The Role of Third-Party Payers in Promoting Multi-Disciplinary Care

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Disclosures

- Kim Holland, MBA, and Daniel Blaney-Koen, JD, have disclosed no relevant, real, or apparent personal or professional financial relationships with proprietary entities that produce healthcare goods and services.

- Steven Stanos, DO – Consulting fees: MyMatrixx; Contracted Research: Grunenthal (payments to Swedish Health System)
Disclosures

- All planners/managers hereby state that they or their spouse/life partner do not have any financial relationships or relationships to products or devices with any commercial interest related to the content of this activity of any amount during the past 12 months.

- The following planners/managers have the following to disclose:
  - Kelly J. Clark, MD, MBA, FASAM, DFAPA – Consulting fees: Braeburn, Indivior
Learning Objectives

- Outline federal policies and initiatives aimed to increase access to comprehensive pain management and public policy initiatives to limit harm from Rx opioids.
- Describe the goals and treatment approaches in an interdisciplinary pain management program.
- Discuss payers’ roles and responsibilities in ensuring appropriate, timely care for individuals who suffer from chronic pain and/or opioid use disorder.
- Identify challenges and opportunities in assuring access to appropriate, evidence-based care.
Objectives

- Federal, state policies and initiatives aimed at increasing access to comprehensive pain management and reducing opioid use
- Goals and treatment approaches in an interdisciplinary pain management program
- Payers roles and responsibilities in ensuring appropriate, timely care for individuals who suffer from chronic pain and/or opioid use disorder
- Challenges and opportunities in assuring access to appropriate, evidence-based care
Federal and State Actions to Address the Opioid Epidemic

- Over 100 federal bills have been introduced. Top issues include:
  - Increasing state funding to expand treatment access/MAT
  - Increasing NIH funding for research non-addictive pain medications and treatment
  - Improving Prescription Drug Monitoring Programs (PDMPs)
Federal and State Actions to Address the Opioid Epidemic

- President’s White House Commission on Opioids issued report with 56 recommendations
- HHS focusing on 5 areas: better data, research on pain/addiction, pain management, targeting overdose reversal drugs, and better prevention/recovery services
- Comprehensive Addiction and Recovery Act (CARA) funds going to states
  - First round of $500 M distributed last year; another $500M to be released in 2018
  - CARA 2.0 - $2B authorized to increase funding for treatment and prevention
Federal and State Actions to Address the Opioid Epidemic

- Omnibus spending bill includes $2.6 billion to states to combat the opioid epidemic
  - HHS to determine how money is to be spent
- President Trump’s initiative to combat opioid abuse and reduce drug supply and demand released March 19th key objectives:
  - Reduce drug demand through education, awareness, and preventing over-prescribing
  - Cut off flow of illicit drugs
  - Expand opportunities for proven treatments for opioid and other addictions
State Opioid Activity

- Over 800 bills have been introduced in state legislatures; top issues include:
  - Limits on initial prescriptions for acute pain
  - Increasing access to treatment providers and facilities
  - Regulating patient brokering and sober homes
  - New requirements for PDMP use/data entry
  - Increasing use of electronic prescribing (e-prescribe)

- Governors and legislators impacting epidemic through Medicaid
  - 8 states have waiver authority to use federal funds to pay for IMD substance use treatment services
  - States also looking to set prescription limits and improve treatment access
Definitions

- Multidisciplinary care
- Interdisciplinary care
- Multimodal (perioperative)
- Multimodal (pharmacologic)
Joe

- 59 yr old carpenter with severe low back and leg pain.
- Recent lumbar laminectomy, ongoing pain
- High dose opioids:
  - Oxycodone CR 40 mg BID, #60
  -  Hydrocodone/APAP  10/325  6/day, #180
- Gabapentin 200 mg at night Soma BID
- Poor sleep
- High depression, anxiety, and catastrophizing scores.
- Relocates from Atlanta to Seattle
Prescription Opioid, Heroin & Illicit Fentanyl Crisis

“Under-treatment” of Pain & Limited Behavioral Health Resources
Fentanyl Deaths

- Illicitly manufactured fentanyl (IMF)
- Unlawfully produced, mixed with or sold with heroin
- Increase in number of fentanyl submissions (426%) & synthetic opioid deaths (79%)
- 2016: illicit fentanyl deaths > those for heroin related deaths

2016 Total OD Deaths: 64,070

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>United States</th>
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<tbody>
<tr>
<td></td>
<td>Jan-16</td>
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<tr>
<td>Heroin (T40.1)</td>
<td>13,219</td>
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<tr>
<td>Natural and semi-synthetic opioids (T40.2)</td>
<td>12,726</td>
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<tr>
<td>Methadone (T40.3)</td>
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<tr>
<td>Synthetic opioids excluding methadone (T40.4)</td>
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<td>Cocaine (T40.5)</td>
<td>6,986</td>
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<tr>
<td>Psychostimulants with abuse potential (T43.6)</td>
<td>5,922</td>
</tr>
</tbody>
</table>

1. CDC, MMWR. Weekly/ August 26, 2016/65(33):837-843.
Abuse, Misuse, Addiction

MEDs
Dose Thresholds
Quality Metrics

Diversion, Overdose
Evidence
Prescribing Metrics
Balance: Starting Point

*primum non nocere* – “Do no harm.”

*deinde benefacere* – “Then, do some good.”

Repent !
The diverter with a pain diagnosis

High dose patient

Non-responder at high doses

Low dose compliant

Rewarding and anxiolytic properties of opioids
“See, now the understanding is that opioids don’t work for chronic pain. Taper.”

“We don’t have access to behavioral health or addiction treatment.”

“It’s cheaper for the insurance company to just pay for opioids.”
Primary Care Provider

- Over next 3 months provider decreases oxycodone by 50% and hydrocodone/APAP by 30%
- Pain is increased in low back, sleep is worse, mood poor

Options?
- Addiction treatment
- Interventional pain treatment
- Pain rehabilitation program
The government’s first broad-ranging effort to improve how pain is perceived, assessed, and treated: a significant step toward the ideal state of pain care.
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Checklist for prescribing opioids for chronic pain

**For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care**

**CHECKLIST**

When CONSIDERING long-term opioid therapy
- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse:
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit
- Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continuous opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- Assess pain and function (eg, PEG), compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
  - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
  - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up, consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify, consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

**EVIDENCE ABOUT OPIOID THERAPY**
- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headaches, and fibromyalgia.

**NON-OPIOID THERAPIES**
- Use alone or combined with opioids, as indicated:
  - Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
  - Physical therapies (eg, exercise therapy, weight loss).
  - Behavioral treatment (eg, CBT).
  - Procedures (eg, intra-articular corticosteroids).

**EVALUATING RISK OF HARM OR MISUSE**
- Known risk factors include:
  - Illegal drug use; prescription drug use for nonmedical reasons.
  - History of substance use disorder or overdose.
  - Mental health conditions (eg, depression, anxiety).
  - Sleep-disordered breathing.
  - Concurrent benzodiazepine use.

**Urinary drug testing:** Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

**Prescription drug monitoring program (PDMP):** Check for opioids or benzodiazepines from other sources.

**ASSESSING PAIN & FUNCTION USING PEG SCALE**

**PCG score** = average of 3 individual question scores (0–10, where 10 = most severe pain or interference)

1. What number from 0–10 best describes your pain in the past week?
   - 0 = “no pain”; 10 = “worst you can imagine”
2. What number from 0–10 describes how your pain has interfered with your enjoyment of life?
   - 0 = “not at all”; 10 = “completely interferes”
3. What number from 0–10 describes how your pain has interfered with your general activity?
   - 0 = “not at all”; 10 = “completely interferes”

#Rx Summit      www.NationalRxDrugAbuseSummit.org
1. When to initiate or continue opioids

<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation</th>
<th>Evidence Category/ Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids used, should be in combination with non-opioid pharmacologic therapy.</td>
<td>A, 3</td>
</tr>
<tr>
<td>2</td>
<td>Establish treatment goals. Continue only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.</td>
<td>A, 4</td>
</tr>
<tr>
<td>3</td>
<td>Discuss with patients known risks and realistic benefits of opioid therapy and responsibilities of patient and clinician.</td>
<td>A, 3</td>
</tr>
</tbody>
</table>
Established patients already taking high dosages of opioids

- “…tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence.”

- Offer in a “nonjudgmental manner”… “the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.”

- Empathically review benefits and risks of continued high-dosage opioid therapy” and “offer to work with the patient to taper opioids to safer dosages”

- “Very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages.”

- Be aware that anxiety, depression, and opioid use disorder “might be unmasked by an opioid taper”

Centers for Disease Control and Prevention MMWR March 15, 2016; 65:p23
Functional Restoration: Interdisciplinary Care
Joe: Comprehensive Evaluation

Pain Psychology

- **Screening**
  - PHQ-9: 13/27
  - GAD-7: 16/21
  - PCS: 37
  - TSK: 32
- **Behavioral:**
  - Uses distraction and denial to cope
  - Poor limit setting
- **Affective/Cognitive:**
  - Maladaptive pain-related thought patterns
  - Depression and anxiety
- **Social:**
  - Interpersonal conflict with wife due to financial issues
  - Unable to work, no overtime income

Pain Medicine

- L5-S1 radiculopathy
- Myofascial pain lumbar and gluteus
- Sleep disturbance
- Depression

**Recommendation**
Structured Functional Restoration Program
# Functional Restoration Program: Interdisciplinary Care

## Outcome Measures

- **Pain VAS**
- **ODI** (disability)
- **GAD-7** (anxiety)
- **PHQ-9** (depression)
- **CPAQ**
- **Activity Engagement**
- **TSK** (kinesiophobia)
- **PCS** (catastrophizing)
- **Rumination**
- **Magnification**
- **Helplessness**
- **Total**
- **6 minute walk test (m)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Wednesday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>Noon</td>
<td>Nursing Lecture</td>
<td>Group Stretching Class</td>
<td>Nursing Lecture</td>
</tr>
<tr>
<td>1:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td>OT</td>
<td>Med Visit</td>
<td>OT Group</td>
</tr>
<tr>
<td>3:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:00</td>
<td>Relaxation Training</td>
<td>Relaxation Group</td>
<td>Relaxation Training</td>
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</tbody>
</table>

### Treatment Team
- Pain medicine
- Physical therapy (PT)
- Occupational therapy (OT)
- Pain psychology
- Relaxation training
- Nursing education

**VAS**: Visual Analogue Scale  
**PHQ**: Patient Health Questionnaire  
**ODI**: Oswestry Disability Index  
**CPAQ**: Chronic Pain Acceptance Questionnaire  
**GAD**: Generalized Anxiety Disorder  
**PCS**: Pain Catastrophizing Scale  
**TSK**: Tampa Kinesiophobia Scale
Medical Management

- Team led by a pain medicine specialist focusing on clarifying diagnoses, managing medications, and coordinating care
- Reassess and improve medication related to mood, sleep, and analgesia
- Appropriate need for repeat imaging or procedures
- Ensure accordance and compliance to program
- Provide team feedback
- Opioid assessment and management
Pain Psychology

Cognitive Behavioral Therapy to target:

- Maladaptive thoughts and behaviors
- Anger and irritability
- Problems in support system
- Problems in communication skills
<table>
<thead>
<tr>
<th>WEEK 1</th>
<th>WEEK 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Education: Neuromatrix model, Gate Control Theory</td>
<td>➢ Mindfulness training for coping with maladaptive thoughts and negative emotions</td>
</tr>
<tr>
<td>➢ Introduction to mindfulness meditation</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>WEEK 3</td>
<td>WEEK 4</td>
</tr>
<tr>
<td>➢ Acceptance toward chronic pain</td>
<td>➢ Maintaining mindfulness practice and other home practice</td>
</tr>
<tr>
<td>➢ Interdisciplinary pain flare plan</td>
<td>➢ Family education and support</td>
</tr>
</tbody>
</table>

**Pain Psychology**
“Biofeedback” Enhanced Relaxation Training
Respiration
Blood Volume Pulse
Temperature
Surface Electromyography (SEMG)
Skin conductance

THE ELECTRODES
## Biofeedback-Enhanced Relaxation Training

<table>
<thead>
<tr>
<th>WEEK 1</th>
<th>WEEK 2</th>
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<tbody>
<tr>
<td>➢ Education about autonomic nervous system and chronic pain</td>
<td>➢ Respiration BFT</td>
</tr>
<tr>
<td>➢ Assessments</td>
<td>➢ Heart Rate Variability</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>WEEK 3</td>
<td>WEEK 4</td>
</tr>
<tr>
<td>➢ Progressive Muscle Relaxation</td>
<td>➢ Guided Imagery</td>
</tr>
<tr>
<td>➢ Autogenic Training</td>
<td>➢ Art therapy</td>
</tr>
<tr>
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</tbody>
</table>
Physical Therapy

• Comprehensive assessment
• “Active” vs. “Passive” treatment
• Movement based therapy
• Strengthening exercises
• Neuromobilization
• Aerobic conditioning
• Home exercise plan
• Time limited
# Physical Therapy

<table>
<thead>
<tr>
<th>WEEK 1</th>
<th>WEEK 2</th>
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</thead>
</table>
| ➢ Assessments  
➢ Movement-based therapy | ➢ Strengthening exercises  
➢ Aerobic conditioning |

<table>
<thead>
<tr>
<th>WEEK 3</th>
<th>WEEK 4</th>
</tr>
</thead>
</table>
| ➢ Neuromobilization  
➢ Active vs passive treatment | ➢ Sex & Chronic Pain  
➢ Home Exercise Plan  
➢ Pain Flare Plan |
Occupational Therapy

• Posture, positioning
• Pacing Techniques & Implementation
• Ergonomic Principles
• Activity Tolerance
• Return to leisure and vocational activities
### Occupational Therapy

<table>
<thead>
<tr>
<th>WEEK 1</th>
<th>WEEK 2</th>
</tr>
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<tbody>
<tr>
<td>➢ Assessments</td>
<td>➢ Posture &amp; Positioning</td>
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<tr>
<td>➢ Pacing Techniques</td>
<td>➢ Ergonomic Principles</td>
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<table>
<thead>
<tr>
<th>WEEK 3</th>
<th>WEEK 4</th>
</tr>
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<tbody>
<tr>
<td>➢ Activity Tolerance</td>
<td>➢ Realistic Schedule</td>
</tr>
<tr>
<td>➢ Therapeutic Movement</td>
<td>➢ Return to leisure and</td>
</tr>
<tr>
<td></td>
<td>vocational activities</td>
</tr>
</tbody>
</table>
# Nursing Education

**WEEK 1**
- Orientation to the program
- Sleeping Better

**WEEK 2**
- Medication Management
  - OTC’s & Adjunctive meds
  - Opioids & other habit forming medications/substances
  - Safety, risk/benefit choices

**WEEK 3**
- Nutrition and chronic pain
- Sex and chronic pain (PT)

**WEEK 4**
- Interdisciplinary maintenance pain flare plan
- Friends & Family Group (Psych)
- Program debrief and Graduation
How do we offer pain biopsychosocially-based pain management and behavioral health interventions when current financial disincentives and barriers exist?
### Reimbursement and Coverage

**Multimodal Interdisciplinary Care**

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>CPT</th>
<th>Units</th>
<th>Allowed per Unit</th>
<th>Allowed as % of Charge</th>
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<td><strong>Commercial</strong></td>
<td>1. H&amp;B Assessment</td>
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<td>36.60</td>
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<td></td>
<td>2. H&amp;B Interventions</td>
<td>50</td>
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<td>3. H&amp;B Reintervention</td>
<td>1,656</td>
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<td>4. H&amp;B Groups</td>
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<tr>
<td></td>
<td>3. 96152</td>
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<td>16.54</td>
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<td><strong>MEDICARE HMO Total</strong></td>
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<tr>
<td><strong>Grand Total</strong></td>
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<td>4,906</td>
<td>20.32</td>
<td>48%</td>
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#### Patient Access Factors
- Co-pays (Multiple)
- Co-Insurance
- Therapy Benefits

#### Hospital System Issues
- Overhead
- Staff Salaries
- Reimbursement
- HC Utilization
Common recommendations for reducing opioid use/promoting alternatives

- Require medical schools to include core competencies in pain management, addiction medicine; similarly include in required CME
- Promote patient education in pain management
- Fund research to build evidence for non-pharmacological pain treatment options
- Support/enforce CDC prescribing guideline for chronic pain
- Improve PDMP functionality, interoperability
- Build substance abuse treatment capacity
- Develop credential, quality measures for free-standing treatment facilities
Summary

- Federal, state policies and initiatives are aimed at increasing access and funding for substance abuse treatment, expanding PDMPs, and research.
- Expanded CARA and focus along five strategic areas by HHS.
- Federal and state bills focused on overdoses vs expanding pain management, provider and public service education about pain and addiction.
- Multi- and Inter-disciplinary model needs to be expanded with greater access and levels of care.
- Challenges and opportunities remain in assuring access to appropriate, evidence-based care.
“Repent”

Change your mind.

Change your thinking.
Solutions, Truths, & Patient Centered Care

Prescription Drug Monitoring Program (PDMP)

Safe Disposal

Unused Meds

Third-Party Payer Track

The Role of Third-Party Payers in Promoting Multi-Disciplinary Care

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THANK YOU

#RxSummit

www.NationalRxDrugAbuseSummit.org