Helping children and families, patients with pain

“When children have pain, it needs to be treated,” said Rita Agarwal, MD, in a recent AMA Advocacy Insights webinar on the stigma facing patients with pain, including young children.

The panel, moderated by Bobby Mukkamala, MD, chair of the AMA Board of Trustees and Substance Use and Pain Care Task Force, also addressed the consequences of untreated pain, the relationship between pain management and health equity, and physician fears when prescribing opioids.

Speakers included: Rita Agarwal, MD, clinical professor of anesthesiology at the Stanford University School of Medicine and past president of the Society for Pediatric Pain Medicine; Edwin C. Chapman, MD, founding member and secretary of the board of directors of the Leadership Council for Healthy Communities; and Cara Sedney, MD, MA, associate professor and residency program director of the West Virginia University Department of Neurosurgery.

Dr. Chapman described the dangers of inaccessible pain medications, saying that “the patients who cannot get access to legal pain medications have no choice and initially move toward street drugs.” With so many of these drugs now being laced with fentanyl, there has been a dramatic rise in overdose deaths related to illicit substances.

Dr. Mukkamala explained this trend, stating that previous policy approaches and the 2016 CDC opioid prescribing guideline focused almost exclusively on how to restrict prescription opioids, increasing the stigma on patients with pain and not addressing the rise in overdose deaths caused by illicit fentanyl, methamphetamine and cocaine. The AMA is pleased the CDC now is proposing to remove the numeric thresholds in the 2016 guideline.

Dr. Sedney’s presentation reinforced this data, focusing on her research into the impact of restrictive opioid prescribing laws on patients. Physicians interviewed as part of the research revealed that fear of disciplinary action led to refusal to prescribe opioids, leaving patients with no choice but to turn to illicit substances.

“When unfortunately, the misapplication of the CDC guideline obstructs much of my ability to assess and treat, and more importantly, it leads to preventable suffering,” said Dr. Mukkamala, citing data from the
National Survey on Drug Use and Health (PDF) that many people who say that they misuse opioid analgesics do so to self-treat pain.

“Nearly all of the patients we interviewed in our study who used illicit substances had started with chronic pain, and many of our participants noted that the sort of care gap where they were unable to continue their medication,” said Dr. Sedney, going on to explain the need for fail-safes to prevent patient abandonment and the detrimental impacts of opioid restriction policies on patients with chronic pain.

Dr. Chapman discussed the need to address both physical and psychic pain, especially in Black communities. “We want to take a village approach, and that village approach of course involves medical treatment and reconciliation at the core, but we also need advocacy and legal surveillance,” said Dr. Chapman. He specifically advocated for a better relationship between the criminal justice system and outpatient treatment as a more equitable step toward managing the overdose epidemic.

“Untreated pain has tremendous consequences,” said Dr. Agarwal. Although there are a number of multi-modal or non-opioid approaches to pain treatment that we should continue to explore, she explained, there are insurance barriers that make these alternatives less accessible. “This is why individualized care is so important,” she said.

View the full webinar discussion for more information.

**Experts guide physicians through out-of-network reimbursements under the NSA**

The No Surprises Act (NSA), which aims to protect patients from the financial impact of surprise medical billing, took effect on Jan. 1. One of the challenges of its implementation since then has been the provider-payor dispute resolution process and the methods by which physicians and insurers can settle out-of-network claims.

As a follow-up to the AMA’s January webinar on the implementation of the NSA, a recent webinar focused on out-of-network payment from health plans to physicians and other providers in surprise medical billing situations using the NSA’s independent dispute resolution (IDR) process. Bobby Mukkamala, MD, chair of the AMA Board of Trustees, moderated the discussion between Joel Ario and Michael Kolber, respectively the managing director and a partner at Manatt Health.

The NSA prohibits balance billing for three types of surprise billing situations:

- Out-of-network emergency services
Some non-emergency services by out-of-network providers at in-network facilities

- Air ambulances

The out-of-network rate, or the amount that out-of-network providers must be paid for the above services covered by the NSA, can ultimately be determined by the newly established federal IDR process in situations where state law does not apply. States have primary authority to enforce the NSA and state law continues to apply so long as it provides better patient protections than those given under federal law. If a state chooses not to enforce the NSA or fails to do so, the federal government is required to step in.

To determine whether state law or federal IDR applies, providers can begin by checking the chart (PDF) created by CMS. For states listed under “bifurcated” or “state-process” providers will then need to analyze the scope of state law.

The following steps outline the service to IDR initiation timeline in the case that federal IDR applies:

1. Service covered by the NSA is provided.
2. Patient pays in-network cost share determined by state law or if state law does not apply, the qualifying payment amount (QPA).
3. Plan makes initial payment or sends denial notice within 30 days.
4. Provider has 30 days to invoke a 30-day negotiation period if unhappy with the payment amount.
5. If an agreement is not reached during this negotiation, the provider has four days to initiate the IDR process through the federal IDR portal.

The federal IDR portal opened on April 15. For negotiations that were ready for the IDR process before the portal opened, the IDR must be initiated by May 6.

For additional information about disputing out-of-network payments using the IDR of the NSA, the AMA developed a toolkit (PDF) to guide physicians. The AMA will continue to update this toolkit as new information becomes available.

View the full webinar discussion for more information.

Helping private practices navigate non-essential care during COVID-19

The AMA has released updated guidance for private practice physicians navigating the provision of care during the COVID-19 pandemic. The resource emphasizes ways physicians and practices should protect their employees, patients and visitors while also operating within the constraints of a national
health care staffing crisis.

The guide includes recommendations to review COVID-19 federal and state guidelines to ensure patient and staff safety and to assist in adjusting workflows to support both staff and patients.

**Debunking regulatory myths: Are physicians prohibited from responding to online patient reviews?**

The AMA’s Debunking Regulatory Myths series provides physicians and their care teams with resources to reduce guesswork and administrative burdens. One myth persists that physicians are prohibited from responding to online patient reviews. Read the latest from the Debunking Regulatory Myths series to learn more.

**AMA STEPS Forward™ webinar: Protecting mental health in disasters: COVID-19 and beyond**

COVID-19 is the most far-reaching and long-lasting disaster in generations, with a long "tail" of expected mental health effects impacting patients, providers and their families. Understanding the range of mental health effects and aspects of risk and resilience are critical to effective response and recovery.

In this AMA STEPS Forward™ webinar, speaker Joshua C. Morganstein, MD, CAPT, discusses how the use of evidence-based early interventions by individuals, organizations and leaders can reduce distress, foster resilience, enhance operational sustainment and help treat psychiatric disorders that may emerge.

**More articles in this issue**

- April 29, 2022: Advocacy Update spotlight on major wins for scope of practice
- April 29, 2022: National Advocacy Update
- April 29, 2022: State Advocacy Update


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