Interdisciplinary Pain Care CARF

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Financial Relationships

CVS/ Aetna

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Learning Objectives

What is interdisciplinary care and why is there the perception that it is not covered.

What can CARF add to development as a standard to reflect quality

My Pain Background

- Fellowship Trained in Pain Medicine , University of Washington Seattle.
- Attending physician Multidisciplinary Pain Center
- Pain and Toxicity Service (Fred Hutch)
- Acute Pain Service
- Hospital Pain Consult Service University of Washington Hospital Seattle
- Currently SME Pain Medicine Aetna/CVS
- Chariman Clinical Policy Council Aetna/CVS

My View

- Interdisciplinary Care is foundation of good care.
- More holistic
- Addresses the whole patient
- Chronic Pain is a deep rut and people need help to escape.
- Solely interventional treatment for most with chronic pain is not adequate
- The general opinion from ASA, ASRA other societies, DOD / VA are the same.

MMR

- Chronic pain is usually caused by a combination of physical, psychological and social factors, known as biopsychosocial factors:

- Biological: Everything in the body, from your DNA to how your internal organs and nervous system work.
- Psychological: Your personality, behaviours, emotions and any learning or coping mechanisms. Factors such as workplace stress, faltering quality of life, depression and anxiety can increase the risk of acute pain becoming chronic.
- Social: Your relationships with family, friends, co-workers and your wider social support network. Economic and demographic factors, such as your background and education also fall into this category.

ASA

ciplinary programs may be used.

III. Single Modality Interventions

This section examines the evidence for the efficacy of individual modalities used in the treatment of chronic pain. The Task Force recognizes that the vast majority of the investigations of these individual treatments were performed in the context of multimodal or multidisciplinary care. Consequently, in all cases, recommendations in this section to use individual modalities are made with the expectation that they will be used as part of the multimodal or multidisciplinary management of patients with chronic pain.

Single modality interventions, as components of a multimodality approach to pain management, include, but are not limited to, the following: (1) ablative techniques, (2) acupuncture, (3) blocks (*i.e.*, joint and nerve or nerve root), (4) botulinum toxin injections, (5) electrical nerve stimulation, (6) epidural steroids with or without local anesthetics, (7) intrathecal drug therapies, (8) minimally invasive spinal procedures, (9) pharmacologic management, (10) physical or restorative therapy, (11) psychologic treatment, and (12) trigger point injections.

1. Ablative Techniques. Ablative techniques include

Interdisciplinary Pain Care

- Evidence Based Support
- But still not the primary method of pain care delivery.
- Not many centers and no clear way to demonstrate quality
- CARF ? Not all centers are CARF accredited
- APS Centers of Excellence.. No objective criteria
- Difficult to create a Centers of Excellence Model.

Clinical Policy Bulletins

First published our Clinical Policy Bulletin

- 0237 Chronic Pain Programs
- Edited by John Loeser MD
- We cover this type of care
- But creating a Policy of Coverage did not drive more interest and usage of this type of care.
- https://aetnet.aetna.com/mpa/cpb/200_299/0237.html

Interdisciplinary Care

- CARF accreditation would have helped
- VA model is only example of use of CARF accreditation
- What is the rate of accreditation now?
- Does this now give us the tool we were missing ?

Why is the type of care not widely used?

- The Biomedical (Cartesian) model
- Drives interventional care
- Most still think this way
- General Education , providers, patients (members)
- Most still unaware of this more “Quantum view of pain”

What can be done?

- Broad education
- To the public
- To other providers
- Development of referral sources
- Get physicians to adopt and use this modality of care
- Things are changing with more consideration to this type of care representing more global care
- Educate Insurers / Payors
- Create Demand

Getting paid for this type of care

- Best would be a CPT code for per diem chronic pain care.
- Has to be negotiated currently
- Based on CPT codes of covered services being delivered
- This does not truly reflect the model and care being delivered.
- What does it take to get a per Diem code created by AMA ?

Do we pay for this care?

- Yes and have for over 20 years
- Why do we pay for interventional care ?
- We pay for what is evidence based
- Built into most of our Pain CPBs is a requirement for comprehensive pain care to accompany this care or no payment,
- We are NOT consciously deciding not to promote this care
- Insurers are much broader in their view these days
- Biopsychosocial care is widely recognized
- Spending on Social Determinants

“Divine is the task to relieve pain.” — Hippocrates