Treating acute and chronic pain in patients with substance use disorder

DAN LONERGAN, M.D.
MEDICAL DIRECTOR,
COMPREHENSIVE PAIN SERVICE
VANDERBILT UNIVERSITY MEDICAL CENTER

Southern Pain Society
September 2018

I have no conflicts of interest
Objectives

- Distinguish between normal or appropriate opioid use, physiologic dependence and opioid use disorder (addiction)
- Discuss treatment strategies for acute and chronic pain in patients with substance use disorder
- List benefits of buprenorphine or methadone MAT for withdrawal and maintenance for patients with opioid use disorder

Brezing and Marcovitz, 2015. For more information: https://www.recoveryanswers.org/addiction-ary/
Low Risk

Aberrant Drug-Taking Behaviors

Non-medical use

Addiction

DSM5 Opioid use disorder

2-3: mild
4-5: moderate
6+: severe

Tolerance

Withdrawal

Using larger amounts than intended

Persistent desire and inability to cut down

Can’t stop despite knowledge of harm

Spending a lot of time using/obtaining/recovering from substance use

Cravings

Using the substance in Dangerous situations

Important social and other activities are given up for drug use

Failed role obligations

Social conflict
Inability (or persistent desire) to stop or reduce substance use

Strong psychological urge to use

Continued use despite knowledge of physical, psychological, and social consequences

#### Uncertain:
Is this patient drug seeking? Is it ok to give opioids?

#### Known SUD Hx:
How do we manage opioid withdrawal?

Will they misuse in the hospital? Will they misuse their PICC?

How to manage acute pain given he/she is on buprenorphine?

Can we discharge her on oxycodone?
Pain and Question of OUD: Overarching principles

- There are distinct populations and there are gray areas
- Risk stratify – how?
- Validate. Frame limits in terms of risks and safety.

<table>
<thead>
<tr>
<th>Physical dependence / tolerance</th>
<th>Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develops in days to weeks</td>
<td>Develops over months to years</td>
</tr>
<tr>
<td>Develops in most patients exposed to opioids</td>
<td>Develops in a small percentage (~8%)</td>
</tr>
<tr>
<td>Will gradually remit with discontinuation</td>
<td>Will not remit and carries high risk of relapse</td>
</tr>
<tr>
<td>Distinct molecular signature</td>
<td>Distinct molecular signature</td>
</tr>
</tbody>
</table>

### Table 1. Risk factors associated with opioid overdose or addiction.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication-related</td>
<td></td>
</tr>
<tr>
<td>Daily dose &gt;100 MME*</td>
<td>Overdose, addiction</td>
</tr>
<tr>
<td>Long-acting or extended-release formulation (e.g., methadone, fentanyl patch)</td>
<td>Overdose, addiction</td>
</tr>
<tr>
<td>Combination of opioids with benzodiazepines</td>
<td>Overdose</td>
</tr>
<tr>
<td>Long-term opioid use (&gt;3 mo)†</td>
<td>Overdose, addiction</td>
</tr>
<tr>
<td>Period shortly after initiation of long-acting or extended-release formulation (&lt;2 wk)</td>
<td>Overdose</td>
</tr>
<tr>
<td>Patient-related</td>
<td></td>
</tr>
<tr>
<td>Age ≥65 yr</td>
<td>Overdose</td>
</tr>
<tr>
<td>Sleep-disordered breathing‡</td>
<td>Overdose</td>
</tr>
<tr>
<td>Renal or hepatic impairment§</td>
<td>Overdose</td>
</tr>
<tr>
<td>Depression</td>
<td>Overdose, addiction</td>
</tr>
<tr>
<td>Substance-use disorder (including alcohol)</td>
<td>Overdose, addiction</td>
</tr>
<tr>
<td>History of overdose</td>
<td>Overdose</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Addiction</td>
</tr>
</tbody>
</table>

*The risk of opioid overdose increases in a dose-response manner at opioid doses of more than 20 morphine milligram equivalents (MME).
†Although addiction is associated with long-term but not short-term opioid use, the prescription of a higher quantity of opioids than is needed for acute pain contributes substantially to the availability of opioids for diversion and abuse.
‡Sleep-disordered breathing refers to conditions that manifest as abnormal breathing patterns during sleep and includes obstructive sleep apnea and central sleep apnea.
§Patients with these disorders are at increased risk because the disposition of various opioid drugs is affected by hepatic and renal impairments, which reduce drug clearance and increase bioavailability.
Known SUD: Overarching principles

- Treat acute pain
- Listen, reflect, ask permission to give feedback
- Offer treatment for addiction
- Frame limit setting in terms of risk and safety
### Pain Threshold and Pain Tolerance

#### At start
- **Pain threshold**: Red arrow indicates a 16% decrease.
- **Pain tolerance**: Blue arrow indicates a 24% decrease.

#### At 1 month
- Pain threshold and tolerance show further decreases compared to at start.

**Chu et al. J Pain 2006**

### Table: Opioid Use and Reasons for Using Opioid in Past 6 Months

<table>
<thead>
<tr>
<th>Category</th>
<th>Chronic Pain</th>
<th>No Chronic Pain</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>35.4</td>
<td>30.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Opioid use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration not for pain relief (yr)</td>
<td>4.6</td>
<td>4.4</td>
<td>NS</td>
</tr>
<tr>
<td>Onset of 1st problem</td>
<td>30.8</td>
<td>26.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Oxycodone most used opioid in last 30d (%)</td>
<td>28.8</td>
<td>39.8</td>
<td>0.004</td>
</tr>
<tr>
<td><strong>First source</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legitimate prescription (%)</td>
<td>73.4</td>
<td>39.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Someone gave them to me (%)</td>
<td>13.1</td>
<td>30.1</td>
<td></td>
</tr>
<tr>
<td>Bought from dealer (%)</td>
<td>5.5</td>
<td>15.3</td>
<td></td>
</tr>
<tr>
<td><strong>Reasons for using opioid in past 6 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ill or in pain from being in withdrawal</td>
<td>7.8</td>
<td>8.1</td>
<td>NS</td>
</tr>
<tr>
<td>Ill or in pain not from withdrawal</td>
<td>5.7</td>
<td>2.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Felt bored</td>
<td>2.8</td>
<td>3.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Someone offered it</td>
<td>3.5</td>
<td>4.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>With others having a good time</td>
<td>2.8</td>
<td>4.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Saw others using</td>
<td>2.3</td>
<td>3.0</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Good mood and wanted to get high</td>
<td>3.8</td>
<td>5.0</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**Weiss et al. 2014**
Maintenance opioids (i.e. methadone or buprenorphine) should provide adequate analgesia even if it’s for acute pain. Giving opioids to patients in MAT is harmful because it will result in a relapse.

Adding opioids on top of methadone or buprenorphine will lead to an overdose. Patients in MAT requesting pain medications are always drug seeking.

Myths

Alford, 2006

Known SUD: Overarching principles

- Treat acute pain
- Listen, reflect, ask permission to give feedback
- Offer treatment for addiction
- Frame limit setting in terms of risk and safety
Motivation Interviewing

- Collaboration
- Evocation
- Autonomy
- Ask-tell-ask

Known SUD: Overarching principles

- Treat acute pain
- Listen, reflect, ask permission to give feedback
- Offer treatment for addiction
- Frame limit setting in terms of risk and safety
Past year receipt of specialty addiction treatment (2013)

- **86%** Did not feel they needed treatment
- **3%** Felt they needed treatment and did not make an effort
- **10%** Felt they needed treatment and did make an effort
- **1%** Received treatment

SAMHSA 2015

**Known SUD: Overarching principles**

- Treat acute pain
- Listen, reflect, ask permission to give feedback
- Offer treatment for addiction
- Frame limit setting in terms of risk and safety
• Evidence present for non-medical use
• Consider discontinuing opioids
• Maximize non-opioid strategies
• Buprenorphine? Methadone?

Moderate Risk
• Risk factors present that make monitoring necessary
• However, no evidence of non-medical use
• Consider alternatives to opioids
• Maximize non-opioid strategies

Low Risk
• Risk factors not present
• No evidence of non-medical use
• Continue to monitor
• Can continue opioids if functional benefit

Questions related to pain and MAT:

Pain related:
How to manage acute pain given he/she is on buprenorphine or methadone?
Will acute pain prevent transition to MAT?

Not pain related:
Is this patient a good candidate for MAT in general?
For patients already on MAT with acute pain

**Methadone**
- Continue methadone
  - Confirm dose
  - Continue regular dose, or reduce if needed
  - May divide methadone dose
  - Provide additional short-acting opioids if indicated
  - At discharge provide "last dose letter"

**Buprenorphine**
- Stop buprenorphine
  - If elective plan to stop bup 1-3 days prior
  - Start full agonists and/or methadone (no more than 20-40mg on day 1)
  - Plan for later re-induction
- Continue buprenorphine
  - Add buprenorphine or full agonists
  - Maximize non-opioids
  - May divide dose

---

**Buprenorphine can be used even in patients experiencing acute pain**

**TABLE 1 (Continued)**

<table>
<thead>
<tr>
<th>Hospital Admission</th>
<th>Total (n = 47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for hospital admission</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>17 (36.2%)</td>
</tr>
<tr>
<td>Other</td>
<td>30 (63.8%)</td>
</tr>
<tr>
<td>Altered mental status</td>
<td>4 (8.5%)</td>
</tr>
<tr>
<td>Others</td>
<td>16 (34.0%)</td>
</tr>
<tr>
<td>Length of hospital stay</td>
<td>11.3 (SD 4.3, range 3-23)</td>
</tr>
<tr>
<td>Number of days in hospital on buprenorphine</td>
<td>5.1 (SD 3.3, range 1-11)</td>
</tr>
<tr>
<td>Acute pain during admission</td>
<td>40 (85.1%)</td>
</tr>
<tr>
<td>Surgery during admission</td>
<td>8 (17.0%)</td>
</tr>
<tr>
<td>Received opioids during admission</td>
<td>37 (78.7%)</td>
</tr>
<tr>
<td>Buprenorphine use</td>
<td></td>
</tr>
<tr>
<td>Maximal dose of buprenorphine</td>
<td>14.5 (SD 9.0, range 2-42)</td>
</tr>
<tr>
<td>Precipitated withdrawal at induction</td>
<td>1 (2.1%)</td>
</tr>
<tr>
<td>Referred to specific provider/clinic at time of discharge</td>
<td>22 (46.8%)</td>
</tr>
<tr>
<td>PDMP-verified receipt of buprenorphine</td>
<td>22 (46.8%)</td>
</tr>
</tbody>
</table>

Suzuki et al Am J Addict 2014
Medication Saves Lives

Maryland: 50% reduction in overdose death with opioid agonist treatment

France: 79% reduction in overdose death with opioid agonist treatment

Treatment of opioid use disorder

Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review)

Cochrane Library
Cochrane Database of Systematic Reviews

Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study

Mattick RP, Broom C, Kimber J, Davoli M
Patients with SUD utilize hospitals at high rates

- Hospitalized in 1997 (%)
- Inpatient days (mean)

n=58,243 pts with SUD in NY Medicaid program (Laine et al 2001)

More costly care
Greater likelihood of re-admission within 30 days

Risk of Leaving AMA

<table>
<thead>
<tr>
<th>Predictive factors</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS-FFP</td>
<td>0.34 (0.21, 0.53)</td>
</tr>
<tr>
<td>Methadone</td>
<td>0.49 (0.32, 0.77)</td>
</tr>
<tr>
<td>Age per 10-year increment</td>
<td>0.57 (0.44, 0.74)</td>
</tr>
<tr>
<td>Community support</td>
<td>0.88 (0.58, 1.39)</td>
</tr>
<tr>
<td>Female</td>
<td>0.90 (0.58, 1.39)</td>
</tr>
<tr>
<td>CDU at count</td>
<td>0.86 (0.52, 1.39)</td>
</tr>
<tr>
<td>Daily alcohol</td>
<td>1.03 (0.67, 1.57)</td>
</tr>
<tr>
<td>Daily heroin</td>
<td>1.08 (0.67, 1.76)</td>
</tr>
<tr>
<td>Daily cocaine</td>
<td>1.21 (0.72, 2.01)</td>
</tr>
<tr>
<td>Daily cocaine and heroin</td>
<td>1.30 (0.83, 2.02)</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>1.59 (0.98, 2.56)</td>
</tr>
<tr>
<td>IDU-active</td>
<td>2.07 (1.40, 3.06)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated factors</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital frequency</td>
<td>1.15 (0.96, 1.24)</td>
</tr>
<tr>
<td>Weekend</td>
<td>2.27 (1.49, 3.46)</td>
</tr>
<tr>
<td>Welfare day</td>
<td>2.95 (1.76, 4.90)</td>
</tr>
</tbody>
</table>
Treating Withdrawal Decreases AMA

Case Discussion

J.D. is a 29 year old male admitted to the medicine service. He recently moved from Georgia to be closer to family. Upon arriving in Nashville, he had an episode of acute pancreatitis and presented to the hospital for pain management. Abdominal CT shows slight fluid around the pancreas, but is otherwise unremarkable. He states that his doctor in Georgia prescribes Morphine ER 15 mg q12h and Oxycodone 10/325 q6h prn. He describes that, in the past, he has gone to the hospital for a pain crisis and was treated with 3 mg hydromorphone IV every few hours for 10 days until his pain was under control. He is frustrated with his pain management during this hospital stay. He was told by his mother that Vanderbilt is the best hospital in the region, but his experience so far is that VUMC doctors lack compassion and are unwilling to do what it takes to manage his pain.

Objectives Met?

- Distinguish between normal or appropriate opioid use, physiologic dependence and opioid use disorder (addiction)
- Discuss treatment strategies for acute and chronic pain in patients with substance use disorder
- List benefits of buprenorphine or methadone MAT for withdrawal and maintenance for patients with opioid use disorder
References

1 Presurgical Psychological Assessment
&
Opioid Risk Assessment
Geralyn Datz, PhD
Clinical Director
Southern Behavioral Medicine Associates PLLC

2

3 Do psych factors affect
treatment outcomes?

4 Why is it important to identify psych factors?

• Psych distress increases pain intensity and disability, contributing to a negative cycle, where functional limitations are perpetuated
• Depression is linked to poor treatment outcome, with patients 3x more likely to be non adherent to medical recommendations made by their physicians than non-depressed patients

5 Factors to consider: Depression
• Pain and depression frequently co exist: 30 to 50% Co-Occur
  • Pain is a strong predictor of onset and persistence of depression
  • Depression is a strong predictor of pain, esp. chronic pain
  • Relative to people with no pain, odds ratio for depression 1.8 with single site pain, and 3.7 with multisite pain [Kroenke et al., 2009]
  • Baseline depression also the strongest independent predictor of subsequent pain at 3 months
6 Factors to consider: Anxiety
   • 35% of those with chronic arthritic pain have an anxiety disorder [vs 17% in general population] [NCS, 2013]
   • Similar prevalence in patients with migraine and chronic back pain
   • People w back or neck pain 2 - 3x more likely to have had Panic Disorder, Social Anxiety or Agoraphobia in past year
   • People with back or neck pain 3- 4x more likely to have had past year PTSD and GAD
   • Patients with anxiety disorders 2-3x more likely to have a painful condition of any kind [Sareen et al., 2005]

7 Pain Treatment Ladder

8 Surgical Readiness
   • Surgical readiness is influenced by several factors
   • These can be readily assessed by psychologists and specific tools

9 Psychological Tests for Pain Patients
   • Pain Patient Profile (P3)
   • Millon Behavioral Medicine Diagnostic (MBMD)
   • Battery For Health Improvement (BHI-2)
   • Minnesota Multiphasic Personality Inventory- 2 (MMPI-2RF)
Testing Overview

- Administer prior to interview
- Use multiple measures for convergence of results, objective data
- Identify areas on non-convergence and follow up in interview
- Choose measures that are both sensitive and specific

Pain Patient Profile (P3)

- Brief Measure, 44 items
- Depression, Anxiety, Somatization and Validity Index
- Normed on community sample and pain population
- No surgical norms
- No prognostic information
- Prone to error

P3 summary points

- Gives a quick view of several domains before seeing patient
- Literature supports that presence of depression, anxiety and somatization may influence treatment outcome
- Not appropriate for presurgical screening as a stand alone measure

MBMD™

- Millon™ Behavioral Medicine Diagnostic
- Designed to evaluate medical patients and the psychosocial factors which influence course of disease and treatment outcome.
- Normed on surgical patients
- 18 to 65, 6th grade
- 25 mins (165 T/F questions)
15 MBMD™

- 165 items, T/F
  - Clinical Scales
  - Negative Health Habits
  - Coping styles
  - Stress Moderators
  - Treatment Prognostics
  - Management guides
  - Response Patterns
  - Validity Indicator
  - Psychiatric indications

16

17 Battery for Health Improvement -2 (BHI-2)

- Ages 18 to 65
- 30 mins (217 multiple choice)
- Rehabilitation and presurgical norms
- Assessment of validity, physical symptoms, psychological, character, environment, and social factors that impact normal course of treatment and recovery.

18 Medical Intervention Risk Report

- Outcome Risk Level
  - Primary, Presurgical and Rehabilitation Risk scores
  - Addiction Potential Risk

19 MMPI-2 -RF

- Minnesota Multiphasic Personality Inventory – 2nd edition – Restructured Form
- Designed for assessment of psychiatric patients originally
- Norms for spinal cord stimulator and spine surgery patients (Block et al)
20 ▶ MMPI-2-RF

- 18+
- 5th grade level
- 45 mins+ (338 items, T/F)

  - Validity Scales
  - Clinical Scales
  - Supplementary Scales
  - Content Scales

21 ▶ The role of the psychological Interview

- Determine presence vs not of risk factors
- Educate the patient about the procedure
- Establish willingness and consent
- If risk factors are present, propose mitigation plan
- Establish rationale for non-surgical candidates
- Make treatment recommendations

22 ▶ Clinical Interview

- Behavioral Observations

  - Pain Description

  - Pain History

  - Sleep Disturbance

23 ▶ Clinical Interview

- Pain Medication History/Compliance

  - Substance Abuse History

  - Motivational Issues
24 Clinical Interview
- Psychological /Psychiatric History
- Relevant Personal History
- Testing Results

25 Clinical Pearls
- Clinical interviews must be comprehensive, and incorporate the “whole person”
- Interviews should incorporate materials from several sources
- Direct and open questioning is needed for assessment of medical compliance and substance abuse history

26 Identifying
Yellow & Red Flags
- Yellow Flag:
  Behaviors or factors which may impair recovery from medical illness
Examples:
  - Anxiety
  - Depression
  - Catastrophizing

27 Suggested Criteria for Concern (Yellow Flags)
  – Belief the procedure will cure all pain
  – Statements that the patient will not be able to cope if the trial does not go well
  – Serious issues of Secondary gain
  – Drug seeking behavior trumps procedure
  – Current or past history of substance abuse
–Abnormal illness behavior
–Mild or moderate sleep debt
–Somatization
–Prominent psych diagnosis

28 Suggested Exclusion Criteria (Red Flags)

–Active Psychosis
–Uncontrolled Mood or Anxiety Disorder
–Severe Sleep Debt
–Active Suicidal Behavior
–Active Homicidal Behavior
–Active Alcohol or Drug Addiction Problems,
–Substance Abuse Patterns
–Serious Cognitive Deficits*
–Serious Sleep Disturbance

29 Retail opioid prescriptions dispensed per 100 persons (2016)

30

31

32 Risk factors for opioid misuse

1. Current substance use disorder
   ● Polysubstance abuse
   ● Personal History of substance use disorder
   ● Family hx of substance abuse
   ● Depression, Anxiety, Mental illness
   ● Younger age (<47)
   ● Hx of childhood sexual abuse

2. Exaggeration of pain
• Unclear cause of pain
• Non compliance with non opioid treatments
• Unapproved use of Pain Rx to treat other symptoms
• Aberrant behaviors: buying, selling, forging rx, taking others, dose escalations, multiple MDs, pharmacies

Assessments for Opioid Misuse/Dependence
• Substance abuse measures
  –SOAPP-R, ORT, PADIT, DAST, AUDIT

• Mental State Eval

• Psychological measures
  –MMPI-2RF, PAI, MBMD, Pain Pt Profile
  –Brief screeners: PHQ 9, GAD 7, PHQ 20

Guidelines for the Chronic use of Opioids (ACOEM, 2011)
• A psychological evaluation is strongly recommended in select patients who have a relatively low threshold for chronic opioid use
• Considerations include:
  –any dissonance between subjective/objective findings
  –the need to add or escalate opioid usage
  –any psychological disorder or prior history of psychological disorder
  –ANY substance use (including tobacco)

Guidelines for the Chronic use of Opioids (ACOEM, 2011)
Identification of risk factors prompts the practitioner to EITHER:
  –include consideration of risk factors in treatment
  –OR recruit assistance from another provider (such as a psychologist or experienced pain physician) to further define relevant psychosocial factors and coordinate with the primary MD
Informed consent
Psychological assessment *

2. Diagnosis

• Risk factors for opioid misuse

Retail opioid prescriptions dispensed per 100 persons (2016)

Thank you!

9. Review diagnoses

– Develop a comprehensive treatment plan includes addressing these factors or, at least, the role they play (hampering) rehabilitation

36 Universal Precautions for Prescribing

1. Diagnosis

2. Psychological assessment *

3. Informed consent

4. Treatment agreement

5. Pre- & post- assessment

(pain level and function)

6. Trial opioid therapy & adjunctive Rx

7. Reassessment

(pain and function)

8. Four As

9. Review diagnoses

(pain, comorbidity)

10. Documentation

37 Risk Factors For Opioid Abuse

• Personal hx of substance abuse

• Family hx of substance abuse

• Young age

• Hx of childhood sexual abuse

• Mental illness

• Psychological stress

• Social patterns of drug abuse

• Polysubstance abuse

38 Addiction vs Tolerance vs Dependence

• In DSM-5 / ICD 10 no “addiction”

• Opioid Use Disorders – include tolerance, dependence and craving, and other behaviors and consequences
• Tolerance is normal and expected and not dependence

• Dependence is characterized by withdrawal

• Addiction and misuse are characterized by the 4 Cs

4 Cs of Addiction - Opioid Use D/O

• Craving - I cant think of anything other than my next use

• Compulsive Use – I want to quit, I need to quit, but I cant

• Compulsion – I need this drug to function

• Continued use despite consequences -- I know this drug is harmful. It has resulted in legal problems, relationship problems, money problems, work problems, loss of sleep, and loss of hope.

Thank you!
Action Reaction: The Results of Six Pain Coding and Reimbursement Trends

Linda Van Horn, MBA
September 23, 2018

Linda Van Horn, MBA
President / CEO
3150 Mercier, Suite 608A
Kansas City, MO 64111
816.822.6800
816.249.2555 ext. 101

l.vanhorn@21stcenturyedge.com
l.vanhorn@isharemedical.com
Linda Van Horn, MBA
Faculty Disclosures

- Board Member, Board of Directors of non-profit DirectTrust
- iShare Medical is:
  - 1 of 35 DirectTrust Accredited Trust Anchors
  - 1 of 6 DirectTrust Accredited Partnership for Patients Trust Anchors
  - 1 of 5 DirectTrust Accredited Governmental Trust Anchors

US Per Capita Spending on Healthcare in 2016 $10,348

- Per Capita US Spending on Healthcare
- Actual from 2010 to 2016 Projected After 2017

Family of four = $41,392
Impact of Reimbursement Trends

Agenda

1. Let's lower physician reimbursement
2. Let's lower outpatient hospital reimbursement
3. Let's raise the cost for patients with higher premiums, co-pays, and deductibles

4. Let's tighten prior authorization, utilization guidelines, and increase denials
5. Let's come up with new payment models around value based care and population health
6. Let's use technology to help us improve care and outcomes and reduce cost
For every action there is an equal and opposite reaction.

Trend 1: Let's lower physician reimbursement

Source: Sir Isaac Newton

2019 Proposed Rule
CMS Overhauls E/M Payment Policies
Established Patient Office Visits

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2018</th>
<th>2019 Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In Office</td>
<td>In Fac</td>
<td>In Office</td>
</tr>
<tr>
<td>99211</td>
<td>Level 1 Est Patient Office Visit</td>
<td>21.99</td>
<td>9.37</td>
<td>24.15</td>
</tr>
<tr>
<td>99212</td>
<td>Level 2 Est Patient Office Visit</td>
<td>44.70</td>
<td>25.95</td>
<td>91.92</td>
</tr>
<tr>
<td>99213</td>
<td>Level 3 Est Patient Office Visit</td>
<td>74.26</td>
<td>52.27</td>
<td>91.92</td>
</tr>
<tr>
<td>99214</td>
<td>Level 4 Est Patient Office Visit</td>
<td>109.58</td>
<td>80.02</td>
<td>91.92</td>
</tr>
<tr>
<td>99215</td>
<td>Level 5 Est Patient Office Visit</td>
<td>147.79</td>
<td>113.19</td>
<td>91.92</td>
</tr>
</tbody>
</table>

Flat rate $91.92 for In Office and $65.60 in Facility
2019 Proposed Rule
CMS Overhauls E/M Payment Policies
New Patient Office Visits

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2018 In Office</th>
<th>2018 In Fac</th>
<th>2019 Proposed In Office</th>
<th>2019 Proposed In Fac</th>
<th>Change In Office</th>
<th>Change In Fac</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Level 1 New Patient Office Visit</td>
<td>45.42</td>
<td>27.40</td>
<td>43.26</td>
<td>25.59</td>
<td>(2.16)</td>
<td>(1.80)</td>
</tr>
<tr>
<td>99202</td>
<td>Level 2 New Patient Office Visit</td>
<td>76.42</td>
<td>51.55</td>
<td>134.45</td>
<td>102.37</td>
<td>58.03</td>
<td>50.83</td>
</tr>
<tr>
<td>99203</td>
<td>Level 3 New Patient Office Visit</td>
<td>109.94</td>
<td>78.22</td>
<td>134.45</td>
<td>102.37</td>
<td>24.51</td>
<td>24.15</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 New Patient Office Visit</td>
<td>167.62</td>
<td>131.93</td>
<td>134.45</td>
<td>102.37</td>
<td>(33.16)</td>
<td>(29.56)</td>
</tr>
<tr>
<td>99205</td>
<td>Level 5 New Patient Office Visit</td>
<td>210.87</td>
<td>172.30</td>
<td>134.45</td>
<td>102.37</td>
<td>(76.42)</td>
<td>(69.93)</td>
</tr>
</tbody>
</table>

Flat rate $134.45 for In Office and $102.37 in Facility

2019 Proposed Rule
Multiple Procedure Indicator
99201 – 99205 and 99211 - 99215

➢ 2019 Multiple procedure indicator is a 2 meaning the second procedure is reduced by 50%
➢ 2018 Multiple procedure indicator is 0 (zero) meaning no reduction for second procedure

<table>
<thead>
<tr>
<th>CPT</th>
<th>Allowable</th>
<th>CPT</th>
<th>Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213-25</td>
<td>109.94</td>
<td>99213-25</td>
<td>45.96</td>
</tr>
<tr>
<td>62323</td>
<td>250.86</td>
<td>62323</td>
<td>252.68</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>360.82</strong></td>
<td><strong>Total</strong></td>
<td><strong>298.68</strong></td>
</tr>
</tbody>
</table>

Net Reduction in Allowable -17.23%
2019 Proposed Rule
Additional E/M Payments Available

➢ Add-on code GPC1x* for primary care providers $5
➢ Add-on code GCG0x* $12 visit complexity inherent to:
  - Allergy/Immunology
  - Cardiology
  - Endocrinology
  - Hematology/Oncology
  - Interventional Pain Management Centered Care
  - Neurology
  - Obstetrics/Gynecology
  - Otolaryngology
  - Rheumatology
  - Urology

* note codes that end in x are placeholder codes that will be replaced when finalized

2019 Proposed Rule
Patients Over Paperwork Initiative

➢ Focus on reducing administrative burden while improving care coordination and outcomes
➢ Give patients ability to make decisions about their own care
➢ Responding to physicians feedback about excessive regulations and paperwork
2019 Proposed Rule
CMS Puts Patients Before Paperwork
Overhauls E/M Documentation Requirements

- Current E/M documentation is “outdated” (HPI, Exam, MDM)
- Scored on one of the following 3 methods:
  - 1995 or 1997 E/M Guidelines
  - Medical Decision Making Only
  - Time Spent Face To Face With Patient
- Must meet minimum documentation of at least a level 2
- Physicians are to continue to use all 5 levels

2019 Proposed Rule
CMS Puts Patients Before Paperwork
Overhauls E/M Documentation Requirements

- Physicians are no longer required to re-record elements of history and physical exam where there is evidence the information has been reviewed
- Record what has changed
- Eliminate re-entry of information re: chief complaint and history recorded by ancillary staff or the beneficiary
- Practitioner would need to document that the information had been reviewed and verified
Historical Look at Medicare Conversion Factors

Source: MGMA

Post-SGR Conversion Factors
MACRA 2016 to 2019 (proposed)

• Non-anesthesia conversion factor:
  – 2019 $36.0463 proposed 1% increase
  – 2018 $35.9996
  – 2017 $35.8887
  – 2016 $35.8043

Increased four years in a row as a part of MACRA (Medicare and CHIP Reauthorization Act of 2015) which repealed SGR
Physicians, ASC’s, and Outpatient Hospitals

- Physicians
  - In Office
  - In Facility
- ASC’s
- Outpatient Hospitals

2018 Medical Allowable Bases on Place of Service (POS)

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physicians In-Office</th>
<th>Physicians In-Facility</th>
<th>ASC In-Office</th>
<th>ASC In-Facility</th>
<th>HOPD In-Office</th>
<th>HOPD In-Facility</th>
<th>Total Paid by Medicare by POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20610</td>
<td>Major Joint Injection</td>
<td>61.92</td>
<td>47.88</td>
<td>29.16</td>
<td>244.68</td>
<td>61.92</td>
<td>77.04</td>
<td>292.56</td>
</tr>
<tr>
<td>62323</td>
<td>Lumbar Epidural</td>
<td>250.56</td>
<td>102.60</td>
<td>283.10</td>
<td>543.34</td>
<td>250.56</td>
<td>385.70</td>
<td>645.94</td>
</tr>
<tr>
<td>64483</td>
<td>Transforaminal Epidural</td>
<td>223.20</td>
<td>115.92</td>
<td>350.20</td>
<td>672.13</td>
<td>223.20</td>
<td>466.12</td>
<td>788.05</td>
</tr>
<tr>
<td>64493</td>
<td>Lumbar Facet 1st Level</td>
<td>175.68</td>
<td>93.60</td>
<td>350.20</td>
<td>672.13</td>
<td>175.68</td>
<td>497.44</td>
<td>819.37</td>
</tr>
<tr>
<td>64494</td>
<td>Lumbar Facet 2nd Level</td>
<td>88.20</td>
<td>53.64</td>
<td>packaged</td>
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<td>packaged</td>
<td>packaged</td>
<td>packaged</td>
</tr>
<tr>
<td>99213</td>
<td>Office Visit - Level 3</td>
<td>74.16</td>
<td>52.20</td>
<td>n/a</td>
<td>113.62</td>
<td>74.16</td>
<td>n/a</td>
<td>165.82</td>
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<tr>
<td>99214</td>
<td>Office Visit - Level 4</td>
<td>109.44</td>
<td>79.92</td>
<td>n/a</td>
<td>113.62</td>
<td>109.44</td>
<td>n/a</td>
<td>193.54</td>
</tr>
</tbody>
</table>

* E/M in HOPD must be the only service performed on that DOS. If performed with a procedure, it is included in payment for the procedure.
2018 In-Office Physician is the Most Economical POS

2018 Medicare Allowable Common Sized Based on HOPD
In-Office Physician is the Most Economical POS

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physicians In-Office</th>
<th>Physicians In-Facility</th>
<th>Facilities ASC</th>
<th>Facilities HOPD*</th>
<th>Total Paid by Medicare by POS In-Office</th>
<th>Total Paid by Medicare by POS ASC</th>
<th>Total Paid by Medicare by POS HOPD*</th>
</tr>
</thead>
<tbody>
<tr>
<td>20610</td>
<td>Major Joint Injection</td>
<td>21%</td>
<td>16%</td>
<td>10%</td>
<td>84%</td>
<td>21%</td>
<td>26%</td>
<td>100%</td>
</tr>
<tr>
<td>62323</td>
<td>Lumbar Epidural</td>
<td>39%</td>
<td>16%</td>
<td>44%</td>
<td>84%</td>
<td>39%</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>64483</td>
<td>Transforaminal Epidural</td>
<td>28%</td>
<td>15%</td>
<td>44%</td>
<td>85%</td>
<td>28%</td>
<td>59%</td>
<td>100%</td>
</tr>
<tr>
<td>64493</td>
<td>Lumbar Facet 1st Level</td>
<td>21%</td>
<td>11%</td>
<td>43%</td>
<td>82%</td>
<td>21%</td>
<td>61%</td>
<td>100%</td>
</tr>
<tr>
<td>64494</td>
<td>Lumbar Facet 2nd Level</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99123</td>
<td>Office Visit - Level 3</td>
<td>45%</td>
<td>31%</td>
<td>69%</td>
<td>45%</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>99214</td>
<td>Office Visit - Level 4</td>
<td>57%</td>
<td>41%</td>
<td>59%</td>
<td>57%</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

* E/M in HOPD must be the only service performed on that POS. If performed with a procedure, it is included in payment for the procedure.
For every action there is an equal and opposite reaction.

Trend 2: Let's lower outpatient hospital reimbursement

Source: Sir Isaac Newton
OPPS Site Neutral Payments
Why does it matter?

• ASC’s and in-office procedure rooms are paid significantly less than outpatient hospital rates
• In 2017, CMS created “off-campus” outpatient department (hospitals bill services with a PO modifier)
  – Applies to outpatient departments established after November 2, 2015
  – Is located more than 250 feet from the hospital’s main entrance
  – On-Campus POS = 22
  – Off-Campus POS = 19

• Payment for off-campus paid significantly less than on-campus outpatient departments:
  – CY 2017 paid 50%
  – CY 2018 Proposed rule was to drop to 25%
  – CY 2018 Final rule dropped payment to 40%
For every action there is an equal and opposite reaction.

Trend 3: Let's raise the cost for patients with higher premiums, co-pays, and deductibles

Source: Sir Isaac Newton

Payment Shift to Patient Responsibility: Deductible, Co-Payments, and Co-Insurance

Average Per Capita Out of Pocket Expense

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>$119</td>
</tr>
<tr>
<td>2016</td>
<td>$1,093</td>
</tr>
<tr>
<td>2016 Family of 4</td>
<td>$4,372</td>
</tr>
</tbody>
</table>

Per capita out of pocket expenditures, 1970-2016

Source: Kaiser Family Foundation analysis of National Health Expenditure data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group - Get the data - NHE

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For every action there is an equal and opposite reaction.

Trend 4: Let's tighten prior authorization, utilization guidelines, and increase denials

Source: Sir Isaac Newton

Prior Authorization

- Time Consuming
- Specific ICD-10 and CPT Codes
- Requires Documentation
- Sometimes asks for documentation from other providers such as PT/OT to prove conservative approach were tried
Utilization Guidelines, LCDs and NCDs

- Many payers have Utilization Guidelines, Medicare has LCDs and NCDs
- NCDs – Policy rules published by CMS
- LCDs - Policy rules published by each of the 12 Medicare Administrative Contractors (MAC’s), explain:
  - Coverage
  - Documentation requirements
  - Clinical indications e.g. CPT / ICD-10 codes
  - Utilization frequency - # of levels per case, # of injections per year, timing between injections
  - Expected outcome e.g. 50% pain relief for at least 6 months

ICD-10 Grace Period Ended October 1, 2016

- Payers are no longer accepting ICD-10 codes in the “right family”
- ICD-10 codes must be specific
- Watch your denials
- Follow Utilization Guidelines
Documentation Required

- Requests for supporting documentation have increased
- Most documentation is faxed or mailed to payer
- Claim attachment as a part of claims processing has stalled
- Practice Management systems do not contain medical records
- Medicare Records are in EHR
- Direct protocol was required for Meaningful Use
- Proposal to use C-CDA and Direct protocol to submit documentation

Packaging

- Surgical Package - components that are an integral part of accomplishing a surgery are included or “packaged” into reimbursement for the procedure and should not be billed separately
- Packaging – any service or supply that is considered to be an integral part of providing the service are packaged into one payment can be done by:
  - AMA in the definition of the code
  - CMS Physicians (RBRVS) packages supplies and some devices for office based procedures
  - CMS Outpatient Hospital (OPPS) packages drugs, supplies, and some devices
Bundling

- Bundling – Two distinct CPT codes that are “bundled” by CMS in the CCI’s and not usually payable separately
- In Outpatient Hospital and ASC’s, Medicare has bundled multiple levels into one payment (there is no additional payment to the facility add-on codes)

Recoupment

- Medicare can recoup money from any provider that shares a Tax Identification Number (TIN) with an obligated provider that owes Medicare regardless of whether that provider is assigned a different Medicare billing number of NPI from the obligated payer
For every action there is an equal and opposite reaction.

Trend 5: Let's come up with new payment models around value based care and population health

Source: Sir Isaac Newton
Value Based Care

Value =
Health Outcomes
Cost of Delivering Care

Michael Porter
Professor Harvard Business School

What is Value Based Care?

Quality Care*
- Safety
- Timeliness
- Effectiveness
- Efficiency
- Equity
- Patient Centeredness

Cost of Care
Historical risk adjusted (age, gender, clinical conditions and genetics) cost per member per year

Source: Institute of Medicine

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Identify Gaps in Care

- Define Clinical Protocols
  - Preventive Care
  - Vaccines and Immunizations
  - Disease Specific Tests
- Use Technology to Analyze “Big Data” to find individual patients who have Gaps in Care
- Check Patient Compliance – Failed to Keep Appointment, Take Medication, Follow care Plan
Define Population

- Ongoing real-time identification of population groups
- Helps ensure that evidence based guidelines are being followed
- Acute (High Cost) Disease
- Chronic Conditions – one or more
- Level Disease is Under Control
- Clinical Input
- Functional Status
- Social Behaviors

Population Health Management

46% of healthcare spending are spent on 5% of the population
Stratify Risk

- Less than 30% of high risk or multiple condition patients were in the same category last year that they are in this year
- Risk Stratification Prioritizes Patients Into Groups According to Need
- Allows Focus to be on Patients with the Greatest or Most Urgent Care Needs
- Proactively Predicting Which Patient is Key
  - Use Clinical Data
  - Use Financial Data
  - Benchmark Data

Engage Patients

- Improved Patient Engagement
- Emphasize Health Behaviors / Lifestyle Changes
- Use Technology to Improve Communications between Patients and Providers
  - Preventive Care Outreach
  - Lab and Test Results
  - Schedule Appointments and Procedures
  - Ongoing Monitoring
Engage Patients (continued)

- Personal and Interactive Care
  - Email, text, phone call, mobile apps, wireless biometric devices
  - Daily Monitoring of Home Devices - BP, Weight, Glucose
  - Overcome Non-Clinical Barriers
  - Incorporate Patient Values Into Care

For every action there is an equal and opposite reaction.

Trend 6: Let's use technology to help us improve care and outcomes and reduce cost

Source: Sir Isaac Newton
Interoperability: 35 Accredited HISPs
Includes Anthem and 2 Federal Agencies

Technology to Improve Care and Outcomes and Reduce Cost

- Interoperability
- Care Coordination Tools For Sharing Medical Records; closing the referral loop
- Telemedicine
- Artificial Intelligence/Health Bots
- Natural Language Processing
- Clinical Decision Support Tools
- Big Data and Analytics
- Predictive Modeling
- Genetics will be used to Personalize Medicine
About the Speaker

Linda Van Horn, MBA
President / CEO
l.vanhorn@21stcenturyedge.com
3150 Mercier, Suite 608A
Kansas City, MO 64111
816.822.8800
816.249.2555 ext. 101

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OBJECTIVES

DISCUSS:

• The **PEARLS** of Success
• **Clinical** Aspects
• **Practice Management** Considerations
• Navigating the **Future**
SUCCESS

DEFINITIONS:

- status of achieving an objective or goal
- accomplishment of an aim or purpose
- attainment of popularity or prosperity

SYNONYMS:

favorable outcome, triumph, affluence, wealth
SUCCESS

PRACTICE GOAL

BEST PATIENT OUTCOMES

Based on EBM - literature, experience
expert consensus, perpetual learning
SUCCESS

PRACTICE GOAL

MULTIDISCIPLINARY Private Practice Environment
- Clinic - dedicated staff
- Ambulatory Surgery Center
- Physical Therapy
- Aquatic Therapy
- Behavioral Pain Management (BPM)
SUCCESS

PRACTICE GOAL

FINANCIAL SUSTAINABILITY

- Revenue greater than overhead
- Stable income
- Secure
- Debt free
SUCCESS

PEARL #1

ATTENTION TO DETAIL
SUCCESS

PEARL #2

ASK THE RIGHT QUESTIONS
CLINICAL

ASK THE RIGHT QUESTIONS

MAKE SURE PATIENTS UNDERSTAND WHAT THEY ARE TALKING ABOUT:

- When I bend backwards I feel my L3-4 disc bulge
- My coccyx
- My sciatica
CLINICAL

ASK THE RIGHT QUESTIONS

COMMON FU MISTAKES:

- I’m no better, I still hurt 10/10
- My neck still hurts since that LESI
- My back still hurts since that LMB RF
  but (-) lumbar ps TTP, (-) ext, (+) SI TTP
SUCCESS

PEARL #3

LISTEN TO YOUR PATIENTS

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CLINICAL

LISTEN TO YOUR PATIENTS

HISTORY

- Location - Laterality
- Character
- Static vs Active
- Chronicity
- Intensity
CLINICAL

LISTEN TO YOUR PATIENTS

PAIN CLASSIFICATIONS

- Acute – Subacute – Chronic
- Nociceptive – Neuropathic
- Radicular – Axial - Stocking-Glove
- Mechanical – Rest
- Focal - Generalized
SUCCESS

PEARL #4

DETERMINE PAIN GENERATOR
BEST WAY TO DETERMINE PAIN GENERATOR

- History?
- Physical exam?
- Electrodiagnostic studies?
- Radiologic studies?
- ???
CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

RADIOLOGICAL STUDIES

- Identify *structural abnormalities*
- Do *NOT identify pain*
- May provide *correlation* with pain
- Reliable?
CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

FALSE POSITIVES IN RADIOLOGICAL STUDIES

Systematic Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations,
American Journal of Neuroradiology, Nov 2014

- Found 379 Pertinent Articles
- 33 Articles met criteria, 3110 asx pp, prevalence of degenerative changes in pain free populations
- “Part of normal aging and NOT associated w pain”

RICHARD S. EPTER, MD
# Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Patients


**RICHARD S. EPTER, MD**

---

## FIG 1. Results of literature search.

### Table 1: Estimated number of patients by age used to inform prevalence of degenerative spine imaging findings in asymptomatic patients

<table>
<thead>
<tr>
<th>Imaging Finding</th>
<th>Age (yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Disk degeneration</td>
<td>273 (9)</td>
</tr>
<tr>
<td>Disk signal loss</td>
<td>46 (2)</td>
</tr>
<tr>
<td>Disk height loss</td>
<td>15 (1)</td>
</tr>
<tr>
<td>Disk bulge</td>
<td>55 (4)</td>
</tr>
<tr>
<td>Disk protrusion</td>
<td>87 (5)</td>
</tr>
<tr>
<td>Annular fissure</td>
<td>167 (5)</td>
</tr>
<tr>
<td>Facet degeneration</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Spondylolisthesis</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

*The number of studies are in parentheses.*

## Table 2: Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients

<table>
<thead>
<tr>
<th>Imaging Finding</th>
<th>Age (yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Disk degeneration</td>
<td>37%</td>
</tr>
<tr>
<td>Disk signal loss</td>
<td>17%</td>
</tr>
<tr>
<td>Disk height loss</td>
<td>24%</td>
</tr>
<tr>
<td>Disk bulge</td>
<td>30%</td>
</tr>
<tr>
<td>Disk protrusion</td>
<td>29%</td>
</tr>
<tr>
<td>Annular fissure</td>
<td>19%</td>
</tr>
<tr>
<td>Facet degeneration</td>
<td>4%</td>
</tr>
<tr>
<td>Spondylolisthesis</td>
<td>3%</td>
</tr>
</tbody>
</table>

*Prevalence rates estimated with a generalized linear mixed-effects model for the age-specific prevalence estimate (binomial outcome) clustering on study and adjusting for the midpoint of each reported age interval of the study.*

---

*CLINICAL*
CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

PAIN PATTERN
Dermatomes

RADICULAR PAIN

Levels of principal dermatomes

- C5: Clavicles
- C5, 6, 7: Lateral parts of upper limbs
- C8, T1: Medial sides of upper limbs
- C6: Thumb
- C6, 7, 8: Hand
- C8: Ring and little fingers
- T4: Level of nipples

Levels of dermatomes:

- T10: Level of umbilicus
- T12: Inguinal or groin regions
- L4, 2, 3, 4: Anterior and inner surfaces of lower limbs
- L4, 5, 6: Foot
- L5: Medial side of great toe
- S1, 2, 4, 5: Posterior and outer surfaces of lower limbs
- S1: Lateral margin of foot and little toe
- S2, 3, 4: Perineum
CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

CERVICAL FACET PATTERNS


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BEST WAY TO DETERMINE PAIN GENERATOR

THORACIC FACET PATTERNS

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CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

LUMBAR
FACET
PATTERNS

FIGURE 4.2.31 Pain distribution in the facet syndrome. Referred pain patterns from facet joints reflect the distribution of the segmental nerve supply at each level involved. Distal reference to the buttocks relates to the caudal migration of posterior branches, whereas limb distribution mimicking root pain results from pain reference in the anterior division of each segmental nerve. (Bous BA: Facet joint injections. In: Stanton-Hicks M, Bous RA (eds): Chronic Low Back Pain. New York, Raven, 1982, pp 199–211.)

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CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

Cervical Disc Patterns

Distribution of pain patterns of cervical disc stimulation

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BEST WAY TO DETERMINE PAIN GENERATOR

Thoracic Disc Patterns

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BEST WAY TO DETERMINE PAIN GENERATOR

Lumbar Disc Patterns
CLINICAL

BEST WAY TO DETERMINE PAIN GENERATOR

SI JOINT PAIN PATTERN
CLINICAL

BEST WAY TO **PROVE & CONFIRM**
PAIN GENERATOR

**DIAGNOSTIC**

NERVE BLOCK / JOINT INJECTION
SUCCESS

PEARL #5

EDUCATE EACH PATIENT
CLINICAL

EDUCATE, EDUCATE, EDUCATE

- Nursing staff, midlevels, front office – reinforce same info
- Chronic pain pts - don’t hear 90% of what you just said
- New Eval – informed consent w meds, PT, AT, BPM, IPM

Questions: so what are we going to do?
CLINICAL

EDUCATE, EDUCATE, EDUCATE

- Explain the *purpose* of each procedure
  
  *NOT* to *fix*

  To *decrease* or *eliminate* pain

- *Realistic* outcome expectations

  Diagnostic Injection DOA (Duration of Action)
  Therapeutic Injection DOA
  RF DOA
  SCS DOA
CLINICAL

EDUCATE, EDUCATE, EDUCATE

- Don’t want patient reporting back to referral source:
  “DIDN’T DO ANYTHING FOR ME”

- Pts must understand WHAT TO EXPECT from their procedure

- Show them questionnaire and their resolved PAIN DRAWING
  -so they will report SUCCESS to their referring provider

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CLINICAL

EDUCATE, EDUCATE, EDUCATE

Must provide REALISTIC EXPECTATIONS

Procedure MAY LAST, not WILL last

STRIVE TO EXCEED PATIENT EXPECTATIONS
SUCCESS

PEARL #6

INDIVIDUALIZE TREATMENT PLAN
CLINICAL

TREATMENT PLAN

- Maximize compliance
- Must be realistic for that patient
- Covered by insurance
- Convenient for transportation
- Schedule ancillaries, next FU/procedure
- Provide in writing EACH VISIT
SUCCESS

PEARL #7

LEARN FROM THE BEST
SUCCESS

PEARL #8

GET GOOD ADVICE

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PRACTICE MANAGEMENT

GET GOOD ADVICE

CONSULTANTS

- Physician Colleagues
- Practice Consultant
- Healthcare Attorney
- Healthcare Accountant
- Financial Advisor
- Private Banker
PRACTICE MANAGEMENT

GET GOOD ADVICE

DEVELOP FRAMEWORK

- Office based vs ASC facility
- Identify offered services
- Location
- Partners
- Employees
SUCCESS

PEARL #9

BUILD

PRACTICE INFRASTRUCTURE
PRACTICE MANAGEMENT

PRACTICE INFRASTRUCTURE

ORGANIZATION

- CEO
- Practice Administrator
- CFO
- Director of Nursing
- Clinic Supervisor
- Director of Behavioral Services
PRACTICE MANAGEMENT

PRACTICE INFRASTRUCTURE

COMMON CORE VALUES

- Courteous and Attentive
- Respectful
- Compassionate
- Integrity
- Trustworthy
- Accountability
PRACTICE MANAGEMENT

PRACTICE INFRASTRUCTURE

DETERMINE DESIRED SERVICES

- Clinic
- ASC
- Aquatic Therapy
- Physical Therapy
- Behavioral Pain Management

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SUCCESS

PEARL #10

YOUR PRACTICE IS ONLY AS GOOD AS THOSE WHO REPRESENT YOU

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PRACTICE IMPRESSION

- Compassion & Competence begins with Front Desk
- Person answers phone
- Scripting
- New patient coordinator
- Excel in customer service
- Weed out bad employees
SUCCESS

PEARL #11

RETAIN YOUR EMPLOYEES
EMPLOYEE RETENTION

- Investment begins at interview
- Employees are practice's greatest asset... & liability
- Best fit for position
- Define employee responsibilities
- Ongoing education and oversight
- Key performance indicators for accountability
- Positive, consistent work environment
PRACTICE MANAGEMENT

EMPLOYEE RETENTION

- Team approach
- Cross training with same core values
- Get feedback with suggested resolutions
- Recognize excellence in your employees
- Incentivize and reward

ALWAYS STAND UP FOR YOUR EMPLOYEES

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SUCCESS

PEARL #12

OPTIMIZE EFFICIENCY
PRACTICE MANAGMENT

PRACTICE EFFICIENCY

- Happy employee...happy life
- Motivate
- Time awareness
- Time studies
- Best workflow models
- WILL MAKE YOU MORE EFFICIENT
PRACTICE MANAGEMENT

PRACTICE EFFICIENCY

- Optimally utilize practice resources
- Implement clear and concise *Operational & Financial Policies*
- Have *target dates* for clinical and financial goals
- Identify, discuss & solve practice issues *ASAP*
- Regular administrative meetings

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SUCCESS

PEARL #13

DOCUMENTATION

DOCUMENTATION

DOCUMENTATION

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PRACTICE MANAGEMENT

DOCUMENTATION

- Electronic Health Record System
- Templates
- LCDs / NCDs
- Phreesia
SUCCESS

PEARL #14

EVERYONE IS A REFERRAL SOURCE
PRACTICE MANAGEMENT

MARKETING

- Face-to-Face
- Knock on doors
- Peer lunches
- Direct mail
- Newspaper/Magazine/Radio/TV Ads
- Billboards
- Marketing Director
PRACTICE MANAGEMENT

MARKETING

- AIM FOR BROAD BASE
  - PC, IM, Ortho, NS, Neuro, PMR, Rheum, GI, Gyn
  - Chiro, PT, OT, community

- GOOD COMMUNICATION with Referring Providers

- GET BRANDED

- EVERYONE = POTENTIAL REFERRAL SOURCE
  - Your family, friends, patient’s family/friends, staff’s family/friends

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SUCCESS

PEARL #15

LEARN FROM YOUR MISTAKES
LEARN FROM YOUR MISTAKES

- Mistakes are one of the best learning tools
- Always be a patient advocate
- Discharging patients
- Satisfied patients = Referrals
FUTURE

WHAT WILL THE FUTURE HOLD?

- Will IPM exist?
- Private Practice?
- Hospital Employees?
- Commercial vs Single Payer Insurance

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FUTURE

WHAT WILL THE FUTURE HOLD?

- Have a VISION for the future
- Map out PLAN OF ACTION to achieve future GOALS
- Anticipate and establish CONTINGENCY PLANS
- Be as prepared as possible to navigate the future
SUCCESS

CONCLUSION

- MASTER THE PEARLS of success
- ASSEMBLE the best people you can find
- Build an outstanding INFRASTRUCTURE

... and DO YOUR BEST TO OBTAIN
THE SUCCESSFUL PRACTICE YOU DESIRE

RICHARD S. EPTER, MD
AUGUSTA PAIN CENTER

Richard S. Epter, MD
706.738.7246(PAIN)

www.augustapaincenter.com