Insurer Coverage of Nonpharmacological Treatments

for Low Back Pain - Time for a Change

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Christine M. Goertz, DC, PhD; Steven Z. George, PT, PhD

The Spine Institute for Quality (Spine IQ),

108 First Ave E,

Oskaloosa, IA 52577

cgoertz@SpineIQ.org

Low back pain is one of the most common reasons patients seek medical care and is highly correlated with opioid use. [1] Both factors have contributed to a major public health crisis resulting from opioid overuse and misuse. In response, last year the American College of Physicians (ACP) [2] developed a guideline consistent with the current US Department of Health and Human Services National Pain Strategy [3] recommending nonpharmacological therapies as a first-line treatment for patients who have low back pain. The ACP guideline is well aligned with individual patient preferences for early treatment of spine-related conditions.

A recent Gallup poll conducted found that 78% of US adults would prefer to use nonpharmacological treatment for back and neck pain before considering pharmaceutical options. [4] Furthermore, research indicates that overall health care expenditures may be lower for US adults with neck and back pain who seek care from complementary and alternative medicine professionals. [5]

The extent to which clinical practice will evolve in response to these compelling factors is unknown. One critical question is whether public and private insurers will adopt policies to support integration of evidence-based guidelines for nonopioid treatment of pain into existing health care delivery systems, as specifically recommended by the National Pain Strategy. [3]

Heyward et al [6] addressed this important question by providing initial data on coverage policies for low back pain regarding a subset of commonly used, evidence-based nonpharmacological therapies obtained via a cross-sectional review of 45 private and public payer websites. The study team provided additional context to these data by conducting 20 qualitative interviews with 43 health plan executives regarding coverage policies on nonpharmacological care.

In this study, Heyward et al found that coverage of some therapies, including physical and occupational therapy and chiropractic, was available in most health plans. In contrast, psychological interventions and acupuncture were much less likely to be included. However, for all covered nonpharmacological therapies, significant barriers to patient access were identified. These included visit limits, prior authorization requirements, and high out-of-pocket expenses. Heyward et al also report that payment policies targeted toward coordination of pharmacological and nonpharmacological care were virtually nonexistent.

Clearly, public and private insurers have not yet widely adopted payor policies that are consistent with the ACP guideline, National Pain Strategy, and reported patient preference. Specifically, most health plans surveyed did not have policies in place that

(1) emphasize the use of nonpharmacological treatments at the forefront of the patient experience;

(2) provide meaningful levels of coverage for care professionals who focus on guideline-adherent nondrug therapies such as spinal manipulation, exercise, massage, acupuncture, and cognitive behavioral therapy; or

(3) use financial incentives that favor the use of nonpharmacologic options over commonly prescribed pharmaceuticals, including opioids.

To effect change in opioid use and misuse, public and private insurer payment policies must align themselves with public health initiatives to address opioid misuse by removing process barriers that limit the uptake of nonpharmacological care. [7] These include addressing the stigma of nonpharmacological treatments as being inferior to conventional medical approaches, creating policies that support care coordination between pharmacologic and nonpharmacologic treatment approaches at the initial point of service, and removing financial barriers.

Relative to stigma, Heyward et al found that health care executives did not believe expanded coverage of nonpharmacological treatments is supported by the existing literature. As outlined in the ACP guideline referenced earlier, in many cases nonpharmacological treatments offer equal benefit or even improved benefit, with lower risk, than commonly used pharmaceutical options. [8] Future coverage policies should be based on unbiased reviews of the evidence that appropriately balance risk with the potential benefit rather than an a priori perspective that nonpharmacological treatments are less desirable alternatives to pharmaceutical options. Regarding coordination of care, health plans are well positioned to adopt policies that reward enhanced communication between patients and health care professionals.

Such communication can make patients better informed partners in the health care decision-making process by facilitating discussion of known risks and potential benefits of both pharmacological and nonpharmacological treatment options and setting realistic expectations for chronic pain management as opposed to hope for a cure. [9] It also can facilitate the delivery of nonpharmacological treatments that are inherently multimodal and therefore require additional coordination or support beyond an initial consult.

Finally, future payment policies should decrease patient out-of-pocket expenses to strongly encourage earlier use of evidence-based nonpharmacological treatment options. Heyward et al found that median out-of-pocket costs for covered nonpharmacological treatments ranged from $25 to $60 per visit for commercial insurers. The usual dose of treatments such as physical therapy and chiropractic care is commonly between 6 and 12 visits. Thus, out-of-pocket expenses can vary from $150 to $720 or more. In contrast, Lin et al [10] found that the median cost of a 30-day supply of preferred generic opioids by commercial insurers is $10. Given the significant differences in cost, many patients do not realistically have the option of seeking nonpharmacological treatment.

Restricting access to opioids without addressing the underlying problem of chronic care management for low back pain is unlikely to positively affect the opioid crisis. Well-conceived guidelines that encourage the use of evidence-based, nonpharmacological treatment options exist and must be enabled by changes in public health policies that better guide care delivery and reimbursement. Health plans are uniquely positioned to bring about the sweeping changes needed to offer diverse pain management options for individuals with chronic pain. The findings from Heyward et al shed light on the ways in which current coverage policies run counter to this strategy and provide the beginnings of a roadmap to implement change on this critical issue.

Conflict of Interest Disclosures:

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