# Business Aspects of a Transitional Pain Program

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AAPM 2022
38TH ANNUAL MEETING

# Disclosures

- David Edwards has documented that he has nothing to disclose.
- I will not be discussing any off-label and/or investigational uses of drugs or products.

# Learning Objectives

By the end of this session, the participants will be able to:

- *Identify Steps to Establish at TPS Service (Vanderbilt Example)*
- *Identify 3 Billing Strategies to Grow and Sustain the Cost of a TPS*
- *List 2 Critical Institutional Cost Savings Important to Track*

# Challenges to Establishment of a Transitional Pain Service

- Costs of new systems
- Costs of new employees
- Development of criteria for consultation
- Development of new treatment protocols
- Measurement of impact (potential reduction of hospital costs, patient outcomes, reimbursement)

# 3 Strategies

**Strategy 1:** start in the pain clinic

- E&M training / perioperative training
- revenue generating

**Strategy 2:** combine inpatient TPS with another pain service (CPS)

- service growth
- revenue generating

**Strategy 3:** identify and demonstrate cost savings

- decreased LOS
- increased DRG
- fewer ED returns matched to increased pain clinic visits
- fewer surgical clinic visits post-op

American Society of Anesthesiologists

QUALITY AND PRACTICE MANAGEMENT | MANAGING YOUR PRACTICE | TIMELY TOPICS IN PAYMENT AND PRACTICE MANAGEMENT

# Distinguishing Between a Pre-Anesthesia Evaluation and a Separately Reportable Evaluation and Management Service

November 2020

ASA Committee on Economics

When providing anesthesia care, the anesthesiologist provides medical services before and after the actual administration of anesthesia to the patient. In the pre-anesthesia period, an essential part of the anesthesiologist's work is to perform a pre-anesthesia evaluation to assess risk and develop an anesthetic plan. The value and payment for this work are included in the anesthesia base units and cannot be separately reported . However, the anesthesiologist may provide evaluation and management (E/M) services to a complex patient that are distinct from the pre-anesthesia evaluation as well as from the surgeon's pre-operative history and physical examination. In this case, the E/M service may be separately reported and paid. **A distinct, preoperative E/M service must be supported by individual circumstances including medical necessity and would not be expected to be performed on a routine basis.**

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# (1) Start in the Pain Clinic: Billing – E&M

## Pre-anesthesia Evaluation

- Assess risks and develop plan for anesthesia
- Develops a plan for anesthetic care
- Must be conducted or updated within 48 hrs of surgery
- Only individuals qualified to administer anesthesia
- Paid within the anesthesia base units (not separately billable)

## Complex Patient E&M Service

- Medically necessary care to optimize underlying medical conditions, coordinate care, and develop transition plans for patient safety and optimal outcomes.
- Work is separate and distinct from anesthetic care plan (falls outside the scope of the pre-anesthesia eval)
- Planning visits >30 days prior to surgery
- Any physician or advance practice provider appropriately licensed
- Paid as separate E&M service

ASA Committee on Economics. (2020) *Timely Topics in Payment and Practice Management. Distinguishing Between a Pre-Anesthesia Evaluation and a Separately Reportable Evaluation and Management Service.* https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/distinguishing-between-a-pre-anesthesia-evaluation-and-a-separately-reportable-evaluation-and-management-service

# Consultation Criteria

Pre-operative Consult Criteria

- Patients on higher dose opioids (>60 MEDD)
- Patients on treatment for OUD

## Vanderbilt Transitional Pain Clinic for Outpatient Pre- and Post-operative Pain Management

### Pre-operative Pain Consultation

Criteria

- patients on higher dose opioids (≥50 MME) - see chart below
- patients on Suboxone

How to Consult

☑ place Ambulatory referral order for **Pain Medicine** (Ref64) and make a comment for pre-op pain management **(TPS)**

- can arrange to be seen same day as pre-anesthesia clinic (VPEC)

### Post-operative Pain Follow-up

Criteria

- only for patients requiring opioids longer than expected by surgeon

How to Consult

☑ surgical service must provide initial discharge prescription, then if help is needed to further taper off opioids and control pain, place Ambulatory referral order for **Pain Medicine (Ref64)** and make a comment for post-op pain management **(TPS)**

| Drug | Dose |
|---|---|
| hydrocodone (Vicodin) | ≥50mg per day |
| morphine | ≥50mg per day |
| oxycodone | ≥40mg per day |
| hydromorphone (Dilaudid) | ≥10mg per day |
| fentanyl patch | ≥25mcg/hr. |
| methadone | ≥15mg per day |
| buprenorphine (Suboxone) | any dose |

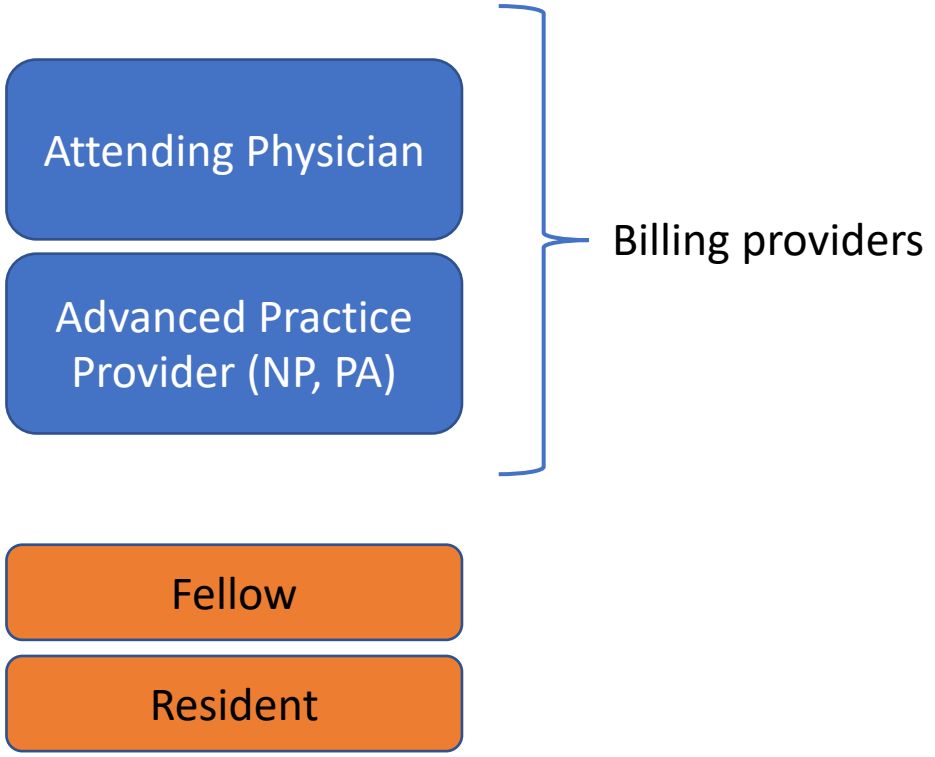
For questions during business hours, call:

(patient is outpatient) **615-207-1203**
(patient is inpatient) **615-686-3919**

For scheduling assistance contact the access center

Location: One Hundred Oaks Pain Clinic

# (2) Inpatient Service Growth Goal




| Daily Costs (Staffing) | | |
|---|---|---|
| MD/DO | 1200 | 1200 |
| NP/PA | 600 | 600 |
| Fellow | 300 | |
| Resident | 200 | |
| | 2300 | $1800 |

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| Daily Costs (Staffing) | | |
|---|---|---|
| MD | 1200 | 1200 |
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| Resident | 200 | |
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| Daily Charges (E&M Billing) | |
|---|---|
| 5 Initial hospital care (avg lvl 2/3) | 793 |
| 10 Subsequent hospital care (avg lvl 2/3) | 828 |
| 5 Subsequent hospital care (lvl 1) | 182 |
| | $1804 |

Service Growth Goal

- >5 Consults per day (25 per week)
- 15 Subsequent visits per day
- Total daily census #20 (400/mo.)
- Less, if procedures/operations performed
- Less, if incorporating telemedicine

# Consultation Criteria

Pre-operative Consult Criteria

- Patients on higher dose opioids (>60 MEDD)
- Patients on treatment for OUD

Inpatient Consult Criteria

- High-risk by O-NET+ criteria
  - On high-dose opioids before admission (>60 MEDD) and with rapid dose escalation
  - Patients newly on opioids with uncontrolled co-morbid psychiatric conditions/concerns
  - On buprenorphine, etc. for OUD with complex care management considerations
- Select patients that primary service requests to be seen after discharge

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# (3) Identify and Demonstrate Cost Savings

## Case Mix Complexity

DRG is determined by the principal diagnosis, secondary diagnosis, surgical procedure, age, sex, and discharge status

DRG with CC (complication or comorbidity) or with MCC (major complication or comorbidity)

1. Determine the principal diagnosis for admission
2. Determine whether or no there was a surgical procedure
3. **Determine any secondary diagnoses that would be considered comorbidities or could cause complications**
    i. A comorbidity is a condition that existed before admission
    ii. A complication is any condition that occurred after admission
        (e.g. F10, F11, F12, etc. substance use disorders; G90 CRPS); M47-M51, etc. spondylosis, disc disorders; T85, etc. pain or stenosis due to nervous system implant

https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P1157.html

# (3) Identify and Demonstrate Cost Savings

Consult Efficiency by Completion Workflow

| | # of Consults Ordered | 25th Percentile Consult TAT (mins) | Median Consult TAT (mins) | 75th Percentile Consult TAT (mins) | Achieving TAT Goal |
|---|---|---|---|---|---|
| Consult Note Signed | 310 | 91.0 | 180.0 | 382 | 91% |
| Boarded for Surgery | 39 | 10.0 | 20.0 | 43 | 100% |
| Patient Status Change | 22 | 32.0 | 111.5 | 175 | 95% |
| Initial Recs Communicated | 5 | 140.0 | 197.0 | 228 | 100% |
| Patient Discharged from Hospital | 3 | 359.5 | 528.0 | 530 | 100% |
| Brief Consult Note | 1 | 129.0 | 129.0 | 129 | 100% |
| **Grand Total** | **380** | **76.0** | **162.0** | **342** | **92%** |

## Service Efficiency Important to TPS

- LOS
- Time to consult
- Time to discharge
- Boarded for procedure

## ED / Surgical Clinic Offload

# Consultation Criteria

Pre-operative Consult Criteria

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Post-operative Consult Criteria

- requiring prolonged pain management, functional improvement, opioid taper

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Location: One Hundred Oaks Pain Clinic

# April 2021, New CPS/TPS Service Chief

Service Chief, Comprehensive Pain Service (CPS);
Director of Transitional Pain Services (TPS)

**Andrew Pisansky, MD MS**

Work Locations: OHO Pain Clinic, VICC
Cancer Pain Clinic, Inpatient Pain

- Chief Resident, BWH Dept of Anesthesiology
- Pain Medicine Fellow, BWH
- VUMC Academic Faculty in Pain Medicine, MSA

# Summary

- *E&M Complex Care in TPS Clinic*
- *Inpatient Combined Services*
- *Value to Hospital*

# Acknowledgement


TPS Services

**Toronto**
Hance Clarke
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**Duke**
Padma Gulur
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**Johns Hopkins**
Marie Hanna
mhanna9@jhmi.edu

**Cleveland Clinic**
Hesham Sharkawy
h_sharkus@yahoo.com


https://www.transitionalpainservice.ca/establish-tps

Resources


Padma Gulur - AAPM Podcast. Episode 36: Transitional Pain Service - ASRA RAPP

Lomanowska AM, Katz J, Ladak SSJ, Slepian PM, Weinrib AZ, Katznelson R, & Clarke H. **Establishing a Transitional Pain Service: A Guide for Health Professionals**. 2021. https://www.transitionalpainservice.ca/establish-tps


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# Key References


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Huang *et al.*, Chronic postsurgical pain and persistent opioid use following surgery: the need for a transitional pain service. *Pain Manag* **6**, 435-443 (2016).

Hanna *et al.*, An Innovative Perioperative Pain Program for Chronic Opioid Users: An Academic Medical Center's Response to the Opioid Crisis. *Am J Med Qual*, 1062860618777298 (2018).

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