The Opioid Epidemic and the Role of Reimbursement

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The attention that prescription opioids have received of late is warranted. They can cause significant side effects, including overdose and even death. However, there has been less discourse about the etiology of the opioid epidemic. Doctors certainly have played a role and would absolutely benefit from additional education on the treatment of chronic pain, the risks of opioids, and strategies to mitigate the risks of opioids when they are indicated. Yet, the etiology is complex, with doctors trying to help patients with legal medicines that their patients want while facing competing mandates, declining reimbursements, and time constraints. It is likely the reimbursement system has contributed to the opioid epidemic.

► Reimbursement System

Government and third-party payers have historically reimbursed providers via the fee-for-service model that rewards quantity at the expense of quality.¹ This reimbursement structure has produced many unintended consequences, one of which is likely a role in the overprescription of opioids. In such a system, providers rarely have more than 15 or 20 minutes for a patient visit. This has created enormous time pressures, and unfortunately the time constraints are getting worse.²

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This reimbursement system does not align with high-quality medical care and does not align with activities that take time. In *Preventive Medicine*, **Dr. Robert Kushner** concludes that time is a barrier to nutrition counseling,³ while **Kimberly Yarnall et al.** found time constraints impede prevention.⁴

The reimbursement system does not facilitate life-style counseling, nor does it align with encouraging prevention. It is not conducive to treating chronic pain optimally and prescribing opioids safely. The treatment of chronic pain and safe-opioid practices take time, and currently providers lack adequate time. Given that explaining physical therapy, cognitive-behavioral therapy, and other medicines can take significantly more time than writing an opioid prescription, it is very likely that the current reimbursement system and the time constraints it has fostered have contributed to the overprescription of opioids.

Limited peer-reviewed literature has explored the relationship between opioid prescribing and time constraints. Yet, **Dr. Anna Lembke**, writing in the *New England Journal of Medicine*, contends that the reimbursement system and time pressures are drivers of opioid prescribing by emergency-room providers.⁵ Additional research is needed to explore this relationship.

Simultaneously assessing risk, mitigating risk, and counseling patients about the negative effects of opioids take time as well. It is very likely that time constraints have hindered the ability of primary-care providers to mitigate the risk of patients on chronic opioids, as well as detect diversion and abuse. For example, **Richard Deyo et al.** found that time constraints are a significant barrier to the use of prescription drug monitoring programs (PDMPs).⁶

To allow providers to treat patients with chronic pain better and curtail the opioid epidemic, government and third-party payers should adopt a more flexible payment system that empowers providers to help their patients best and give their patients the adequate time and resources that their unique and complex medical conditions need.

Operationally, health systems should decentralize the schedules to give physicians more freedom to tailor their schedule to the unique needs of patients. Some patients can be seen in a 20-minute visit. Many complicated patients such as pain patients cannot. Those patients deserve as much time as their complicated medical conditions necessitate. Seeing a patient whose medical issues require an hour of time in 20 minutes is not an example of efficiency. Giving providers on the ground more control over their schedules would help them treat patients with chronic pain more safely, decrease the prescription of opioids, and allow physicians to mitigate the risk of chronic opioids better. It would likely have other benefits as well.

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Another option to tackle these unintended consequences would be for government and third-party payers to let providers establish and reimburse for “pain visits”—a visit solely devoted to chronic pain. This would allow primary-care providers greater flexibility and time to meet the needs of their chronic-pain patients and also allow providers to focus solely on pain in regular visits as opposed to in between an already crammed visit of poorly controlled diabetes, hypertension, chronic kidney disease, hyperlipidemia, and other complicated comorbidities. The first option would be a broader solution to a broader problem.

► Non-Face-to-Face Reimbursement

Non-face-to-face care such as telephone, e-mail, and care coordination are an integral part of patient-centered medicine. However, historically, providers have not been reimbursed for these services.⁷ The AMERICAN ACADEMY OF PEDIATRICS has concluded that lack of reimbursement for telephone encounters are a barrier to their use.⁸ It has likely deterred telephone encounters and other non-face-to-face activities as well.

It takes time to treat chronic pain best, as well as mitigate risk with chronic opioids. It involves time in the exam room, but it also involves time away from the exam room—such as checking the PDMP before the visit to look for prescriptions from other providers. It could involve a provider personally speaking with consultants such as psychiatrists and pain-management staff to foster the best plan to treat a patient’s pain. It could involve speaking with consultants to learn what other medicines the patient is receiving. It could involve calling another provider or pharmacist when there are concerns about doctor shopping, diversion, or abuse. All of the above activities, in appropriate circumstances, could help a doctor to treat patients with chronic pain better and more safely. Yet, all of those activities, despite their importance, have historically not been recognized as work by insurance companies and government payers.

Christi Hildebran *et al.* conclude that lack of reimbursement for checking PDMPs is a barrier to their use.⁹ In doing so, this has likely deterred their use and worsened the opioid epidemic. Yet, the problem of third-party payers not reimbursing physicians for time spent on opioid risk mitigation and its effects are likely much broader.

It is important that physicians work with their patients, staff, consultants, and pharmacists to treat chronic pain safely and mitigate opioid risk. In light of additional information and the new CENTERS FOR DISEASE CONTROL AND PREVENTION opioid guidelines, this should be a top priority. Hopefully, government and third-party payers will recognize the importance of these

On the path to treating chronic pain safely and mitigating opioid risk, physicians must partner with:

- patients
- staff
- consultants
- pharmacists

efforts and will start reimbursing physicians for them. This would encourage these activities and also provide the impetus for employers to give physicians both the time and ability to do this. It would also likely fuel innovation and population health to pain management to ensure patients are treated appropriately and risk is mitigated.

► Conclusion

Robert Vigersky *et al.* cite payment issues as challenges to providers caring for patients with diabetes.¹⁰ It is very likely that this has hindered the ability of primary-care providers to treat patients with chronic pain and has contributed to the opioid epidemic as well. Additional research is needed to explore the role that the reimbursement system and time constraints have played in the problem. Hopefully, healthcare leaders will engage and work with providers to understand the complexities of these issues in the trenches and how best to solve them.

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