Cost Containment
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Disclosures
• None

Learning Objectives
• Determine whether or not a diagnostic test is appropriate in a given pain management clinical situation
• Calculate the relative costs of selected pain management therapies using an online tool
• Identify common areas of potential cost containment in pain management
Financial Terminology

- **Gross domestic product:** total value of goods and services produced and sold by a country. Personal Expenditures + Business Expenditures + Government expenditures + (Exports - Imports) = GDP
- No surprise… US spends more money on health care than any other country in the world, both in terms of total figure as well as % of GDP
- In 2015, spending on health care was approximately $3.2 trillion, or 17.8% of GDP

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Putting $$$ into Perspective

- **How much is $3.2 trillion?**
- Distance from earth to moon is roughly 240,000 miles
- 5280 ft per mile = 1.276 billion feet from earth to moon, or 2.552 billion feet for round trip

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Putting $$$ into Perspective (cont’d)

- Dollar bill is ~7 inches long, or 0.625 feet long
- $3.2 trillion in one dollar bills, lined up end-to-end, would reach 2 trillion feet
- 2 trillion feet / 2.552 billion feet (one round trip to moon) means a line of $3.2 trillion one-dollar bills would stretch to the moon (and back)…
Putting $$$ into Perspective (cont’d)

- 783 times
- So, let’s begin looking at HOW a lot of that goes to treating pain and what we can do about it

While We Weren’t Looking

- Not the fault of any one of us, or 2 of us, or even 100 of us
- We go to work, check schedule of who is coming in, and put our heads down and shoulders into dealing with uncomfortable, sometimes irritable, sometimes quite sick patients and their family members
- Day in, day out, we focus on care of patients more than the cost of that care

“Talented Amateurs”

- Pain management frequently involves identifying risk of addiction to medications, and learning to recognize aberrant behaviors, to keep patients and ourselves out of trouble
- Helps if we become “Talented Amateurs” in field of addictionology
- Society also needs us to become “Talented Amateurs” in field of medical economics!
Where Does the Money Go?

- Nothing comes for free
- Every transaction requires some type of currency (whether that is cashed cash, or some calculated value of a service we provide or item we trade). For every dollar we spend, some goes to pay for food, some for shelter, some for taxes, etc.
- 1970: 7% on health care
- 2015: 17.8% on health care


Where Does the Money Go? (cont'd)

- Percentage spent on some segments was fairly stable (approximately same % to doctors/healthcare providers) from 1970-2010
- Less for hospital care, and meds (-), more for nursing home and “other” (Assisted Living, Home Care)


How Do We Pay for Health Care?

- 1970: 40% Out of pocket, 22% Private Ins., 20% Medicare/Medicaid, 18% Other (VA, etc)
- 2010: 14% Out of pocket, 35% Private Ins., 40% Medicare/Medicaid, 11% Other (VA, etc)

Health Care and $: Nothing Else Like It

- No other transactions in our society like those in health care
- MOST THINGS IN LIFE: you want it, you negotiate for it, you buy it, you own it
- HEALTH CARE: one person orders a product for another person, and “unseen forces” pay for the bulk of it
- OPM: more addictive than opium

Let’s See…What Will I Have?

- Favorite burger joint: order burger, fries, drink. You can fine-tune the order (single or double burger, up sized fries or not, bottle of water vs fountain drink)
- Info boards tell prices and calorie counts. You can make decisions based purely on economics, purely on health reasons, or any combination thereof

Wouldn’t It Be Nice…

- …to have a menu for healthcare products and services?
- …to know what things REALLY cost?
- …to be able to help patients while making good decisions regarding stewardship of resources?
**Take Responsibility, Take Control**

- We do not control what a particular drug costs
- We do not control what an MRI costs
- We do not control what a UDT costs

*But*

- We DO control which patient gets which medication (out of a list of options, usually)
- We DO control whether or not an MRI is even needed
- We DO control frequency/type of UDT in our practices

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**Controversy**

- Not every provider feels it is his/her responsibility
- JAMA survey of 2400 physicians: only 1/3rd felt they bore a “major responsibility” for controlling healthcare costs
- Who did they think, then, bore the responsibility?
  - Trial lawyers
  - Health insurance companies
  - Pharmaceutical manufacturers


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**We Hold the Reins**

- Even if...
  - there were no trial lawyers
  - each patient’s health insurance plan cost half as much
  - each medication cost only half as much as it does today

- We who put pen to paper and write the orders for tests, treatments, DME, and prescriptions have THE MOST control of who gets what, when, and how often. Therefore, we direct virtually ALL the healthcare spending that is done
How Did We Get Here? Technology

- Better prevention:
  - Automotive safety
  - GFI outlets
  - Unleaded paint and gas, radon detection
- Better response:
  - 911
  - Community CPR
  - Needle stick prevention


Technology: A Double-Edged Sword

- Better treatments: of acute and chronic diseases:
  - CAD, DM, COPD, various cancers; diseases detected sooner and treated more definitively; ESRD legislation in 1972
- Life expectancy has increased
  - (up — By from 1970-2010)
  - By 2050, 20% of people living in US will be over age 65


A good new home is one where you can’t see the smoke from your parents’ chimney.

Dutch proverb
Moving Up, Moving Out

- Lower birth rate, more mobile society + fewer marriages = fewer kids to take care of their parents in their old age
- Raising own kids, saving for own retirement, and also planning for the needs of parents who may be living well into 80s and beyond = overwhelming

Chronic disease + aging population + social mobility = $$$


The Heart of the Matter

- More people living longer means more people will be in the situation of having developed a chronically painful condition
- Many just need a little help in having enough relief to maintain functional independence
- As of 2013, 53% of working RNs were 50 years or older
- Nursing home care: average in 2015 was $250/day
- Over $91,000 per year, per patient
- Suddenly, the cost of other things begins to come into focus…


Costs Associated with Chronic Pain
Costs Associated With Chronic Pain

PATIENT:
- Lost time from work/enjoyable pursuit, lack of independence (eg, have to wait on someone else for help), waiting in medical offices
- Costs of copay/coinsurance, diagnostic tests, medications, prior records, drug testing
- 2003 study of 28,000 workers. Average of 4.5h/week lost productive time due to pain
- $60 BILLION lost (in 2003 dollars); only ¼ of that was from absenteeism. Rest was ON THE JOB.


Costs Associated With Chronic Pain (cont'd)

PROVIDER:
- Reviewing records before patient ever arrives, to look for "red flags"
- Risk assessment including synthesis of thorough mental health, substance abuse, family history, and past responses to treatments
- Obtaining REAL informed consent (not "sign here")
- Answering calls re: lost/stolen meds, coverage issues, pharmacy problems
- Waiting on reimbursement from insurer

Costs Associated With Chronic Pain (cont’d)

INSURER:
- Paying the bulk of the cost for medication that may or may not be appropriately handled (also, branded vs generic)
- Paying for drug testing costs
- Paying for more frequent visits (often monthly, since many meds for pain are C-II)
- Paying for more complex visits than in management of many other chronic disease issues (pain issue, addressing comorbidities, medication management, drug test interpretation, decision to order labs/procedures or not, etc.)
Cost Containment Tips

Cost Containment: Imaging

- 42 yo man complains of chronic LBP; PMHx includes motorcycle injury at age 18. Never had leg pain, weakness, bowel/bladder control problems
- Brings MRI disc and radiology report from when he was 40 yo. Records reveal DDD, no listhesis; has had routine treatment with oxycodone 30m QID
- Patient says he can’t afford to pay privately any more. Just got Medicaid coverage, so comes to you for treatment

Cost Containment: Imaging (cont’d)

- Disc desiccation at L4-5 with protrusion producing mild impingement on thecal sac. Disc desiccation at L3-4 also with small protrusion producing mild impingement on the thecal sac
- IMPRESSION: Multiple levels of lumbar degenerative disc disease
Cost Containment: Imaging (cont’d)

- Majority of people with no back pain had one or more levels of “degenerative disc disease” in a classic study.
- 64% of 98 asymptomatic people had one disc bulge; 38% had at least 2 disc bulges.
- Prior MRI for this man was never really indicated, since he never had any radicular symptoms or incontinence/weakness.
- TIP: MRI only if patient would be a candidate for procedure/surgery.


Even if “surgical candidate….”

- Study tracked nearly 350 patients deemed appropriate for lumbar fusion.
- Randomized to surgery or a program involving PT, meds, and 75h of behavioral therapy (psychology).
- After 2 years, 20% of surgical/24% of rehab returned to work, and the rest had similar distributions of Oswestry Disability Index scores.
- 42% lower costs in the rehab group.


Cost Containment: Imaging

- Symptoms of compression fracture (axial pain, tender on percussion, history of fall/cough/trauma with fairly rapid onset of pain).
- If bedbound by pain, vertebroplasty/kyphoplasty may get them up quickly and help prevent complications like bedsores, DVT, pneumonia.
- MRI with STIR sequence can help gauge whether or not candidate for vertebral augmentation.
- Otherwise, more conservative measures (calcitonin nasal spray, bracing) may help relieve the pain fairly quickly, without sedation.


Cost Containment: Imaging (cont’d)

- For low back pain without radiculopathy, still need to know whether or not there is any segmental instability (i.e., spondylolisthesis) prior to PT/OT/interventional therapy vs refer for neurosurgical opinion
- **IF MRI IS ACTUALLY INDICATED:** Prices vary greatly; patient may be better off negotiating a “cash pay” price than to get it done under a high-deductible insurance plan
- Kaiser Health: investigative reporters were quoted prices up to $5,000
- **TIP:** Private organizations can help to negotiate with imaging centers for flat-rate MRIs ($300-$400 range to start)


Cost Containment: Imaging (cont’d)

- **Document medical decision-making, either FOR or AGAINST ordering imaging studies**
- **FOR:** easier for office staff to get authorization from insurer
- **AGAINST:** account info should be compiled in database. Use info to negotiate when it comes time to renew contracts with insurers. Prove that **YOU SAVE MONEY** by **USING BEST PRACTICES**
- Either way, documenting your medical decision-making is important for your E&M billing

Cost Containment: Imaging (cont’d)

- **Online tool, free of charge, can help guide you quickly through the thought process of evidence-based medicine**

**American College of Radiology Appropriateness Criteria**

www.acr.org/Quality-Safety/Appropriateness-Criteria
Cost Containment: Drug Testing

- UDT: commonly used to monitor adherence to therapy
- Know testing limits (EIA vs mass spec)
- "Liquid gold": GCMS @ $300 test, 12 tests/day x 250 days/yr = $900k/yr
- Heavily marketed: "more is better" from UDT lab perspective
- TIP: Risk eval/stratify + patient education = reduced illicit behaviors
- No need to test every patient every time


Cost Containment: Genetic Testing

- Lots of "buzz" about PGT, and it's heavily marketed
- THEORY:
  - Knowing which patient is able to metabolize which medication effectively minimizes costly "trial and error" and ADEs
- PRACTICE:
  - No matter what medication a patient may metabolize most effectively, insurance coverage may limit options

TIP: only order if you intend to DO SOMETHING with the results, not simply to "explain why" patient's complaints of pain are refractory to various opioids

Cost Containment: Labs

- Other labs (liver/kidney function)
- Potentially hepatotoxic meds (eg, combination opioids/paracetamol, tizanidine) or nephrotoxic meds (eg, NSAIDs)
- TIP: request recent labs from PCP or have patient bring copy
Cost Containment: Meds

- **HUGE** cost; often invisible cost
- $1/mg for opioids; $0.04/mg for pure gold (at $1200/oz, 31.1g/oz)
- We order, patient receives, “faceless” third party pays for most of it
- Manufacturer may have contracted for one price to one insurer, and another price to another insurer
- **TIP:** use technology to learn the relative prices of what you prescribe

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Cost Containment: Meds (cont’d)

- Pharma company copay cards reduce cost to an individual
- Does not change cost to us ALL
- Higher premiums, Medicare/Medicaid taxes, increased costs built into **EVERYTHING WE PURCHASE**
- $1500/vehicle at GM prior to collapse went for healthcare costs (including $17mil just for Viagra in 2006)

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Cost Containment: Meds (cont’d)

- GoodRx.com
- Free online tool to shop/compare
- Sorts by ZIP code
- Example: 37923 (my home)
  - Generic morphine 180mg 90’s: Kroger: $65 CVS: $99
  - Brand-name MSContin:
    - Kroger: $602, CVS: $596

Cost Containment: Meds (cont’d)

- Example:
  - oxycod/acetaminophen 10/325mg #120
    - Kroger: $65
    - CVS: $1.42
  - Branded Percocet 10/325mg
    - Kroger: $51.97
    - CVS: $29.25


Cost Containment: Procedures

- Precision therapies by qualified providers can help, but waste still occurs
- Big difference in knowing HOW to do something and knowing WHEN to do it
- Patient with back and leg pain, MRI shows disc herniation at L5-S1; ? epidural steroid injection
- TIP: weigh the independent diagnostic value of each procedure

Cost Containment: Procedures (cont’d)

WASTEFUL PROCEDURES, WASTED $$

- Patient complained of right sided lower back pain, buttock, and dorsal high pain.
- Physician performed right L4-S5 and L5-S1 facet injection, right SI joint injection, right L4 and L5 ESI, and an IM injection of ketorolac all at the same appointment

Diagnostic value: Zero. If relief, no way to know what helped. Could have just been the ketorolac!
Cost Containment: Value over Time

- SCS: Cost upwards of $30,000 for screen and implant. But, may be worth it
  - Example: Opana ER 40mg q12h plus eszopiclone 3mg qHS = $900/mo
  - Visit: $200/mo; UDT $300 each (4x/yr) + meds at $900/mo = $7,200 at 5 yr
  - Even if still needs SOME meds following SCS, may still be much less costly
  - AFTER: Visit + UDT + meds (down to $110/mo for oxycodone/APAP 10mg QID) + SCS = $54,600 at 5 yr

Cost Containment: Overall Efficiency

- Each person, doing a little, can make a big difference
- Large companies take great pains to maximize small steps that save money
  - UPS: Always make right turns; carry pen in left pocket if right-handed; trucks with key fobs instead of keys.
    One minute of “idle” time per day per driver = $14.5 million/year
  - Kroger: Infrared scanners throughout the store + algorithms = average wait time reduced from 4 minutes to 30 seconds
- EMR can help identify “bottlenecks” in patient flow through office


Cost Containment: Overall Efficiency (cont’d)

Since our practice’s conversion in 2004:
- Increased productivity by 25% (from 20 patient/day to 25 patient/day)
- Spaced steps by eliminating “chart room” put to better use
- Saved steps/time for staff who open records and view rationale for the test/treatment ordered while on phone for “peer to peer” calls
- Able to send/receive messages re: patients between staff at different offices, view our own and others’ schedules in case of illness
- Streamlined billing (ready to bill before patient walks out the door)

Cost Containment: We All Play a Role

- 691,400 physicians
- 151,400 NPs
- 86,700 PAs in 2012
- 20 patients/day, 5 days/week, 50 weeks/year = 4.65 billion patient encounters
- If we just save $50 off the total cost of each encounter (eg, efficiency, avoiding unnecessary tests, lower medication costs), that would save $230 billion annually
- $230 billion of savings = >7% of $3.2 trillion spent
- Couldn’t we collectively use a 7% raise?
- Health care is not FREE, but we can use good sense to reduce burden


Thank You!