AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-19)

Introduced by: North American Neuromodulation Society

Subject: Coverage Limitations and Non-coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis
Coverage Limitations and Non-coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, There is a worsening opioid crisis in the United States and in 2017 there were more opioid related deaths than all other drugs, motor vehicle accidents, firearm related deaths, or suicides (1); and

Whereas, According to the Centers for Disease Control (CDC) more than 68% of the 70,200 drug overdose deaths in 2017 involved an opioid (2); and

Whereas, Xignificant initiatives by the CDC and state medical boards to curb the prescription of opioids has so far not resulted in a decrease in opioid related deaths (3); and

Whereas, The decreased availability of prescription opioids has contributed to an increase in the use of illicit opioids including heroin, and heroin laced with fentanyl, causing an increased number of unintentional deaths (4); and

Whereas, The marked decrease in the utilization of interventional pain procedures from 2009-2017 secondary to an increase in regulations and requirements regarding these procedures, has directly correlated with the increase in opioid related deaths during the same duration, and this is an ongoing public health crisis (5); and

Whereas, Current AMA policy supports quality care for patients with pain including patient access to non-opioid and interventional pain management treatments (H-185.931); supports timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care (D-450.956); is committed to better access and delivery of quality pain care including through clinical practice (D-160.931); and opposes legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence- based, comprehensive pain care (H-95.930); and

Whereas, There are multiple evidence based guidelines and studies regarding the effectiveness of interventional pain procedures based on prospective cohort and/or randomized controlled trials including but not limited to: sacroiliac joint blocks and radiofrequency ablation (6-12), medial branch blocks and radio frequency ablation (for cervical, thoracic and lumbar facet arthritis) (13-17), genicular nerve blocks and radiofrequency ablation (for non-operable knee arthritis or pain) (18-22), femoral and obturator nerve blocks and radiofrequency ablation (for non-operable hip arthritis or pain) (23, 24), suprascapular nerve blocks and radiofrequency ablation (for non- operable shoulder arthritis or pain), spinal cord and peripheral nerve

stimulation; yet limitations and noncoverage decisions for these as well as many other interventional pain management procedures by multiple private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans exist, which have no regard to the basis and variability in severity of patient spine, nerve, and joint pathology or patient presentation (6-10); and

Whereas, There is non-inclusion of many diagnoses and conditions which have been to shown to be of benefit with regards to spinal cord stimulation and peripheral nerve stimulation that multiple private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans are omitting from their coverage policies; therefore be it

RESOLVED, That our American Medical Association support coverage of sacroiliac joint blocks and radiofrequency ablation, facet (spine joint) medial branch blocks and radiofrequency ablation, genicular blocks and radiofrequency ablation for non-operable knee arthritis or pain, femoral and obturator nerve blocks and radiofrequency ablations for non-operable hip arthritis or pain, suprascapular nerve blocks and radiofrequency ablations for non-operable shoulder arthritis or pain, and other arbitrarily limited non-covered interventional pain management procedures, by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans (Directive to Take Action), and be it further

RESOLVED, That our AMA support coverage of spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans by ICD-10 codes that have been linked to the respective Current Procedural Terminology (CPT) code set as outlined in the AMA CPT Manual. (Directive to Take Action)

Fiscal Note: Not yet determined

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RELEVANT AMA POLICY

Workforce and Coverage for Pain Management H-185.931

1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.
6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.
Citation: CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18

Pain as the Fifth Vital Sign D-450.956
Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.
Citation: BOT Rep. 19, A-16

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.
4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.
5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.
Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18

Legislative Pain Care Restrictions H-95.930
Our AMA will oppose legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence-based, comprehensive pain care.
Citation: Res. 228, A-16