

Pain Medicine 2016: Emerging Issues in Policy, Coverage and Payment

2017

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Dr. Alan Jay Schwartz: Hello. This is Alan Jay Schwartz, Editor-in-Chief of the American Society of Anesthesiologists' 2017 *Refresher Courses in Anesthesiology*, the latest research and educational findings. The focus of the *Refresher Courses in Anesthesiology*'s CME program and the modules featured is to educate learners on current developments in the science and clinical practice of the specialty of anesthesiology. Returning for a second year, we will be speaking directly with individual authors to learn about their expertise, perspective and insight regarding the featured module.

Today, we are pleased to present the following one-on-one conversation with fellow RCA editor Dr. Amanda Burden and author Dr. Kevin Vorenkamp. They will be highlighting the module titled "Pain Medicine 2016: Emerging Issues in Policy, Coverage and Payment."

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Dr. Amanda Burden: Hello, and welcome. I am Amanda Burden. I'm Associate Professor of Anesthesiology at the Cooper Medical School of Rowan University in New Jersey, and I'm here today with Dr. Kevin Vorenkamp, who is Director of the Pain Medicine Fellowship at the Virginia Mason Medical Center in Seattle, Washington. Dr. Vorenkamp's Refresher Course lecture is titled "Pain Medicine 2016: Emerging Issues in Policy, Coverage and

Payment.” And he’s going to talk to us today about several of these key changes and issues that we all need to be mindful of in healthcare policy.

As he discusses in his very interesting, very insightful Refresher Course lecture, the last several years have seen large-scale changes in healthcare policy, which includes everything from the enactment by President Obama of the Affordable Care Act in 2010 to more recent issues, including repealing the sustained growth rate formula and the movement toward MACRA, which Dr. Vorenkamp will talk about more. He will also talk to us about some of the new CPT codes and some of the issues that affect how it is that we as physicians are reimbursed, and how it is that we as physicians can best help our patients get the care that they need.

So, Dr. Vorenkamp, thank you so much, and welcome. We appreciate your time and your expertise.

Dr. Kevin Vorenkamp: Thank you. In today’s discussion, I am going to focus on three major areas. First, I will discuss MACRA implementation, with a focus on MIPS reporting for pain medicine physicians. Next, I’ll discuss advocacy and state coverage issues threatening safe and effective treatment of patients with painful spinal conditions. Finally, I’ll highlight the CPT changes which took effect in January 2017 regarding intrathecal and interlaminar epidural injections.

The Medicare Access and CHIP Reauthorization Act, or MACRA as it’s commonly termed, was signed by President Obama on April 16th, 2015. That’s replacing the sustainable growth rate formula. Although many physicians at the time were excited to avoid the 21% cut in Medicare reimbursement per the SGR formula, concerns regarding MACRA are becoming increasingly apparent. Under MACRA, physicians will receive future Medicare payments by participating in one of two broad categories: payments through the Merit-

based Incentive Payment System, or MIPS; or through an Alternative Payment Model, or APM. The Quality Payment Program, or QPP, will begin in 2019 and be based in many instances upon 2017 performance.

The stated goals of the MACRA program are to achieve cost containment, to reward those practices that demonstrate high performance, and to reduce payment to those practices that fail to adhere to standards of patient care. These changes are incremental, with the maximum adjustment factor at 4% for 2019 and rising by 1% to 2% annually until achieving 9% in 2022 and beyond. Of note, these adjustments target a budget-neutral endpoint. Therefore, if a lower threshold of achievement is targeted, a high percentage of practices will achieve the target. This would then result in minimal positive payment adjustments, whereas those that do not reach the target would have higher penalties. This is indeed the case for 2017, when the threshold is set at a minimal level of three points.

Most pain medicine physicians will participate in the MIPS reporting, so the remainder of my QPP discussion will focus on that aspect. Each of the four parts of MIPS—quality, cost, advance care information, and improvement activities—will be weighted and used to calculate a composite performance score on a scale from zero to 100, from which CMS will calculate and compare the composite scores for all eligible professionals, as outlined in table 1. Most relevant to pain medicine physicians is the lack of applicable quality measures although many pain societies, including ASA, are providing input on potential targets. Some of the approved measures for 2017 are nicely outlined in Matthew Popovich’s March 2017 *ASA Monitor* article.

The MACRA final rule for 2017, with a low threshold as mentioned of only three points, allows flexibility with the “pick your pace” options, allowing practices to avoid penalty while allowing those practices that are prepared for full implementation to potentially qualify for positive payment adjustments.

The four MIPS reporting options for 2017 are outlined in table 2. As noted in that table, cost is not weighted in 2019, so there were only three measures that can be reported. To avoid penalty, physicians must report one measure in each of the quality and improvement categories or report the required measures of the ACI performance category.

I'm going to now shift my discussion to discussing advocacy and state coverage issues. As outlined in the article, an intense advocacy effort from the Multi-Society Pain Workgroup, including the ASA, as well as tireless energy from several Washington State physicians, resulted in sustained coverage for interventional pain procedures in Washington State. Washington State physicians led an effort of engagement, with nearly 100 pain medicine physicians and patients appearing at the meeting in March 2016. Speakers emphasized that maintaining access to spinal injection therapies can provide patients with the significant benefits of pain relief, improved function, and quality of life. These therapies may also prevent patients from seeking unnecessary surgery or from using or starting opioids, which is particularly important in light of the national epidemic of opioid abuse.

Despite the overall positive ruling in Washington State for maintained coverage, this experience served as a precursor to the events in the adjacent state of Oregon, where a negative outcome ensued. Despite multiple efforts from several societies and the MPW, the Oregon Health Authority declined to overturn its decision to eliminate coverage for epidural steroid injections effective July 1st, 2016.

In regards to CPT coding changes, effective January 1st, 2017, there were eight new codes to report intrathecal or interlaminar epidural injections. These new codes replace the four prior codes, and imaging guidance is no longer separately reportable for these procedures. A summary of these changes appear in table 3. Also, the work relative value units, or RVUs, are relatively stable over the past

few years but are still decreased overall when compared with the values in 2013. These are listed in table 5.

Dr. Amanda Burden: Dr. Vorenkamp, thank you so much for going through all of that really important information for our practices and, more importantly, for our patients and their care. That is really distressing to hear about what happened in Oregon. And as I'm listening to you, I wonder what advice you have for physicians. Especially for physician anesthesiologists, what can we do in view of these changes and these potential threats to our patients and their care?

Dr. Kevin Vorenkamp: I would say, start local. So, start by being involved with your own hospital system, with your own community; and show your worth to the community, to the physicians you take care of. This will mean doing more than just providing the injections, but coordinating care with the other physicians. These physicians in your local community are also the ones that are guiding decisions at the state level, and those certainly have implications at a national level.

At the state level, remain engaged in your medical societies, both at the state and national level. Every state has a Carrier Advisory Committee for Medicare carriers. Each state will have an anesthesiologist, and several states have pain medicine representatives as well. So, find out who the CAC representative for your state is, and stay in line and aware of issues as they come up.

And finally, when faced with a negative decision, either with private payers or state payers or Medicare contractors, present the evidence and be active. Engage your community and other physicians. In Washington State, we were able to get over 100 different physicians and patients to actually appear at the meeting, which made them actually move the meeting to a bigger venue because of the great amount of people that arrived.

Dr. Amanda Burden: It's really wonderful to hear about how you've demonstrated that physicians, especially we physician anesthesiologists, are so engaged with our patients and can make real change because of that. Thank you so much for this really interesting information that is so necessary and helpful for all of us. We greatly appreciate your time.

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Dr. Kevin Vorenkamp: Thank you very much.

Dr. Amanda Burden: And now back to you, Dr. Schwartz.

Dr. Alan Jay Schwartz: Thank you for joining us today and participating in this insightful conversation with this month's featured author. Be sure to join us for next month's one-on-one author interview. To purchase the full subscription of the 2017 *Refresher Courses in Anesthesiology* program, please visit www.asahq.org, click on the Shop ASA link, and search for RCA.

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