

The WPI's Review of Wisconsin's Managed Care Climate for Pain Management: Opportunities for Improvement

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ABSTRACT

Background: Reimbursement obstacles, such as inadequate insurance coverage, have been identified as barriers to adequate pain management. The purpose of this study was to determine Wisconsin insurers' and managed care organizations' (MCOs) policies and practices regarding pain treatment and MCO medical directors' perceptions of barriers to providing effective pain management for their enrollees.

Methods: A descriptive qualitative design was used with semi-structured interviews of 6 administrative executives of commercial health management organizations' products from the major insurers in Wisconsin.

Results: None of the companies interviewed had systematically tracked data or had processes in place to allow them to track, analyze or trend data specific to pain management. Chronic noncancer pain is recognized more frequently as an insurance coverage issue because of high drug costs. Pharmacologic and interventional therapies are routinely covered compared with nonpharmacologic therapies with some prior authorizations, especially for newer medications. A uniformly identified barrier was lack of a comprehensive, interdisciplinary, integrated approach to pain management and inadequate data on the cost effectiveness of various approaches.

Conclusions: Opportunities exist to educate and improve communication between health care profession-

als, purchasers of health care (employers), primary care providers and pain specialists. The economics of pain management needs to be made more "visible" through the development of coding and tracking mechanisms.

BACKGROUND AND RATIONALE

The Wisconsin Pain Initiative (WPI) (formerly the Wisconsin Cancer Pain Initiative) is an interdisciplinary effort aimed at improving the management of pain. The WPI is a World Health Organization demonstration project and has served as a role model and leader for other state initiatives since its inception in 1986. WPI is a cooperative effort of clinical care facilities, higher education, government, and health care professionals including physicians, nurses, pharmacists, social workers, and other professionals throughout Wisconsin. The initial goals of the WCPI were to improve the knowledge and skills of health care professionals to assess and treat cancer pain, educate patients and families about drug and non-drug therapies, and dispel fears concerning pain management. More recently, WPI's emphasis has shifted to projects aimed at making pain relief a priority in Wisconsin's health care system. While much work has been accomplished in helping organizations "institutionalize" improved pain management practices,¹ obstacles to quality pain management continue to exist. Major barriers to effective pain management include inadequate knowledge of health care professionals, patients, and the public; lack of institutional commitment; regulatory concerns; and limited access to and reimbursement for interdisciplinary care. In particular, inadequate insurance coverage has been identified as a barrier to adequate pain treatment.²

Reasons for lack of coverage include exclusion of the treatment by a patient's health insurance policy, exhaustion of patient benefits, treatment that is deemed unnecessary by a third party provider, or treatment

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deemed less cost-effective than another treatment.³ Many insurance plans cover high-technology interventions (delivery of drugs through implanted pumps, nerve blocks, spinal cord stimulation, epidural drug administration) with more limited or no coverage of other therapies (cognitive therapy, physical therapy, and other non-drug techniques) that may be more appropriate, cost effective, and efficacious in the long run.⁴

In 1997, the American Pain Society (APS) convened a Managed Care Task Force to seek a better understanding of the dynamics of managed care organizations (MCOs) and to give pain specialists a greater opportunity to participate in development of quality pain programs.⁵ A primary recommendation of the Task Force was to shift treatment programs from a procedural orientation to a behavioral orientation. The task force identified issues that influence the provision of pain care to individual patients and the development of pain management programs by MCOs. These include:

1. Primary care professionals (PCPs) and medical directors lack of knowledge about pain management.
2. PCPs' frequent need to refer pain patients to pain specialists.
3. MCOs' perception that pain providers are overutilizing treatments.
4. The difficulty of measuring the outcomes of pain management programs.
5. The lack of clinical practice guidelines, particularly ones based on outcomes research rather than on expert "consensus."

The primary purpose of this study was to describe the current policies, practices, and barriers to pain management of Wisconsin insurance plans. The results of this study will be used to develop future collaborations between the WPI, third party payors, and health care professionals.

METHODS

Procedure and Measures

Executives from 8 major Wisconsin health care insurers (identified through a list of companies available from the Office of the Commissioner of Insurance) were contacted to participate in the study in the summer of 2003. The 8 invited insurers were targeted because their plans covered the largest geographical areas of the state compared to all other insurers and were felt by the study team to provide a good representation of the state's insurance companies. Approval for this project was obtained from the University of Wisconsin-Madison Health Sciences Institutional Review Board.

Six insurers agreed to participate and were inter-

viewed over the phone or in person. A survey instrument used to structure the interviews was modified from an instrument used in Connecticut³ and included 21 open-ended items about policies and procedures for pain management and 11 items rated on a 6-point Likert scale about barriers to providing effective pain management for enrollees. A copy of the survey instrument was forwarded to all the executives prior to their interview and all interviews were conducted by 1 person. Completed surveys were used as sources of data. The survey questions can be grouped into the following categories:

- Have various types of pain (acute procedural, surgical, chronic [persistent] non-cancer, chronic [persistent] cancer, end-of-life) been identified as issues needing special attention, how were these issues brought to the company's attention, and have any special responses or resources been allocated to address these various types of pain?
- Are specific treatments covered, do any require prior authorization, and what reasons were given for exclusion of coverage?
- Does the company employ a pain management expert to consult about claims?
- Does the company have treatment or care policies/guidelines for the various types of pain?
- Does the company track, manage, or analyze data specific to pain management?
- What pharmacy and hospice benefits are included, and what drugs are restricted or require prior authorization?
- Are physician prescribing patterns monitored and why?
- What are the perceived barriers to providing effective pain management for enrollees?

Participants

The 6 participating companies represented 26% of the total 23 Wisconsin insurers, with enrollees in all but 1 of 71 counties. The total subscriber enrollment for the 6 companies that participated (as of January 2003) was 821,634 lives. Based on Wisconsin Bureau of Health Information statistics⁶ this represents 17% of the estimated 4.9 million Wisconsin household residents covered by health insurance. In Wisconsin, 64% of the population have insurance through their employers, 5% have private insurance, 22% have Medicare or Medicaid, and 9% have no insurance.⁶ These rates are similar to national averages, except the percentage of uninsured in Wisconsin is significantly lower than the national average of 15%. Five of the 6 companies surveyed had at least 90% of enrollees in commercial HMO products,

with up to 5% of enrollees with Medicaid HMO, 5% Medicare HMO, and up to 10% Indemnity. The sixth company's enrollees were divided almost equally between commercial HMOs and PPOs.

RESULTS

Types of pain identified as issues needing special attention, how the issue was brought to the company's attention, and any special responses

Chronic (persistent) non-cancer pain was most frequently (67%) identified as an issue requiring special attention in health care plans. This came to the attention of the companies as a result of a combination of factors, including an increase in cases with high utilization of services and a claims analysis identifying high cost enrollees. Fifty percent of respondents identified chronic cancer pain as an issue needing attention due to high prescription drug costs and input from case management. Acute procedural/surgical pain and pain management at end of life were less frequently identified as problematic issues (33% each) and were brought to the company's attention through case management. Management of any type of pain was not brought to the attention of any company through a grievance or appeals process. Two companies indicated that pain management was not specifically in company policy in any form. These companies relied on their providers to create and implement pain management policies or guidelines.

Specific treatments covered, prior authorization, and reasons for exclusion

Interventional techniques including epidural or intrathecal drug delivery, nerve blocks, trigger point injections, steroid injections, implanted pumps, and spinal cord stimulation are all uniformly covered except for 1 plan that did not cover implanted pumps or spinal cord stimulation because it considered these methods experimental. If the procedure is covered, prior authorization is necessary most often for spinal cord stimulation (100%), implanted pumps (80%), and epidural/intrathecal drug delivery when done as an outpatient procedure (50%). Evaluation and treatment by a pain specialist or pain clinic is covered by all companies, however, prior authorization is required by 50% of companies for a patient to be seen for a pain specialist and 67% of companies for a patient to be seen in a pain clinic.

Nonpharmacologic therapies are less frequently covered than are analgesics or interventional techniques. The services of mental health professionals, i.e., pain psychologists or behavioral health specialists, are covered by all plans, with 1 company requiring prior authorization, and 1 limiting coverage to psychologists only.

Support groups were not covered by 1 plan. Physical and occupational therapy services are covered by all plans; all require prior authorization and all limit the number of visits. Chiropractic treatment is a state-mandated benefit, meaning all health insurance policies must cover services provided by a chiropractor if the policy provides coverage for the same services if performed by a physician or osteopath; the plans uniformly limited the number of visits to the mandated level.

Coverage for other nonpharmacologic interventions, listed as "complementary therapies," in order of highest to lowest was trans-electrical nerve stimulation (TENS) (83%), biofeedback (50%), guided imagery, acupuncture, hypnosis (each 33%), and massage (16%). The most common reasons provided for exclusion of coverage is a lack of understanding of evidence for the effectiveness of the treatments and cost. Some of these therapies may be covered if they are provided by an employed provider of the plan's related health system or by an in-network behavioral health specialist.

Does the company employ a pain management expert to consult about claims?

Five of the 6 plans (83%) contract with pain management experts with specialized training, in whom they expressed great confidence. Salaried or contract pain experts were identified as anesthesiologists, neurologists, rheumatologists, psychologists, and psychiatrists.

Treatment or care policies/guidelines for the various types of pain

All of the plans focus on pain management on an individual case management or claims analysis basis. All companies indicated that they did not have the systems or resources to look at the issue of pain management on a broader level. Some, however, did indicate a desire to respond to the issue in the future, and plan to do so by adding human resources or developing teams to work on more complex cases and management processes. All of these plans relied on their provider networks at some level to develop and follow specific policies and procedures related to pain management. None have specific policies on acute pain management and only 1 has policies on chronic non-cancer pain management. Two of the 6 companies have an internal chronic pain management program, with 1 of these relying on providers for this service. Another did not have a specific program but instead relied on providers to effectively manage chronic pain, and another expressed a desire to implement a program of this sort. None of these companies have, or have plans to implement, policies or guidelines regarding pain management at the end of life. They rely

on contracted hospice and palliative care professionals to provide care management guidelines.

Tracking, managing, or analyzing data specific to pain management

None of the companies interviewed had systematically tracked data or had processes in place to allow them to track, analyze, or trend data specific to pain management. The companies rely on their provider networks to do tracking or analysis of pain management-specific data. Data identified as available for tracking were limited to numbers of pain clinic referrals and current procedural terminology (CPT) codes for invasive modalities such as trigger point injections. The only enrollee-wide data available to plans are claims data, which, while detailed, do not include specifics on pain management.

Pharmacy and hospice benefits, restricted drugs, prior authorization

Hospice care is contracted through specific providers, and all of the medical directors expressed confidence in the pain management capabilities of these providers. Services for pre-hospice patients (those not yet eligible for hospice services) are not considered “bridge” or “pre-hospice” but are coded and billed as are services for regular enrollees, and are subject to the same restrictions in coverage.

All of the plans surveyed have a pharmacy benefit, and 4 of the 6 outsource the management of their pharmacy benefits. These 4 plans rely on the manager for physician and staff education for contracts with pharmaceutical companies, to process claims, and to make formulary decisions. Pharmacy benefits of these 6 plans cannot be generalized because it is the employer, not a standard of care, who determines the structure of the benefit. In general, insurers and employers use closed formularies and tiered plans to steer physicians and enrollees toward less expensive alternatives whenever appropriate. Two and 3 tier plans are common, including a \$5 or \$10 co-pay for generic and \$20-\$50 co-pay or 30% co-insurance for name brand drugs. Time limits are usually a 30-day supply and 1 year on refills, and some plans require that patients try generic drugs first before name brand benefits are allowed. The annual maximum benefit varies widely depending on insurer and employee plan from \$20,000/year/enrollee to no maximum annual benefit.

Policies on specific analgesics varied. All plans restrict COX-2 non-steroidal anti-inflammatory drugs (NSAIDs); most require prior authorization, and several plans indicated that the majority of COX-2s (available on the market at the time of the interviews) were

non-formulary. Two plans restricted the use of controlled release oxycodone (Oxycontin®, Purdue Pharma, Stamford, CT). Transmucosal fentanyl (ACTIQ®, Cephalon, Frazer, PA) is non-formulary for 1 plan and 3 other plans restricted use by requiring prior authorization or moving it to a second tier benefit.

Monitoring physician prescribing pattern of analgesics

Half of the plans systematically monitor physician prescribing practices, while half do not. However, some of the plans that do not systematically monitor prescribing practices use pharmacy claims data to monitor for high medication doses for individuals, but not high volume prescribing by specific physicians. One plan monitors for scripts of multiple opioids for individual patients, another reviews high-cost enrollees, and another said that they expected the prescribing practices of pain specialists to be different from that of other physicians. Physicians have expressed concern over profiling prescribing practices, and one medical director indicated that his company had implemented an educational program for physicians on prescribing analgesics. All of the medical directors indicated that all of their non-pain specialist physicians would benefit from education about the efficacy of various pain management treatments, including analgesic therapies.

The perceived barriers to providing effective pain management for enrollees

One of the uniformly identified barriers was lack of a comprehensive, interdisciplinary, integrated approach to pain management and inadequate data on the cost effectiveness of various approaches (Table 1). Similarly, inadequate data on patient outcomes from various pain treatments and an inability to identify patients who will fail pain management treatments were identified as major barriers. All of the medical directors we interviewed expressed willingness to expand coverage for various treatments if their providers come to consensus about the clinical benefits and cost-effectiveness of said treatments. Several medical directors also mentioned accessibility and availability of pain centers and pain specialists as significant barriers.

DISCUSSION

Wisconsin MCO executives who participated in this study echoed the concerns identified by the panel of MCO medical directors convened by the APS in 1997.⁵ Although they indicated many pain patients receive inadequate pain care, they feel challenged by the lack of evidence-based clinical practice guidelines, the difficulties associated with measuring the outcomes of various

pain treatments, and are concerned about over-utilization of expensive medications and procedures as well as complementary therapies. Chronic pain, particularly chronic non-cancer pain, was identified by most participants as a major issue primarily due to the high cost of analgesics. The cost of drugs per individual patient is the major factor that draws the attention of the MCO, not the diagnosis or a physician's individual prescribing practices.

Accessibility of specific treatments is quite similar and is restricted by treatment type rather than pain diagnosis. The COX-2 selective NSAIDs, controlled-release oxycodone and transmucosal fentanyl, are the most restricted drugs, likely due to their cost. There is less coverage of nonpharmacologic therapies than of interventional and pharmacologic therapies. Surprisingly, many "complementary" modalities may be covered if provided by a recognized health care professional. Mental health and physical therapies are routinely covered, but there are restrictions on the number of visits or they require prior authorization. Referral to a pain specialist or interdisciplinary pain treatment program is covered, but usually requires prior authorization or referral. Furthermore, the availability of these forms of treatment centers is limited.

Few insurers have specific policies about pain treatment and, contrary to the APS Managed Care Task Force findings,⁷ insurers reported high confidence and reliance on physician judgment for treatment choices. The Wisconsin insurers interviewed were in agreement with the APS Task Force that there is not enough education for and communication among providers. Insurers would like to see more research and evidence-based practice guidelines. Of note, during the course of this study, a Wisconsin Medical Society task force, which included representatives from the insurance industry, developed and published *Guidelines for the Assessment and Management of Chronic Pain* for primary care professionals.⁸

Tracking data about pain management is variable and often limited to pharmacy benefits. This barrier was echoed by the Wisconsin Office of the Commissioner of Insurance, which reported in a telephone communication⁹ that although they receive inquiries from insurance beneficiaries about insurance gaps for pain management, they do not track issues related to pain management because there is no coding system specific to symptom management. Unless a coding mechanism for pain management is developed or insurance companies receive more medical record data with each claim, we will continue to be challenged to isolate pain man-

Table 1. Perceived Barriers to Providing Effective Pain

| Management for Enrollees | | | |
|--|---|------|--------------------|
| Item | N | Mean | Standard Deviation |
| Lack of scientific evidence for the efficacy of pain treatments | 6 | 1.50 | 1.38 |
| Pain management is not easily amenable to capitation | 5 | 1.40 | 1.52 |
| Lack of consensus on appropriate pain treatments | 5 | 2.40 | 1.34 |
| Lack of available pain centers and specialists | 6 | 2.33 | 1.37 |
| Lack of a comprehensive, interdisciplinary, integrated approach to pain management | 6 | 3.58 | 2.01 |
| No evaluation information on pain treatment centers | 6 | 1.75 | 1.78 |
| Inadequate data on patient outcomes from various pain treatments | 6 | 2.67 | 1.63 |
| Inadequate data on cost-effectiveness of various approaches | 6 | 3.00 | 1.55 |
| Inability to identify patients who will fail pain management treatments | 6 | 2.67 | 1.75 |
| Physicians are unwilling to treat patients because of underpayment for services | 6 | 0.83 | 1.69 |
| Lack of communication with health care professionals | 5 | 2.20 | 2.17 |
| Scale 0 = Not a Barrier, 5 = Extreme Barrier | | | |

agement fees and measure cost-effectiveness of pain management.

Several limitations need to be recognized when interpreting the findings reported in this study. These include the exploratory and qualitative nature of this study and the limited sample size. Results cannot be generalized to other states or types of insurance plans.

In conclusion, the WPI identifies the following opportunities to improve third party reimbursement practices and their influence on pain management in Wisconsin:

- Develop mechanisms to improve education of and communication among managed care executives and health care professionals so that they understand the benefits of providing a range of effective pain management strategies.
- Advocate for insurers to increase coverage of behavioral treatments for chronic pain.
- Collaborate with the Wisconsin Office of the Commissioner of Insurance to develop a coding

mechanism to track and analyze pain management issues and further explore inadequate reimbursement and insurance gaps for pain treatment.

- Promote increased growth of available comprehensive, interdisciplinary pain management programs for treatment of chronic pain in the state.

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