

Pain Assessment and Treatment in the Managed Care Environment

A position statement from the American Pain Society

Purpose

The American Pain Society (APS) offers this statement in an effort to improve pain management for people receiving care through managed care organizations (MCOs)* and to assist MCOs in advancing the quality of pain management services and the patient satisfaction and clinical outcomes for people receiving those services.

Background

Pain is a major health problem in this country and is the most common symptom that prompts people to seek medical care. It is the second leading cause of medically related work absenteeism, resulting in more than 50 million lost workdays each year. Employers are concerned about its effect on health-care costs and premiums, and it is the leading cause of disability in the working-age population, with both private disability plans and the Social Security system being significantly affected (*The Impacts of Pain*, 1997; Louis Harris and Associates, 1996; Osterweis, Kleinman, & Mechanic, 1987). Back pain alone produces chronic disability in approximately 1% of the U.S. population, and another 1% are temporarily disabled by it (Bigos, Bowyer, Braen et al., 1994). Each year at least 2% of the American work force suffers a compensable back pain problem, with state and private workers' compensation systems searching for more effective ways to provide medical care (Dembe, Himmelstein, Stevens, & Beachler, 1998). Chronic pain problems have also become significant for the elderly, and the frequency of these conditions can be expected to increase with the aging of the population. In sum, persistent or chronic pain problems are a significant public health problem. Epidemiologic projections vary depending on definitions, of course; but conservative statistics suggest a chronic pain prevalence of at least 2% of the adult population (Verhaak, Kerssens, Dekker, Sorbi, & Bensing, 1998).

Problems for Health Plans

More and more Americans are being covered by managed care plans, with 85% of working Americans now enrolled in HMOs or other forms of managed care. Last year nearly 5 million Medicare beneficiaries were enrolled in HMOs, with approximately 86% of these (or about 11% of all beneficiaries) covered by full-risk programs (Health Care Financing Administration, 1997). Approximately 83.7 million Americans are now members of 789 HMOs (American Association of Health Plans, 1998; "News and Trends," 1998). Nevertheless, managed care industry growth is no longer accompanied by reliable profits ("News and Trends"), and plans are increasingly focused on managing high-cost areas such as chronic diseases. Due to the prevalence of chronic pain conditions in the population now served by managed care plans, it is important for MCOs to actively respond to the healthcare needs of patients with such clinical problems. Many plans, in fact, may find that the cost impact of chronic pain problems is greater than that for all other typically diagnosed chronic conditions (Fishman, Von Korff, Lozano, & Hecht, 1997).

*We take this term to refer to all types of healthcare delivery systems in which care is influenced by someone in addition to the provider or is potentially influenced by economic or other nonmedical factors under the control of the plan. It includes fully insured plans, employer-sponsored and ERISA-exempt programs, government-subsidized plans under the Medicare and Medicaid programs, and public or private workers' compensation plans. This term, as used in this statement, is applicable regardless of the plan type, source of premiums or funding, proprietary status, or the level of risk assumed.

Chronic pain in older Americans is becoming a more widely recognized problem, with HCFA policy experts now recommending “disease state management” programs for chronic pain in the Medicare program (Fox, Ethredge, & Jones, 1998). Such management may be even more important under the new Medicare options, which are becoming available to beneficiaries through health plans and providers (Christensen, 1998; Sofaer, 1998).

Finally, rapid escalation of medical care costs and disabilities in the workers’ compensation environment have been fueled, in part, by poor diagnosis and care of pain-related conditions and cost shifting from group health plans (Butler, Hartwig, & Gardner, 1997). These factors have led many employers to seek better pain management from their workers’ compensation vendors and cooperation or integration from their health plans. Currently about 41% of all employees work in states with some type of mandatory or permissive workers’ compensation managed care laws (Lane, 1998).

Position Statement

APS recognizes that, historically, group health programs and MCOs have received uneven quality of care for patients in pain and that it has been reasonable to question the value of such services. Therefore, APS supports health plans’ attempts to implement systematic methods of pain assessment and management to facilitate quality care and to obtain reasonable outcomes for pain management activities. APS recommends the following principles and components for an effective pain management program.

Assessment and Referral

1. All patients benefit from timely and effective assessment and treatment of pain by their primary care providers (PCPs). When treatment is not effective, early access to appropriate specialists can result in improved outcomes (as defined in the section on quality and outcomes).
2. It is appropriate for MCOs to justify the referral of patients in pain and the utilization of treatment methods used for such patients. Therefore, reasonable criteria for referral and utilization should be developed, distributed to providers, and used in this process.

Education of Primary Care Providers

There is an insufficient level of credentialed experts among managed care PCPs to provide appropriate care for most patients with chronic pain conditions. Furthermore, primary providers are often unclear as to when patients with acute or chronic pain may benefit from referral for consultation or treatment. Therefore, MCOs should provide information and management activities that help PCPs make these determinations.

Provider Credentialing

It is appropriate for MCOs to credential pain specialists based on appropriate professional qualifications. Where referral to comprehensive multidisciplinary treatment programs may be considered, an MCO should require additional accreditation and/or certification that meet the needs of the plan(s).

Management of Chronic Pain

It is widely acknowledged that chronic pain problems tend to be qualitatively different from acute pain (Merskey & Bogduk, 1994), not only temporally but also in character and response to treatment. The care of chronic pain problems requires specialized expertise, because chronic pain problems do not respond reliably to many of the strategies used for the treatment of acute pain and because inappropriate care for chronic pain conditions can often lead to clinical exacerbation and increased suffering and disability. Therefore, it is appropriate for plans to develop policies and strategies

that can facilitate the following:

1. Identification of members with chronic benign pain conditions or syndromes
2. Appropriate referral of such members to specialized providers
3. Education and assistance to PCPs in accomplishing these objectives
4. Development of disease state management programs for chronic pain, similar to those designed for other chronic diseases. Such programs should
 - a. provide pathways and guidelines that encourage the appropriate utilization of pain specialists and other resources.
 - b. result in the documented effectiveness of the chosen treatment strategies.

Quality and Outcomes

It is appropriate for MCOs to require documentation of quality of care and outcomes that allow primary providers and plans to make appropriate, evidence-based decisions on referrals to pain specialists and treatment programs. These should minimally include evidence of outcomes, wherever appropriate, for:

1. Physical parameters
2. Functional status
3. Healthcare utilization
4. Occupational/disability-related measures
5. Patient satisfaction

Guidelines

With respect to clinical pathways and guidelines, APS recommends that MCOs use the following principles in managing care for patients in pain:

1. APS has promulgated clinical practice guidelines for the management of acute pain, cancer pain (American Pain Society Quality of Care Committee, 1995), and pain associated with sickle-cell disease (Benjamin et al., 1999) and recommends the clinical guidelines published by the U.S. Agency for Health Care Policy and Research (Acute Pain Management Guideline Panel, 1992; Jacox, Carr, Payne et al., 1994).
2. APS acknowledges that there are currently no evidence-based guidelines, nor widely accepted consensus guidelines, for the management of chronic benign pain conditions. It is appropriate for MCOs to generate their own internally derived clinical pathways for chronic pain treatment based on local patterns of practice, availability of resources and specialty care, and needs of the insured or covered populations.
3. Because it is acknowledged that some specific types of care for chronic pain conditions are not helpful and often produce medical and/or behavioral complications, it is appropriate for MCOs not to provide such care whenever empirically derived case profiles, lack of evidence-based guidelines, or medical necessity decisions justify the denial.

Communication

Where appropriate, MCOs should make reasonable attempts to provide appropriate case coordination and communication with patients' disability carriers, employers, and other relevant stakeholders, within the legal and ethical bounds of professional confidentiality and privileged communication.

