the patient's initials or patient number here \_\_\_\_\_. You may want to pick a patient you have discharged from your practice. Alternatively, you may feel better about using a patient record where you think your documentation is really good. Also, be sure your chart is current.

Set aside 30 minutes for Self-Audit Lesson #1 – no phone, no pharmaceutical representatives, no staff interruptions, nothing.

### Review the Self-Audit Lesson #1 Check List

Before you review your patient record, review the checklist on History and Physical Evaluation accompanying this article. Also, use my website to locate your state materials on History and Physical Evaluation (register and then use the tab called "Handy Handbooks"). If you need help doing this, call my office and talk to Libby Amero. She will help you find your state stuff. Read your state material on history and physical evaluation. Save your state materials in your notebook. You will need them later.

### Compare the Patient Record with the Self-Audit Check List

Review the Patient Record, looking for all material related to Self-Audit Lesson #1 – History and Physical Evaluation. If you determine you are in compliance, check the box. If you determine that there is a step you are not doing or are unfamiliar with, circle the box. When you reach the end of the checklist, go back and see if you have any circles.

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## Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

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## President's Column

Benjamin Johnson, MD, MBA

I recently had the opportunity to do a Tennessee "walkabout", during which I spent a month visiting with several pain specialists in Memphis and Knoxville. We shared a wealth of information, and I learned a great deal by gaining an understanding of their individual perspectives of our field. I am encouraged to report that multidisciplinary pain management is alive and well in the state of Tennessee. Although we have experienced setbacks, and continue to be under attack by regulatory bodies as well as healthcare payors, our patients are still receiving excellent multidisciplinary care. However, the most difficult service to render is the provision of pain-oriented psychological and behavioral care. In spite of this barrier to interventional treatment success, I was encouraged to see that diligent efforts were being made to prescribe medications responsibly; and that interventional procedures were being treated as one component of a comprehensive pain treatment armamentarium. Many thanks to Drs. Roger Cicala, Autry Parker and Joe Browder for sharing their time, talents, and expertise with me during my Tennessee walkabout.



In this issue of the newsletter, we have an interesting group of articles and we hope you find them enlightening.

## Eight Months After Katrina

Joe Chen, MD

It has been eight long months since Hurricane Katrina forever changed the face of the Mississippi Gulf Coast. Someone asked me immediately after the storm what I needed. "Food, water, and shelter" was all that I could think of during the days after the storm. As the months passed, my wish was for my city to return better than ever. I have been amazed at the resilience of the residents. The positive outlook has been an amazing thing to be part of. Everyone is working together to rebuild the Mississippi Gulf Coast bigger and better than ever. Since the storm, the coast has been busy rebuilding. The casino industry plans to come back bigger and better than ever. Condominium developers are swarming the coast. Small business owners are starting to return. The residents who had originally decided to leave after the storm are now starting to return. The sight, sound, and smell of the coast after Katrina will never leave me. I had opened my pain clinic within a week of the storm. I actually noticed that immediately after the storm, my patient's pain scores dropped. They were to busy trying to survive. The topic of my office visits with my patients always steers to a discussion about what impact Katrina had on them. Hurricane Katrina taught me a lot about human behavior. We live in such a regimented world. It has been amazing to see how people can adapt in the most adverse conditions. One last thing that I learned in treating patients is that your familiar face and your listening skills are the best tools that you have in handling their pain.

# Applying Study Results in Your Practice; 1: Chance and Statistical Testing.

Ike Eriator, MD, MPH

Statistics is indispensable in a medical practice. Apart from the concerns devoted to utilization statistics, resource allocation, audit, etc, statistics also plays a huge role in the therapy we offer to our patients. When we see the result of a study on an interesting topic, we often ask if we can apply it to our patients. To make a correct decision based on the data, we must know how it was obtained and whether the conclusions are statistically appropriate. If there are statistical errors, the conclusions may be incorrect. Our knowledge of statistics helps us to make that judgment. Bad statistics often lead to misuse of resources, exposure of our patients to unjustified risks, inconvenience and unnecessary work for us.

Unfortunately, the use of statistics is often viewed as a ritual designed to assuage the last holders of absolute power (editors of journals), and perhaps the regulatory agencies, rather than being utilized because the techniques are scientifically important. Just as we do not need to know how to build a car in order to drive one, we do not have to be statisticians to understand the value and use of statistical methods. There are many available resources to help us in understanding and applying statistics (see Altman, 1991, Guyatt et al., 1995, Greenhalgh, 2001, Riegelman, 2005). In this series, we will examine the nuts and bolts of statistical conclusions and how they are used in articles.

## Variability and Statistics:

We live in a world that is full of variations. Variability is inherent in all biological systems. It not only occurs between people, it is often seen in the same person from time to time. We know that pain is subjective and the level varies from patient to patient. Even in the same patient, pain levels can be different at different times depending on so many factors. It is interesting to note that Henry Beecher (1955), the protagonist of the placebo effect, was one of the great pioneers of pain management.

Our patients could get better due to the treatment we have provided. The improvement may also be due to a natural regression towards the mean (they were going to get better anyway). They may also get better because of the placebo effect. So before we attribute the changes in our patients' condition to the effect of our medication or procedure, we need to ensure that chance or natural variation did not play a role.

**Statistics** has been described as the study of chance. Statistics deals with the collection, organization, analysis, interpretation and presentation of numerical information. Biostatistics is the application of statistics to the biological sciences. Descriptive statistics is concerned with the organization, presentation and summarizing of data. Inferential statistics is concerned with generalizing the findings from our sample of data to a larger group of subjects. For instance if we give a certain anticonvulsant medication to forty patients with diabetic neuropathic pain (lets call this group A) and compare them with another forty similar patients who remain untreated with the medication and

receive only a placebo (lets call them group B), we are not just interested in these eighty patients. We will be interested in knowing whether all patients with diabetic neuropathic pain will respond to this anticonvulsant. When we generalize from our study group (which is called the **sample**), we are making an inference about a larger group of subjects (which is referred to as the **population**). The reader is also interested in applying the result of such a study to his patients.

## Hypothesis Testing:

Is there a difference in effect between groups A and B? Is the difference due to the effect of the anticonvulsant, or could it have happened by chance? Hypothesis testing is considered a uniform decision making criterion that is superior to the subjective impressions of the data. The majority of statistical analyses deal with comparison, for instance, between the group with the anticonvulsant treatment (A) above and the group with placebo (B). It is helpful to think of most statistical tests in terms of signal-to-noise ratio. The signal (the important effect) is based on the observed difference between the groups. The noise is the variability in the measure between individuals within the group. If the signal is not large enough to rise above the noise, then it is reasonable to assume that there is no real effect. Hypothesis testing involves three steps (Aschengrau and Seage, 2003). First the null and alternate hypotheses are specified (see more below). Then, the compatibility of the study results with the null hypothesis is determined. Then a decision whether to reject or not reject the null hypothesis is made.

Statisticians usually generate a hypothesis that states that there is really no difference in effect between the two groups. This is called the **null hypothesis**. The assumption is that any observed effect difference between these two groups will be merely due to chance or natural variability. Of course, the **alternate hypothesis** will be that there is a real difference between groups A and group B. The null hypothesis is assumed to be true in statistical testing until proven reasonably false. To conceptualize this adequately, let us use the analogy of our legal system. A person is assumed to be innocent until proven guilty. Just like the prosecutors in legal cases have to present evidence to prove guilt, evidence has to be presented to prove that the null hypothesis is false. Just like in the legal system where effort is made to avoid convicting an innocent person by presenting proof of guilt beyond reasonable doubt, in statistical testing, the evidence for a false null hypothesis has to be very strong (Dawson and Trapp, 2004). It is helpful to think of the p-value as an indication of the strength of evidence against the null hypothesis.

Still using the analogy of the legal system, we prefer to err in the direction of setting the guilty free, instead of convicting the innocent person. In hypothesis testing, it is preferable to miss a significant difference rather than conclude there is a significant difference when really there is none. In statistical parlance, the error of falsely rejecting the null hypothesis is called **Type I error** and is often denoted by **alpha ( $\alpha$ )**. **Type II error** or **beta ( $\beta$ )** is the error of falsely retaining the null hypothesis. If we apply this concept to the anticonvulsant for diabetic neuropathic pain above, we come up with a few different possibilities. We could correctly conclude, based on effect differences between group A and B that the

anticonvulsant does not make a difference (and not reject the null hypothesis). The accused is really not guilty and is set free. We may also correctly conclude that the medication makes a difference (and reject the null hypothesis). The accused is guilty and is convicted. But we may falsely conclude that the medication effect is different from that of placebo (and so we falsely reject the null hypothesis and commit a type I error. We find an innocent person guilty). We may also falsely conclude that the medication effect is no different from the placebo (we retain the null hypothesis and commit a type II error. We let a guilty person go free). Type I and II errors are related. As we decrease the chance of missing a significant difference (decreasing beta), we are increasing chance of falsely concluding that there is a difference. Again, using our legal analogy, a society that decides to decrease the number of guilty people that go free will have more innocent people that are convicted. We can simultaneously decrease both types of errors by increasing the sample size.

We should always visually look at the data. Sometimes, the differences are so grotesquely obvious that we would not care for statistical analysis. Sometimes the difference is so negligible and whether formally significant or not, it is too small to be of any practical importance. Our intuition and reasoning are not only helpful; they are required in determining the appropriateness of the study results and the applications in our practice.

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## Editorial

Benjamin Johnson, MD, MBA

In the last newsletter, I began a series of articles based on the typical business issues encountered in the operation of a pain management practice. The initial installment focused on personnel selection and the cost of labor. This second installment will present additional issues regarding the cost of practice.

I am addressing cost issues first, because it is easier to reduce cost than to generate revenue. In a market such as ours, where reimbursements and profit margins are declining, cost control should be at the forefront of every pain specialist's mind. The types of costs related to cost control can be categorized as follows:

1. Fixed costs
2. Variable costs

Fixed costs are those which are present whether one patient or one thousand patients are put through the system. These are costs such as office leasing, personnel costs, electronic medical record systems, practice management system costs, capital equipment costs, janitorial costs, licensing and credentialing costs, etc. These costs are more difficult to control after initial setup, and are best controlled in the planning phase of the practice. One of the most expensive and potentially treacherous examples of fixed costs is the medical information system. Electronic medical record (EMR) and practice management systems are tempting solutions to the age-old problems of cumbersome paper charts, handwriting legibility, data analysis for billing/coding accounting, electronic submission of billing, etc. However, they can also be economic "black holes" if the service support is not responsive or the software not adaptable to the practice needs. For example, some systems may be designed for an internal medicine practice, but are unable to accommodate the interventional part of a pain practice. Sometimes, the EMR can be a wasted venture because an inefficient paper system is simply converted into an electronic system, without first challenging the operational efficiency of the paper system. This scenario can quickly worsen if promised software developments or modules do not materialize; or if the system developer goes out of business, as has happened in several instances, leaving the practice with a useless system costing tens of thousands of dollars, as well as a fragmented medical record system. Indeed, this scenario has resulted in the eventual demise of several practices. It is a difficult, but necessary task for the practice management team to wade through the marketing efforts of the system developer to find a cost-effective, value-oriented electronic system that will support the practice's present and future needs. Also, the ability of the software platform to communicate with other EMR systems is a feature to be desired.

Variable costs are expenses that increase with each additional patient seen. These costs include disposable supplies, office

supplies, laundry costs, paper management, waste disposal, inventory maintenance, etc. These costs are easier to control, since there is a wealth of vendors with which to negotiate prices for the needed supplies. Additionally, there is opportunity to take advantage of economies of scale in regard to supplies such as needles, tubing, syringes, etc.

Once the cost of a procedure can be calculated and separated into fixed and variable costs, a break-even analysis can be created for each component of the practice's payor mix. This information can then direct marketing, advertising efforts, contractual negotiations. Ideal patient throughput volumes can also be calculated from a breakeven analysis.

For example, let's assume the following facts:

- Fixed costs of running the practice: \$200,000
- Variable cost per patient: \$22
- Revenue per patient: \$102
- Current patient volume: 2500 patients last year

In this scenario, the total cost of seeing the 2500 patients is equal to the total revenue generated from the patients, which is a breakeven situation. If this scenario is put into a graphic format, the breakeven point would occur where the revenue and total cost lines intersect. If we could increase the number of patients to 3000, we would generate a \$40,000 profit. If we then increased the number of patients to 6,000, we could generate a \$280,000 profit. Of course, we could also modulate the level of service to increase the revenue generated from each patient, or reduce the variable cost for each patient to increase the profit.

Using the breakeven patient volume as a starting point, the daily patient volume can be increased until inefficiencies become noticeable. Signs of reaching the point of maximum efficiency include:

- 1) Employee morale changes
- 2) Equipment limitations
- 3) Scheduling limitations
- 4) Waiting room limitations
- 5) Parking limitations
- 6) Examination room limitations
- 7) Logistical limitations
- 8) Physical plant limitations
- 9) Increasing amounts of employee overtime charges
- 10) Increasing cost per patient

After the point of maximum efficiency (throughput volume) has been calculated, one of several business choices are possible:

- 1) To maintain the maximum efficiency volume with interval assessments and adjustments. This approach embodies the philosophy of "kaizen", which is a process of continual systematic refining and improvement.
- 2) To expand portions of the operation so as to further increase efficiency and throughput, if sufficient demand is present.
- 3) To right-size or scale down the operation if breakeven cannot be achieved in spite of all efforts to maximize economic, clinical, and administrative efficiency.

The next article will address the issue of operational efficiency.

## Coping with Phantom Pain

Leo S.

With Commentary by Daniel Doleys, PhD

Below is a paper submitted by Leo S. in completion of the requirements for a college course April 8, 2005. It is being presented here as part of a case study involving Leo S.

### Coping with Phantom Pain

#### Introduction

This report will explore many ways of how different people cope with phantom pain. Phantom pain presents in patients after they have a limb amputated. It can be a mild sensation, a constant stabbing pain, and a whole list of different sensations that changes from patient to patient. The medical profession has many tools to help the patient who has phantom pain.

#### Method of Obtaining Facts

Interview: Doleys, Daniel M, Ph.D., Pain and Rehabilitation Institute. 12 Dec. 2001-Peresent

Management of Postoperative Pain. 13 Feb 2000. 3 Mar. 2005.

[http://www.oqp.med.va.gov/cpg/pain/pain\\_cpg/content/extremities/amputation.htm](http://www.oqp.med.va.gov/cpg/pain/pain_cpg/content/extremities/amputation.htm)

McVeigh, Sonja Alexandra, BSc. Phantom Menace: The Mystery of Phantom Limb Pain: A Case Report and review of the Literature

<http://utmj.netfirms.com/issues/78.1/pdf/neurology.pdf>

Mayo Clinic Brain & Nervous System Center. 13 Feb. 2004. 8 Apr. 2005. <http://www.mayoclinic.com/invoke.cfm?DS00444>.

Ray, Toni. Helping Phantom Limb Pain. 1998. 3 Mar. 2005.

Home Page. Applied Perception and Service Learning, at Stephen F. Austin State University. 1998. <http://hubel.sfasu.edu/courseinfo/SL98/phantom4.html>

#### Graphic #1

<http://www.bfe.org/protocol/figfive1.gif>

#### Graphic #2

[http://www.oqp.med.va.gov/cpg/pain/pain\\_cpg/content/extremities/amputation.htm](http://www.oqp.med.va.gov/cpg/pain/pain_cpg/content/extremities/amputation.htm)

#### Facts

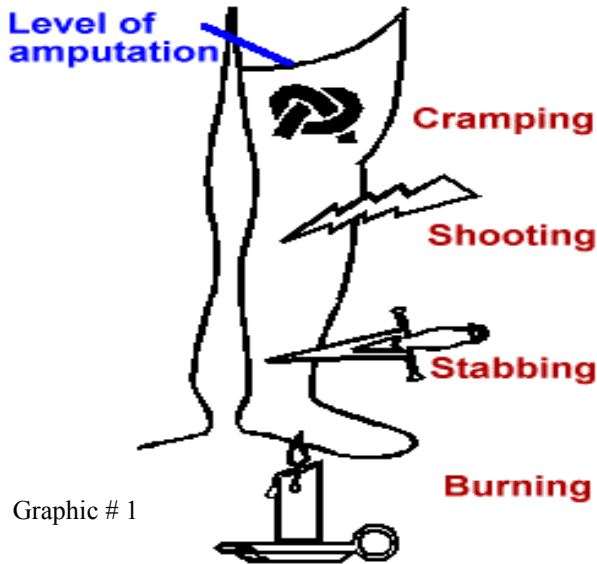
1. "Notably, in up to 70% of patients, phantom pain persists 25 years after the amputation." (McVeigh 22).
2. "By many of the amputees the pain is described as totally unbearable." (Ray 1).
3. "Some amputees experience the opposite of phantom pain – phantom pleasure. One Man

tells about feeling an orgasmic sensation in his lost foot during sex.” (Ray 1)

4. Many orthopedic doctors think that the patient should not be in any pain after they amputate the limb.
5. Doctors have many avenues to help their patients that are having phantom pain.
6. Patients that are experiencing phantom pain have a lot of options to help themselves get through day to day problems.

**Discussion**

1. Since seventy percent of amputee patients experience problem with phantom pain, the medical profession needed to address the problem.
2. Many of the amputees have reported that the pain is unbearable. As you can see in the illustration the complaints range from cramping, shooting, stabbing, and burning.
3. Some amputees report that they have phantom pleasure instead of phantom pain. This condition is very rare, although many amputees would trade the pain for pleasure any day of the week.



Graphic # 1

4. After many appointments with Dr. Doleys, I learned that many other amputees have experienced the fact that their orthopedic doctor that did their amputation thought that they had cut off their pain with their amputated limb.
5. Doctors have a lot of options to offer their patients who are experiencing phantom pain.
  - Medications
  - Bio-feedback
  - Transcutaneous electrical nerve stimulation (TENS)
  - Acupuncture
  - Hypnosis
  - Spinal cord stimulation
  - Deep brain stimulation
  - Pain clinic
  - Support system

Here is an evidence table that shows some pre and postoperative options.

	Intervention	Sources of Evidence	QE	R
1	Preoperative infusions of local anesthetic alone or local anesthetic with opiate and/or clonidine may be useful in minimizing post-operative phantom limb pain.	Jahangiri et al., 1994 Bach et al., 1988	I I	B B
2	Some studies using preoperative infusions have not demonstrated any benefit.	Nikolajsen et al., 1997 Elizaga et al., 1994	I I	D D
3	Patients receiving preoperative, intraoperative, and postoperative epidural bupivacaine and morphine had outcomes similar to patients receiving epidural bupivacaine and morphine postoperatively alone.	Nikolajsen et al., 1997	I	D
4	Postoperative infusions of local anesthetic along the sciatic or posterior tibial nerve are a safe and effective method for the relief of postoperative pain but do not prevent residual or phantom limb pain.	Pinzur et al., 1996 Pinzur letter	I III	A C
5	Postoperative infusions of local anesthetic into nerve sheaths provide excellent postoperative analgesia following upper extremity amputation, but do not affect long term phantom limb pain.	Enneking et al., 1997 Iacono et al., 1987	II-3C Review paper; not rated	
6	In those patients with a significant component of phantom limb pain, tricyclic antidepressants or anti-epileptic medications may need to be initiated in the postoperative period.	Baron et al., 1998		
7	TENS treatment of BKA is not supported.	Finsen et al., 1988	I	D

QE = Quality of Evidence; R = Recommendation (See Appendix A)

6. The medical profession has given the amputee many options to deal with their phantom pain. The list given in #5 of the discussion gives a good start to go over with their doctor and family.

### **Conclusions**

The author of this report is a below knee amputee (BKA). He is one of the lucky ones to have been referred to one of the best full service pain clinics in the nation. He has had the option of any of the points listed in #5 of the discussion. It is the opinion of the author that the most important option of all listed is having a good support system. He also has used ninety percent of the points listed with great results.

### **Recommendations**

It is the recommendation of the author to anyone going through phantom pain to do their due diligence. Check out all pain clinics in the area they live in. It might be worth traveling to one a little out of the way to get the service they deserve. Work the plan that the doctors lay out. Do not be afraid to tell the doctor that something is not working. The amputee is the one with the phantom pain, not the doctor. The author found most of this information out before he was referred to the pain clinic that finally helped him.

### **Commentary**

The above is being published, unedited, with the approval of its author, Leo S. He has kindly allowed me to tell his 'story'. On 7-00, at the age of 43, he suffered an on the job injury when he fell some 18 feet fracturing several bones in his left arm, right ankle and right foot. He had a closed reduction and percutaneous pin fixation of the left arm. He also underwent open-reduction with internal fixation of the ankle and foot. In all, he had 11 operations culminating in a below the knee amputation on the right because of an under-treated infection resulting in osteomyelitis. When first seen on 12-01 he had pain in the left arm, bilateral shoulders from chronic use of crutches, stump pain, painful prosthesis, and phantom pain. His average pain rating was 7.6/10 with activity interference ratings ranging from 7-10/10. As might be expected, Leo was depressed, frustrated, angry, and overwhelmed by the devastating changes from a very strong, physical, productive man, to being periodically wheelchair bound, without a job or any significant social support.

His psychosocial background included his parents divorcing when he was very young. Leo was high school educated but gave minimal effort. He had been married, his children and extended family were all on the West coast while he resided in Alabama. He felt his lawyer had, 'sold him out', and was living at the poverty level. He had a history of over-use of alcohol, including DUIs, and regular use of illicit drugs. His family of origin was punctuated with members suffering from depression alcohol/drug problems.

Leo had undergone several trials of physical therapy, multiple prosthetic modifications, and various medications. Once his medication was adjusted, he was maintained on Oxycontin ® 20mg bid, Elavil ® 25 qhs, Remeron ® 15 mg qhs, Neurontin ® 2400 bid, and Piracetam ® 800 mg bid. He did agree and sign a medication agreement. His medication management was monitored by Dr. Don Cornelius. Because Dr. Cornelius had a background in addiction, pain medicine and psychiatry, we felt comfortable treating Leo with opioids despite his history with drugs and alcohol. It should be noted that Leo's urine drug tests were always consistent with his prescribed medications and without any evidence of illicit drugs over the four plus years of treatment in our clinic. In addition, he never demonstrated any overuse, misuse, or evidence of pharmacological tolerance. Other aspects of his treatment included individual behaviorally based therapy sessions with the undersigned approximately each two weeks, home based physical therapy, vocational counseling and bibliotherapy. Although he lived some 90 miles from the clinic, he gladly made the trip as he had been unable gain any benefit from local clinics.

Much to his credit, Leo obtained a Pell Grant and enrolled in a local junior college pursuing a degree in computer aided drafting but only after having to pass adult education classes and the GED test. It is not hard to understand the difficulties he had adjusting to being in college and competing with much younger students. He eventually found his work and construction experience to be of some help in his classes. Imagine, living alone, recent BKA with multiple pains, surviving on the poverty level, and starting college after nearly 25 years of leaving high school!!! Remarkably, Leo graduated in the summer of 2005 and has returned to California where his extended family lives to pursue employment.

Among his various accomplishments while in treatment are (1) invited speaker at the Adult Education graduation, (2) induction in to the National Honor Society for Adult Education, an award given to less than 5% of students, (3) an overall GPA of greater than the 3.0 on a 4.0 scale, (4) regular participation as an 'instructor' in our pain education classes with emphasis on 'coping and acceptance', (5) achieving a walking tolerance to 15-20 minutes on a treadmill at speeds ranging from 3.4 – 4.0 miles per hour with an incline of 15 degrees, for brief periods of time. Although his average numerical pain rating was still 5/10, he reported being 80% improved overall, and confident in his ability to manage his pain.

Leo is an ordinary man with an extra-ordinary motivation to overcome the obstacles he faced. He has been an inspiration to all who have been involved in his treatment. If all goes well, he will be participating in a workshop on neuropathic pain at the annual meeting of The Southern Pain Society, October 27-29, 2006 in Birmingham, Alabama.

# Southern Pain Society

## Annual Meeting Daniel Doleys, PhD

The Southern Pain Society's annual meeting will be held at the new Ross Bridge Resort and Spa, in Birmingham, Alabama, October 27-29, 2006. It is being co-sponsored with The Pain and Rehabilitation Institute (PRI) of Birmingham. The meeting is titled "*Clinical Pain Medicine and Management*". The emphasis is on the diagnosis and treatment of various pain disorders in the clinical setting. Headache/ head pain, fibromyalgia, myofascial pain, visceral pain and hyperalgesia, pain following spinal cord injury, and low back pain are but a few of the disorders that will be discussed. Afternoon workshops include pelvic pain, neuropathic pain, and the business of pain management. Dr. Sam Hassenbusch will present a special luncheon lecture on Complex Regional Pain Syndrome(s) with emphasis on case presentations and the "disease" aspects of CRPS. Lectures on the impact of cognitive dysfunction/dementia, and coping vs. acceptance in pain management are likely to provoke a good deal of interest. In keeping with the interdisciplinary emphasis of SPS, the program faculty features nurse practitioners, physical therapist, psychologists, and several medical sub-specialties.

Patients will be a part of this year's meeting as well. Mr. Neal is a local television celebrity battling fibromyalgia. His accounts of his experiences involving his diagnosis and treatment are both instructive and inspirational. We are anticipating that Leo (see his article in this issue of SPS Newsletter) will return from his new job in California to discuss his fight with neuropathic, particularly phantom, pain

Jennifer Bolen, former Assistant U.S. Attorney with the U.S. Department of Justice, well known to many of us from her previous lectures and contributions to the SPS Newsletter, will do an afternoon workshop that is offered as a separate event to those in the medical and non-medical community, i.e. law enforcement, interested in the legal and regulatory issues surrounding pain medicine, particularly the prescribing of opioids. Her website, [www.legalsideofpain.com](http://www.legalsideofpain.com), is a remarkable resource. This workshop is complemented by a discussion of addiction and pain, and the use of opioids by the primary care physician.

The Ross Bridge Resort has gained national attention since its opening in 2005. It boasts one of the longest golf courses in the country, about 8400 yards from the tips, for those who are brave enough. Indeed, The Champion's Tour has moved its annual tournament in Birmingham to this venue as of May, 2006. The resort has much to offer the non-golfer and those that just want to relax and enjoy the setting. The nightly serenade by a lone bag-piper is a unique and rare treat. For more information see their website, [www.rossbridgeresort.com](http://www.rossbridgeresort.com).

So, please spread the word. Register early as hotel rooms at special convention rates are limited. And encourage a colleague, especially if they may be interested in joining SPS, to attend. Tentative dates for future SPS meetings include Nashville in '07 and New Orleans in '08.

Thank You:

The Planning Committee:

Representing SPS: Ms Lori Postal, Charles MacNeill, MD, Eric Pearson, MD, and Todd Sitzman, MD.

Representing PRI: Maureen Crocker, P.T., Lesley Rickman, J.D., Donald Parsons, CRC, Leanne Cianfrini, Ph.D

Co-chairs: Daniel M. Doleys, Ph.D. and Ben Johnson, MD

### Regulatory Self Audit—Continued from page 1

Make note of the areas you circled and use your state materials and clinical journals to learn more about those areas so you can improve your compliance.

### Conclusion

This exercise may seem ridiculously simple, but it is very similar to the process an investigator or law enforcement officer undertakes when they review your files. To me, a self-audit is a very easy way to put your mind at ease or give you a road map to improved patient protection and physician compliance.

### History & Physical Evaluation Check List

- Take a general patient history.
- Take a specific patient pain history pain, including past treatments for pain such as medications/other surgeries/treatments and names of treating physicians OR review a recent (within the last 30 days) report from a credible source and document your review and impressions.
- Obtain the patient's self-report about current pain: nature, intensity of pain, pain levels and descriptive terms, and document the patient's initial reports.
- Perform a condition-appropriate physical examination\* OR review a recent report (within the last 30 days) from a credible source.
- Get records of past treatments for pain directly from prior providers. Communicate with these providers as appropriate.
- Ask patient about (1) history of substance abuse, and (2) first degree family member's substance abuse,

continued on page 10

## REGISTRATION FORM

Southern Pain Society and the Pain and Rehabilitation Institute  
Meeting: Clinical Pain Medicine and Management  
Ross Bridge Hotel, Birmingham, Alabama  
October 27-29,2006

Please complete the following and mail to: Convention Registration, c/o Ms Lesley  
Rickman, P&RI, 720 Montclair Road, S-204, Birmingham, Alabama 35213  
Or FAX to: 205-591-4420  
Or by Phone: 205-591-7246

### REGISTRATION INFORMATION:

Name and Degree: \_\_\_\_\_  
e-mail address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Daytime phone number: \_\_\_\_\_ FAX: \_\_\_\_\_  
Profession: \_\_\_\_\_ Professional License # \_\_\_\_\_

### REGISTRATION FEES:

	SPS Member	Non-member	J. Bolen Workshop additional	Total
Doctoral level:	\$200.00	\$220.00	\$100.00	_____
Non-doctoral:	\$150.00	\$170.00	“ \$100.00	_____
Student:	\$100.00	\$120.00	“ \$100.00	_____

J. Bolen workshop only: \$100.00 ----- \_\_\_\_\_

### Method of Payment:

\_\_\_\_\_ Check enclosed: Payable to SPS/PRI  
\_\_\_\_\_ MasterCard \_\_\_ VISA Name on card (please print): \_\_\_\_\_  
Acct # \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
Cardholder signature (required): \_\_\_\_\_

### How Did You Hear About This Conference:

\_\_\_ I am a SPS member \_\_\_ SPS Newsletter \_\_\_ Mailed brochure  
\_\_\_ e-mail \_\_\_ Colleague \_\_\_ Industry representative \_\_\_ PRI staff \_\_\_ Other

If registering more than one person, please duplicate this form and complete for each individual registrant.

For Ross Bridge hotel reservations call: 1-800-593-6419 and ask for Southern Pain Society convention rates.



## Southern Pain Society

2474-302 Walnut Street  
Cary, North Carolina 27511

Phone: (919) 303-3100  
Fax: (919) 303-9666  
info@southernpainsociety.org

### Address Correction Requested

*We're on the web!*  
[www.Southernpainsociety.org](http://www.Southernpainsociety.org)

**Regulatory Self Audit Continued from Page 8** including alcohol, prescription drugs, illicit drugs. Do not overlook alcohol, tobacco, or morbid obesity problems. Communicate with addiction and mental health professionals as appropriate.

- Consider whether to use an early consult/referral for pain condition, abuse issues, etc. NOTE: Some states require an evaluation by a specialist.\*
- Use Risk Assessment Tools (Zung Depression Scale, DAST-20, ORT, SOAPP, PDQ, CAGE, PDI, etc.) to support your decision-making and document your response to test scores in the medical record.
- Order urine/serum test (comprehensive) to corroborate patient's self-report and to establish base-line clinical issues.\*

#### Legend:

**Single Asterisk (\*) means this depends on state licensing board requirements and standards of care. Base source: Federation of State Medical Boards *Model Policy for the Use of Controlled Substances to Treat Pain* (May 2004).**

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