What's New in Pain?
Ask me Anything!

Shalini Shah, M.D.

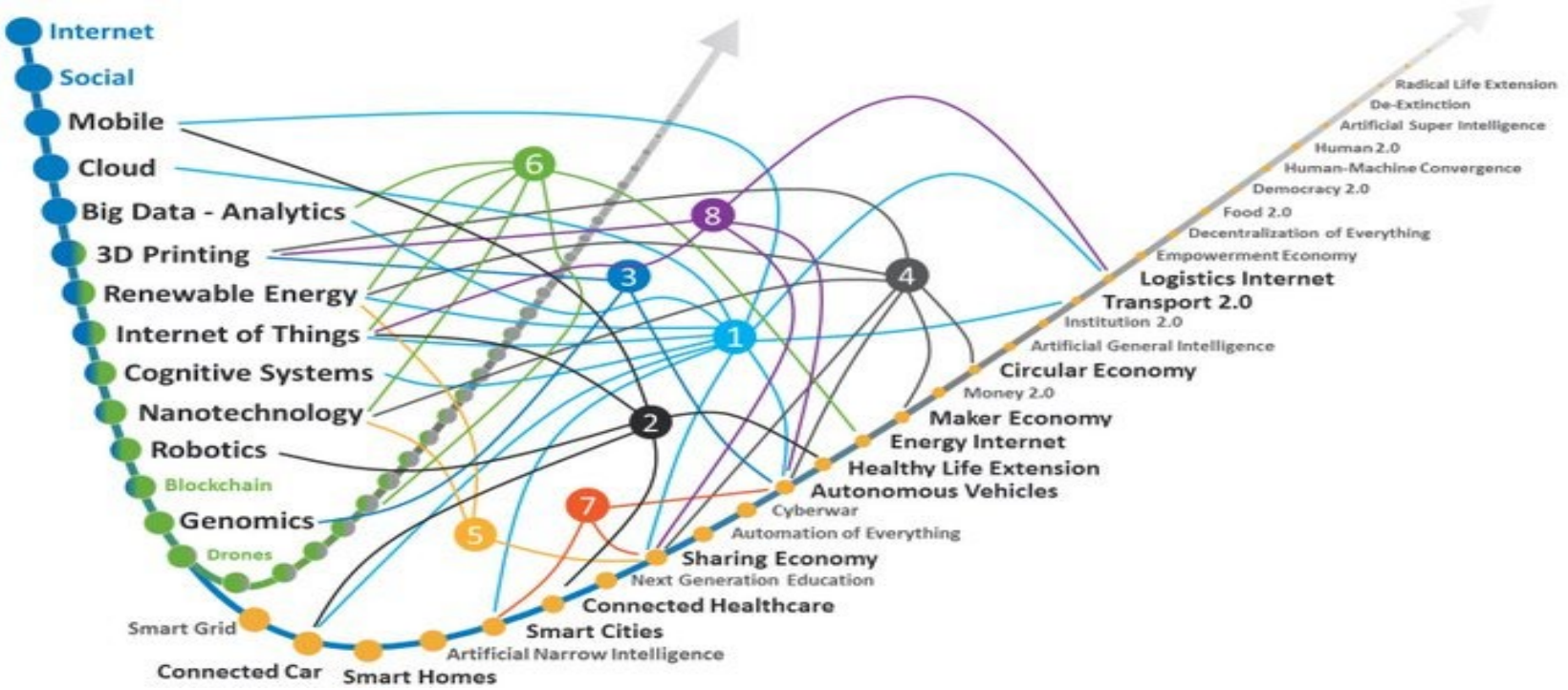
Vice-Chair, Dept of Anesthesiology & Director, Pain Services UC Irvine Health

President, California Society of Interventional Pain Physicians (CALSIPP)

Disclosures

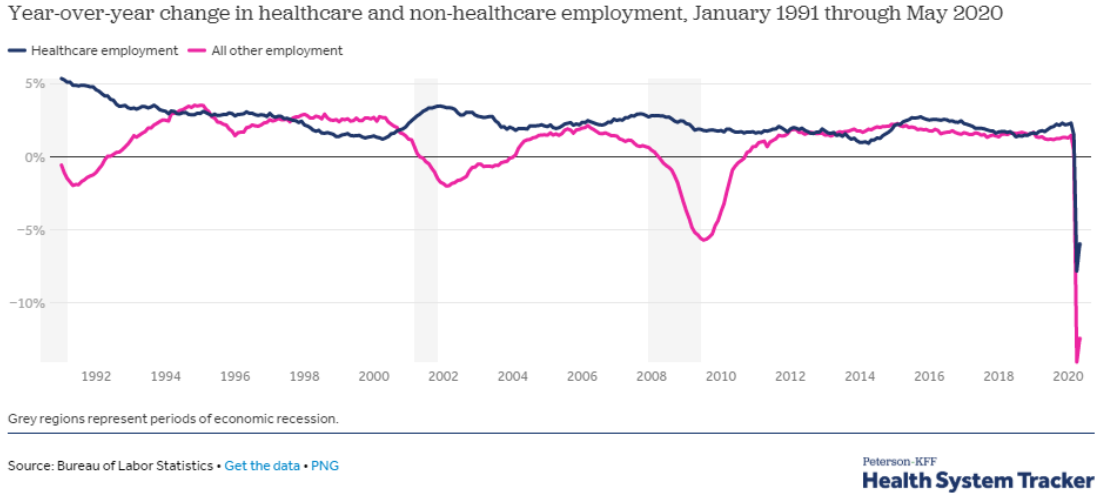
- Consultant/Chair, Scientific Advisory Board, Masimo Corp
- Consultant Allergan, Inc
- Consultant/KOL SPR Therapeutics

Connecting the Dots:

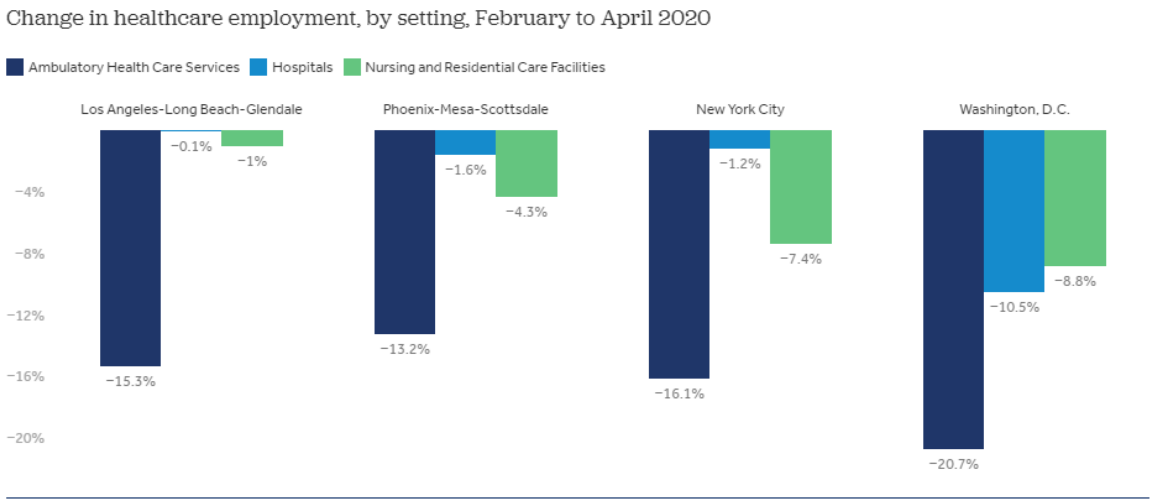


What impact has the coronavirus pandemic had on healthcare employment?

Employment in healthcare settings decreased drastically from February through April, but rebounded slightly in May



Ambulatory health services have seen the sharpest declines in employment across metropolitan areas



Source: KFF analysis of Bureau of Labor Statistics data • Get the data • PNG

Peterson-KFF
Health System Tracker

The Bright Side Of Covid-19: Seven Opportunities Of The Current Pandemic

Forbes

Jeroen Kraaijenbrink Contributor ⓘ
Leadership
I write about leadership and strategy in the age of too much

HealthCare Innovation and COVID:

Barbara Corcoran of 'Shark Tank' | Santiago Felipe/Getty Images

'Shark Tank's' Barbara Corcoran Says Now's the 'Perfect Time' To Launch a Business: 'The World Belongs To the New'

THE WALL STREET JOURNAL.

WSJ NEWS EXCLUSIVE | HEAL

Covid-19 Pandemic Drives Patients—and Deal Makers—to Telemedicine

Several remote-care services are selling themselves or going public amid a telehealth boom

BI Business Insider

Telehealth company American Well is going public IPO S-1 analysis

3 days ago

MDLIVE

Teladoc HEALTH

dr. on demand

Avizia

betterhelp

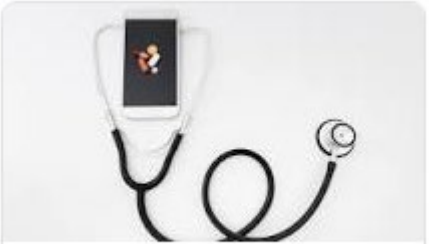
MDLIVE

Teladoc Health

Doctor on Demand, Inc.

Avizia, Inc.

BetterHelp



MJ Medical Economics

Google Cloud, Amwell to partner on telehealth

Can Amwell prescribe Xanax?

Please note that doctors on **Amwell** are not allowed to **prescribe**: Controlled substances (narcotics, anxiety medications, ADHD medications. Muscle relaxants. Medications for erectile dysfunction.

Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

Tech

Telehealth could grow to a $250B revenue opportunity post-COVID-19: analysis

by Heather Landi | Jun 1, 2020 10:53am

An analysis by McKinsey estimates that 20% of all emergency room visits could potentially be avoided via virtual urgent care offerings and 24% of healthcare office visits and outpatient volume could be delivered virtually. (AndreyPopov/GettyImages)

JAMA Network™

Viewpoint

May 27, 2020

More

Treating Patients With Opioid Use Disorder in Their Homes

An Emerging Treatment Model

Lori Uscher-Pines, PhD[1]; Haiden A. Huskamp, PhD[2]; Ateev Mehrotra, MD[2]

» Author Affiliations | Article Information

JAMA. 2020;324(1):39-40. doi:10.1001/jama.2020.3940

HIMSS

Global Edition

Study: Kaia Health's back pain app outperforms standard therapy, online education

While both approaches reduced participants' lower back pain, the company's exercise therapy app was significantly more effective in a direct comparison.

By **Dave Muoio** | May 08, 2019 | 11:32 am

SHARE Share 254

A randomized controlled trial recently published in **npj Digital Medicine** found Kaia Health's app-based exercise therapy for lower back pain (LBP) to be an effective treatment for multidisciplinary patients, and could be more effective than a standard strategy of individual physiotherapy sessions paired with online education.

TOPLINE DATA

SHARE

Policy & Management

MAY 31, 2019

Machine-Learning Algorithms Superior to Current Criteria For Predicting Opioid Overdose Risk

Two of five machine-learning algorithms developed by researchers at the University of Florida and the University of Pittsburgh outperformed the other three in predicting the risk for opioid overdose. Moreover, the two similarly highest-performing algorithms were three times as likely to identify high-risk patients as the current criteria used by the Centers for Medicare & Medicaid Services (CMS).

SHARE

Online First

JANUARY 4, 2021

Researchers Urge Including Machines on Opioid Stewardship Teams

SHARE

Online First

OCTOBER 5, 2020

AI Could Identify Patients at Risk for Severe Post-op Pain

Researchers hope to find those most susceptible to postoperative opioid use disorder

2021 Medicare Physician Fee Schedule

- Changes effective January 1, 2021
- CMS is aligning their Evaluation and Management (E/M) guidelines with the American Medical Association Current Procedural Terminology (CPT)
- Most significant changes to E/M coding since 1997

Key Highlights

This alignment will:

- Retain the 5 levels of service for established office/outpatient visits, 99211-99215
- Reduce new patient services to 4 levels of office/outpatient visits, 99202-99205
- Coding will no longer be based on extent of history and physical exam documentation
- Providers can choose their level of service either by time spent in visit (both before, during and after on day of encounter) or complexity of medical decision making (MDM)
- Teaching Physician rules have not changed, at this time, but CMS may address the guidelines in the future

- ***All other E/M services that are defined by the 3 components (History, Exam, and MDM) will continue to use 1995 and/or 1997 Documentation Guidelines until further review has been completed***

Medical Decision Making

Medical Decision Making requires two of three elements:

1. Number and complexity of problems addressed at the encounter
2. Amount and/or complexity of data to be reviewed and analyzed
3. Risk of complications and/or morbidity or mortality of patient management

Time Based Coding

Times for Codes 99202-99205 and 99212-99215		Work RVUs for Office/Outpatient E/M Codes	
New patient	**Minutes**	2020 Work RVU	2021 Work RVU
99202	15-29	0.93	0.93
99203	30-44	1.42	1.60
99204	45-59	2.43	2.60
99205	60-74	3.17	3.50
Established patient	**Minutes**		
99211	N/A	0.18	0.18
99212	10-19	0.48	0.70
99213	20-29	0.97	1.30
99214	30-39	1.50	1.92
99215	40-54	2.11	2.80

Prolonged E/M Visit - 99417
wRVU = 0.61

- Used when total time exceeds level 5 visit by 15 min

Impact of 2021 Changes: CMS Estimates

- Several states recently passed legislation for the independent practice of Nurse Practioners
  - Non specific re: specialty
  - ? Training programs/”diploma mills”/ “Epidural Schools”
  - Severe threat to IPM
  - Large supporters of these legislations include hospital associations and large academic medical center conglomerates
    - At times physician leadership at individual hospitals support

Statement on Practice of Pain Medicine

Developed By: *Committee on Pain Medicine*
Approved: *December 13, 2020*
Download PDF

The complex nature of Pain Medicine requires a multidisciplinary approach and specialized skill to effectively diagnose the cause and develop safe and effective treatment plans. Extensive training in Pain Medicine is requisite to develop this skill to minimize harm and maximize patient recovery and relief. Pain Medicine is a subspecialty involving many areas of interest and different medical disciplines. The Accreditation Council for Graduate Medical Education (ACGME) defines specific educational requirements for Pain Medicine fellowship programs and also recognizes the importance of distinct clinical training in anesthesiology, neurology, physical medicine and rehabilitation and psychiatry.

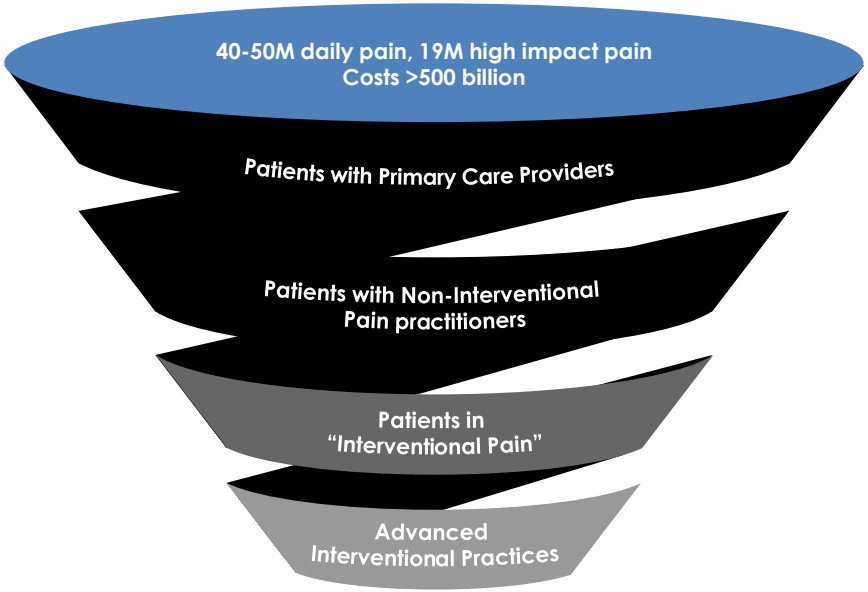
Pain can be both a symptom of a primary disease or a disease in and of itself. Pain and pain treatment impact the patient psychosocially and biologically in multiple domains. This complexity creates significant challenges and risk in diagnosis and management and necessitates lifelong training and continuing education in medicine. Pain physicians prepare for this role through preclinical undergraduate study, medical school education resulting in an allopathic or osteopathic doctorate (MD or DO), a residency program of at least four or more years of training followed by an additional one-year ACGME Pain Medicine fellowship. Also requisite is completion of medical licensure examination, oral and written board examinations in the primary specialty and a subspecialty board examination in Pain Medicine. Lifelong continuing medical education in the original medical field as well as Pain Medicine is required to maintain certification. Only with this preparation can physicians be suited to learn the diagnostic, management and interventional skills necessary to effectively practice Pain Medicine.

Pain Medicine is the practice of Medicine. Nurse anesthesia training and licensure or other non-physician educational courses are insufficient to meet competencies for the independent practice of Pain Medicine. The licensure, training and clinical experience of non-physicians is insufficient to provide the medical expertise required for the evaluation, diagnosis and management of complex pain, especially, advanced invasive interventional procedures.

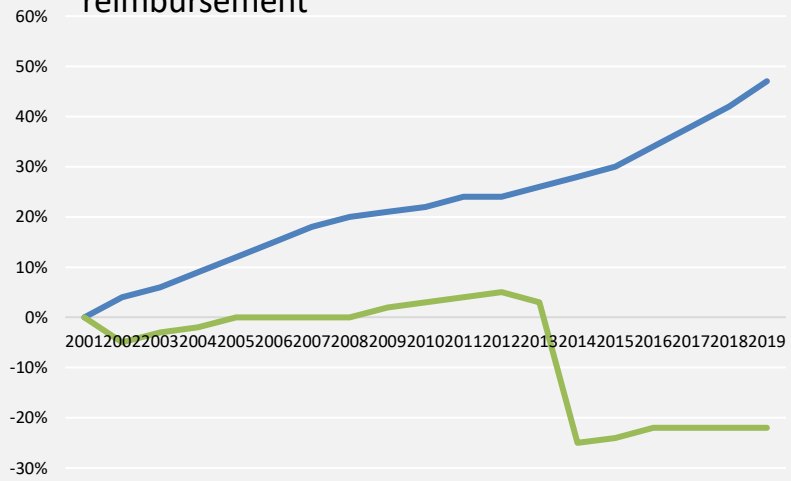
The ASA strongly opposes the independent practice of pain medicine by non-physician providers. Advanced practice nurses may work together with and under the supervision of Pain Medicine physicians. In preserving our patients' best interests, the ASA maintains an ongoing commitment to the delivery of safe, multidisciplinary, physician-led pain care.

Our Current realities as pain practitioners

Most CHIPs have never see a pain specialist



Rising Overhead, decreasing reimbursement



Dahlhamer J, Lucas J, Zelaya, C, et al. Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:1001–1006
Pitcher MH, Von Korff M, Bushnell MC, Porter L. Prevalence and profile of high impact chronic pain in the United States. Journal of Pain. August 8, 2018. (NIH Report).
Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press. https://doi.org/10.17226/13172.

UCI Health

Key current challenges:

Faced by the interventional pain field

01

Pain patients are not **aware** of their treatment options and neither are their PCPs

Awareness Crisis

02

Those who get in to Pain Clinics face preauthorization and payment chal;langes

CMS and Payer Denials

03

Regulators and policymakers are out of touch with the IPM communities and current data

Dark Forces against IPM

CDC options are Ineffective

HHS Best practices report is a sensible approach

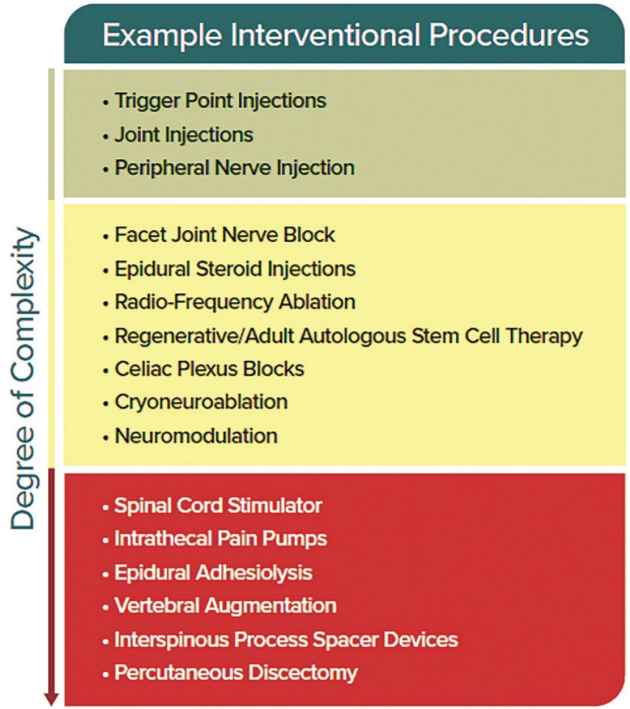
" Several guidelines agree that first- and second-line drugs for neuropathic pain include anticonvulsants tricyclic antidepressants, and SNRIs."....CDC 2016

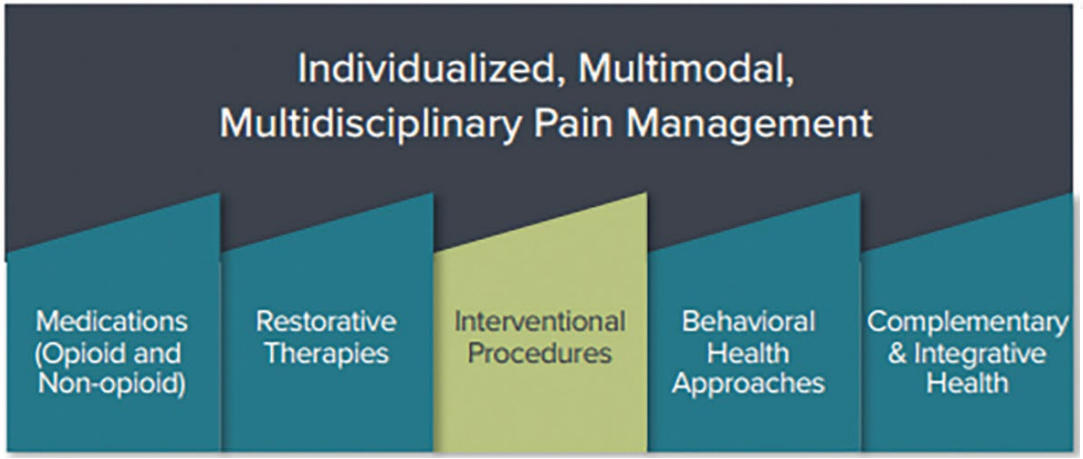
Early referral, every Chronic high impact pain patients, ideally before starting opioids, modified from 2019 HHS Best Practices Report

Why: Because we offer accurate diagnosis and multiple options

- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65:1–49.
- ***file:///C:/Users/mpat0/Desktop/pain-mgmt-best-practices-draft-final-report-05062019.pdf***

HHS best practices report has a sensible approach





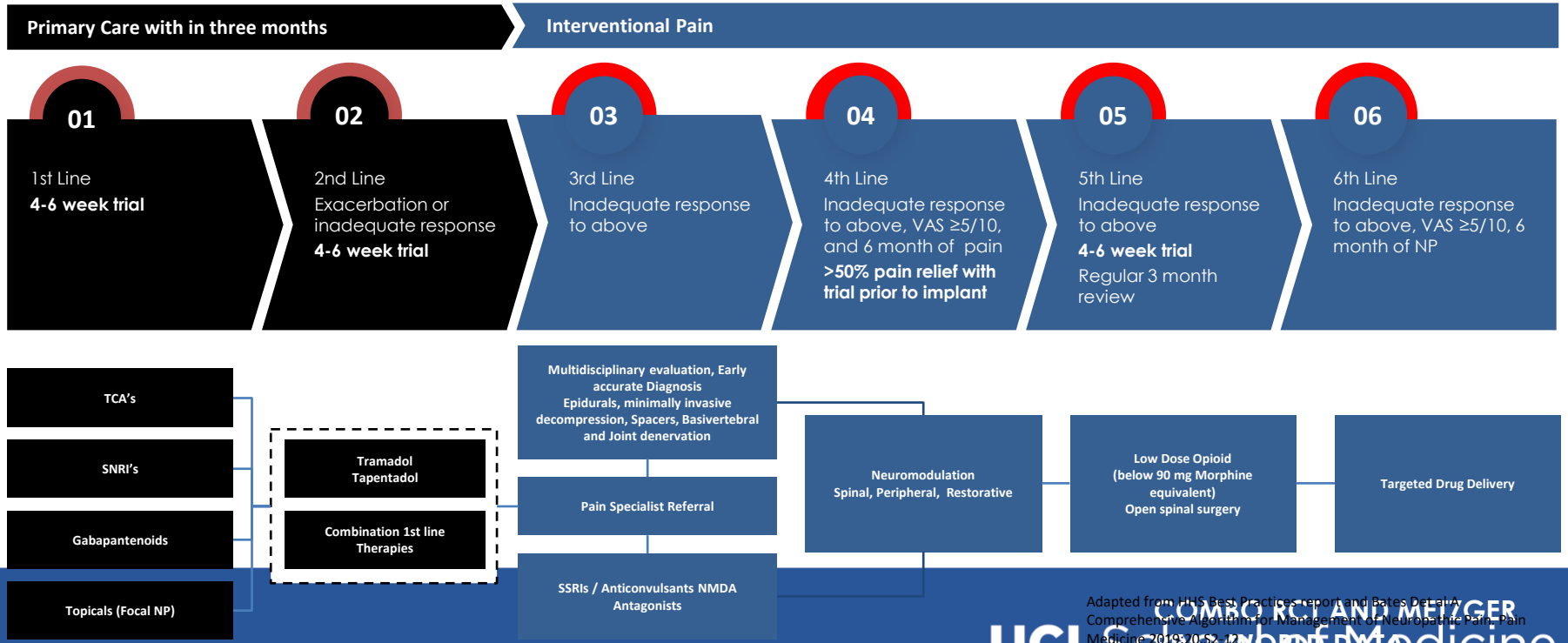
Best Practices Task Force Recommendation 1b:

"Develop effective **educational** resources for primary care providers to improve the current understanding and knowledge of pain treatment modalities, initially available treatments, and **early** referral to pain specialists"

file:///C:/Users/mpat0/Desktop/pain-mgmt-best-practices-draft-final-report-05062019.pdf

New literature based algorithm

Decreases pain, suffering and delays in care, ensure access to every patient

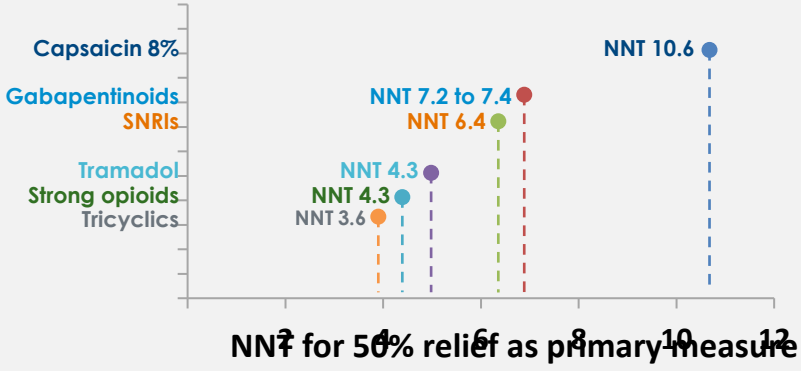


Adapted from HHS Best Practices report and Bates D et al. A Comprehensive Algorithm for Management of Neuropathic Pain. Pain Medicine 2019;20:S2_12

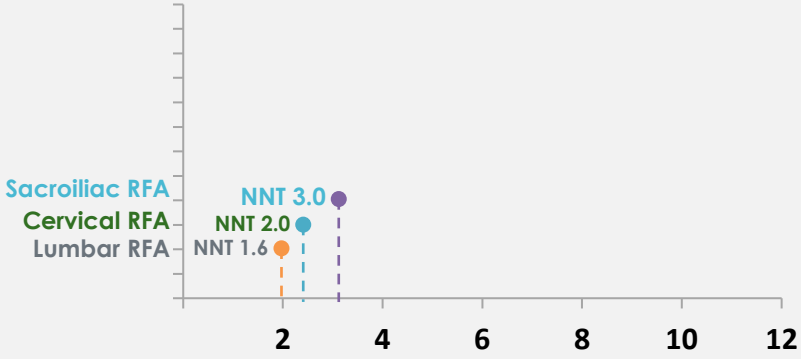
Primary Care Doctors Are Ill-equipped

We have made significant progress

Commonly prescribed medications
NNT= Numbers needed to treat



Interventional Pain Procedures
Low NNTs for highly effective therapies



Shah et al, Number Needed to Treat (NNT): An Effective Metric for Demonstrating the Value of Interventional Pain Management. In press. *Pain Physician*

Finnerup et al. Pharmacotherapy for Neuropathic Pain in Adults: A Systematic Review and Meta-Analysis. Lancet 2015:14,162-73
Cook RJ, Sackett DL. The number needed to treat: A clinically useful measure of treatment effect. BMJ 1995;310:452–4.
Engel A et al. The Effectiveness and Risks of Fluoroscopically-Guided Cervical Medial Branch Thermal Radiofrequency Neurotomy: A Systematic Review with Comprehensive Analysis of the Published Data. Pain Medicine 2016; 17: 658-669
Patel N et al. A Randomized, Placebo-Controlled Study to Assess the Efficacy of Lateral Branch Neurotomy for Chronic Sacroiliac Joint Pain. Pain Medicine 2012;13:383-395
Van Zundert eta la. Diagnostic medial Branch Block before lumbar radiofrequency Zygapophyseal (Facet) Joint Denervation. Anesthesiology 2010:113;276-286

No one said the future will be easy