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Q&A
WITH DR. MEDLAW

Underlying Principles of Payment

The COVID-19 crisis has put many practices under great stress as far as payments as patients lose insurance coverage or cannot cover bills. However, it is essential to remember that the underlying principles in these situations have not changed. Let's look at a few questions that came in before the crisis to reinforce these basic points.

Q: *I converted my family practice to all-cash last year and it has worked out well in most cases - I offer very competitive pricing and the time I don't spend dealing with paperwork I can spend with my patients. However, I have one patient who is always behind, and this has continued even on a $20 per month payment plan. I see him at least every 3 months to follow his diabetes, so this is really backing up. He is actually a great patient otherwise, but this non-payment cannot just continue. Can I terminate him now just for non-payment? Can I make payment a requirement for a new appointment?*

Yes, to your first question but no to your second. The situation in which a patient is under active care that cannot be suddenly discontinued, which would be what most doctors understand to be abandonment, does not apply here. With enough notice, termination is possible. As long as you do not breach your fiduciary duty to not abandon your patient, you may withdraw for any reason. However, keeping him in your practice but refusing to see him until he pays is "internal abandonment"—the patient is kept on the rolls of the practice but gets no care. If you keep him on, he is to be treated as any patient would be, regardless of payment status.

Q: *As a small-town doctor, I have always been lenient on collecting co-pays and dealing with deductibles when patients really cannot afford them. I put a note in the chart of any patient I don't collect on explaining the circumstances. However, I have colleagues who say that it is fraud.*

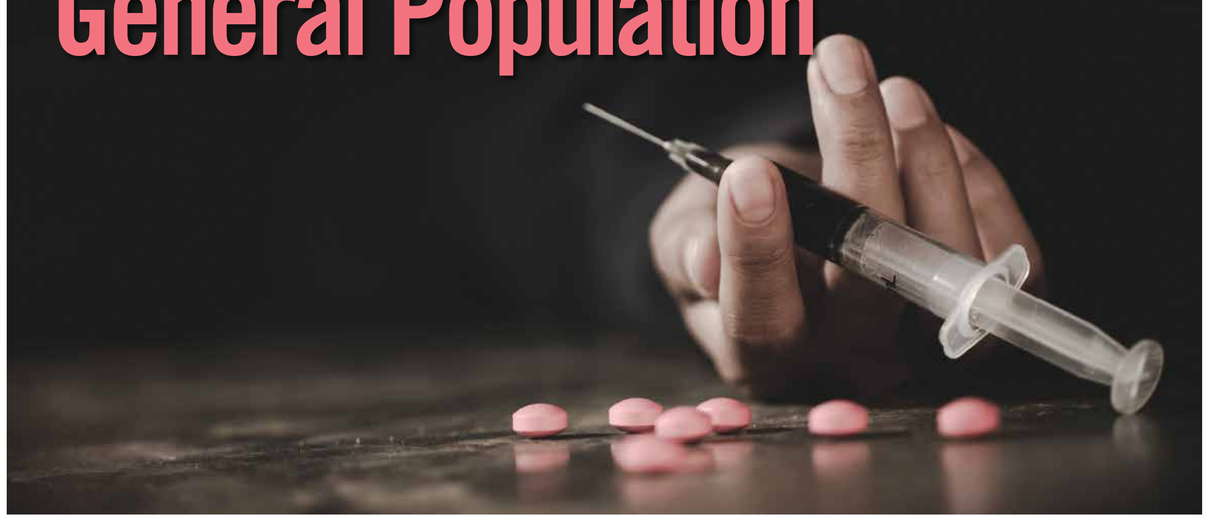
This can be very risky for you. While AMA Opinion 6.12 says that when the share the patient is responsible for "is a barrier to needed care because of financial hardship, physicians should forgive or waive" it, that is an aspirational ethics statement, and you are still bound by the payor relationships that you have that bind you to collect. If you waive a co-pay, correct your billing to reflect it. There is also the problem of violation of the Anti-Kickback Statute if you do not collect co-pays or apply deductibles to patients in federal healthcare programs. Following the rules with both private and governmental payors should let you keep on helping your patients without risk to yourself.

Q: *How come a hospital can get a patient set up with Medicaid so they can get paid, but I can't pay a premium on a patient's insurance so that it doesn't lapse so that I can get paid?*

You cannot pay for a policy under which you will benefit by the insurer paying you. The hospital, by contrast, is not making a payment and is just assisting the patient to obtain access to what they are eligible for.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.

Death from Opioids Far Less Likely in Cancer Patients than General Population



From 2006 through 2016, death from opioid overdose was 10 times less likely to be listed as the primary cause of death in individuals who had cancer compared with individuals who did not have cancer, Fumiko Chino, MD, Memorial Sloan Kettering Cancer Center in New York, and colleagues reported in a research letter published in *JAMA Oncology*. "Opioid-related deaths in the cancer population are much rarer than in the general population," the authors observed. "Continued care should be taken when treating cancer-related pain."

Death certificate data were obtained from the National Center for Health Statistics between 2006 and 2016. "All deaths owing to opioids were included," the authors noted. "If present, cancer was noted as a contributing cause." Over the decade reviewed, 193,500 deaths due to opioid overdose were documented in the general population. This compared with 895 deaths in the population who had cancer.

Over the same period, opioid-related deaths in the general population increased from 5.33 per 100,000 to 8.97 per 100,000. In contrast, opioid-related deaths in individuals with cancer increased from 0.52 per 100,000 to 0.66 per 100,000.

The researchers noted that some cancer types seem to be associated with a higher risk of opioid overdose. This includes head and neck cancer, which represented 12% of opioid-related deaths in this study, despite head and neck cancer representing less than 4% of new cancer diagnoses.

On the other hand, "one-third of patients experience cancer-related pain after curative treatment," they emphasized. This is an important observation, as prescribing restrictions to reduce the risk of opioid abuse have reduced access to needed pain control in patients on active cancer treatment and for long-term survivors who continue to experience pain.

PDMPs & Opioids

In a separate research letter also published in *JAMA Oncology*, investigators found that the number of oncology patients registered with Medicare who filled a prescription for opioids declined in states where mandatory-access prescription drug monitoring programs (PDMPs) had been enacted. As Ilana Graetz, PhD, Rollins Emory University in Atlanta and colleagues pointed out, more than 30 states have now enacted laws mandating use of PDMPs to reduce inappropriate opioid prescribing.

For their data, researchers used the Medicare Part D prescriber files for the years 2013 through to 2017, restricting their sample to practitioners who specialized in medical or hematologic oncology. "By 2017, 21 states had implemented mandatory-access PDMPs, including 5 states that explicitly exempted the reviewing requirement for patients with cancer," Dr. Graetz and colleagues explained.

Compared with practitioners in states with no mandated PDMP, the proportion of oncologists' patients who filled an opioid prescription declined by 4.8% between 2013 and 2017 in states where mandatory PDMP orders had been enacted. In states where mandatory PDMPs had been implemented but which exempted cancer patients, the comparative decline was 2.8%.

"There is growing concern that some physicians—burdened by the task of consulting a PDMP and added scrutiny over their prescribing — have reduced their opioid prescribing even for patients with legitimate pain management needs," the investigators observed. "From our early results, we find that exemptions for patients with a cancer diagnosis did not shield Medicare patients treated by a medical or hematologic oncologist from the unintended spillovers of mandated PDMP requirements." As more states consider policies to curtail the opioid crisis, "it is critical to understand how [these policies] affect both problematic and legitimate opioid use."

Underreporting in Patients With Cancer?

Commenting on findings from both studies, James Murphy, MD, University of California, in San Diego and colleagues pointed out that as noted by Chino, et al. themselves, physicians may have been far less likely to consider opioid overdose as a cause of death among patients with cancer than in the general population. "This misattribution bias could lead to underreporting of opioid-related mortality among patients in this population," they suggested. Nevertheless, the editorialists felt that the data provided by Chino, et al. should reassure healthcare professionals that death from opioid abuse is rare among cancer patients and that rates have not increased much over time.

They also pointed out that Graetz, et al. evaluated prescription practices only among oncologists and not from other opioid prescribers. That said, they felt the study demonstrated that prescription practices in states where PDMPs had been mandated had reduced opioid prescriptions only modestly—"[suggesting] that oncologists continue to prioritize pain management," they noted.

The editorialists acknowledge that the opioid epidemic continues to be a "critical public health concern" and one deserving of public policy attention. Nevertheless, considerable concern has been expressed that overly conservative policies may be undermining the need for good pain management and leave much of cancer-related pain undertreated. "The available research… underscores the fact that the needs and risks of patients with cancer diverge from the general noncancer population," they stated. "We need to make sure we protect individuals with cancer," Dr. Murphy and colleagues emphasized.

In Case You Missed It

Clinical Score Predicts Poor Pain Control After Spine Surgery

A score based on seven variables can accurately predict the probability of poorly controlled pain after elective spine surgery, according to a study published in the *Journal of Neurosurgery: Spine*. Researchers conducted a retrospective study in adults undergoing elective cervical or thoracolumbar spine surgery. A prediction model was developed based on 25 candidate variables. The model was transformed into an eight-tier risk-based score, which was simplified into a three-tier Calgary Postoperative Pain After Spine Surgery (CAPPS) score. In the first 24 hours after surgery, 57% of 1,300 spine surgery patients experienced poorly controlled pain. The prediction model incorporated seven significant variables: younger age, female sex, preoperative daily use of opioid medication, higher preoperative neck or back pain intensity, higher Patient Health Questionnaire-9 depression score, surgery involving ≥3 motion segments, and fusion surgery. The model had good discrimination (C-statistic, 0.74) and calibration (Hosmer-Lemeshow goodness-of-fit) for predicting outcome. The probability of experiencing poorly controlled pain was 32%, 63%, and 85%, respectively, in low-, high-, and extreme-risk groups stratified using the CAPPS score; these results were mirrored by observed incidence rates of 37%, 62%, and 81%, respectively, in the validation cohort. "This score can be used to facilitate preoperative patient education and the development of personalized clinical care pathways to improve postoperative acute pain outcomes," the authors write.

Recovery Protocol Cuts Opioid Use After Elective Neurosurgery

Enhanced recovery after surgery (ERAS) protocols can reduce postoperative use of opioids in patients undergoing elective spine and peripheral nerve surgical procedures, according to a study published in *Pain Medicine*. Study investigators report on a single institution's 18-month experience with an ERAS pathway in elective spinal surgery. The need for opioid use one month after surgery was examined for 1,141 patients prospectively enrolled in an ERAS protocol compared with a historical cohort of 149 consecutive patients (control group). The team observed a significant reduction in use of opioids at one, three, and six months after surgery (38.6% vs 70.5%, 36.5% vs 70.9%, and 23.6% vs 51.9%, respectively). In the ERAS group, use of patient-controlled analgesia was nearly eliminated (1.4% vs 61.6%). Compared with controls, ERAS patients mobilized faster on postoperative day 0 (63.5% vs 20.7%). Additionally, fewer patients in the ERAS group required postoperative catheterization (32.7% vs 40.7%), and length of stay was decreased in the ERAS group (3.4 days vs 3.9 days). "Previous publications have demonstrated ERAS implementation in neurosurgery practices primarily through minimally invasive spinal surgery, but our neurosurgical practice has been actively applying ERAS principles to elective spine and peripheral nerve surgery since 2017, in coordination with a variety of departments across the health system," a co-author said in a statement. "This study captures the exciting benefits of this protocol for minimizing opioid use, decreasing length of stay, and more —without impacting patient satisfaction."

Teens With Chronic Pain May Find Support on YouTube

This article was originally published by Reuters and is written by Manas Mishra.

Teens with painful chronic illnesses may find that YouTube can provide a support network, a new study suggests. Comments on YouTube videos directed at youth with chronic pain were supportive and encouraging, researchers reported in *The Clinical Journal of Pain*. And the information was generally reliable.

"Social media is often cited as a way for teens to meet and gain social support, yet there are negatives to social media as well," said study leader Paula Forgeron of the University of Ottawa. "We wanted to understand if adolescents with chronically painful conditions used social media (YouTube) to share their experiences and if they gain social support through posting." Comments left by viewers "revealed the crucial need of adolescents with chronic pain" for information, social support and emotional validation. The "overarching message" of the comments, according to the researchers, was, "You are not alone!" Viewers often shared their suffering and struggles to find coping mechanisms.

The researchers focused on 18 YouTube videos directed at youth with chronic pain. Ten had been posted by pediatric hospitals, two by foundations, one by a researcher, and five by adolescents themselves. Most videos discussed treatments, working with psychologists and physiotherapists, the benefits of exercise, and the impact of chronic pain on relationships and activities. None of the videos had any victimizing comments, the authors found.

Videos produced by adolescents were viewed more often and received more comments and likes than those produced by professionals. Future videos should therefore include adolescents as part of the team, the researchers suggest.

The authors acknowledge that among the study's limitations is that adolescents using YouTube in this study may not represent all adolescents with chronic pain. Also, the videos were all in English, and all but one featured only Caucasian adolescents. Furthermore, experiences with YouTube videos likely don't translate directly to other popular platforms, given that posters on YouTube must first create a video and then post it, whereas Snapchat and Instagram, for example, allow for more in-the-moment sharing.

Nevertheless, the researchers say, "Social media presents a robust milieu to disseminate knowledge to adolescents with chronic pain." They conclude that while YouTube is already being used by adolescents with chronic pain, more research is needed "on how best to harness the medium for maximum benefit."