JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CMS/CSAPH Joint Report -A-15

Subject: Coverage for Chronic Pain Management
(Resolution 112-A-14)

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Referred to: Reference Committee E
(Saundra S. Spruiell, DO, Chair)

Resolution 112-A-14, submitted by the American Academy of Pain Medicine and referred by the House of Delegates asked:

> That our American Medical Association (AMA) and interested stakeholders advocate for a minimum set of health insurance benefits for people in pain severe enough to require ongoing therapy. At minimum, a proposed program of treatment categories should include:
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> > 1) Medical management
> > 2) Evidence- or consensus-based interventional/procedural therapies
> > 3) Ongoing behavioral/psychological/psychiatric therapies
> > 4) Interdisciplinary care
> > 5) Evidence-based complementary and integrative medicine (e.g., yoga, massage therapy, acupuncture, manipulation)
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> That our AMA advocate for parity in coverage for people with pain, similar to that accorded people with mental-health disorders.
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> That our AMA and interested stakeholders advocate for an interdisciplinary clinical approach that recognizes the interdependency of treatment methods in the treatment of chronic pain.
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> That our AMA and interested stakeholders recommend and provide expertise for legislation to require that all payers offer coverage for a comprehensive, interdisciplinary pain program, which would include such care modalities as cognitive-behavioral therapy, for patients who have disabling pain and have failed more conservative therapy.

The House of Delegates voted to refer Resolution 112-A-14 because, although support was expressed for a comprehensive approach to chronic pain management and appropriate insurance coverage, questions were raised about the level and scope of coverage highlighted in the resolution. The resolution was assigned to the Council on Medical Service and the Council on Science and Public Health for development of a joint report.

BACKGROUND

Scope of the Problem

Chronic pain is a widespread and costly medical condition. According to a 2011 report published by the Institute of Medicine (IOM), approximately 100 million adults suffer from chronic pain in the United States, and chronic pain costs between $560 and $635 billion each year in medical costs and lost productivity.[1] Medical costs were based on an analysis of the Medical Expenditure Panel Survey, restricted to adults ages 18 years or older, who were civilians and noninstitutionalized; indirect costs were based on an analysis of individuals 24-65 years of age in an effort to capture the active labor force. Therefore, these figures are likely conservative estimates because they exclude the costs of pain affecting institutionalized individuals, military personnel, children under age 18, personal caregivers, and productivity of both younger (<age 18) and older (>age 65) workers. The IOM estimates that a person with moderate pain generates approximately $4,516 more in health care expenditures annually than a person without pain, and a person with severe pain generates health expenditures $3,210 higher than those of a person with moderate pain.

Factors Influencing Opioid Prescribing

Analgesic strategies include pharmacologic, rehabilitative, psychological, interventional, surgical, neurostimulatory, and complementary/alternative approaches. Pharmacologic strategies are commonly used for the management of acute pain, pain related to trauma/injury, and in patients with cancer or other serious illness. During the last few decades, growing numbers of patients with persistent noncancer pain have been offered long-term opioid therapy. This change in prescribing behavior has been influenced by several competing interests. Undertreatment of cancer pain was identified as a significant issue, and the aggressive use of opioid analgesics was endorsed as the most effective approach to address patient suffering. With the advent of a new array of prescription opioid products, this approach was extended to patients with persistent noncancer pain, despite a lack of evidence from long term, randomized controlled trials. In both the hospital and outpatient settings, promotion of the concept of pain as the 5th vital sign, and the evolution of patient satisfaction surveys that include a focus on the extent to which a patient's pain is relieved, created a practice environment that promoted opioid use.[2] The adoption of the "pain standard" by The Joint Commission in accreditation processes for hospitals and other healthcare organizations also has been cited as a contributor to increased opioid prescribing by physicians.[3] Despite the substantial burden of chronic pain in the United States, access to multidisciplinary care and reimbursement for nonpharmacologic approaches are woefully inadequate, furthering contributing to the routine use of opioid analgesics.[4]

Harms Attributable to Opioid Analgesics

While some patients with persistent noncancer pain benefit from the use of opioid analgesics, an increase in the number of prescriptions for opioid analgesics has been paralleled by a large increase in adverse consequences, including drug abuse, addiction, diversion and unintentional overdoses and deaths. Drug overdose deaths in the United States have increased steadily and now exceed 38,000 annually; opioid analgesics are involved in more than 40% of such deaths.[5] During the past decade, the number of patients seeking substance abuse treatment for the primary abuse of prescription pain relievers has increased six-fold and the estimated number of emergency department visits related to the nonmedical use of opioid analgesics increased 79% from 201,280 in 2006 to 359,921 in 2010.[6] Opioid therapy for persistent noncancer pain in older adults also is associated with an increased risk of fall-related injuries, all-cause mortality, and hospital stays.[7,8]

Additionally, nearly one-third of Medicare Part D recipients being treated with opioid analgesics have prescriptions from multiple prescribers.[9]

A recent systematic review issued by the Agency for Healthcare Research and Quality found a lack of evidence to support the long-term use of opioids for managing persistent noncancer pain.[10] In addition to the risks associated with long-term opioid therapy, patients who are unable to access effective, safe pain management services and/or those who have developed an opioid use disorder may find themselves engaging in nonmedical use of opioid analgesics and exposing themselves to additional risks associated with the use of illegal drugs. In particular, there has been resurgence in heroin use in recent years, leading to increases in overdoses and deaths from this substance.[11]

INTERDISCIPLINARY APPROACHES TO CHRONIC PAIN MANGEMENT

As noted in Resolution 112-A-14, there is increasing evidence that interdisciplinary, comprehensive approaches are more effective than surgical or pharmacological therapy alone for many patients who require treatment for chronic pain. As a perception, pain may or may not correlate with an identifiable source of injury, and the sensation of pain is modified by individual experiences, medical and psychiatric comorbidities, cognition, expectations, emotions and memory. As such, effective pain management strategies must be tailored to each individual, and are likely to require a multi-faceted approach.

Comprehensive chronic pain management approaches aim to achieve pain control, eliminate maladaptive pain-related behaviors, and improve coping for patients who suffer from chronic pain. While interventional or prescription treatments may address acute pain symptoms, behavioral treatments are designed to identify social and environmental factors that provoke pain or discourage healthy behaviors. In addition, patients who suffer from persistent pain experience higher rates of comorbid psychiatric disorders (e.g., depression, anxiety), as well as sleep disturbances. These conditions must be managed concurrently in order to maximize the efficacy of treatments that specifically target the physical symptoms of pain. A particularly challenging clinical presentation is the individual with combined pain and addiction.

A comprehensive pain management plan generally requires a physician-led, interdisciplinary team approach to reduce symptoms and improve psychological and social functioning, reduce disability, and achieve rehabilitation.[12] A multimodal approach may require the combined efforts of: (1) physicians knowledgeable in pharmacologic and/or interventional procedures; (2) physicians or other health professionals trained to diagnose and/or treat mental health disorders or conditions that may result from, cause, or exacerbate pain and suffering; (3) physical therapists or rehabilitation specialists who can assess physical conditioning requirements; and (4) nurses knowledgeable about chronic pain management approaches. Team members can provide valuable assistance in sustaining patient optimism and participation in their own recovery. Other evidence-based complementary and integrative approaches (e.g., yoga, massage therapy, acupuncture, manipulation) may be beneficial in some patients and also should be reimbursable. In some cases, the services of an addiction medicine specialist are needed within the team approach.

Several studies have evaluated the clinical- and cost-effectiveness of multidisciplinary pain centers, supporting their efficacy.[13-17] A recent systematic review of multidisciplinary treatments for persistent pain showed they were effective in patients with chronic lower back pain and fibromyalgia, although they exhibited less robust effects in patients with persistent pain of mixed etiology.[18] Another investigation found that changes in depression and disability were associated concurrently with changes in pain beliefs and catastrophizing in patients undergoing multidisciplinary treatment.[19] Patients who are able to accept their condition are likely to benefit

most from the treatment in terms of pain reduction, and such interventions also facilitate return to work.[18,20,21] Although the use of opioids for the long-term treatment of persistent noncancer pain remains controversial with many patients exhibiting poor outcomes, patients with severe pain and pain-related disability who are treated with opioids have been found to have better outcomes when managed in multidisciplinary pain clinics.[22]

BARRIERS TO ACCESS TO COMPREHENSIVE PAIN MANAGEMENT TREATMENTS

Although a broad consensus exists in the medical community that comprehensive, interdisciplinary approaches to chronic pain management are often more effective than single modality treatments, access to such care is limited. Lack of adequate insurance coverage has a significant impact on the affordability of such treatments. As noted in Resolution 112-A-14, health insurance policies generally provide coverage for prescription drugs or medical interventions (e.g., surgery for lower back pain) to treat chronic pain, but coverage for more comprehensive therapies that involve ongoing interdisciplinary care is more limited or difficult to access.[a] Patients and their physicians are often required to follow a step therapy approach, pursuing more traditional treatments before a plan will cover interdisciplinary care. Patients also may be subject to insurer "fail first" protocols that require a patient to try – and fail – on a particular course of treatment before the insurer will authorize the preferred course of treatment prescribed by the physician. In addition, plans may limit coverage for certain treatments, restricting access for patients who need ongoing pain management services.

A related but distinct barrier to patient access to appropriate chronic pain management treatment is a lack of professionals qualified to treat and manage patients with chronic pain, particularly in a physician-led, interdisciplinary framework. Despite the advantages of multidisciplinary pain care, access to such care is limited in the United States due to the fact that only about one such facility or clinic exists for every 670,000 patients with chronic pain in the United States.[23] Even if insurers provided full coverage for comprehensive chronic pain management therapies and services, the workforce does not currently have sufficient capacity to treat the population of patients in need of specialized care.

RELEVANT AMA POLICY

Policy D-160.981 expresses the AMA's strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine. In particular, it encourages relevant specialties to collaborate in studying the body of knowledge encompassed by the field of pain medicine; the adequacy of medical education in the principles and practice of the field of pain medicine; and appropriate training and credentialing criteria for this multidisciplinary field of medical practice.

Policy H-410.950 provides guidelines on invasive pain management procedures for the treatment of chronic pain. It defines interventional chronic pain management as the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The policy specifies that invasive pain management procedures require physician-level training, but that certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician.

[a] See for example www.aetna.com/cpb/medical/data/200_299/0237.html; https://www.healthpartners.com/public/coverage-criteria/pain-programs/

The AMA has several policies that address the use of controlled substances in supporting pain relief and chronic pain management. Policy D-120.971 calls on the AMA to support a dialogue between the Drug Enforcement Administration and physician groups to assist in establishing a clinical practice environment that is conducive to pain management and the relief of suffering, while minimizing risks to public health and safety from drug abuse or diversion. Policy D-120.947 calls on the AMA to consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, and to urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, in order to develop the most appropriate solutions to prevent these incidents.

AMA policy is generally cautious with respect to supporting benefit mandates, which have the potential to increase the costs of health insurance and limit innovation in the health insurance market. For example, Policy H-185.964 opposes new health benefit mandates unrelated to patient protections, and Policy H-165.856 states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. However, the AMA also supports value-based decision making at all levels of the health care system (Policy H-450.938). In particular, the AMA supports value-based insurance benefit designs, which balance the clinical benefit gained relative to the money spent (Policy H-185.939).

Consistent with an interdisciplinary approach to chronic care management, the AMA has developed extensive policy over the past two years supporting physician-led team-based care. Policy H-160.906 defines elements of a strong physician-led team-based care model, including a patient-centered focus that emphasizes teamwork and each member of the team taking responsibility for clearly defined roles and responsibilities consistent with his or her training and education.

DISCUSSION

It is acknowledged that pain, and in particular chronic pain, is a condition that should be evaluated and managed similar to other chronic medical conditions, like diabetes or hypertension. Since 2001, facilities accredited by The Joint Commission have been required to follow pain management standards, including recognizing the right of patients to appropriate assessment and management of pain; educating patients suffering from pain and their families about pain management; and addressing the individual's needs for symptom management in the discharge planning process. Yet there is general agreement that the approach to chronic pain management in the United State needs improvement, and that traditional treatment approaches combined with insurer-driven barriers do not provide sufficient relief to help patients effectively live with and manage their pain. In the context of ongoing concerns about prescription drug abuse it is critical that policymakers examine the barriers that prevent patients from receiving appropriate and comprehensive pain management services that may be safer and more effective than reliance on pharmacologic treatments alone.

The Councils believe that there should be an increased focus on comprehensive pain management approaches that are physician-led and recognize the interdependency of treatment methods in addressing chronic pain. In light of the evidence that comprehensive, interdisciplinary pain management approaches can be more clinically appropriate and cost-effective than traditional treatment options, expanding health insurance coverage to include these modalities seems likely to improve the value of spending on chronic pain care management, and may ultimately result in lower costs across the system for conditions related to chronic pain.

The Councils believe that our AMA should support health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services should be equivalent to coverage provided for medical or surgical benefits. However, pursuing legislative action to ensure coverage of specific chronic pain management benefits (as called for in the fourth resolve of Resolution 112-A-14) could potentially limit the flexibility of health insurers to design and modify their pain management coverage options so that they reflect the maximum value to patients and are responsive to current and evolving evidence.

In addition to advocating for expanded insurance coverage for comprehensive chronic pain management services, efforts must be made to address the lack of professionals qualified to treat and manage chronic pain patients, and the limited availability of multidisciplinary centers of care. Accordingly, the Councils recommend that our AMA advocate for support for efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services.

The Councils are aware that some state legislatures and regulators have introduced proposals that require physicians to follow certain protocols either prior to prescribing or in conjunction with opioid treatment.[b] On one hand, the AMA supports the development of voluntary guidelines that can help inform physician decision-making in the use of opioids to treat and manage pain. At the same time, the AMA has expressed concern that mandates on what physicians and patients must do for patients in chronic pain can have unintended consequences. The Councils note that these mandates may not be appropriate for all patients, and that patients' access to care may be limited by the current lack of coverage for these services, as well as the lack of professionals trained to provide comprehensive pain management services.

RECOMMENDATIONS

The Councils recommend that the following recommendations be adopted in lieu of Resolution 112-A-14, and that the remainder of the report be filed:

1. That our American Medical Association advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician-led and recognize the interdependency of treatment methods in addressing chronic pain. (New HOD Policy)

2. That our AMA support health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. (New HOD Policy)

3. That our AMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.. (New HOD Policy)

Fiscal Note: Less than $500

[b] http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Laws/House/2876-S.SL.pdf. www.healthy.ohio.gov/~/media/HealthyOhio/ASSETS/Files/edguidelines/EGs%20no%20poster.ashx. www.in.gov/pla/files/Emergency_Rules_Adopted_10.24.2013.pdf. www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain_policy_july2013.pdf.

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