The Role of Nonpharmacological Approaches to Pain Management

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Coverage of Nonpharmacologic Treatments for Low Back Pain Among US Public and Private Insurers

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Abstract

IMPORTANCE Despite epidemic rates of addiction and death from prescription opioids in the United States, suggesting the importance of providing alternatives to opioids in the treatment of pain, little is known regarding how payers' coverage policies may facilitate or impede access to such treatments.

OBJECTIVE To examine coverage policies for 5 nonpharmacologic approaches commonly used to treat acute or chronic low back pain among commercial and Medicare Advantage insurance plans, plus an additional 6 treatments among Medicaid plans.

Key Points

Question Among US insurers, what are the coverage and utilization management policies for nonpharmacologic treatments for chronic, noncancer low back pain?

Findings In this cross-sectional study of 45 Medicaid, commercial, and Medicare Advantage plans, most plans covered at least physical and occupational

Enormous Variation in Coverage, and **Terms** of Coverage

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Large Cost Differences Between Rx and Non-Rx Treatments

Median copay for physical therapy visit for in-network commercial insurer: $30[1]

Typical dose of physical therapy is 6 to 12 visits:
$180 to $360

1 Heyward J, Jones CM, Compton WM, et al. JAMA Open. October 2018.
2 Lin DL, Jones CM, Compton WM, et al. JAMA Open. June 2018.

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Median cost of 30-day supply of generic opioid = $10[2]

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Plan costs important driver of coverage decisions

"There's almost a fear factor among policy makers - they don't want to open up more benefits because it's almost always going to cost more and if my competitors don't do it, then we'll have adverse selection."

(C-4, MD-4) - Medicaid Medical Director

"The things that we don't cover, we haven't ever covered; to cover them would require a budget action, and you know, with the Medicaid expansion, we are a purple-y state, we have a pretty strapped budget, it would be really hard to add a new benefit, just based on the expense".

(M-3, MD-5) - Medicaid Medical Director

Rare coordination between “medical” and “pharmacy” benefits

“I could see [the pharmacy and medical sides] talking and coordinating, but we would need a more comprehensive program to do so. I don’t see a plan like this one, which is so huge and has so many moving pieces doing it by themselves. We would need a vendor to guide us. It’s just too complicated and we have too many benefit designs.”

(C-6, MD-6) - Commercial Medical Director

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