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Reopening Pain Practices

On June 2, AAPM presented a live webinar titled "Re-opening and Revitalizing your Pain Practice Amidst the COVID-19 Pandemic." The following document was prepared by course presenters as a resource to assist pain providers seeking guidance on safely caring for patients during the COVID-19 pandemic.

The COVID-19 pandemic resulted in unprecedented challenges to healthcare in general and to pain management practices in particular. Chronic pain patients being one of the most vulnerable patient populations under normal circumstances, have been affected particularly hard during the pandemic when pain management practices were closed and most treatment modalities, including medical management, physical therapy, psychological interventions, and interventional procedures were not available. Additionally, loss of revenue from not rendering services put a tremendous financial strain on pain practices.

This APPM webinar and the following expert opinion guidance, which was put together by experts from academic and private practices, addresses some of the challenges of reopening pain management practices. We understand that local conditions vary quite a bit from region to region and that this set of recommendations needs to be tailored to each physician's practice and local regulations, as well as the current state of the pandemic in their region. These re-opening topics include: patient care in light of the ongoing pandemic, safety measures when reopening a pain clinic in order to protect both healthcare workers and patients, risk stratification of pain management procedures based on urgency vs. the increased risk of contracting COVID-19, the important role of telemedicine, the financial impact of the pandemic and available resources, and how to prevent the physicians burnout during pandemic and beyond. These main points were highlighted in the webinar noted and linked above.

1. **CDC Guidelines on Reopening Practices**

    - Patients should be screened by phone prior to an office visit for Covid-related symptoms, contacts with Covid-positive patients and travelling outside of the area within 14 days of appointment.
    - When entering the office, patients should wear a mask, their temperature should be taken and the same questions regarding Covid-19 symptoms or exposure should be asked again.

- In order to decrease patient traffic, an effort should be made to perform as many appointments as possible via telemedicine.
- Assure sufficient supply of PPEs for your office staff and providers.
- Prepare waiting room by spacing chairs 6 feet apart; limit the number of non-patient visitors as much as possible.
- Disinfect frequently touched surfaces, e.g. counters, beds, seating, C-arm, laptops, etc. with EPA-registered disinfectants after each patient.
- Ensure that clinic staff know the right ways to don and doff PPE safely.
- Encourage changing scrubs daily and use of shoe covers.
- Train your staff how to recognize Covid-19 symptoms and how to quickly triage and isolate sick patients.
- Emphasize universal precautions: hand hygiene, cough/sneeze etiquette.
- Ask staff to quarantine at home if they get tested and are sick.

2. **<u>Screening vs Testing</u>**
   - All patients should be screened.
   - The following patients should be tested:
     - Patients scheduled for procedures under MAC or GA due to potential aerosolization of saliva, e.g. vertebral augmentation, SCS or intrathecal pump trial or implant, multilevel RFA, etc.
     - High risk patients with symptoms.
     - Residents of LTC facilities and prisons with symptoms.
     - Patients with exposure to individual(s) who tested positive for SARS-CoV-2.
   - The test should be done within 3 days of the procedure.
   - The most reliable test has been RT-PCR using nasopharyngeal swabs, throat swabs or more recently saliva.
   - Different manufactures are targeting different parts of RNA gene such as the envelope, nucleocapsid, spike, RNA-dependent RNA polymerase and ORF1 genes.
   - Sensitivities of these tests are comparable.
   - In most symptomatic individuals, viral RNA in the nasopharyngeal swab becomes detectable as early as day 1 of symptoms and peaks within the 1st week of symptom onset.
   - Positivity starts to decline by week 3 and subsequently the virus becomes undetectable.
   - In severely ill hospitalized patients, PCR can be positive
     > 3 weeks after illness onset, in some cases > 6 weeks.
   - Positive PCR result reflects detection of viral RNA and does not necessarily indicate presence of viable virus.
   - CDC indicates that healthcare workers can return to work if at least 72 hrs have passed since recovery defined as:

    - resolution of fever without the use of antipyretics
    - improvement in respiratory symptoms
    - at least 10 days passed since the first symptoms appeared.
- Specificity of most of RT-PCR tests is 100% as they are specific to the genome sequence of SARS-CoV-2.
- Especially important for patients with mild to moderate illness who may present late beyond the first 2 weeks of illness onset.
- Antibody detection is an important tool in understanding the extent of the disease in the community.
- It is aimed at identifying individuals who are immune and potentially protected from becoming infected.
- IgM and IgE can be detected as early the 4th day after symptom onset, higher levels occur between the 3rd and the 4th week of illness.
- IgM begins to decline and reaches lower levels by week 5 and almost disappears by week 7, IgG persists ≥ 7wks.
- ELISA-based IgM and IgG antibody testing has ≥ 95% specificity for diagnosis of Covid-19.
- The long-term persistence and duration of protection conferred by the neutralizing antibodies remains unknown.

3. **<u>Risk Stratification for Interventional Procedures and Surgery</u>**
    - SARS-CoV-2 & Corticosteroids Recommendations
        - No conclusive evidence, but given the Influenza data, and known immune suppressant effects, corticosteroids could potentially increase risk of COVID-19 related illness.
        - When medically necessary: use lowest dose of steroids.
        - Consider non-steroid alternatives when possible.
        - Dexamethasone may be favorable (non-particulate steroids have shorter duration of action).
        - Obtain informed consent stating the potential risk.

4. **<u>Telemedicine During the Pandemic: CMS Changes</u>**
    - Telemedicine reimbursement is the same as for in-person visits (CPT codes NP-99201-99205, EP-99211-99215).
    - Telephone restriction waiver.
    - CMS is waiving the video requirement for certain telephone evaluation and management services.
    - CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits (CPT codes 99441-99443, 98966-99968).

- CMS is waiving limitations on the types of clinical practitioners that can provide Medicare telehealth services.
- Telephone visits with residents would not meet requirements for supervision.

5. **Covid-19 and Healthcare Provider Burnout**
    - COVID-19 Pandemic Specific
        - Changed workload
        - Reduced/unstable work force (sick/quarantine)
        - Limited ability for compassionate care
        - Risk of infection (self/family)
        - Lack of resources and knowledge
        - Risk of the second wave of infection

6. **Economic Impact on Practices**
    - CMA COVID-19 PHYSICIAN FINANCIAL HEALTH SURVEY RESULTS
        - 95% are worried about financial health
        - 64% decline in revenue since March 1, 2020
        - 49% had to lay off or furlough physicians/staff
        - 65% have reduced physician/staff hours
        - 34% had to cut physician/staff salaries
        - cmadocs.org/covid-19
    - Payroll Protection Program
        - All small businesses are eligible
        - The loan has a maturity rate of 2 years and an interest rate of 1%
        - No need to make loan payments for the first six months
        - No collateral or personal guarantees required
        - No fees
        - The loan covers expenses for eight weeks starting from the loan origination date (if the obligations began before February 15, 2020)
        - The loan can be forgiven and essentially turn into a non-taxable grant
        - At least 75 percent of the PPP loan must be used to fund payroll and employee benefits costs.
        - The remaining 25 percent can be spent on:
        - Mortgage interest payments
        - Rent and lease payments
        - Utilities
        - If you stick to these guidelines, you will be able to have 100% of the loan forgiven (effectively turning it into a tax-free grant)

- **Provider Relief Funds**
    - Part of CARES Act for hospitals and physicians to cover lost revenue and expenses related to COVID-19
    - May 15th HHS updated distribution of the Provider Relief Funds
    - Only Medicare FFS physicians who received a share of the $30 Billion distribution are eligible
    - Second distribution will be $20 Billion

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