Interventional Pain Techniques for the Primary Care Provider

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Interventional Pain Techniques for Primary Care

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NEW ORLEANS, LA

About Me

- Residency in Anesthesiology
- Fellowship Pain Medicine
- Board Certified Anesthesiology and Pain Medicine
- Licensed Acupuncturist
- No Financial Conflicts to Disclose

Goals

- Review of recent relevant literature and discussion
- Assessment of the pain patient
  PE, Imaging, Initial Treatment.
- An Overview of the Various Treatment Options in your office and mine

What is Chronic Pain?

- Pain is chronic or persistent when we must accept that the painful condition is not reversible.
- Similar to other forms of chronic disease in it's impact on psychosocial function, etc.
- This is where "management" comes in, as in diabetes, management is crucial.

How Prevalent is Chronic Pain

In the U.S.A.

- 40 million American suffer from chronic pain
- 22 million have conditions limiting basic everyday functions such as walking, lifting, carrying.
- 18 million Americans visit the doctor each year for back pain.
- Pain is the 1st or 2nd commonest complaint for visits.

Barriers to Effective Treatment of Chronic Pain

- Pain is notoriously difficult to study, we have animal models but its always debatable how relevant those are.
- No lab values or other ways to objectively measure pain.
- Difficult to measure our successes, especially in attempts to rigorously study.

BMC Primary Care Journal

Slatman et al 2022

Factors used by general practitioners for referring patients with chronic MSK pain: a qualitative study

- Interviewed 14 Dutch PCPs about referral patterns etc (COVID)
- Identified 28 factors mentioned by 50% of interviewed GP.
- Found that 90% of GPS interviewed mentioned unfamiliarity with treatment options as an influencing factor.

BMC Primary Care Journal

Slatman et al 2022

Factors used by general practitioners for referring patients with chronic MSK pain: a qualitative study

- Other commonly mentioned factors showed a focus on location of pain as well as patient's acceptance of pain or lack thereof

Pain Medicine Journal, 2018

- Becker et al
- Pain Management for Primary Care Providers: A Narrative Review of High-Pact Studies, 2014-2016
- Reviewed several "high-impact studies" relevant to PCPs and pain focusing on non-opioid treatment options.

Pharmacotherapy for acute lumbar pain

- Review of 2 studies questioned efficacy of cyclobenzaprine and oxycodone/ APAP when added to naproxen (5)
- Suggested oral steroids in the presence of acute sciatica led to modest improvement at 3 weeks (4)

Total Knee Replacement

- TKR was found to be more efficacious than nonsurgical management for pain and functional improvement for knee OA (Skou et al)
- TKR was associated with a higher risk of adverse events.

Medical Cannabinoids, etc

- Evidence for efficacy in chronic neuropathic pain (1)
  - Modest effect, adverse effects common
  - Low to moderate quality of evidence, significant risk of bias
- Meaningful improvement with meditation, mindfulness, CBT, etc. (9,10)

Prevention

- 4 trials gave low-quality evidence of a short-term protective effect of exercise on incident low back pain (16)
- Exercise plus education reduced incident LBP at short and long-term follow-up but had no effect on prevention of LBP-related sick leave at short- or long-term follow-up (16)
- Increasing amounts of time per day spent in light-intensity physical actitieis were significantly associated with less incident disability and less disability progression, event after controlling for socioeconomic and clinical factors (17)
- One study demonstrated a dose- response relationship between increased steps and decreased disability (18)

Interventional Pain Treatments

- Manchikanti et al. published a response to the Chou paper which contradicted his findings and reported significant efficacy (20)

ESIs and spinal stenosis

Primary Care and Pain

- What can you do for the acute, subacute, chronic pain patient?
  - Comfort, interest, experience, practice environment.
- What are reasonable initial treatment options you can provide?
  - Workup, referral, medication, interventions, insurance, etc.
- When are good times to make a referral to a specialist?
  - Comfort, interest, experience, practice environment.

Primary Care and Pain

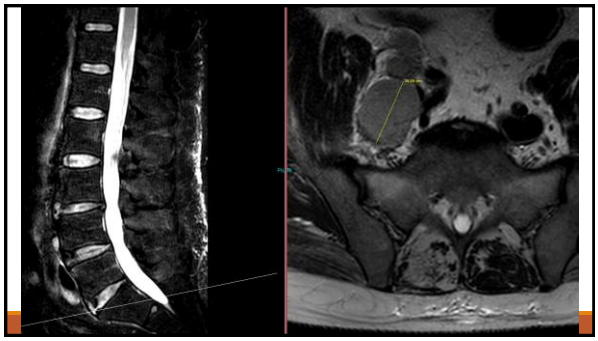
- Weight Loss
- Encourage exercise
  - Core Strength and flexibility
- Education
  - Posture, workplace, proper mechanics

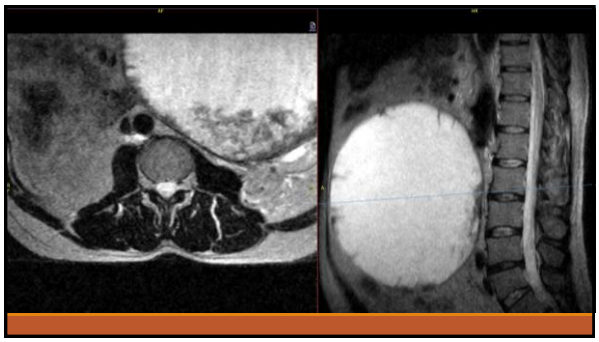
Imaging

- Plain films
  - Rule of VCF, instability, general structure in the spine
  - Rule out fracture, displacement in hips, shoulder, etc.
  - Tip: when in doubt A/P and lateral views will usually get started.
  - In many cases MR imaging will not be approved by insurance until performed.

Imaging

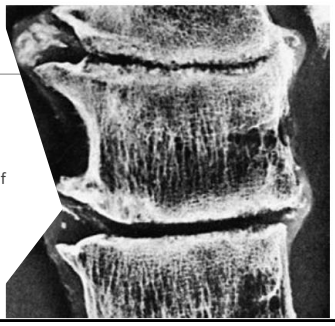
- MRI- Gold standard for assessment of painful spinal conditions
- While there are indications for use of contrast, not typically required.
- Even if an MRI is unlikely to affect treatment (e.g. facet disease), occult findings are not uncommon.





Spine General Considerations

- MRIs don't always correlate with clinical findings.
- MRI is a part of the puzzle
- The dominant lesion on MRI if often not the dominant pain generator.
  - E.g. severe spinal stenosis but the pain generator is facet syndrome.



The Physical Exam

- *"I used to think that the brain was the most fascinating thing in the whole universe… Then I thought, what's telling me that?"*

  Emo Phillips

- This is not a full neurologic exam, I'm looking for clues to the source of the pain, and I am looking for obvious neurologic involvement, clear red flags.

Fortin's finger test:

- The patient can indicate location of the pain with 1 finger infero-medially to the posterior superior iliac spine…

A few landmarks

- C7 spinous process
- T7 spinous process- inferior scapular border
- L2 level- end of spinal cord in adult
- L4/5 spine- superior aspect of iliac crest
- Ask the patient to point to the area of chief complaint as specifically as possible, e.g. with one finger. *This is the most important landmark. Note the spinal level*

Inspection

- Gait: Antalgic or Normal, assist device? Steady or not?
- Overall: Habitus, Dress, Hygiene, Skin, Distress
- Mental, psychological state
- Scoliosis, station, respiration, communication

Cervical and Lumbar Exam Pearls

Pain with extension → Posterior elements

Pain with flexion → Anterior elements

Pain with left or right rotation
- May indicate most affected side
- Spondylosis, typically ipsilateral
- Myofascial, typically contralateral

Pearls

- Note spinal level correlate(s)
- Cervical
  - Paraspinal pain often indicates facetogenic pain
  - Pain in the midline, often base the neck often indicates epidural inflammation or discogenic pain
- Thoracic
  - In the absence of trauma or VCF, thoracic pain is most often cause by spasm of the paraspinal musculature due to underlying lumbar and/or cervical disease.

Pearls

- Lumbar
  - Lower disc pain, especially L4/5 and L5/S1
    - Often radiates and will be described as hip pain
    - Often mimics GT bursitis
    - May radiate to the groin, inguinal area.
  - Lower lumbar facet pain
    - Lumbar facets about 2.5 cm off midline.
    - May radiate into the legs. Most commonly posterior hips to the knees
    - Will occasionally radiate even to the feet and suggest radiculopathy

Pearls

- Lumbar radiculopathy, active annular tears
  - In the acute or subacute phase, the patient, even used to chronic pain, will be miserable
  - These patients are invariably tender in sciatic notch(es).
  - This may mimic SI joint pain and is often confused.
  - May often confused with piriformis syndrome.

Vertebral Compression Fracture

- Spinal Percussion (worst area last because you may be done after that)
- They do not all hurt, acutely or chronically.
- Do not perform unnecessary maneuvers.

Back Exam

- Straight Leg Raising Test (Lasegue's)
  - Raise knee straight until pain is felt
  - Note angle, usually 10-60 degrees.
  - Elicits pain at segmental site of spinal lesion
- Typically:
  - Central spine/disc lesion: mid-line pain
  - Lateral spine/disc lesion: ipsilateral LE
  - Intermediate spine/disc lesion: both

Sacroiliac Joint

- Fortin's Finger
- Testing for SI joint pain- stick a needle in it.
- Difficult to assess in presence of radiculopathy
- Not as common as reported, in my opinion. There are risk factors.
- None are very predictive:
  - Compression Test, Patrick's Test, etc.

Neurological Exam

- Looking for obvious deficits
- Looking for meaningful asymmetry.
- The patient will often tell you where you might focus.
- Looking for red flags

Neurological Exam

Motor exam

- Biceps C5, 6
- Triceps C6, 7, 8
- Four finger abduction C8, T1
- ***Note: you have covered the entire brachial plexus with these selected groups.**

Neurological Exam

Motor Exam

- Hip flexors (iliopsoas) L2,3,4
- Knee flexors L5, S2
- Foot plantar flexors S1,2

Summary

- Look for concordance, do these findings add up and support diagnosis?
- Do they make sense given the chief complaint, history, and imaging?
- Are there reds flags affecting care?

Acute, 1st time lumbar raduculiits

- 3 weeks of severe lower back pain with radiation to the right medial ankle.
- Not improving with NSAIDS. No injury. Not able to work, has been mostly bedridden
- Subjective weakness right leg, antalgic gait, some distress.
- No red flags, no contraindication for NSAIDS, opioid therapy
- Initial treatment
  - Toradol, TPI and/ or oral steroids. +/- short course tramadol, muscle relaxant
  - Hesitate to initiate adjuvants initially but not wrong
  - Plain films, plus MRI if has access to it.
  - Referral

Opioid Therapy

- Comfort, interest, experience, practice environment.
- Know your CDC Guidelines, DEA material.
- Monitoring
  - PMP
  - UDS
- Be comfortable with frank discussions about history, abuse, alcoholism, etc.
- Set your limits, amount, time, etc.

In the News

9-0 Supreme court decision 2022

The decision gives physicians charged with illegally prescribing opioids a fighting chance against law enforcement by requiring that prosecutors prove that they had criminal intent, rather than simply having to show that their prescribing did not conform to standardized guidelines.


SCIENTIFIC AMERICAN

A Recent Supreme Court Ruling Will Help People In Pain

By ruling in favor of two doctors accused of enabling pill mills, SCOTUS is clarifying opioid prescription practices

In-clinic options

- Joint, other injections
- Trigger point injections
- IM injections
- Acupuncture *


Injection Techniques in Musculoskeletal Medicine: A Practical Manual for Clinicians in Primary and Secondary Care 5th Edition, Kindle Edition

Kindle Hardcover Other Sellers

In-clinic options

- Trigger point injections
  - Great for acute or recurrent pain.
  - Often just local or local plus steroid
  - Blackbelt tip #1
    - Use non-particulate steroid like Decadron if you're new.

In-clinic options

- Trigger point injections
  - Blackbelt tip #2
    - Acute sciatica loves an ipsilateral sciatic notch injection. 10-15 mg dexamethasone in 5-10 cc 1% lidocaine. Find the tender most point and get in there deep.

In-clinic options

- Trigger point injections
  - Blackbelt tip #3
    - Thoracic spine- stay within 2cm of the midline spinous process. Angle inwards.
    - Pneumothorax is the #1 complication of TPI.

Occipital Nerve Block

- Blindly
  - Often sufficient
- For modulation of migraine, upper cervical pain
- For diagnosis and treatment of true occipital neuralgia

Case Report

58 year old female

26 months of posterior headaches after trauma, had lumbar and cervical complaints initially.

Lumbar problems resolved with ESIs.

Cervical ACDF was performed which mostly resolved cervical complaints.

Occipital Headaches, slightly greater right than left

Occiput to the crown, occasionally farther forward.

Constant moderate to severe pain

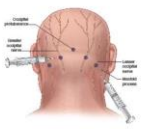
Allodynia
- Putting on clothing hurts
- Can't get a haircut
- Cant tolerate ACP

Debilitating when flared.

Occipital Nerve Block

- Performed blindly
- 1 month follow up
- Brief Flare at injection site
- At 1-week symptoms resolved entirely for 2 weeks
- At 1 month, only intermittent symptoms, about 80% relief.
- This was in July, haven't heard anything further.
- Consider U/S Guided, RF

Occipital nerve block



Acupuncture

In Louisiana, requires a separate license for physicians and 200 CME hours of training.

There are several organizations offering courses for licensure

It could be a very interesting journey and a way to enhance your practice.

Acupuncture

In my opinion, nothing comes close to acupuncture in terms of

- Cost
- Side Effects
- Complications
- For many, the effectiveness

General Considerations

- Do no harm
- Can the procedure be performed safely
- Do the benefits outweigh the risks?
  - Decreased medication usage
  - Improved qulaty of life
- Consent
- Alternatives

So what are we doing anyway

- Diagnosing- often in partnership with referring physicians
- Avoiding and or limiting the role of medications
- Enabling increased function, exercise, participation in physical therapy
- Decreasing pain due to inflammation
- Interrupting transmission of pain sensations
- Neuromodulation

IPM

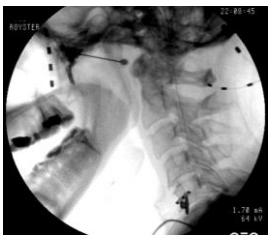
- Acupuncture
- Interventional Headache
- Spine Treatments
- Peripheral Treatments
- Implantable Therapies
  - Intrathecal Drug Delivery
  - Spinal Cord Stimulation
  - Vertiflex Superion

Acupuncture

Cupping… Yeah, got in trouble for that one

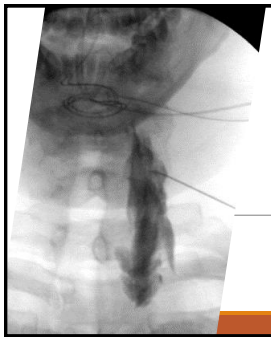
Referral Considerations

- Generally, IPM is a reasonable referral for chronic pain of any origin, once red flags excluded.
- We manage stable, non-operative conditions chronically.
- We evaluate and diagnosis acute and sub-acute conditions
- We work closely with spine surgeons, orthopedists, etc. and can make those referrals up the treatment chain as needed.



Sphenopalatine Ganglion Block

- Chronic Headaches
- V2 Trigeminal Neuralgia
- Pulsed RF is a great option



Stellate Block AP

NICE LONGITUDINAL SPREAD

STELLATE BLOCKS FOR SYMPATHETICALLY MEDIATED PAIN OF THE HEAD, UPPER EXTREMITY AND THORAX.

SIMILAR TO SPG BLOCKS IN CLINICAL PRACTICE FOR HEADACHES

Cervical Joints and Cervicogenic Headaches

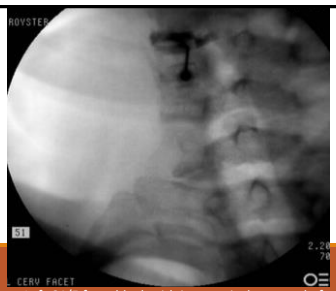
Atlanto-occipital joints- rarely used in my practice.

Atlantoaxial joints
- up to 10-20% of occipital headaches after whiplash

C2/3 Facet Joints
- 20-30% of headaches after whiplash injury

C3/4, C4/5

Soft tissues

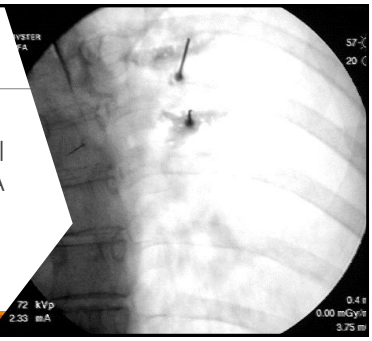


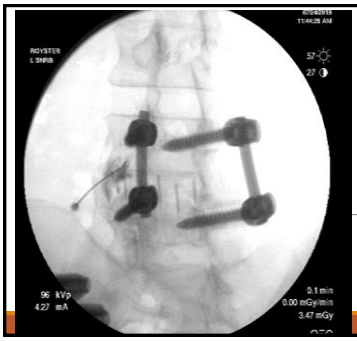
Left C4/5 facet block with intra-articular spread of contrast.

Non- and Post-operative Shoulder Pain

- Suprascapular nerve blocks
- Pulse RFA

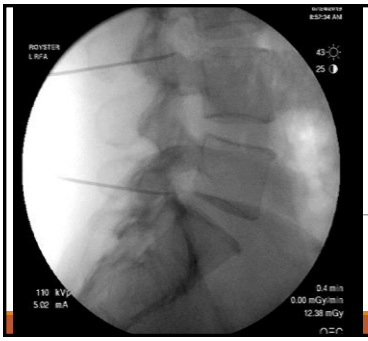
Intercostal Blocks and RFA





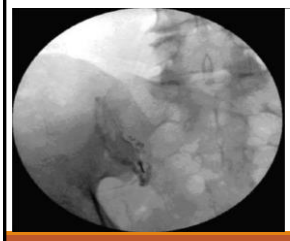
Lumbar considerations

- Disc supplementation, biologics
- Spinal stenosis on MRI is often not clinically the dominant issue. Often, facetogenic pain that is is invariably present is dominant.
- Facet and or medial branch blocks, RFA are the mainstay for chronic neck and back pain.



In position for Lumbar Medial Branch RF

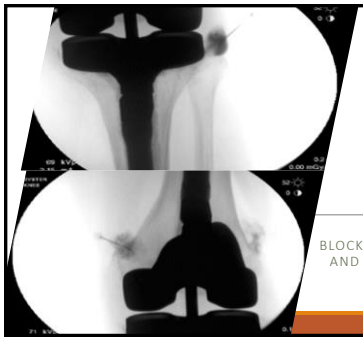
Sacroiliitis



- Intra-articular injections
- Peri-articular infiltrations
- Radiofrequency (RF) ablation.
- Percutaneous fusion

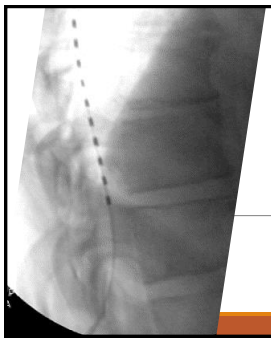
Knee, shoulder, and hip pain

- Overall, 46% of patients reported persistent pain at the surgical site - 53% after TKR and 38% after THR



Genicular Ganglion Block and RFA

BLOCK OF THE SUPERIOR AND LATERAL INFERIOR BRANCHES



Spinal Cord Stimulation

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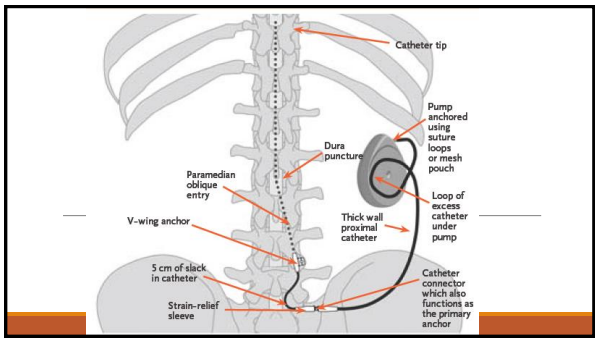
Intrathecal Drug Delivery



Questions?

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The End!

THANK YOU FOR YOUR ATTENTION

Neuropathic Pain: Can CGRP Modulation Help?

Raghav Govindarajan, MD

Neuropathic Pain: Can CGRP Modulation Help?

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Disclosures:

I have received financial compensation for serving on the speakers bureau for Biohaven

Talk structure

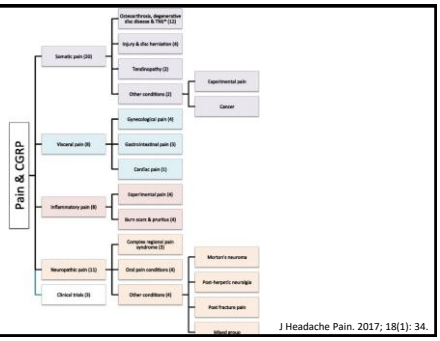
- Role of CGRP in pain modulation
- CGRP modulation in migraine
- CGRP therapy for migraine
- CGRP therapy for neuropathic pain

CGRP:
Distribution and Function

- Widely distributed – central (α) and peripheral (β) nervous systems
- CGRP containing nerves provide innervation to all
- the major organs: brain, heart, lung, kidney, etc.
- Effects on respiratory, endocrine, gastrointestinal,
- central nervous, immune, and cardiovascular
- systems
- Functions
- Vasodilation, inflammation
- Nociception, hyperalgesia

By binding to this receptor, αCGRP will suppress deleterious effects mediated by the angiotensin II type 1 (AT1) and endothelin type A (ETA) receptors, as well as reduce the activity of the sympathetic nervous system (SNS)

Distribution of CGRP in central and peripheral nervous system



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Role of CGRP in Migraine

CGRP modulation in Migraine

Types of CGRP modulation

CGRP in Migraine

- CGRP is released into jugular venous system during migraine
- Serum CGRP levels are elevated in chronic migraine
- CGRP infusion evokes migraine
- Small-molecule CGRP-receptor antagonists (gepants) effectively abort migraine attacks
- Anti-CGRP and anti-CGRP-receptor monoclonal antibodies prevent episodic migraine (EM) and chronic migraine (CM)

Small Molecule vs Mab

Small Molecules	Monoclonal Antibodies
• Target specificity lower	Target specificity high
• Clearance (liver, kidney)	Clearance RES
• Size <1 kD	Size ~150 kD
• Oral	Parenteral
• Can cross BBB	Do not cross BBB
• Half-life = minutes to hours	Half-life = 3–6 weeks
• Immunogenicity (no)	Immunogenicity (yes)

Telcagepant

- 19,820 acute attacks were treated with telcagepant: "Telcagepant was generally well tolerated when administered for the acute intermittent treatment of migraine for up to 18 months. The incidences of triptan-related and drug-related adverse events favored telcagepant over rizatriptan"
- Preventive trial: Out of 660, 13 patients had ALT elevation ≥ 3 × the upper limit of normal and 7 of these had an AST elevation ≥ 3 × the upper limit of normal. 2 patients had very high symptomatic transaminase elevations that occurred within 2-6 weeks of treatment initiation and resolved after treatment discontinuation.

Rimegepant

- Two Phase 3 trials
- Pain freedom at 2 hours: rimegepant in Study 301 and 302: 19.2% and 19.6%, vs 14.2% ($p < 0.03$) and 12.0% ($p < 0.001$) in the placebo groups
- Freedom from the most bothersome symptom (MBS) for rimegepant in Study 301 and 302: 36.6% and 37.6%, respectively, vs 27.7% ($p < 0.002$) and 25.2% ($p < 0.0001$) for placebo
- AEs comparable to placebo

Ubrogepant

Endpoints	Statistics	Placebo (N=456)	Ubro 50mg (N=423)	Ubro 100mg (N=448)
Co-Primary Endpoint 1: *Pain Freedom 2 Hours After Initial Dose*	**Pain Free at 2 Hours, %**	11.8	19.2	21.2
	Adjusted p-value	-	***0.0023***	***0.0003***
Co-Primary Endpoint 2: *Absence of Most Bothersome Symptom[1] 2 Hours After Initial Dose*	**Absence of MBS[1], %**	27.8	38.6	37.7
	Adjusted p-value	-	***0.0023***	***0.0023***

Ubrogepant

- LFTs
- 6 cases with ALT >3x ULN
- 1/6 on pbo
- 5/6 on ubrogepant
- 2/5 are ALT>5x
- 1/5 is ALT>10x

CGRP Monoclonal Antibodies

- Erenumab (Aimovig) SQ – Episodic & Chronic Migraine – monthly
- Galcanezumab SQ – Episodic & Chronic Migraine, Cluster – monthly
- Fremanezumab SQ – Episodic & Chronic Migraine - monthly/Q12 weeks
- Eptinezumab IV – Episodic & Chronic Migraine - monthly/Q12 weeks

- mAb against CGRP receptor vs. CGRP:
- Receptor mAb block receptor from signaling transmission vs removal of excess CGRP released from perivascular trigeminal nerve endings

Erenumab: Phase 3 data

- Episodic migraine
- 70 mg vs placebo
- Treatment Q month for 12 weeks
- Reduction in number of migraine days/month: 2.9 vs. 1.8 (placebo)

- Chronic Migraine (STRIVE)
- 70 mg vs 140 mg vs. placebo
- Treatment Q month for 24 weeks
- Reduction in migraine days/month: 3.2 vs. 3.7 vs. 1.8 (placebo)
- AE: Injection site pain, URI, Nausea

Galcanezumab: Phase 3 Data

- Episodic Migraine (EVOLVE-1/2)

- 240/120mg vs. 240mg vs. placebo
- Treatment Q month x 6 months
- Reduction in monthly migraine headache days: 4.73 vs 4.57 vs 2.81 , 4.29 vs. 4.18 vs. 2.28
- 50% response rate- 60% vs 40%
- 100% response rate - less than 20% vs. 5%

- Chronic Migraine (REGAIN)

- 240/120mg vs. 240mg vs. placebo
- Treatment Q month x 3 months
- Reduction in monthly migraine headache days: 4.83 vs. 4.62 vs. 2.74
- 50% response rate 27.6% vs. 27.5% vs. 15.4%
- AE: Injection site reaction, injection site pruritus

Galcanezumab: Phase 3 for Cluster headache

- Episodic cluster headache trial
- 106 patients
- average 17.5 cluster headache attacks per week at baseline
- once-monthly galcanezumab 300mg vs placebo.
- statistically significant difference in the reduction of weekly attacks
- (-8.7 for galcanezumab vs -5.2 for placebo; P=.036).
- Significantly more patients on galcanezumab achieved ≥50% reduction in weekly cluster headache attacks
- Discontinuation rates: 8% treatment group and 21% placebo group
- Chronic cluster headache trial – no efficacy

Fremanezumab: Phase 3 Data

- Episodic Migraine (HALO)
- 225mg vs. 675mg/placebo/placebo vs. placebo
- Q month for 3 months (group 2 only 1 treatment)
- Reduced headache days: 3.7 vs. 3.4 vs. 2.2

- Chronic Migraine (HALO)
- 675/225/225 vs. 675/placebo/placebo vs. placebo
- Q month for 3 months
- Reduced headache days: 4.6 vs. 4.3 vs. 2.5
- 50% responders: 40.8% vs. 37.60% vs. 18.10%
- AE: Injection site pain, injection site induration, injection site erythema

Fremanezumab: Phase 3 Data

- Frequent episodic migraine (PROMISE 1)
- 100 mg vs. 300 mg vs. placebo IV
- Treatment Q 3 months x 24 weeks
- Reduction of migraine days: 30.8% vs. 31.5% vs. 20.3%
- 19-23% had 100% response – no migraines for 3 months vs 14%
- AEs similar to placebo

Fremanezumab: Phase 3 Data

- Chronic Migraine (PROMISE 2)
- Primary endpoint – drop of 8.2 monthly migraine days vs 5.6 for placebo p<0.0001
- Rapid Day One prevention: reduction in migraine risk on Day One post-infusion 52% vs 27% placebo, p<0.0001
- Responder rates for month 1-3
- 61% - ≥ 50% reduction in migraine days vs 39% for placebo, p<0.0001
- 33% - ≥ 75% reduction in migraine days vs 15% for placebo, p<0.0001
- 15% - 100% response for a full three months vs 5% for placebo, p<0.0001
- All other pre-specified key secondary endpoints were met with very high statistical significance

Anti-calcitonin gene–related peptide monoclonal antibodies for neuropathic pain in patients with migraine headache

- Patients with a diagnosis of both refractory migraine headache and peripheral neuropathy (diagnosed by electrodiagnostic studies) with neuropathic pain, as well as a minimum of a 1-year follow-up visit after starting treatment, were included.
- Refractory migraine was defined as a persistent migraine headache (more than 15 days per month) that failed to respond to two or more medications.

Muscle & Nerve. 2021;63:563–576

- Patients were excluded from the study if they had a recent stroke or a history of stroke.
- We collected data on patient demographics, clinical features, medications taken for neuropathy and migraine headache, scores on the Neuropathic Pain Scale (NPS), and number of migraine headache days (MHDs) per month. NPS scores and number of monthly MHDs comprised the patient-reported data

Neuropathic Pain Scale

- The NPS is a patient-reported scoring system for assessing neuropathic pain, including monitoring response to treatment.
- The descriptors or domains evaluated contain include: intense, sharp, hot, dull, cold, sensitive, itchy, unpleasant, deep, and surface.
- Scores range from 0 to 100. Scores were recorded both before and after treatment with anti-CGRP monoclonal antibodies.

TABLE 1 Patients' characteristics, NPS scores, and number of monthly MHDs.

Patient no.	Age (year)	Gender	Cause of neuropathy	NPS score at baseline	MHDs/month at baseline	Medications regimen at baseline	Medications regimen at 12 months after administration of anti-CGRP
1	48	F	Diabetes	90	22	Gabapentin 900 mg 3 times daily + duloxetine 60 mg twice daily	Gabapentin 300 mg 3 times daily + duloxetine 60 mg
2	52	M	Diabetes	90	18	Gabapentin 900 mg 3 times daily + tramadol 50 mg twice daily + amitriptyline 50 mg at bedtime	Gabapentin 600 mg 3 times daily
3	54	F	Diabetes	80	20	Gabapentin 1200 mg 3 times daily + nortriptyline 50 mg twice daily	Gabapentin 600 mg 3 times daily
4	58	F	Diabetes	90	16		Pregabalin 50 mg + duloxetine 30 mg
5	60	M	Diabetes	90	18	Pregabalin 150 mg twice daily + duloxetine 60 mg twice daily	Gabapentin 300 mg 3 times daily
6	39	M	Alcohol	80	18	Gabapentin 1200 mg 3 times daily + duloxetine 60 mg twice daily + tramadol 50 mg twice daily	Gabapentin 300 mg tid + topiramate 25 mg once daily
7	38	M	TS-HDS	90	21	Gabapentin 900 mg 3 times daily + topiramate 75 mg bid	Pregabalin 50 twice daily + topiramate 25 mg twice daily
8	42	F	TS-HDS	100	21	Pregabalin 150 mg twice daily + topiramate 100 mg twice daily	Gabapentin 300 mg 3 times daily + topiramate 25 mg twice daily
9	44	F	Idiopathic	90	18	Gabapentin 600 mg 4 times daily + duloxetine 60 mg twice daily + topiramate 50 mg bid	Gabapentin 600 3 times daily + duloxetine 30 mg twice daily
10	56	M	Idiopathic	90	22	Gabapentin 1200 mg 3 times daily + duloxetine 60 mg twice daily	Topiromate 75 mg twice daily
11	57	M	Diabetes	90	18	Topiromate 100 mg twice daily + duloxetine 60 mg twice daily	Gabapentin 300 3 times daily + amitriptyline 50 twice daily
12	44	F	Idiopathic	90	21	Gabapentin 1200 mg 3 times daily + amitriptyline 50 mg twice daily	Amitriptyline 75 mg twice daily
13	45	F	Idiopathic	90	22	Amitriptyline 75 mg twice daily + pregabalin 100 mg twice daily + tramadol 50 mg twice daily	Nortriptyline 25 mg twice daily + gabapentin 300 3 times daily
14	42	F	Idiopathic	90	22	Nortriptyline 100 mg twice daily + gabapentin 1200 mg 3 times daily	Gabapentin 600 mg 3 times daily + topiramate 50 twice daily

Abbreviations: F, female; M, male; MHD, migraine headache day; NPS, Neuropathy Pain Scale; TS-HDS, trisulfated disaccharide kbuA25-GlcNS-6S.

Results

With treatment of anti-CGRP monoclonal antibodies, patients reported a 41.7% decrease in NPS scores from 89.3 at baseline to 52.1 at 12 months posttreatment ($P < 0.05$).

In addition, there was a 33.3% decrease in MHDs per month from 19.8 at baseline to 13.2 at 12 months posttreatment ($P < 0.05$)

Neuropathy pain (A) and migraine headache scores (B) before and after the administration of anti-calcitonin gene–related peptide monoclonal antibodies

Questions?

Thank you

Peripheral Nerve Interventions

Mercy Udoji, MD

Legal Issues for Telehealth and E/M Billing During and After COVID

David Vaughn. Esq. CPC

Telehealth & E/M

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CMS List of Telehealth Codes

- CMS has an Excel spreadsheet of codes
  - Status field will have 1 of 3 categories
  - Blank status = permanent
  - Temporary addition for PHE = will end 151 days after the PHE
  - Available up through 12/31/23
- Also says whether audio only is allowed

Commercial Insurers

- Don't have to follow Medicare
- Can have their own network rules

Where Can Provider Be

- Provider does not have to be at office
- CMS has no payment restrictions
- You bill as if you were at the office
- But there may be state law restrictions
  - If you are out of state
  - If the patient is out of state

Out of the State or Country

- Cannot bill telehealth out of the country
- Out of State:
  - If you are on vacation in another state
  - Need to check the laws of that state
  - ASIPP has Interstate Telemedicine Guidelines
  - Shows rules for each state

Where Can the Patient Be

- Insofar as reimbursement is concerned
  - Pt can be anywhere in the country
  - Could be at home
  - State laws may affect scope of practice
- Usually, Pt has to be at "originating site"
  - Another provider's office or facility
  - In a rural area

Telephone Only Calls

- 99441-99443
  - 99441 – (5-10 minutes) – document at least 5
  - 99442 – (11-20 minutes)
  - 99443 (21-30 minutes)
- MD or QHP (NP/PA)
- Not originating from E/M w/i past 7 days
  - Or leading to new E/M in next 24 hours

Payment for 99441-99443

- 99441 = 99212
- 99442 = 99213
- 99443 = 99214

Telephone Only Codes Will They Become Permanent

- Proposed 2023 Fee Schedule Rule
  - 99441-99443 will not be made permanent
- 3 Sunset dates for telehealth codes
  - Permanent codes will not sunset
  - Category 3 codes sunset 12/31/23
  - "Temporary addition for the PHE"
    - Sunsets 151 days after PHE per Proposed Rule

Incident to Direct Supervision

- During PHE the direct supervision changed
  - No longer had to be in the office
  - Could be supervising remotely via audio/visual
  - Merely have to be available, not attending Live
- That will cease after the PHE

Telehealth POS Codes

- CMS
  - POS is where you would have seen the Pt
  - For office-based, that is POS 11
  - Don't use POS 02 = facility rate reimbursement
- Other payers
  - POS 10 – Telehealth where Pt in their home
  - POS 02 – Telehealth where Pt not in their home

Telehealth Modifiers

- CMS
  - 95
- Commercial
  - 95, or
  - GT – Interactive audio/video communications

Audio-Visual Telehealth Visits

- 99202-99205
  - New patients
- 99211-99215
  - Established patients
- Must document that interactive audio-visual telecommunication device used

Audio-Visual Visits

- Two pathways to bill
  - Time
  - Medical Decision Making ("MDM")

Coding Pathway #1: Time

CPT Code	Minutes
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

Counseling Time

- Old Rule:
  - Time only used when counseling
- New Rule
  - Don't need counseling to bill time
  - You can count counseling time; not required
- Hospital E/M
  - Billing by time requires counseling; no changes

Face and Non-Face Time 99202-99215

- Count: Face Time
- Count: Non-face time
- Do Not Count: Non-face time if no face time
  - There must be some face time in the visit
  - Non-face time is an "add-on" to face time

Activities Included in Time

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing an examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Documenting clinical information in the record
- Referring and communicating with other health care professionals
- Independently interpreting test results (not separately reported)
- Communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Time Not to Be Counted

- Do not count time spent on the following:
  - The performance of other services that are reported separately
  - Travel
  - Teaching that is general and not limited to discussion that is required for the management of a specific patient

Recommended Time Documentation

"I spent the following minutes today related to this patient:

- Preparing to see the patient (e.g., review of tests):_____
- Obtaining and/or reviewing separately obtained history:_____
- Performing an examination and/or evaluation:_____
- Counseling and educating the patient/family/caregiver:_____
- Ordering medications, tests, or procedures:_____
- Documenting clinical information in the record:_____
- Referring/communicating with other health care professionals: _____
- Interpreting test results (not separately reported): _____
- Communicating results to the patient/family/caregiver:_____
- Care coordination (not separately reported):_____

Total: _____

Coding Pathway #2: MDM

Number of Elements

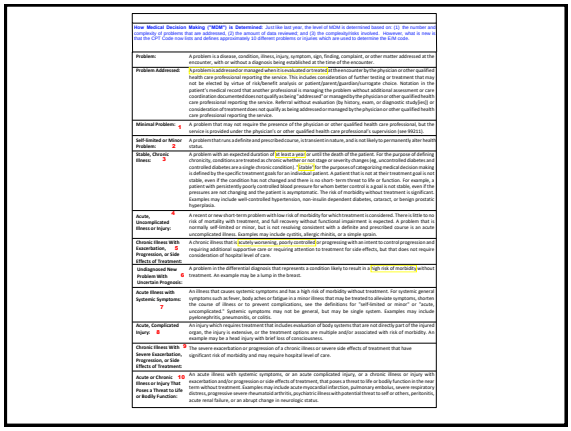
- MDM has 3 elements/components:
  - Problems
  - Data
  - Risk
- 2 out of 3 elements must be met

4 MDM Levels

- There are 4 levels of MDM
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity
- These determine which code to bill

MDM Level: Type of Problems

MDM Level	Types of Problems
Straightforward	1 Self-limited or minor problem
Low	2 or more self-limited or minor problems; or 1 stable chronic illness; or 1 acute, uncomplicated illness or injury
Moderate	1 or more chronic illnesses w/exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or 1 undiagnosed new problem with uncertain prognosis; or 1 acute illness with systemic symptoms; or 1 acute complicated injury
High	1 or more chronic illnesses w/severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function



How Medical Decision Making ("MDM") is Determined: Just like last year, the level of MDM is determined based on: (1) the number and complexity of problems that are addressed, (2) the amount of data reviewed, and (3) the complexity/risks involved. However, what is new is that the CPT Code now lists and defines approximately 10 different problems or injuries which are used to determine the E/M code.	
Problem:	A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
Problem Addressed:	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being "addressed" or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.
Minimal Problem: 1	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).
Self-limited or Minor Problem: 2	A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
Stable, Chronic Illness: 3	A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.
Acute, Uncomplicated Illness or Injury: 4	A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.
Chronic Illness With Exacerbation, Progression, or Side Effects of Treatment: 5	A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.
Undiagnosed New Problem With Uncertain Prognosis: 6	A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.
Acute Illness with Systemic Symptoms: 7	An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for "self-limited or minor" or "acute, uncomplicated." Systemic symptoms may not be general, but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.
Acute, Complicated Injury: 8	An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.
Chronic Illness With Severe Exacerbation, Progression, or Side Effects of Treatment: 9	The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.
Acute or Chronic Illness or Injury That Poses a Threat to Life or Bodily Function: 10	An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

MDM Element #2: Data

- Categories of Data:
  - Tests, documents, orders, and independent historian
    - Imaging ordered, external notes reviewed, etc.
    - Hx obtained from someone other than the pt when pt is unable to provide adequate hx
  - Independent interpretation of test not separately reported
    - Does not apply if you are already billing for the service
  - Discussion of management or test interpretation with external physician

Risk MDM Levels

MDM Level	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low risk of morbidity from additional diagnostic testing or treatment *Examples Only:* over the counter drugs, PT, crutches, brace
Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples Only:* • Prescription drug management • Decision re: minor surgery w/identified pt or procedure risk factors • Decision re: elective major surgery w/out identified pt or procedure risk factors • Dx or treatment significantly limited by social determinants of health
High	High risk of morbidity from additional diagnostic testing or treatment *Examples Only:* • Drug therapy requiring intensive monitoring for toxicity • Decision re: elective major surgery w/identified pt or procedure risk factors • Decision re: emergency major surgery • Decision re: hospitalization • Decision not to resuscitate or to de-escalate care b/c of poor prognosis

Crosswalking MDM Levels to Correct CPT Code

Code	MDM Level[1]	Type of Problems	How Much Data[2]	Type of Risk[3]
99211	N/A	N/A	N/A	N/A
99202 99212	Straight-forward	1 Self-limited or minor problem	**Straightforward Data:** Minimal or no data	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	2 or more self-limited or minor problems; or 1 stable chronic illness; or 1 acute, uncomplicated illness or injury	**Limited Data:** Need **1 out of 2** categories **Cat. 1:** Tests and documents: Need 2 of the following: Review of prior external note(s) from each unique source Review of the result(s) of each unique test; Ordering of each unique test **Cat. 2:** Assessment requiring an independent historian	Low risk of morbidity from additional diagnostic testing or treatment Examples from CPT: None
99204 99214	Moderate	1 or more chronic illnesses w/exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or 1 undiagnosed new problem with uncertain prognosis; or 1 acute illness with systemic symptoms; or 1 acute complicated injury	**Moderate Data:** Must meet **3 out of 3** categories: **Cat. 1:** Test Orders & Reviews: Need 3 of the following 4: Review of prior external note(s) from each unique source Review of the result(s) of each unique test; Ordering of each unique test Assessment requiring an independent historian **Cat 2:** Test Interpretation Independent interpretation of test done by another MD/QHP **Cat 3:** Discussing Test Results with Another Provider Discussion of management or test interpretation with external physician/other qualified health care professional	Moderate risk of morbidity from additional diagnostic testing or treatment Examples from CPT: 1. Prescription drug mgmt. 2. Decision re: minor surgery w/identified pt or procedure risk factors. 3. Decision re: elective major surgery w/out identified pt or procedure risk factors. 4. Da/Tx significantly limited by social determinants of health
99205 99215	High	1 or more chronic illnesses w/severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive Data:** Must meet **3 out of 3** categories **Cat. 1:** Test Orders & Reviews: Need 3 of the following 4: Review of prior external note(s) from each unique source Review of the result(s) of each unique test; Ordering of each unique test Assessment requiring an independent historian **Cat. 2:** Test Interpretation Independent interpretation of test done by another MD/QHP **Cat. 3:** Discussing Test Results with Another Provider Discussion of management or test interpretation with external physician/other qualified health care	High risk of morbidity from additional diagnostic testing or treatment Examples from CPT: 1. Drug therapy requiring intensive monitoring for toxicity. 2. Decision re: elective major surgery w/identified pt or procedure risk factors 3. Decision re: emergency major surgery. 4. Decision re: hospitalization. 5. Decision not to resuscitate or to de-escalate care b/c of poor prognosis

1 Level of MDM is based on meeting 2 out of 3 elements of MDM

2 Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1

3 Per the AMA's June 2021 CPT Assistant "the element encompasses the work of both the possible management options selected, as well as those considered but not selected, after sharing the MDM with the patient and/or family."

E/M AUDIT DEFICIENCIES

Type & Status of Problem

- Failure to define the problem as chronic vs. acute
- Failure to define "chronic" as per the AMA def
  - Expected duration of at least 1 year or until death of the patient
- Failure to state acute complicated/uncomplicated
- Failure to status of problem
  - Stable vs. exacerbated
  - Stable = pt is at treatment goal

Number of Problems Treated

- Issues:
  - One chief complaint w/multiple diagnoses listed in the assessment
  - Multiple diagnoses w/one treatment plan
- Recommendation:
  - List each problem being treated on the DOS
  - Document separate treatment plan for each problem being treated

Data Issues

- Imaging/Tests results carried forward from previous DOS
  - Must indicate if reviewed on this DOS
  - Must relate to the MDM process
- Failure to document independent interpretation vs. review of report
  - Must state that images were reviewed and independent interpretation was performed
- Failure identify each of the separate external notes or previous records reviewed

Risks

- Failure to identify patient and/or procedure risk factors in the visit note
  - A statement that risks were discussed w/pt is insufficient
- Failure to indicate medication management
  - Medications cannot just be listed
  - Must include dosage, frequency, side effects, etc.
  - Must document risk of specific meds prescribed

AMA E/M FAQs

Providers from Same Practice

- Q: If Dr. A from the practice ordered laboratory tests, but Dr. B from the same practice reviewed the results with the patient during the follow-up visit, will Dr. B get credit for reviewing the test results since Dr. B did not order them?
- A: No, the key consideration is "from the same practice." If the 2 physicians are from the same practice and same specialty, Dr. A would get a single credit for the order and review as part of the MDM.

AMA CPT Assistant, May 2021

Providers from Different Practice

- Q: If Dr. A from a practice ordered laboratory tests; however, the patient relocated and went to Dr. B from a different practice who reviewed the test results with the patient during the encounter. Does Dr. A get credit for ordering the tests and does Dr. B get credit for reviewing the test results?
- A: Yes, in this scenario, Dr. A and Dr. B would each get credit for the MDM data element. Key consideration is "from a different practice." Dr. A would get a single credit for ordering the test and Dr. B would get credit for reviewing the test results toward the level of MDM.

AMA CPT Assistant, May 2021

Counting Tests for Data

- Q: How should ordering multiple tests be counted for Category 1 of the MDM element of Data? For example, if the MD orders a CBC, lipid panel, and glucose test during the same encounter, would this count as ordering 3 unique tests, and if so, would this meet the required number of items in Category 1 even if there were no review of prior notes and no review of results?
- A: Yes, those 3 tests would count as 3 unique tests toward meeting the requirement for Category 1 of the MDM element of Data. The tests are unique even if they are all in the same category of test (ie, all blood tests). The review of the test results is included even if the review is not performed at the same encounter.

AMA CPT Assistant, May 2021

In-House Lab Tests

- Q: When may a physician use in-house tests (ie, rapid strep, rapid flu, CBC) and testing as data elements toward MDM selection?
- A: According to the E/M technical corrections, point of care testing (POCT) are tests that do not require separate interpretation (ie, they are test results only). The ordering of these tests by a physician may be used as data elements for MDM selection even though the tests may be reported separately. Ordering and reviewing a test are considered a single component for MDM.

AMA CPT Assistant, July 2021

Assessing the Level of Risk

- Q: What is the AMA's recommendation for accurately assessing the level of risk for a specific patient encounter when it is not noted in the record?
- A: The AMA does not have a recommendation for assessing the level of risk for a particular patient when the level of risk is not noted in the record. We do, however, suggest discussing the documentation with the provider for clarification. Risk for any procedure depends on specific pt risk factors and circumstances as they are assessed by the provider. As an example, a procedure may be determined high to be high risk for one pt, depending on their specific circumstances, while the same procedure may be assessed as moderate or even low risk for a different pt. The provider makes the determination based on their evaluation of the specific pt circumstances & risk factors. The risk of pt mgmt criteria applies to the pt mgmt decisions made by the reporting provider as part of the reported encounter.

AMA CPT Knowledge Base 8/12/21

Prescription Management

- Q: Is it true that medical prescription management is always considered at a minimum moderate risk? If yes, is this regardless of the particular risk associated with a prescription medication?
- A: No. Three components are required for MDM. Regarding considering moderate risk, it is based on the physician's assessment of that particular patient's risk factors and comorbidities for that specific encounter. There are no single "standard" risk factors that would make a patients MDM moderate risk, although medical prescription management is in the moderate risk category.

AMA CPT Knowledge Base 12/1/2021

QUESTIONS?