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Pain-Related Care and the Affordable Care Act: Summary of Common Practices

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This paper provides a brief overview of key findings in the Institute of Medicine (IOM) 2011 report on pain, how public and commercial insurers approach pain management, and the pain-related provisions in the 2010 Patient Protection and Affordable Care Act (ACA).

Institute of Medicine Key Findings

The IOM released a report, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, summarizing findings and recommendations on how to address the gaps in pain prevention, care, education and research. The report identified the following recommendations related to service delivery and reimbursement:[1]

- Develop strategies for reducing barriers to pain care
- Promote and enable self-management of pain
- Support collaboration between pain specialists and primary care clinicians, including referral to pain centers when appropriate
- Improve the collection and reporting of data on pain
- Expand patient and public education, including prevention
- Revise reimbursement policies to foster coordinated and evidence-based pain care

The IOM report also identified six treatment areas associated with pain care and where lack of coverage can be a barrier to effective pain care:[2]

- Medication
- Regional anesthetic interventions
- Surgery
- Psychological therapies
- Rehabilitative/physical therapy
- Complementary and alternative medicines (CAM)

Coverage of Pain-Related Treatments

Payers approach pain care through two distinct patient populations: those who are at the end of their lives and those who are experiencing pain related to an injury or illness. End-of-life (EOL) patients are typically enrolled in hospice or palliative care programs focused on making them feel comfortable with pain management as a key service.

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[1] Institute of Medicine. June 29, 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-transforming-Prevention-Care-Education-Research.aspx (accessed 12/10/13).

[2] Ibid.

Patients who experience pain and are not EOL receive pain care when it is associated with a condition (i.e., diagnosis) for which treatment is rendered. For example, most public and private payers do not provide coverage for physical therapy when it is prescribed solely for pain management. Instead, physical therapy is covered by Medicaid and commercial health plans[3] when it is expected to improve or restore the patient's function and by Medicare when it is expected to maintain the patient's function.[4] When a diagnosis cannot be determined, a patient may face barriers to covered pain management services.

Figure 1 provides a general overview of public and private coverage of the IOM recommended treatment categories, with Blue Cross Blue Shield of Michigan (BCBSM) serving as the example for private insurers. Limitations on coverage, which vary by procedure, are not fully reflected in the table.[5]

Figure 1: Public & Private Payer Coverage of Pain-Related Treatments

Payer	Pain-related Treatments					
	Medications	**Regional Anesthetic Interventions**	**Surgery**	**Psychological Therapies**	**Rehabilitative/ Physical Therapy**	**Complementary and Alternative Medicines (CAM)**
Medicaid	✓	No state specific data found	✓	✓	✓	✓[e]
Medicare	✓	✓	✓	✓[c]	✓[d]	✓[e]
Private Insurers (BCBSM example)	✓	✓	✓	✓	✓	✓
Veterans Health Administration (VHA)	✓	✓	✓	✓	✓	✓[f]
U.S. Department of Defense (DoD)/ TRICARE[a]	✓	✓	✓	✓	✓	✓[g]
Federal and State Workers' Compensation Programs[b]	*State:* ✓ *Federal:* ✓	*State:* ✓ *Federal:* ✓	*State:* ✓ *Federal:* ✓	*State:* No state specific data found *Federal:* ✓	State: ✓ *Federal:* ✓	*State:* No state specific data found *Federal:* ✓

[3] Beginning in 2014, the essential health benefits mandate requires non-grandfathered individual and small group plans, Medicaid benchmark or benchmark equivalent plans, and basic health plans to cover both habilitative and rehabilitative services; therefore, these plans likely cover physical and occupational therapy services to maintain function.

[4] As the result of a 2013 lawsuit against the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services (CMS) issued revised program manuals clarifying that the potential for improvement from the physical and occupational therapy is not required for coverage of the services. Rather, these services are also covered by Medicare and Medicare Advantage plans to maintain condition and prevent backsliding. The lack of restoration potential alone cannot serve as the basis for denying coverage.
Centers for Medicare and Medicaid Services. 2013. Jimmo v. Sebelius Settlement Agreement Factsheet.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf (accessed 12/10/13).

[5] Institute of Medicine. June 29, 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*.
http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-transforming-Prevention-Care-Education-Research.aspx
(accessed 12/10/13).

"✓" indicates the payer offers coverage for procedure(s) within the treatment category

[a] TRICARE is the health care program of the DoD Military Health System and is administered through managed care support contracts. The program offers service members and their families three main health plan options (TRICARE Prime, TRICARE Standard, and TRICARE Extra) that allow them to receive care from private health care providers.

[b] The Federal Employees' Compensation Act (FECA) is the workers' compensation program for federal employees and provides medical benefits to employees who are injured or become ill in the course of their federal employment. FECA covers all medical costs associated with the treatment of the work-related injury or illness. FECA benefits are paid out of the congressionally appropriated Federal Employees' Compensation Fund. In contrast, state workers' compensation programs are regulated by the state and provided through private insurance, state insurance funds, or self-insurance. Policies and programs vary widely among states.

[c] In 2014, Medicare beneficiaries will be responsible for paying a 20 percent coinsurance for outpatient psychological counseling services. In previous years the coinsurance was 35-40 percent.

[d] Most health plans have limitations on physical therapy and occupational therapy services. For 2014, Medicare has a $1,920 annual cap for physical and speech therapy and a $1,920 annual cap for rehabilitative services. Many Medicare Advantage plans have chosen not to institute a therapy cap.

[e] Medicare and most state Medicaid programs only cover chiropractic services for manual manipulation of the spine to treat a subluxation (when one or more bones in the spine move out of position). A few state Medicaid programs, such as Florida and Rhode Island, have covered other CAM services, including acupuncture and massage therapy.

[f] Every VHA provider has a specific requirement to make chiropractic services available onsite.

[g] While some military medical facilities may offer services like acupuncture and chiropractic care, these are reserved for active duty members only. CAM services are largely excluded under TRICARE.

Sources: Kaiser Family Foundation, State Facts, Medicaid Benefits, 2011; Centers for Medicare & Medicaid Services; BCBSM; TRICARE; VHA; Department of Defense, Report to the Congress: Complementary and Alternative Medicine within the Military Health System, 2011; Department of Defense, Report to the Congress: The Implementation of a Comprehensive Policy On Pain Management by the Military Health Care System; Congressional Research Service, The Federal Employees' Compensation Act (FECA): Workers' Compensation for Federal Employees, June 2013.

Reimbursement for Pain-Related Treatments

Insurers use a broad range of methods to pay health care providers for rendering services, including those related to pain. Common payment methods include:[6]

- **Capitated Payments** – A provider receives a single payment for a range of services for a designated group of patients over a fixed time period regardless of how many of those services each patient receives (e.g., A primary care provider receives a payment every month for each health plan member assigned to his or her practice).
- **Episode or Bundled Payments** – A group of providers, who may cross multiple settings, receive a payment for a group of services related to a patient's treatment or condition.
- **Fee-for-Service** – A provider is reimbursed a fee for each service he or she renders.
- **Perspective Payment System (PPS)** – A provider receives a fixed, predetermined payment for specific diagnoses regardless of the actual costs that resulted from the care. Medicare uses separate PPSs for different facility types (i.e., hospitals, inpatient rehabilitation facilities, skilled nursing facilities, etc.).

Medicare, workers' compensation programs, and commercial health plans traditionally use fee-for-service to reimburse providers, while commercial health maintenance organizations (HMO) typically use capitation models. Medicaid reimbursement methodologies vary by state, but fee-for-service and capitation are most common. Even within these

[6] M. Hansen. 2013. *Payment Reform*. (Denver, CO: National Conference of State Legislatures). http://www.ncsl.org/documents/health/PaymentRTK13.pdf (accessed 12/10/13).

identified reimbursement models, the ways in which pain-related treatments are reimbursed and the amount of the reimbursement differ by health plan, provider, procedure and where the treatment takes place.

Figure 2 provides a general overview of the reimbursement methodologies used by public and private payers for the IOM recommended treatment categories, with BCBSM serving as the example for private insurers.

Figure 2: Public & Private Reimbursement Methodologies for Pain-Related Treatments

Payer[a]	**Pain-related Treatments**					
	Medications	**Regional Anesthetic Interventions**	**Surgery**	**Psychological Therapies**	**Rehabilitative/Physical Therapy**	**Complementary and Alternative Medicines (CAM)**
Medicaid[b]	States use varied methods. Most estimate the acquisition cost for a prescription drug and add a dispensing fee.	No state specific data found	Varies by state	35 states use fee-for-service to reimburse for psychologist services for individuals enrolled in adult Medicaid.	33 states use fee-for-service to reimburse for occupational therapy services for individuals enrolled in adult Medicaid. 35 states and DC states use fee-for-service to reimburse for physical therapy services for individuals enrolled in adult Medicaid.	26 states use fee-for services to reimburse for chiropractic services for individuals enrolled in adult Medicaid.
Medicare	Medicare Part D sponsors negotiate prices with pharmacies and manufacturers. The negotiated price includes the ingredient cost and dispensing fee.	Fee-for-Service	Fee-for-Service and Prospective Payment System	Fee-for-Service	Fee-for-Service (Outpatient Facility) and Prospective Payment System (Inpatient and Nursing Facility)	Fee-for-Service
Private Insurers (BCBSM example)	Fee-for-Service	Fee-for-Service	Fee-for-Service	Fee-for-Service	Fee-for-Service	Fee-for-Service
Veterans Health Administration (VHA)[c]	VA negotiates pricing and purchases directly from wholesalers and manufacturers.	Global Budget	Global Budget	Global Budget	Global Budget	Global Budget

Payer[a]	Pain-related Treatments					
	Medications	**Regional Anesthetic Interventions**	**Surgery**	**Psychological Therapies**	**Rehabilitative/ Physical Therapy**	**Complementary and Alternative Medicines (CAM)**
U.S. Department of Defense (DoD)/TRICARE[d]	DoD negotiates prices with pharmacies and manufacturers.	Fee-for-Service	Fee-for-Service and Prospective Payment System	Fee-for-Service	Fee-for-Service and Prospective Payment System	Fee-for-Service
Federal and State Workers' Compensation Programs[e]	*State:* Varies by state *Federal:* Based on the Average Wholesale Price (AWP) for prescription drugs plus a dispensing fee, or on the Usual and Customary charge amount (whichever is less).	*State:* Fee-for-Service *Federal:* Fee-for-Service	*State:* Varies by state *Federal:* Fee-for-Service and Prospective Payment System	*State:* Fee-for-Service *Federal:* Fee-for-Service	*State:* Varies by state *Federal:* Fee-for-Service and Prospective Payment System	*State:* Fee-for-Service *Federal:* Fee-for-Service

[a] All payers appear to be relying largely on single modality approaches.

[b] In July 2011, almost 75 percent of Medicaid beneficiaries were enrolled in a managed care program. Benefits that are not included in a state's managed care contract are often provided on a fee-for-service basis or by a non-comprehensive prepaid health plan.

[c] The VHA, within the Department of Veterans Affairs, is appropriated a fixed amount of funds by Congress. Those funds are distributed to 23 regional service networks. The amount distributed to each region is determined by the Veterans Equitable Resource Allocation (VERA) system, an allocation method based on the number of patients served in the region and the severity of their conditions. VHA facilities do bill third-party payers (e.g., private insurance) for non-service-connected care. The funds generated from third-party payers go to the billing VHA facility. The VHA does reimburse for care provided at non-VHA facilities, using fee-for-service, when a veteran is unable to access care at a VHA facility in emergencies, if a covered service cannot be provided at a VHA facility, or due to geographic inaccessibility.

[d] Reimbursement rates for TRICARE are generally aligned with Medicare. Health care providers who are employed at military medical facilities are salaried, like the VHA, and do not receive reimbursements from TRICARE for the care they provide.

[e] Reimbursement rates for the services covered by FECA are determined by the Department of Labor's Office of Workers' Compensation Programs fee schedule, which are generally aligned with Medicare. Similar to FECA, fee-for-service is the most common payment method among state workers' compensation programs. Payments made under state programs are generally greater than Medicare payments.

Sources: Kaiser Family Foundation, State Facts, Medicaid Benefits, 2011; Centers for Medicare & Medicaid Services; BCBSM; Congressional Research Service, Military Medical Care: Questions and Answers, January 2014; Congressional Research Service, Health Care for Veterans: Answers to Frequently Asked Questions, February 2014; Government Accountability Office, Access to Civilian Providers under TRICARE Standard and Extra, June 2011; U.S. Department of Labor, OWCP Medical Fee Schedule 2013; Workers' Compensation Research Institute, April 2014, Workers' Compensation Laws as of January 1, 2014.

In order to better focus on effective reimbursement and coverage for pain management services, considerations for payers are included in *Figure 3*.

Figure 3: Considerations for All Payers as They Develop & Advance Pain-Related Reimbursement Methodologies

Considerations for All Payers
Analytical bandwidth to engage in pilots testing new coverage and reimbursement methods
Need for specific information around codes, treatments, medical policies, etc.
Goal to assure that total costs do not rise
Need for analysis to show the costs and benefits, which can help make the business case for change

Payer Efforts to Address Pain

There is some movement by payers to specifically address pain, including the following examples:

- **Blue Cross Blue Shield of Michigan (BCBSM)** – In 2009, Michigan's Office of Financial and Insurance Regulation approved language changes to BCBSM certificates and riders to allow treatments of pain management as a payable benefit when therapeutic services have been established as safe. Essentially, this action increases enrollee access to more pain management services related to their diagnosis(es). For example, a physician can now be paid for the injection of an anesthetic agent to control diagnosed back pain.[7]
- **Florida Medicaid Provider Access System (MediPass)** – The Florida Legislature enacted language in 2002 to create the Integrative Therapies Pilot Project, a chronic pain management program that incorporated complementary and alternative therapies (e.g., acupuncture, chiropractic services and massage therapy) into the care of beneficiaries diagnosed with chronic fatigue syndrome, chronic back or neck pain, and fibromyalgia.[8] The program reported a 9 percent decrease in per member per month costs, increased physical and mental function among beneficiaries, and high patient satisfaction.[9] The program ended in 2011, but a similar program is being piloted in Rhode Island.
- **Centers for Medicare & Medicaid Services (CMS)** – CMS has incorporated pain-related quality measures into several of its programs, such as the Physician Quality Reporting System (PQRS) and the Medicare Physician Fee Schedule via Value Based Modifiers. Examples of these measures, which have been endorsed by the National Quality Forum, are included in *Figure 4*.

[7] Blue Cross Blue Shield of Michigan.
[8] Health Management Associates, Inc. 2008. *Integrative Therapies Pilot Project: A Holistic Approach to Chronic Pain Management in Medicaid*. http://www.aomsm.org/Resources/Documents/Florida%20Study-CAM%20and%20Chronic%20Pain.pdf (accessed 12/10/13).
[9] Ibid.

Figure 4: Examples of CMS Quality Measures

CMS Program	Measure	Description
Home Health Compare	Improvement in Pain Interfering with Activity	Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.
Home Health Quality Reporting	Pain Assessment Conducted	Percentage of home health episodes of care in which the patient was assessed for pain, using a standardized pain assessment tool, at start/resumption of care.
Hospital Compare	Pain management (summary measure)	Patients who reported that their pain was "Always" well controlled
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	166v2: Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
Medicare Part C Plan Finder/Star Rating	C13 -Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year. (This information about pain screening or pain management is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)
Medicare Physician Quality Reporting System	Measure #131 (NQF 0420): Pain Assessment and Follow-Up	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present/
Physician Value-Based Payment Modifier	Measure #131 (NQF 0420): Pain Assessment and Follow-Up	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.
Physician Value-Based Payment Modifier	Lower Back Pain: Repeat Imaging Studies	Percentage of patients with back pain who received inappropriate imaging studies in the absence of red flags or progressive symptoms (overuse measure, lower performance is better).
Source: Centers for Medicare & Medicaid Services, CMS Measures Inventory, 2013.		

CMS is also engaged in demonstration projects and policy changes that could impact the reimbursement and delivery of pain care, including:

- **Bundled Payment for Care Improvement (BPCI) Initiative** – CMS is conducting a number of care and reimbursement demonstrations to encourage coordination among providers and more efficient use of services. CMS began the BPCI initiative in 2013. The three-year initiative uses four broadly defined models to test the use of bundle payments (paid either prospectively or retrospectively) for 48 episodes of care, such as spinal fusions. The four models of care span acute and post-acute providers and services.[10]

[10] Blue Cross Blue Shield of Michigan. [1] Centers for Medicare & Medicaid Services. Bundled Payments for Care Improvement (BPCI) Initiative. http://innovation.cms.gov/initiatives/bundled-payments/ (accessed 12/10/13).

- **Chronic Care Management Services** – CMS continues to examine how care management is reimbursed. In 2015, Medicare intends to start providing a separate reimbursement for non-face-to-face chronic care management services for beneficiaries with multiple (two or more) significant chronic conditions. Currently, this payment is bundled into payments for evaluation and management services, but many physicians believe it does not adequately describe the services provided. CMS hopes the policy improves the management and decreases the costs of chronic diseases. The separate reimbursement for non-face-to-face chronic care management services is expected to be further defined via the Physician Fee Schedule rulemaking process for calendar year 2015.[11]

Pain-Related Prescription Drugs

Prescription drug coverage includes coverage for "pain killer" drugs such as morphine and Vicodin, but public and private payers are concerned about the associated costs and risks for abuse and addiction. These concerns are evident in policies commonly utilized by payers; including, quantity limits, prior authorizations, step therapy, and "lock-in" programs (members are restricted to a single pharmacy and/or prescriber group). BCBSM, for example, requires documentation that members have experienced treatment failure of or intolerance to two other long-acting opioids before they receive Oxycontin.[12]

Pain Management and the ACA

The ACA contains three key provisions to increase understanding and improve the delivery of evidence based care for pain management:[13]

- **Section 4305** - Requires the U.S. Department of Health & Human Services (HHS) to partner with the IOM to convene the Conference on Pain. The Conference is charged with:
    - Evaluating the adequacy of pain-related care and treatments in the general population and among identified groups;
    - Identifying barriers to pain care; and
    - Establishing an agenda for both the public and private sectors that will reduce barriers and improve pain research, education and care.

- **Section 409J** – Establishes the Interagency Pain Research Coordinating Committee (IPRCC) to coordinate all pain-related research within HHS and other federal agencies. IPRCC's duties include:
    - Developing a summary of advances in pain care research relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;
    - Identifying research gaps on the symptoms and causes of pain; and
    - Providing suggestions on how best to disseminate information on pain care.

- **Section 759** – Encourages HHS to award grants, cooperative agreements, and contracts to health profession schools, hospices, and other public and private entities for the development and implementation of programs that provide pain care education and training to healthcare professionals.

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[11] U.S. Department of Health and Human Services. December 10, 2013. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014: Final Rule. *Federal Register*, 78(237): 74229-74823. https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory (accessed 12/10/13).

[12] Blue Cross Blue Shield of Michigan. Prior Authorization/Step Therapy Program. http://www.bcbsm.com/providers/help/plan-documents-and-forms/pharmacy-services/blue-cross-blue-shield-of-michigan/prior-authorization-step-therapy-program.html (accessed 12/10/13).

[13] Patient Protection and Affordable Care Act. 2010, Pub. L. No. 111-148, 124 Stat. 119. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf (accessed 12/10/13).

Given IOM's recommendations related to improved service delivery, ACA provisions that focus on improved coordination, alignment of incentives, and quality, while not directly related, may also have an impact on pain care. These include provisions such as Accountable Care Organizations, Value Based Purchasing, and the Multi-payer Advanced Primary Care Practice Demonstration.

With regard to coverage, the ACA's required Essential Health Benefits, the minimums set of benefits that must be offered by non-grandfathered individual and small group health plans and by Medicaid benchmark or benchmark-equivalent health plans, includes coverage for each of the recommended treatment areas except for complementary and alternative medicines. However, medical policies may differ among health plans.

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