Welcome to the first formal Newsletter of the Colorado Pain Society, intended to update and inform our membership and others who have an interest in caring for patients with various painful conditions. CPS is actively involved in advocacy for our patients, members, and other pain care providers through efforts with Colorado legislators, The Colorado Medical Society, The Consortium for Prescription Drug Abuse Prevention, The Division of Workers Compensation, and various national and state specialty societies. We have a strong interest in education and invite you to our upcoming annual CME meeting (details below).

MEMBERSHIP

CPS has 89 members across various specialties and disciplines. We would ask that all our members help us to reach out to prospective new members across all pain, primary, addiction, psychiatry/psychology, and surgical practices that have a strong interest in pain management, education, and patient advocacy. This invitation extends to physicians, APPs and psychologists. There are also membership opportunities for Patron (retired in good standing) and Sponsoring (subject to Board approval) memberships. Practitioners interested in joining or updating their memberships may contact Annellie at copainsociety@gmail.com.

COLORADO PAIN SOCIETY 5TH ANNUAL CHRONIC PAIN CONFERENCE 2022

It is not too late to sign up to join us September 23-25, 2022, at The Hythe in Vail, CO for 13 hours of CME, and camaraderie. Meeting details and registration can be found at:

https://coloradopainsociety.org/annual-meeting-2022/

PRIOR AUTHORIZATION UPDATES / MEDICAL COVERAGE POLICIES

The burdensome process of acquiring prior authorization (PA) for patient care is one that consumes staff and provider time, is costly, contributes to staff and provider burn-out, and hinders the delivery of timely care to our patients, occasionally causing them to abandon care altogether. Colorado House Bill 19-1211, "CONCERNING PRIOR AUTHORIZATION REQUESTS SUBMITTED BY PROVIDERS FOR A DETERMINATION OF COVERAGE OF HEALTH CARE SEVICES UNDER A HEALTH BENEFIT PLAN.", which went into effect on January 1, 2020, makes it necessary that insurance carriers are transparent with both their coverage policies and denial records, sets ground rules for timely processing of authorization requests and denials, and includes provisions allowing carriers to exempt certain compliant providers from prior authorization requirements. The language in the law pertaining to this exemption eligibility is as follows: “(II) (A) A CARRIER OR ORGANIZATION MAY OFFER PROVIDERS WITH A HISTORY OF ADHERENCE TO THE CARRIER’S OR ORGANIZATION’S PRIOR AUTHORIZATION REQUIREMENTS AT LEAST ONE ALTERNATIVE TO PRIOR AUTHORIZATION, INCLUDING AN EXEMPTION FROM PRIOR AUTHORIZATION REQUIREMENTS FOR A PROVIDER THAT HAS AT LEAST AN EIGHTY PERCENT APPROVAL RATE OF PRIOR AUTHORIZATION REQUESTS OVER THE IMMEDIATELY PRECEDING TWELVE MONTHS. AT LEAST ANNUALLY, A CARRIER OR ORGANIZATION SHALL REEXAMINE A PROVIDER’S PRESCRIBING OR ORDERING PATTERNS AND REEVALUATE THE

PROVIDER'S STATUS FOR EXEMPTION FROM OR OTHER ALTERNATIVE TO PRIOR AUTHORIZATION REQUIREMENTS PURSUANT TO THIS SUBSECTION (4)(B)(II)."

On a national level, H.R. 8487, "Improving Seniors' Timely Access to Care Act of 2022", which has bipartisan support, was recently marked up and passed by the Ways and Means Committee, sending it on to Congress. More information about this bill and topic can be found at: https://www.ama-assn.org/practice-management/prior-authorization/big-step-bill-streamline-prior-auth-medicare-advantage

Achieving prior authorization for appropriate care for our patients is only one slice of the pie. Payers, including Medicare, are more strictly adhering to medical necessity policies, requesting supporting documentation before payment, performing audits, and even requesting "take-backs" of payments for prior services. It has become increasingly important for providers and their staff to have a working knowledge of carriers' medical policies, provide thoughtful documentation that supports medical necessity, and be able to educate patients, staff, and referral sources on the prescribing, imaging, or clinical performance parameters related to the requested medical care. Efficiently navigating through this process leads to staff and provider time and cost savings, greater patient, provider, and referral source satisfaction, and, most often, appropriate, cost-effective care.

CPS is currently in discussions with the major Colorado payers regarding appropriate contacts, submission processes, and other logistical concerns pertaining to requests for practice and carrier specific prior authorization success rates and eligibility for prior authorization exemptions. We will share this information in future correspondences to our membership and others. We do suggest that practices start now to become better versed in their relevant medical policies and begin quality assurance and operational efficiency self-assessments that we think will prove to be valuable.

Included below are links to some major carriers' interventional pain medical policies, and summaries of Medicare policies related to facet joint procedures and epidural steroid injections. Although the private insurance carriers' policies often mirror those of Medicare, there are usually a few differences of significance within each of the medical policies. Please follow these links, and explore other carrier medical coverage policies, as well.

Interventional Pain Medicine Policy Links:

Medicare (MC): Novitas Solutions Jurisdiction H;
https://novitas-solutions.com > Part B Provider > LCD > Medical Policy Search Tool > 64493, 64635, 62323, or 64483

BCBS (AIM; Not all BCBS plans follow these guidelines):
https://aimspecialtyhealth.com/resources/clinical-guidelines/musculoskeletal/

United Healthcare (UH): https://www.uhcprovider.com/en/policies-protocols/commercial- policies/commercial-medical-drug-policies.html

Cigna (Evicore): https://www.evicore.com/cigna-search-result? cat={61D43AFA-5ECD-4098-9047-7A12074FF085}&search=

Cigna https://www.evicore.com/cigna

Aetna TFESI http://www.aetna.com/cpb/medical/data/700_799/0722.html
Aetna Facet Injections, RFA, and ILESI
http://www.aetna.com/cpb/medical/data/1_99/0016.html

<u>Facet (zygapophysial joint) Procedures 64490-95, 64633-36 (Medicare)</u>

1. Indications (document): a) 3 months of conservative care, b) moderate to severe axial pain with
functional limitation, c) no untreated radicular pain or claudication, d) no other known causefunctional limitation, c) no untreated radicular pain or claudication, d) no other known cause
2. Save images; must use contrast; “hot” RFA only (not pulsed)
3. Medial branch blocks (MBBs) for diagnosis, intended radiofrequency ablation (RFA)
4. Intra-articular facet blocks after 2 sets of MBB (80% relief), justify no RFA (anatomic barrier, electrical device); repeat if 50% relief for 3 months
5. Facet cyst lysis or aspiration: use 64999, may perform with ESI
6. MBB/Facet: 4 sets per 12 months per region
7. RFA if 2 sets of MBBs with 80% relief; 2 sets per 12 months per region
8. Two levels covered, must justify 3rd level on appeal (initial denial)

<u>Transforaminal and Interlaminar Epidural Injections 64483-4, 62323 (Medicare, Lumbar)</u>

1. Indications (document):
a. Radicular pain,
b. Neurogenic claudication,
c. Post laminectomy syndrome,
d. LBP with central or lateral disc herniation, high grade annular tears, facet hypertrophy or osteophytes causing canal or foraminal stenosis (not bulge or minor annular tear),
e. 3/10+ pain with functional impairment,

f. Failure of 4 weeks of CM (exceptions: moderate pain with work/functional loss, severe pain, unable to tolerate non-surgical care, prior successful LESI for same condition)
2. Contraindications:
a. Major risk factors, history, or strong clinical suspicion of cancer
b. Spinal infection risk factors (new LBP with fever, recent infection, IV drug abuse, immunosuppression)
c. Signs of cauda equina syndrome (new urine retention, bowel incontinence, saddle anesthesia, rapidly progressing neurological deficits)
d. Co-existing medical conditions (medical, spine mass or trauma, coagulopathy, presenting CNS pathology symptoms)
3. Procedural requirements:
a. Image guidance, contrast (unless contraindicated), save images
b. Local anesthetic alone (SNRB with post-block pain assessment), or maximum 80 mg triamcinolone, 80 mg methylprednisolone, 12 mg betamethasone, 15 mg dexamethasone per session

Working knowledge of these and other carrier's policies has become critically important. Please become familiar with the medical policies, and then educate your staff and providers, as well as referring physicians, on the documentation and medical necessity parameters of your commonly performed procedures (as well as medications, imaging, and conservative care).

CLOSING

Please provide your feedback, ideas, and new member referrals. We hope to see you at the CPS Annual Meeting.

Sincerely,

J. Scott Bainbridge, MD / CPS Board of Directors