Neurosurgery One

A New Treatment for Chronic Lower Back Pain Transcript

Dr. Mobley (00:04):

Hello, welcome. My name is Lloyd Mobley. I practice in Castle Rock Colorado and I have offices in Lone Tree and Castle Rock. I am with neurosurgery one and I am a neurosurgeon. I have been in practice for over 16 or 17 years in the Colorado region and I trained in Omaha, Nebraska. If you're watching right now, you probably have low back pain or know somebody that does. You may know that the lifetime prevalence of low back pain in the general population is about 60 to 85%. So that means most people will get back pain sometime in their life.

(00:49):

As a neurosurgeon, I do see patients with low back pain all of the time, and I see a lot of them. Most of the time the low back pain will go away simply with time. However, sometimes people would need some kind of intervention to help them with their pain. I commonly prescribe a variety of conservative treatments for patients including physical therapy, spinal injections, acupuncture, massage, chiropractic treatment, and a variety of other treatments that I call conservative treatments. A majority of patients do respond to these and can get on with their life with little or no black back pain.

About Chronic Low Back Pain (01:32):

But what if you continue to have low back pain? If you have low back pain that lasts more than 12 weeks, you have chronic low back pain. So what are your options? Well, surgery is usually the next option for most people after they have gone through the conservative treatments that I or others have prescribed. This could be any number of surgeries including a laminectomy, a discectomy or even a fusion which many of you watching either have had one of these procedures or have been recommended to you. I do a lot of these procedures for my patients and they're all very reasonable options for the right situations. But sometimes, and in your case it may be the same way, it may not be for you.

(02:20):

So if you don't want any of these options what if you or you've already had surgery and you still have low back pain? If this sounds like there applies to you, keep listening. There's a new procedure called the Intracept procedure. This targets a specific type of pain called vertebrogenic pain. Now the vertebra is a vertebral body, which is the bone in your back. This procedure can help a large number of patients that have chronic low back pain, and it can help them have less pain and sometimes have no pain at all in a of circumstances. And the best thing is if you are a good candidate, you can look forward to having a high success with this procedure and a pain relief that is long lasting.

(03:14):

So let's take a step back now and talk about low back pain and where low back pain comes from. Number one muscle or ligament strain. This is probably one of the more common types of back pain and it is often treatable by over-the-counter medications. Anti-inflammatories is what we call them or NSAIDs like ibuprofen or Aleve or any other number ones on the market sometimes rest, physical therapy, other types of therapies and time. Another source of pain is the intravertebral disc which is people just generally call it the disc, and we call it the intravertebral disc because it's between the two bones in your body. The disc can bulge, they can herniate, they can degenerate and get arthritic, or at least cause arthritis in the joints in the back of the spine. They can push on the nerves, they can, they can cause nerve pain as well, which you will feel as a pain that goes down your leg to the foot.

(04:17):

They can degenerate they cause axial low back pain and axial means straight up the middle of the back so your low back hurts. This type of pain often requires further treatments beyond those utilized seen with muscle and ligament strain. These include injections and sometimes surgery. Another source of pain is the arthritis pain. And I will point this out on the slide here. Arthritis pain is pain that you'll see in the joints themselves, which is in the back of the spine near the nerves and sometimes can actually, the joints can grow and push on the nerves as well. So you can have a disc pushing on the nerve and the joint pushing on the nerve and you can have back pain, pain from the joints as well. And sometimes the muscles will react by in getting inflamed and tighten up and you can have muscle pain as well.

(05:08):

So it's kind of a feedback loop which gets worse. So arthritis is certainly a problem. Osteoporosis basically you can have a weak back where the bone gets weaker and as you age you are more prone to that bone breaking sometimes with little or no no because you can bend over or sneeze and if you have a weak enough bone it can break it can be very painful. These are treat easily treatable with something called a kyphoplasty, which I've certainly will probably go into in further detail in a future live stream, but you can look up kyphoplasty if you have a rectal fracture which is painful.

(05:51):

So there are certainly other reasons for pain, but those are the main ones. So now that you understand where back pain usually comes from, I'm going to show you I'm going to share with you the newest scientific findings that has given us an understanding of where another type of low back pain comes from or at least some of the other types of back pain that we thought we understood better actually comes from in a certain percentage of patients. I'm going to circle back to the disc. Remember when I told you that there can be pain that comes from a disc? When I was in neurosurgical in neurosurgical training there used to be a procedure called IDET, which

is the intradiscal electrodermal therapy and we thought a lot of pain came from the disc itself and so the disc degenerates and we can have a interventional doctor put a needle in, inject it with dye and tell us, yes, there's pain when you inject a pressurized dye into a disc space. And so we thought that the disc was causing pain so we would stick a needle and we'll go to the thing here and the doctor, which was also a pain doctor or an interventionalist, would stick a needle in the disc and the needle would end up right there and then he or she would put a catheter inside the disc and loop it around and then he would heat up that whole length of catheter and they would try to burn the pain fibers in the disc. The problem is it didn't work very well.

Surgeries for Low Back Pain (07:32):

The IDET results, and we, we'll go back to the slide here. They did a couple studies which were powerful studies. They did retro or prospective studies where they went forward. They treated some people with IDET, some people with nothing. And in one of the studies placebos actually let me define that term. A placebo is a treatment that someone thinks they're getting a real treatment, they don't know they're getting a treatment or not and they actually don't get one at all. And so the best studies will give you a treatment which is defined in the study that we're trying to study or the treatment that we're trying to study. And the placebo, which is basically a sham where the patient thinks they're getting, they don't know what they're getting. And so half the people will get this, the treatment half will not. And then that way we can objectively look at who really got better and then the people that look at the results, they're blinded by the actual treatment.

(08:27):

So they don't know who got what treatment, they're just tabulating how well the patient did. And so what that does is it pretty much makes everything so objective and then the results speak for themselves. And in this case the results did speak for themselves and they didn't do very well. The IDET procedure VAs improvement, which is the visual analog score only went improved by 1.3 points and we will understand that later when I talk about the intracept, the ODI improvement only went improved by seven and in another study they really didn't go up at all. So the IDET was abandoned, I don't know they may still be doing it but it's not paid for by insurance companies for the most part. And because people didn't do that well they moved on. So let's move on and I'm going to talk to you about the science behind the intercept procedure.

About the Intracept Procedure (09:24):

So the reason why people didn't get better with the idet is because it turns out the pain is actually coming from the bone itself, which is right next to the disc. So if you pressurize the disc, there are nerves inside of the bone that go right up to the disc like roots that go down from a tree trunk and they go down to the disc both up and down in the bone and that is called the BASA vertebral nerve. So we find out it was actually coming from the bone. So those tendrils, they go up to the bone and they're just a normal part of our lives. We all have them but when the disc degenerates

and starts to go bad the signals actually start ramping up. So that is called verteogenic pain. And if you haven't heard of verteogenic pain, don't worry about it.

(10:20):

A lot of doctors haven't and I'm out trying to educate various doctors, chiropractors, physical therapists and other providers to help them understand what we're now understanding to be actually of the cause of a lot of people's pain. Most times all of the treatments I've discussed so far don't work and you know may be stuck in chronic pain oftentimes leading to chronic opioid use which are narcotics or pain pills as you know them. And you've probably heard in the news it is a problem and opioids are not the best treatment actually they're probably one of the worst treatments for chronic pain. But that's sometimes the best people can do and they try to get by with that. There are a lot of side effects and so we need to get past that. So how do you know if you have verteogenic pain? Well in this study of well in this treatment that they've studied extensively, now we they've found that people that have modic changes and we'll go to the slide here again.

(11:21):

Modic changes is something that you probably don't know you have and you may not even have it in the report on your MRI. a doctor like myself or a radiologist has to look at it and detect that there are modic changes and basically when the disc generates the bone around, it can change colors and it can be quite distinctive or very, very subtle. And I'm used to picking up the subtleties and I can tell if people have modic changes. You can have type one modic changes, which I won't get into the high details here, but there are two types of modic changes. The good news is no matter which type of motive change you have are a good candidate and people basically got the same relief from this treatment.

How is the procedure done?(12:07):

And then another part of the good news is that if you have verteogenic pain, the procedure I'm about to discuss has a very good chance of reducing your pain. Intracept is an outpatient minimally invasive procedure that targets the basal vertebral nerve. And remember that's the nerve that goes into the back of the bone and goes up and down towards the discs. It may also be called BVN which is the basal vertebral nerve. And this is responsible for the verteogenic pain that we're talking about. So the procedure itself is done with a patient comfortably asleep. I make a small cut in your skin and then I place a metal needle. It's a large needle but you're asleep and you don't get to see it. And I push it right into the bone. I just kind of tap it in and I use two different x-rays machines to know that I'm going exactly where I need to go, which is basically dead center inside of the bone.

(13:03):

And at that point I will put a catheter out right next to basically right in the middle of the BVN or that basal vertebral nerve and that probe has a tip on it that can heat up and we call that an ablation or radiofrequency treatment and that is heated for 15 minutes while you're asleep and we're watching you carefully and taking good care of you and sometimes putting another needle in while it's heating up because of you may have more than one vertebral body that is affected. And so each body vertebral body ablation takes about 15 minutes. So it could take anywhere between 15 to 45 minutes or so depending on how many levels you have after the procedure and with very little recovery time afterwards you get to go home and pretty much resume normal activity the next day. Now of course because you had general anesthetic, we will have you take it easy and not do too much, but that should be it.

Results from Intracept Procedure (14:00):

Sometimes it can take a little off or to kick in and as I show you the results, you'll kind of see how over time the results actually improve incrementally even up to a five year mark. So how well does this procedure work? We talked about the idet and we know it didn't work very well. So this procedure itself looks at the same two markers of pain that are very common in pain studies. One is the VAs. Now the VAs is the visual analog scale or the visual analog score. And it's basically what if you've been in to see a doctor, they'll ask you what is your pain between zero and 10, they'll say zero is no pain and 10 is the worst pain you've ever had. Now some people you may be included come in and say it's a 15 and which is not possible in that scale.

(14:52):

But as a doctor I understand that when you say that that means you, you're done with the pain, it it's psychologically just damaged you so much that you know want to get across that you're having so much pain. But the scale itself goes from zero to 10. And as you can see, I'll show you on the slide here you may it have seen it with happy faces and sad faces, but a score of zero out of 10 is a very happy face. Nobody wants to be in pain and you're happier when you're not in pain all the way up to the scale of 10. Now the ODI score is called the Oswestry disability index and it is a questionnaire that you may have filled out in the past and all the studies that we do typically use this cause it's very powerful in determining what kind of disability you have.

(15:40):

They'll ask you questions like how well do you do these tasks? Does it get in the way of this in your life? And there's 10 questions with 5.8. And so we score them the higher the number, the worst pain you have or the worst, it affects you functionally in your life. And so if you have 10 questions with five points each, the possible, the highest possible point score is 50 and then we do a modified odi, which we double it so it's easier to look at as a percentage. And so if you have 50 points, that's the worst you can get a hundred percent modified ODI score. And so going back to the slide you have zero to 20 is minimal disability. So if you have zero pain or up to 20, it really doesn't affect you that much. 21 to 40 is moderate, 41 to 60 is severe, 61 to 80 is crippling

pain basically impinges on all aspects of your life and 81 to a hundred basically most people in that scale are bedbound and or exaggerating their symptoms.

(16:37):

And I have to assume unless other ways noted that people aren't exaggerating their symptoms but that these are real. If you're anywhere in the 60 plus or even 40 plus you're certainly in a lot of pain. And so these studies at least and the studies for the intercept uses the same measures and here is what they found. The first study I'm going to kind of go over is the SMART trial and you can Google and look it up on the intracept website. They enrolled 225 patients they randomized them, meaning half of 'em or so got treatment, half of 'em did not. They didn't, did not know which treatment they received and so was blinded and the results are the patients who were treated with in intercept did very well. After three months, their ODI score fell over 20 points. And so you'll see from the screen that the ODI score went from 42.4 down to 22.1 and that was at the three month mark.

(17:39):

And if you march it out to two years, it continued to go down to 18.8. Now this is not one individual patient, it's conglomeration of the average of all the patients. That is a total of 54% reduction in the odi the VAs, which is the visual. An analog scale was very similar. It went from 6.73 out of 10 down to a 3.8 out of 10 at the two, the three month mark and then it went down again to 3.13, which is a little bit lower at two years, which is a 53 point or a 53% decrease.

(18:19):

So let's look at the longer-term study. Is the pain going to come back if you've had any procedure, if you have an injection, the pain's going to come back. Most of the time that doesn't mean injections are not good, are they're good at helping us figure out where the pain is coming from? Is there a specific area versus multiple areas? And sometimes people do get longer term pain relief but with that and as well as ablations of the facet joints, which is the arthritis I showed you before, oftentimes that pain comes back as well. So they did a longer-term study with the SMART trial and that was called the smart five year trial. It showed even a more sustained pain relief. So with the odi now we're going back to the 24 month which was 18.8. At the end of the other study going out three more years it went down even more to 16.9.

(19:07):

The visual analog score also went down as we finished at 3.13 at the end of two years it continued to go down to a 2.35. So if you're living at a 6.73 on average, which is what all these patients were, if you put them all together, that is a big drop. That is a 65% decrease in your visual analog scale. Now what that also means is that there were some people who had more pain at the end but they may have started at a higher pain. This is just averages. On the flip side, that also means that some patients had maybe little or no pain but comparative to 6.73. I think a 2.35

is definitely a decrease and at five years that definitely is a sustained result. So in terms of how well a procedure works these results are I think quite amazing and that's why I'm so excited about this treatment. The procedure is relatively quick, it's minimally invasive. You go home the same day the results are good and they do stand the test of time.

Who is eligible for Intracept? (20:17):

So let's talk about what makes you eligible for the procedure. To be eligible for this procedure, you need to have the following three things. You need to have low back pain for more than six months. So that's beyond the chronic pain of 12 weeks. So you have to have low back pain for six months and most people that come to see me fit that bill. So acute pain meaning new pain we don't jump to this treatment, we try the conservative treatment. So by the time you've had conservative treatments, you've usually had six months of pain. Number two is you have to had treatment for that low back pain also for more than six months. And so if you've had number two then you've definitely had number one because if you had treatment for six months then you've also had the pain for six months. So really number two and three are the ones we need to focus on.

(21:01):

And then also modic changes on MRI and that's what I was talking about earlier. Those visual changes that I see in the bone on the MRIS which correlate with changes inside the bone physiologically in your body that make the basal vertebral nerve grow more tendrils, that makes it at more active, it makes the pain signals start firing that goes up to your brain. So if you don't know how to determine if you have these changes, which most people don't or you haven't had an MRI, don't worry I'm able to evaluate you and tell you if you are a good candidate for this procedure.

(21:41):

So if you or somebody, a friend, family member, acquaintance, coworker, anybody and they want to discuss this procedure and your back pain with me, call the number up on the screen and that we'll put up at the end and it's I'll verbally tell you and so you can write it down now if you'd like. It's 720- 797-7646 and it's option five to make an appointment with me and just tell 'em that you heard this talk today and they will try to get you in as soon as possible. I have held open several clinic appointments over the next couple of weeks for today's viewers or for your friends and family anybody that calls in and says that they saw this in intercept presentation just tell 'em you saw the Facebook stream and want to tell me and want to talk to me about intercept and make an appointment. So we'll just leave it up to any questions you have and I think some have already come in and so I'll start with the first couple, and I'll read them out loud and answer them the best I can.

Question and Answer. (22:52):

So the first question is in intercept applicable and or preferred over rfa, which is radiofrequency ablation and injections in the si. I'm guessing that means SI joint I'll talk about both but I'm, I'm going to go with the assumptions. It's the SI joint. So I didn't talk about the SI joint but the SI joint is very close to the lumbar spine and it can be very difficult to tell the difference between the pain in the back and the pain in the SI joint. The SI joint if you were to put your hand on your hips and put your thumbs where the dimples are that's kind of where the bone of the sacrum, which is the kind of pizza shaped bone at the bottom of the spine meets with the iliac bones which are your hip, your hip bones out here and that hip bone basically the iliac bones and you can look that up I L I A C meets with the sacrum in two joints.

(23:47):

There's one on each side, one this way and one this way. So the SI joint can cause a considerable amount of pain and off topic I do treat SI joint pain on both conservatively with I send people for injections and there is procedure that I do as well. It's another minimally invasive procedure that I put too little dowels inside the joint and people get really good pain relief and that's actually a great topic for another live stream. But the question is, is it preferred over those two treatments, the RFA and the injections of the SI joint? The in intercept cannot treat SI joint pain unfortunately because it is vertebro inside the bone it targets different nerves but you may actually have, may have joint pain and modic changes which would cause back pain which is really close to the SI joint. So if you're getting good relief from an injection in the SI joint, then we can rule out vertebro pain and focus on the SI joint pain and I can also treat you for the SI joint pain. So those are great treatments for the SI joint. If you're talking about the S one bone, which I don't think you are the S one bone can be treated with intercept if asthmatic changes. So that's first question. Thank you, that was a very good question.

(25:06):

So is this procedure a good option for sciatic pain from paraform syndrome? So I'll go into the background real quick of perma syndrome. So people that have sciatic pain or pain going down their leg often have pain coming from the disc pushing on the nerve and that's called a radiculopathy. Sometimes people have sciatic pain and sciatic is a catchall term for any pain that kind of goes shooting down the back of the leg. And so we can't always tell if someone says I have sciatic pain, I don't know if it's the nerve from the spine being pinching on it or if it's coming from somewhere along the length of the nerve which is the actual sciatic nerve is a big bundle of different nerves besides the S one nerve. And the point is the sciatic nerve goes through kind of a little notch area where their perfors muscle, if it's tight, overly tight, it can push on the sciatic nerve and cause a similar pain which is not spinal in origin but it is from the perfors.

(26:00):

Simple answer is no, it cannot treat that. Now if you are having vertebro back pain which affects how you move and get around in life and that affects how your pure forms reacts to that and can

tighten up and make the cytokine worse, yes and a lot of people will have a disc herniation and that disc herniation will push on the S one nerve and they also have be tumorogenic back pain and sometimes they also have perfor syndrome. So there are a variety of things that we cannot have to work through. So if you're doing therapy for perfor syndrome and maybe have had an injection in the perfor muscle to kind of loosen it up and you get relief, then you focus on that and unfortunately in intercept cannot treat that but it may treat a comorbid problem that you have which could be verte orogenic pain.

(26:48):

Okay, I have tried PT and injections but I am still suffering. What steps should I take to see if I'm a candidate for intercept? So you've mentioned PT and injections and those are the two things that I usually recommend. If you've not had an MRI then you can either ask your primary care provider or whoever's kind of directing your treatment for an mri. alternatively I do have a lot of people that come see me because they don't want to order the MRI or it's more convenient or you may not have to have a referral from your pcp, you can come see me because if you've had injections in PT that means you've already kind of been in the system. I'm happy to see you and order the mri. If you've had the mri. unfortunately if you read the report you may not see modic changes even, especially if they're subtle notated on the actual report.

(27:38):

So the best thing is to come see me. I will continue to look at conservative options for you because most I'd say 20 to 25% of the people at the most end up having surgery at some point under my guidance. So one thing that I'll mention is that just because you come see me doesn't mean that you will need surgery or that I'll recommend surgery. I am happy to talk to you about both options and if it makes sense to have surgery then yes. So the answer to the question is come see me, we'll order an MRI if you haven't had one, if you have had one, bring it with you or at least let us know where you have had it and we can upload it and take a look at it together.

(28:19):

So this question is, I have a pinched nerve and on my MRI they found low back pain arthritis, they're both very painful and all I have done are injections. Would this be a good treatment for me? I think I'll go back to the same we'll go back to those three things. It sounds like you've probably had pain for at least six months and have had treatment for at least six months. So now we just need to find out do you have modic changes? So this is a good kind of intro back to go back to those three things. Don't know, let's look at your mri. What I can say is if you have modic changes then we can address the back pain with the intercept. One thing also that I did not mention is that generally it's accepted to under the L three, L four and L five and S one bone and no higher.

(29:12):

However, if any of those bones are affected and you have higher ones, we can try to work around that. So it is generally for the low back L 3, 4, 5 and S one. However we can also talk about other treatments potentially treatable with injections to find out how much pain is coming from the nerve being pinched versus your arthritis because everyone gets arthritis but not everybody has back pain from arthritis. So you may have a pinched nerve and leg pain and back pain and the back pain may be from the vertebro pain and not their arthritis. Or it could be a combination of both because the intercept is such a minimally invasive procedure. What I am now recommending to patients is that they consider the intercept to deal with their back pain, at least cut out that piece of the pie. So if your pain is a big piece of pie and half of your pain that's wrecking your life is coming from protegen back pain. If we can get rid of that then we can kind of drill down on the other things. But there are a lot of other things that you probably haven't talked about with someone about your arthritis, about your pinched nerve and like I said with the last question, you can come see me without any kind of pressure to do any treatment beyond just talking about it and getting educated. So I'm happy to do that.

(30:32):

Can you review a patient's MRI without a patient coming into your clinic? We do not have a process by which you can do that as of right now. One thing you can do if you have an mri, start by looking at the report. If you don't see modic changes, which is M O D I C on the report anywhere, which a lot of times you won't, even if you have them then you might be able to have somebody else tell you if you have 'em. But if they're not used to looking for them then that may not be a good idea. I think the best way to see if you have them is to come see me. Now from what I've seen, it's about 20 to 25% of people that have chronic low back pain and have not had treatment adequate for them will have some kind of mode changes. And so there's a good chance you have it. It's not more than 50 50, which is not great, but if you've lived with it this long, if there's a chance that we can get you feeling better, I think it's worth it to come in, take a look at the scans and maybe I'll even uncover a treatment option that's not surgery that may have been not addressing up to this point.

(31:45):

Next question is I have low back pain. Should I come see a surgeon or a physiatrist to explore treatment? I think physiatrists are excellent physicians to take people through and help diagnose sources of pain help direct treatments, conservative treatments. As far as what I can recommend for conservative treatments and what they recommend are very similar. What they can do that I can't is that because they're physiatrists, they are well-versed in how the body works kin genetically, physiologically, how it moves what kind of things that you can do with them or with physical therapy. And a lot of physiatrists actually are osteopaths, but they're dos and they can do osteopathic manipulation and get you feeling better which can be basically a first step in getting you feeling better. So I think if you've kind of in the beginning of your journey and have not had many concerted treatments, I think a physiatrist is as excellent. You can see me and oftentimes I will refer people to physiatrists. If you haven't had MOIC changes or haven't had an MRI or and you get one, you have motor changes, then I think in my mind most treatments are not going to

treat verte orogenic pain very well. So if you have changes in chronic back pain, I'm probably best suited to getting you the incep procedure and then trying other things if your pain doesn't go away.

(33:23):

Is this procedure preferred at facets at L two through five over rfa? So it all depends on where the pain is coming from. If you do not have modic changes, then basically we have to just focus on the facet joints. So if you've had facet inject, if you have facet arthritis and we think it's coming from the back, the facet joints, which are the joints that I showed you on the arthritis slide, if you've bend backwards, that will often aggravate the facet joint pain. If you've had injections and the pain goes away immediately then comes back, we probably know you have set joint pain and therefore an RFA probably will help you if you've had responses to the injection at the facet joint. If you've had facet joint pain for a long time and maybe treatments aren't working anymore, then it might be time to explore if you have modic changes and see if that is also what's going on. Because you can certainly have both because they kind of go hand in hand as the disc generates the joint spaces, the joint itself gets less competent and you get fent arthritis along with it. So you can have both, but I certainly think they're two separate pain generators and both are good treatments for each of those two pain generators.

(34:45):

Is this procedure commonly covered by insurance? I did not go over that on the slide going through the slide and I'm glad you asked that because this is a new procedure. It has been out for several years but hasn't been used very much because it didn't have a code. Now they have a given it a temporary code, which is kind of a how a bill becomes a law. The cartoon from the eighties, I'm just a bill from Capitol Hill. This is the same thing. A procedure doesn't become a paid procedure until it goes through a process of getting a temporary code than a permanent code. Our best guess is that the permanent code is going to, I think it's going to come out early next year, but with a temporary code, we are twisting the arms of insurance companies to approve these if they approve the procedure after usually several letters from me, phone calls.

(35:41):

The company itself helps with, they have a doctor scientist that helps them send letters to the insurance companies until they say yes. And we're very, very aggressive and persistent and that's where you have to have patients. Until we get a permanent code, it could take at least 45 days to several months to get it approved. Some people will opt to pay for it. It is, it's not as expensive as surgeries, but it's not cheap either. So surgery centers cost money, doctors anesthesiologists. So we really, really try hard to get it approved, but it can take some time. So if you've had chronic pain for a while I think it's worth coming in, getting the authorization started and at least we can start our process and work with interest up company to really twist their arms and get these companies used to the fact that this is a great procedure, people get great results, and even though they haven't seen this come across their desk, doesn't mean that they shouldn't approve it.

So we're kind of in that phase of really having to fight hard for you. Hopefully it will be less next year. So right now I think all insurance companies are saying no right off the bat but we're working hard and educating them and it's a process. But if it doesn't get approved, we won't have you do the procedure without you knowing it. We will be in touch with you every step of the way until we either get it approved or we have to decide to go a different direction.

(37:09):

Do you offer telehealth appointments? We do. So yes. That's an easy question. So I think those questions really covered almost everything that we had and any holes that I missed certainly those questions did kind of hit some of the things that I didn't really get into. So thank you for joining us today. Thank you for joining me. I appreciate your time and spending it with me and learning about this intercept procedure that I'm so excited about and very excited about helping you or at least exploring ways to help you, even if it's not with Intercept. I look forward to meeting you with you. Call the phone number that we will provide them to make an appointment with me. They will try to get you in as soon as possible. And like I said, we have open appointments and we will get you in as soon as possible. Thank you.