December 13, 2016

Re: IDDS for Chronic Pain

Members of the ODG Editorial Advisory Board:

In May 2016, the American Academy of Pain Medicine (AAPM) co-signed, with dozens of other medical professional societies, a letter to the Work Loss Data Institute regarding the Official Disability Guidelines for intrathecal drug delivery systems (IDDSs) in the treatment of chronic non-cancer pain. The letter both expressed concerns about proposed revisions to the guidelines and provided evidence in support of continued coverage. Space restrictions in that instance permitted only a very condensed review of the published – including peer reviewed – evidence for the favorable benefit-to-risk ratio of this modality in appropriately selected patients.

We were disappointed to learn that, despite this mustering of the evidence to support IDDS, the ODG apparently is proposing the elimination of IDDS as an important treatment modality for managing chronic non-cancer pain in worker’s compensation cases. Accordingly AAPM is writing once again to express its objection to this proposed decision.

For many years this modality has been accepted in medical practice. Multiple comprehensive review chapters attest to its value with a depth of detail that was not possible in the brief summary letter submitted this past May. For example, the AAPM textbook, *Comprehensive Treatment of Chronic Pain by Medical, Interventional, and Integrative Approaches*¹, which was assembled by the American Academy of Pain Medicine and published by Springer Publishing in 2013, contains two chapters (chapters 61 and 66) that describe in depth the medical and economic advantages of IDDS, respectively. We would be happy to provide you with electronic of paper files of both chapters if you so desire.

A chapter in the 2009 edition of *Cousins and Bridenbaugh’s Neural Blockade In Clinical Anesthesia and Management of Pain*², provides a comprehensive review of the evidence supporting IDDS. In collaboration with one of the foremost international leaders in the field of pain control (Professor Michael Cousins of Sydney, Australia), I myself described the role of IDDS in permitting, among other therapies, spinal infusion of agents such as ziconatide, which has an FDA-approved indication for pain requiring that it may only be administered by the spinal route. Many other examples are provided in this chapter, which is not attached because of its length (again, we will be happy to provide it if you wish). Thus, denial of payment for IDDS flies in the face of FDA conclusions regarding the appropriateness of such therapy in selected patients.
Additionally, in Cousins and Bridenbaugh’s Neural Blockade: In Clinical Anesthesia and Management of Pain, we included as an appendix a still earlier document prepared by the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists. That document contains evidence-based guidelines for the use of IDDS. This concise document has been updated according to an evidence-based methodology, and published in 2013. The link to access this updated, evidence-based guideline is http://fpm.anzca.edu.au/documents/pm6-2013.pdf. Because this guideline was prepared by internationally respected authorities who have no financial ties with the US health care system, it should be viewed as authoritative and unbiased.

The value of this modality has been acknowledged for over a decade by independent third parties with no financial interest in US-based payment decisions. In the face of such evidence, denial of payment for IDDS would contradict FDA conclusions regarding the appropriateness of such therapy in selected patients.

We hope that the above more detailed information will, by calling to your attention in greater detail the evidence for this modality in the treatment of appropriately selected patients, allow you to reconsider your decision. Many other sources of information could be cited; for example, our organization’s journal, Pain Medicine, has published 10 articles in the past 4 years on IDDS. Other journals in the area of pain provides similar documentation.

We thank you in advance for your consideration of what is still only a small portion of the extensive available literature supporting the use of this modality.

Very truly,

Daniel B. Carr, MD, DABPM
President, AAPM

References

