



## **Minimum Insurance Benefits for Patients with Chronic Pain** *A Position Statement from the American Academy of Pain Medicine*

### **Executive Summary**

The Institute of Medicine (IOM) has documented a public health crisis of chronic pain in the United States, yet the country is ill equipped to address it in the setting of the current healthcare delivery system. Patients with persistent, ongoing pain experience endemic barriers to care, many related to non-existent or insufficient insurance coverage and reimbursement for evidence- and consensus-based therapies. The result is a reductionist approach to pain management whereby the default treatments are prescription (often opioids) and procedural rather than the comprehensive, biopsychosocial approach called for by the IOM.

The American Academy of Pain Medicine (AAPM) has set a goal to advocate for a minimum set of health insurance benefits for people in pain severe enough to require ongoing therapy. The AAPM further calls for an interdisciplinary clinical approach that recognizes the interdependency of treatment methods in the treatment of chronic pain. Legislation designed to seek parity for chronic pain treatment could require that, at minimum, all payers should offer 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. Reconciling the disparities between patient need and financially viable therapies can move the medical community and society forward toward safer and more effective pain care.

### **The Epidemic and Economic Burden of Pain**

Pain affects more people than heart disease, cancer and diabetes combined, and more than 100 million suffer from chronic pain in America, according to the Institute of Medicine's 2011 report: *Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research* [IOM 2011]. The report illuminates the state of pain as a public health problem, stating findings and recommendations from diverse fields of medicine, epidemiology, public health, ethics, and psychology. What emerges is a picture of the extraordinary burden pain places on the nation and on individual lives, as a cause of disability and use of

medical services, and in its destruction of quality of life and productivity. As a result, the IOM committee called for pain relief, research, awareness, and education to be given the status of a national priority.

Currently, health coverage standards for pain do not reflect that status. As with other medical conditions, private and public payer policies regarding pain are influenced by cost-containment imperatives. However, persistent pain is expensive in itself, costing the nation from \$560 to \$635 billion annually when taking into account medical costs and lower productivity due to lost time at work and lower wages [Gaskin & Richard 2012]. The total cost of pain outweighs the annual costs of the six most costly major diagnoses—cardiovascular diseases (\$309 billion); neoplasms (\$243 billion); injury and poisoning (\$205 billion); endocrine, nutritional, and metabolic diseases (\$127 billion); digestive system diseases (\$112 billion); and respiratory system diseases (\$112 billion)[Gaskin & Richard 2012].

In addition, the burdens imposed by prescription drug abuse and related mortality pose further public health risks. The Office of National Drug Control Policy reports that young people abuse prescription drugs second only to marijuana, and one-third of people who start using illicit drugs begin with prescription drugs [ONDCP 2011]. Moreover, prescription analgesics are associated with more than 16,000 deaths, with frequent contributions from other pharmaceuticals [Jones et al 2010].

Together, these statistics suggest it is time to look at the country's approach to coverage and reimbursement for chronic pain therapies to align policy with the evidence base and to minimize the potential for harm associated with reductionist reimbursement strategies.

### **Problems With Current Coverage**

The best evidence for assessment and treatment of a number of conditions (e.g., acute pain, cancer-related pain, low-back pain, musculoskeletal pain, neuropathic pain etc.) and pain comorbidities (e.g., depression) has been assembled in credible guidelines, within which the current consensus on associated therapies is also presented. One of these is the Pain Medicine Position Paper of the American Academy of Pain Medicine, which provides the following perspective on the progress toward recognizing pain as a multifactorial experience requiring a comprehensive treatment approach:

“ Neuroscientists were the first to recognize that the nervous system contained the substrate for pain transmission and awareness. They attempted to remove pain and suffering by devising techniques to

interrupt the pain pathways. Although based on sound principles, these techniques frequently were inadequate because they failed to recognize the complex, causal interaction of biopsychosocial factors in the phenomenological pathway to chronic pain conditions and diseases and the inherent plasticity in the nervous system, which allowed the development and propagation of pain even after a noxious stimulus was removed or a nerve from a painful body area was severed [Dubois et al 2009].”

The IOM committee acknowledged the complex, challenging nature of treating chronic pain and agreed that interdisciplinary, comprehensive care is the best approach to support [Mackey 2012]. The IOM committee further called on entities that include the Department of Health and Human Services (HHS), The Veterans Administration (VA), The Department of Defense (DoD), and large healthcare providers to reduce barriers to pain care [Mackey 2012].

Unfortunately, the U.S. healthcare delivery system is rife with inconsistencies that may inadvertently push the gradient to the prescribing of pharmaceuticals in the absence of sufficient reimbursement for interdisciplinary care. In many countries around the world, the availability of interdisciplinary programs is increasing. In contrast to other industrialized nations, according to an analysis by Michael Schatman, PhD, published by the International Association for the Study of Pain, the United States now has only one interdisciplinary program for every 670,000 patients with chronic pain [Schatman 2012].

Further difficulties with current coverage include the limited time allowed to provide comprehensive services and the inconsistency of available benefits to all patients with chronic pain. Lack of uniformity, for example, was shown in the final rule for the Final Fee Schedules for Physicians and Ambulatory Surgical Centers issued by the Centers for Medicare and Medicaid Services (CMS), which featured significant cuts to physician payment when they perform epidural injections in the office setting and a 20% increase in payments for the same services performed in hospital outpatient departments [Federal Register 2013].

Insurance coverage logically affects clinical practices when it comes to therapeutic choices. For example, despite uncertain effectiveness of lumbar fusion for back pain in injured workers, California’s rates of the surgery through workers’ compensation (WC) in 2008-2009 was 47% higher than in Washington, which has a more restrictive lumbar fusion coverage policy [Martin et al 2013]. Moreover, California had higher hospital costs, more invasive surgeries, more complications and more reoperations

An additional problem with the healthcare insurance system should be noted. The majority of states list methadone as a preferred long-acting analgesic for pain to reduce Medicaid costs [Berens & Armstrong 2011]. However, according to the Centers for Disease Control and Prevention (CDC), methadone is involved in about one-third of unintentional opioid-related overdose deaths while representing only about 2% of all opioids prescribed [MMWR 2012]. Therefore, AAPM calls on all payers, public and private, to discourage the listing of methadone as preferred or else to provide extensive and expert medical education in prescribing and consuming it.

## **Lack of Adequate Coverage for Treatment Options**

### *The Uninsured and Underinsured*

There is a mismatch between the widespread prevalence of chronic pain and the available insurance benefits for treatment options. According to data from the National Health Interview Survey reported by the CDC, 47.3 million persons of all ages were uninsured during the first three months of 2012 [Cohen & Martinez 2012]. By the end of December 2013, during the initial enrollment period under the Affordable Care Act of 2010, nearly 2.2 million people enrolled to receive coverage [HHS 2014] but significant numbers remain uninsured. Low incomes associated with uninsured status further limit access to medical services and may relegate the population to the lowest cost, generic prescriptions, which may or may not be optimal.

### *Barriers to Coverage for the Insured*

An additional segment of the population is underinsured, having access to coverage that limits benefits or requires out-of-pocket of expenses that may put many services out of reach for lower income people. Despite protections to coverage provided under the Affordable Care Act, an analysis by Avalere Health reported in Kaiser Health News found that many people with chronic conditions may still be underinsured, spending greater than 10% of their incomes on medical care, excluding premiums [Andrews 2014]. In addition, access to specialist care and services such as physical therapy are expected to be subject to limitations [Andrews 2014].

At times the indication of chronic pain is itself a limitation to adequate coverage. For example, Public Employees Health Plan in Utah as of 2007 limited benefits to 50% of the cost of services to people with a diagnosis of chronic pain after five visits [written communication from Marilyn Dillon, CPC, president at Certified Medical

Billing Systems, Salt Lake City, Utah, May 23, 2013]. Considered against the background of the significant impairment that often limits the earning abilities of many patients with chronic pain, it is clear that many therapies must remain out of reach. Furthermore, standard commercial insurance policies routinely limit complementary and alternative therapies and comprehensive interdisciplinary care.

### **Minimum Benefits for Pain Patients**

The idea of developing a program of mandatory benefits, as espoused in this paper, would extend to pain "severe enough" to potentially benefit from such treatment, that has failed or is expected to fail more conservative therapy, and that is not expected to resolve within the foreseeable future. At minimum, a proposed program of treatment categories should include the following framework:

- 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 (CIM - e.g., yoga, massage therapy, acupuncture, manipulation)

The parity in coverage for people with pain should be similar to that accorded people with mental-health disorders [MHPAEA 2008]. Limited visits and reimbursement is not appropriate for patients who have ongoing, sometimes progressive, incurable pain conditions.

### **Evidence for Interdisciplinary Care**

Traditionally, pain care has adhered to a medical model, primarily delivered by physicians. In 1953, John Bonica, MD, launched a new era in thinking about multispecialty pain care with the publication of his textbook, "The Management of Pain [Bonica 1953]." Bonica wrote of pain disorders as complex and multi-dimensional and proposed that a multispecialty team should treat pain. In a white paper published in 2010, the American Pain Society further distinguished between "multidisciplinary" care, in which multiple specialties may operate independently of one another, and "interdisciplinary" care, which is preferred and is marked by specialists working collaboratively to treat all aspects of a patient's pain (e.g., underlying pathology, behavioral, and psychosocial)[Turk et al 2010]. However, the

terms multidisciplinary and interdisciplinary care are used interchangeably within this document when discussing study results that used terminology understood to apply to delivery of care using multiple disciplines.

Building on work from the International Association for the Study of Pain, Turk and fellow APS colleagues listed members that may comprise an interdisciplinary team, contingent upon the patient population and disorders being treated [Turk et al 2010]:

- Patient
- Family
- Physicians (e.g., psychiatrist, anesthesiologist, addictionologist)
- Nurses
- Psychologists
- Physical therapists
- Occupational therapists
- Recreational therapists
- Vocational counselors
- Pharmacists
- Nutritionists/dieticians
- Social workers
- Support staff
- Volunteers
- Others

The key is collaboration among the various providers to deliver effective care to the patient. To work effectively together, the interdisciplinary care team must communicate openly; share common and measurable goals; deliver customized, evidenced-based, multimodal therapies; document progress and share feedback;

refer patients to other healthcare providers as appropriate; encourage active patient participation; and share systematic quality improvement efforts; among other strategies [Turk et al 2010]. After discharge from the interdisciplinary care program, maintenance is provided by a primary care physician with ongoing therapeutic care and feedback from the interdisciplinary team members, as needed.

Interdisciplinary care has a significant evidence base in the treatment of chronic nonmalignant pain, which is not reflected in insurance coverage policies as noted by the APS authors who wrote:

“ ... despite the large and growing body of research supporting both the clinical effectiveness and cost-effectiveness of interdisciplinary care, there continues to be reluctance among third-party payers to cover the costs of all components of such care. This is somewhat of a paradox -- in the days when there are calls for evidence-based health care and when pay-for-performance has become something of a mantra, there is continuing refusal to pay for the care with the best evidence. [Turk et al 2010].”

The following brief summary of relevant literature pertaining to interdisciplinary pain care programs begins with a seminal 1992 meta-analysis. Comprising 65 studies and encompassing 3,089 patients, the study found superior effects of multidisciplinary treatments for chronic back pain compared with no treatment, waiting list and single-discipline treatments such as medical treatment or physical therapy [Flor et al 1992]. Most programs included psychological and medical treatments as well as physical or occupational therapy and lasted an average of seven weeks. Measures of pain and mood improved and held steady over time as did behavioral variables, including return to work or healthcare utilization.

A Cochrane Review to study chronic pelvic pain interventions in women found a single high-quality randomized, controlled trial (RCT) including 106 patients that compared standard care to multidisciplinary treatment, encompassing physiotherapy, psychology and attention to dietary and environmental factors [Stones & Mountfield 2002]. Follow-up was for one year, and a positive multidisciplinary care outcome was found via a self-rating scale and daily activity (Odds Ratio: 4.15, 95% confidence interval 1.91 to 8.99) though not on pain scores. The authors concluded evidence supports multidisciplinary care in this patient population based on the single RCT.

A qualitative review by Guzmán and colleagues of 10 randomized, controlled trials compared care that was coordinated among multiple disciplines to non-multidisciplinary rehabilitation or usual care for patients with disabling low-back

pain [Guzmán et al 2002]. The investigators graded strength of evidence rather than pooling effects for meta-analysis, citing heterogeneity of study methodologies. They found strong evidence of improved function and moderate evidence for improved pain with >100 hours of multidisciplinary, biopsychosocial rehabilitation with a functional restoration approach. At less intensive use (<30 hours), evidence was limited.

However, relatively short treatment durations of intensive interdisciplinary care have been shown to be of benefit for patients who suffer from chronic back pain. Significant pain intensity (67%) and functional (33%) improvements were achieved within three weeks in an interdisciplinary outpatient setting for patients with back pain and sciatica [Artner et al 2012], although the methodologies and concepts of the study have been called into question [Kaiser et al 2013]. The therapeutic regimen in this pilot program consisted of interventional injection techniques, medication, exercise therapy, back education, ergotherapy, traction, massage therapy, medical training, transcutaneous electrical nerve stimulation, aquatraining and relaxation.

The literature supporting interdisciplinary care in back and pelvic pain is counterbalanced by two qualitative reviews that returned less conclusive results, one for fibromyalgia and widespread musculoskeletal pain in 1,050 patients [Karjalainen 2000] and another for shoulder and neck pain that included 177 patients [Karjalainen 2001]. The benefits of multidisciplinary care were uncertain based on a limited level of evidence and inconsistent findings among low-quality, under-powered RCTs [Ospina & Harstall 2003].

Improvements in study design and reporting methods are needed in research going forward. Regardless, interdisciplinary pain care programs are lacking adverse effects common to pharmacotherapy and interventional procedures [Schatman 2011], have evidence for long-term treatment gains of up to 13 years [Patrick et al 2004], and have demonstrated clear cost effectiveness compared with conventional medical treatments for chronic pain [Gatchel & Okifuji 2006].

The 2010 Practice Guidelines from the American Society of Anesthesiologists and the American Society of Regional Anesthesia and Pain Medicine is a credible, evidence-based source that states the multi-specialty therapeutic approach is a legitimate treatment strategy for patients with chronic pain [ASA 2010]. The guideline task force found evidence of multiple RCT's that multidisciplinary treatment programs are effective compared with conventional treatment programs in reducing pain intensity reported by patients for periods ranging from four months to one year. The task force did not find sufficient RCTs to conduct a meta-



analysis, nor was evidence adequate to compare multimodal therapies with single modality therapies.

The “Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain” cites evidence that patients with severe pain and pain-related disability who are treated with opioids have better outcomes when managed in multidisciplinary pain clinics [Canadian guideline 2010]. The guideline goes on to note that treatment modalities and diagnostic approaches vary among such programs, which are not widely available in Canada.

As suggested by these references, the philosophical evolution in care advanced herein is representative of a broad, evidence-guided, clinical consensus. Of course, gaps exist in the evidentiary link between bench science and clinical effectiveness for a range of therapies throughout all of medical practice; these gaps are not limited to Pain Medicine. But the decision to withhold or refuse payment for any therapeutic modality until all such gaps are closed is neither practical nor ethical.

Of late, there are some encouraging signs that payer policies are beginning to align with science. A policy from Aetna insurance, updated in May 2013, quotes relevant supporting evidence and concludes that the interdisciplinary/multidisciplinary treatment approach should be covered for members who meet the all of the following criteria [Aetna 2013]:

- If a surgical procedure or acute medical treatment is indicated, it has been performed prior to entry into the pain program
- Member has experienced chronic non-malignant pain (not cancer pain) for six months or more
- Member has failed conventional methods of treatment
- Member has undergone a mental health evaluation, and any primary psychiatric conditions have been treated, where indicated
- Member's work or lifestyle has been significantly impaired due to chronic pain
- Referral for entry has been made by the primary care physician/attending physician
- The cause of the member's pain is unknown or attributable to a physical cause, i.e., not purely psychogenic in origin

## **Evidence for Cognitive-Behavioral Therapy**

Cognitive-behavioral therapy (CBT) represents an important and viable treatment modality within the broader spectrum of pain management. It is a psychological intervention that incorporates cognitive restructuring and the teaching of behavioral techniques to alter behavior. There is an emphasis on learning, personal control, expectations and problem solving [Veehof et al 2011]. Several recent meta-analyses of CBT (and other psychological therapies) for chronic pain have found significant benefits for pain intensity and other outcomes that include depression and pain-related interference [Veehof et al 2011; Hoffman et al 2007; Williams et al 2012].

In a meta-analysis of 22 randomized controlled trials, reviewers found benefits for psychological intervention – particularly CBT and self-regulatory treatments -- in chronic low-back pain in the areas of pain intensity, pain-related interference, health-related quality of life, and depression compared with control treatment groups [Hoffman et al 2007]. Short-term pain interference and long-term return to work measures were better with a multidisciplinary treatment approach that included a psychological component when compared with active controls.

A Cochrane Review that included 35 studies with 4,788 participants found improved pain, disability, mood, and catastrophizing immediately after treatment in patients with chronic pain (excluding headache) when compared with usual treatment and waiting list [Williams et al 2012]. Improvements in mood were maintained at six months but not for pain and disability.

In a systematic review and meta-analysis of acceptance-based therapies (e.g., mindfulness techniques), investigators found an effect size on pain of 0.37 in 14 controlled studies and an effect size on depression of 0.32, outcomes that were equivalent to those of CBT [Veehof et al 2011]. The authors concluded CBT is still standard treatment, but that other therapies could supplement as matched to patient characteristics. They further suggested, for future research purposes, that measures other than pain intensity (e.g., pain interference) may better describe the benefits reported by patients.

A Cochrane Review found CBT to be moderately superior to a wait-list control for short-term pain intensity in chronic low-back pain (standardized mean difference, 0.59 [CI, 0.10 to 1.09]), but not for functional status (standardized mean difference, 0.31 [CI, -0.20 to 0.82])[Ostelo et al 2005].

In summarizing the evidence of meta-analyses conducted over the last two decades, Morley and colleagues recently concluded that, overall, CBT has a beneficial average effect for disability, depression and the pain experience without evidence of harm [Morley et al 2013]. To reduce the dilution effect of poorly designed and executed trials, the authors further called to improve investigation methods to better study CBT and its effect.

Though numerous studies show CBT to be effective for chronic pain, most commonly when delivered as part of multidisciplinary care but also as a single modality, some patients appear to benefit more than others [McCracken & Turk 2002]. Those more oriented toward self management, with more positive emotional perceptions toward pain and perceived disability, do better than patients who see their pain as uncontrollable and who suffer high distress accordingly [McCracken & Turk 2002]. This type of study and analysis to identify which patients benefit from CBT should continue.

In general, CBT for chronic pain is time limited, of 6 to 10 weeks duration. The magnitude of the effects is generally small-to-moderate, and benefits for CBT extend to adults, children and older adults. However, symptom alleviation, particularly for adults, is not always long lasting. Of note, most analyses examine CBT alone rather than CBT as part of a multidisciplinary approach, which would be the ideal clinical scenario. The lack of adverse effects for CBT combined with clinical benefits that are similar in magnitude to biomedical treatments (which do produce adverse effects), bolsters the argument to extend coverage for CBT.

## **Recommendations**

In all tiers of the healthcare system, from the uninsured to those on public and private plans, coverage is needed for comprehensive, interdisciplinary modalities of treatment like CBT, physical therapy, stress management, rehabilitation,

complimentary and integrative therapies (CIM) and alternative therapies and medications that are known to be effective and safer than usual care.

At minimum, all payers should provide three months coverage for an

interdisciplinary integrative pain evaluation and treatment program for people with pain that is severe enough to warrant ongoing therapy, that has failed or is not expected to respond to first-line therapies, and that is not expected to resolve in the foreseeable future.

The Mental Health Parity and Addiction Equity Act requires insurance groups that offer coverage for mental health or substance use disorders to provide the same level of benefits as for medical treatment [MHPAEA 2008]. In a similar but distinct parity arrangement, we propose mandated coverage for CBT but recommend that such therapy be covered as part of medical management of pain, not behavioral management. This recommendation aligns with the necessary base of expertise and services within pain management needed to appropriately treat patients with chronic pain.

In addition, coverage for monitoring measures to reduce the abuse and diversion of prescribed medication should extend to urine drug testing and checks of the state prescription monitoring database, where available. These measures are supported by fair evidence of benefit for patients on opioids for chronic pain management and, although subject to limitations, are considered essential by experts in the field [Manchikanti et al 2012; Chou et al 2009].

A further strategy is to align incentives with patient outcomes rather than the current fee-for-service reimbursement that rewards volume over quality. When outcomes are rewarded, clinicians are more likely to use therapies seen to be effective.

Additionally, it is recommended that payers work with providers to set up bundles, or some form of “global fee” that covers pain diagnoses. A predetermined payment to a healthcare provider or group based on historical reimbursement for all services related to a specific diagnosis is one possible method to align incentives. Such an approach could allow for bundled services that include behavioral therapy, education, training, medical management, and physical therapy or rehabilitation. Care must be taken to adjust for higher risk and to tie financial incentives to patient outcomes. Given careful structuring and adequate oversight, alternative payment systems could allow for cost control while extending interdisciplinary care to many more patients with pain.

## **Summary**

To address the country’s pain crisis with competence and compassion, it is necessary to improve the healthcare delivery system so that comprehensive treatment is available to all patients with chronic pain. It is the responsibility of AAPM to help effect change in these areas through elucidating the science and providing the leadership to make a difference in these key areas. Comprehensive treatment of chronic pain draws from multiple disciplines to address physical and

psychosocial components of pain. The interdisciplinary approach may encompass some combination of the following therapeutic areas:

- Medical management
- Physical therapy
- Occupational therapy
- Biofeedback
- Vocational and recreational therapy
- Psychological counseling (e.g., CBT)
- Complementary and Integrative Medicine

The pain community's efforts to date have been largely conceptual identifying the need for change but no specific steps identified to move forward. To move from the conceptual to the practical and tangible will require alliance of organizations interested in making the world better for people in pain.

### **About AAPM**

With over 2,500 members, the American Academy of Pain Medicine is the premier medical association for pain physicians and their treatment teams. Now in its 31st year of service, the Academy's mission is to optimize the health of patients in pain and eliminate pain as a major public health problem by advancing the practice and specialty of pain medicine through education, training, advocacy and research. Information is available on the Academy's website at [www.painmed.org](http://www.painmed.org).

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