Vermont Chiropractic Physicians

Part of the Solution to Vermont's Opiate Crisis

VMS Education & Research Foundation

helping physicians help patients & communities

SAFE AND EFFECTIVE TREATMENT OF CHRONIC PAIN IN VERMONT

Vermont Medical Society Foundation White Paper

This report is the first in a series of reports from the VMS Foundation providing the views of Vermont physicians and other leaders on topics critical to the future of our state's health care system

Submitted by
Cyrus Jordan, M.D., MPH Director,
VMS Foundation November 2012

Supported by

THE PHYSICIANS FOUNDATION

Follow the Money

Current payment policies discourage: **1) use of evidence-based complementary and alternative medicine treatments;** 2) team approach to caring for chronic pain patients; 3) case management; and 4) spending appropriate time with complex patients. Initial goals for payment redesign are highlighted in **Figure 6.**

Follow the Money Improvement Goals

- Prior authorization policies will be modeled after the Vermont consensus recommendations
- Reimbursement policies for care givers will recognize the complexity of managing patients with chronic pain
- ***Coverage policies will encourage the use of treatment approaches for chronic pain that reduce or eliminate the use of controlled substances***
- Payment policies will encourage the use of multi-disciplinary teams
- Reimbursement policies for care givers will make Vermont an attractive practice setting for practitioners specializing in chronic pain and addiction medicine

Figure 6

“One very big issue is how the insurance companies are actually driving a lot of the dependence on opioids. For example research shows that for chronic non-specific low back pain, chiropractic manipulation, acupuncture, and massage are all helpful. Yet many insurance companies won’t cover these. But they will cover the Percocet, which has not been proven to be helpful in research.” – ***Vermont Primary care physician***

Background

Practices for treating patients with conditions that cause chronic pain vary among the medical professions as much as the professionals themselves. Pain is subjective and treatment of pain can be complex.

With increasing problems stemming from prescription drug misuse and abuse, the Unified Pain Management System Advisory Council was created on June 3, 2012 pursuant to 18 V.S.A § 5(3). The Council's purpose is to advise the Commissioner of Health (the Commissioner) on matters relating to the appropriate use of controlled substances in the treatment of chronic, non- cancer pain and addiction, and in preventing prescription drug abuse.

The Council was appointed by the Commissioner and approved by the Governor. The Council is composed of a variety of prescribers and dispensers who are committed to improving the care and management of patients with chronic, non-cancer pain. With staff support from the Vermont Department of Health, the Council met six times between September 2012 and February 2013. It also and created three subcommittees (System Improvement, Pain Management and Medical Affairs), each of which met several times to work on specific issues.

Recommendations (cont.)

3. Improvements to the VPMS - Recommendations regarding ways to improve the utility of the VPMS and its data; and

4. Evidence-Based Training Modules -Recommendations for the continuing education of all licensed health care providers in the state who treat chronic pain or addiction or prescribe controlled substance in Schedule II, III or IV consistent with a unified pain management system.

Alternative Treatments

The Council supports advocacy for prescribers to use and insurance companies to cover evidence- based alternatives to opioid medications that include (but are not limited to):

- Chiropractic
- Massage Therapy
- Acupuncture
- Biofeedback
- Injections interventional pain
- Naturopathic physicians
- Hypnosis
- Non opioid pain medications
- Neuropathic pain medications/treatments
- Physical Therapy

Three Basic Questions

- Is there any evidence to suggest that increased utilization of chiropractic services will have any effect on the usage of opioids?
- Is there any evidence that lowering co-payment amounts for chiropractic physicians visits will result in increased utilization of chiropractic services?
- Will lowering chiropractic co-payments increase insurance costs?

Annals of Internal Medicine | ORIGINAL RESEARCH

Spinal Manipulation, Medication, or Home Exercise With Advice for Acute and Subacute Neck Pain

A Randomized Trial

Gert Bronfort, DC, PhD; Roni Evans, DC, MS; Alfred V. Anderson, DC, MD; Kenneth H. Svendsen, MS; Yiscah Bracha, MS; and Richard H. Grimm, MD, MPH, PhD

Background: Mechanical neck pain is a common condition that affects an estimated 70% of persons at some point in their lives. Little research exists to guide the choice of therapy for acute and subacute neck pain.

Objective: To determine the relative efficacy of spinal manipulation therapy (SMT), medication, and home exercise with advice (HEA) for acute and subacute neck pain in both the short and long term.

Design: Randomized, controlled trial. (ClinicalTrials.gov registration number: NCT00029770)

Setting: 1 university research center and 1 pain management clinic in Minnesota.

Participants: 272 persons aged 18 to 65 years who had nonspecific neck pain for 2 to 12 weeks.

Intervention: 12 weeks of SMT, medication, or HEA.

Measurements: The primary outcome was participant-rated pain, measured at 2, 4, 8, 12, 26, and 52 weeks after randomization. Secondary measures were self-reported disability, global improvement, medication use, satisfaction, general health status (Short Form-36 Health Survey physical and mental health scales), and adverse events. Blinded evaluation of neck motion was performed at 4 and 12 weeks.

Results: For pain, SMT had a statistically significant advantage over medication after 8, 12, 26, and 52 weeks ($P \leq 0.010$), and HEA was superior to medication at 26 weeks ($P = 0.02$). No important differences in pain were found between SMT and HEA at any time point. Results for most of the secondary outcomes were similar to those of the primary outcome.

Limitations: Participants and providers could not be blinded. No specific criteria for defining clinically important group differences were prespecified or available from the literature.

Conclusion: For participants with acute and subacute neck pain, SMT was more effective than medication in both the short and long term. However, a few instructional sessions of HEA resulted in similar outcomes at most time points.

Primary Funding Source: National Center for Complementary and Alternative Medicine, National Institutes of Health.

Ann Intern Med. 2012;156:1-10. www.annals.org
For author affiliations, see end of text.

Annals of Internal Medicine | ORIGINAL RESEARCH

Spinal Manipulation, Medication, or Home Exercise With Advice for Acute and Subacute Neck Pain

A Randomized Trial

Gert Bronfort, DC, PhD; Roni Evans, DC, MS; Alfred V. Anderson, DC, MD; Kenneth H. Svendsen, MS; Yiscah Bracha, MS; and Richard H. Grimm, MD, MPH, PhD

In this study, 80 of the 90 patients randomly assigned to medication management **were prescribed opioid medications**. For pain, Spinal manipulation and exercise both had a statistically significant advantage over medication.

Intervention: 12 weeks of SMT, medication, or HEA.

Measurements: The primary outcome was participant-rated pain, measured at 2, 4, 8, 12, 26, and 52 weeks after randomization. Secondary measures were self-reported disability, global improvement, medication use, satisfaction, general health status (Short Form-36 Health Survey physical and mental health scales), and

similar outcomes at most time points.

Primary Funding Source: National Center for Complementary and Alternative Medicine, National Institutes of Health.

For author affiliations, see end of text.

High proportions of patients with LBP prescribed opioids

- 42% in a prospective study of patients with work-related LBP received opioids.
- 61% in a large health maintenance organization with LBP received opioids, 19% chronic use

Deyo RA et al. J Am Board Fam Med 2009;22:62-8; Franklin GM et al. Clin J Pain 2009;25:743-751; Deyo RA et al. J Am Board Fam Med 2011; 24:717-724; Luo X et al. Spine 2004;29:884-891; Webster BS et al. Am J Ind Med 52;162-171

Cross-Sectional Analysis of Per Capita Supply of Doctors of Chiropractic and Opioid Use in Younger Medicare Beneficiaries

William B Weeks, MD, PhD, MBA,
Professor, The Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, NH
Christine M Goertz, DC, PhD
Professor, Palmer College of Chiropractic, Palmer Center for Chiropractic Research, Davenport, IA

- "The study population consisted of younger, disabled Americans who were enrolled in Medicare fee-for-service; these patients are highly disabled and are likely to have a high prevalence of opioid use."

Conclusion

- “Per-capita supply of Doctors of Chiropractic and per-capita Medicare spending on Chiropractic Manipulative Therapy were strongly inversely correlated with the percentage of younger Medicare beneficiaries with at least 1, as well as with 6 or more, opioid prescription fills.”

Application of Study Findings

- “Addressing the increase in opioid use and the sequelae of such use should be a public health priority. While further study is warranted, our preliminary findings suggest that America’s opioid epidemic might be reduced should Medicare consider a clinical trial of chiropractic spinal manipulation prior to conventional medical care for patients with neck or back pain.”

Report to the New Hampshire Insurance Department: Copayments for Chiropractic Care and Physical Therapy Services

Prepared for the State of New Hampshire Insurance Department
by Compass Health Analytics, Inc. December 2014

The state of New Hampshire proposed legislation that increases patients' access to chiropractic care and physical therapy services by lowering patient out-of-pocket costs. The purpose of this study is to better understand the impact of this legislation, specifically how the member cost sharing changes are likely to affect both cost and utilization for these services as well as their impact on overall cost.

Consistent with the results found in the landmark RAND Health Insurance Experiment (RAND HIE), Compass found that for both chiropractic and physical therapy services lower copayment levels were associated with higher spending on those services.

For patients who used chiropractic services, increased use of chiropractic services corresponded to a statistically significant increase in overall cost. However, there was also a smaller but statistically significant relationship between increased chiropractic costs and lower non-chiropractic costs.

“Again, consistent with past studies, Compass found that any use of and the amount of use of chiropractic care was associated with lower use of opioids. “

“The results of the study as a whole indicate that copayment level and use of chiropractic and physical therapy services are related, and that, although the results of the study could be limited by selection bias, it is likely that lowering copayment levels will lead to increased use of these services, which will likely lead to higher overall costs that are not completely offset by reductions in costs for other services.”

Co-Payment Levels In This Study

- Average co-payment level of $0 was assigned to ‘a) **Zero Co-pay’**
- Average co-payment of greater than $0 and up to $10 was assigned to ‘b) **Low Co-pay’**
- Average co-payment of greater than $10 and up to $20 was assigned to ‘c) **Medium Co-pay’**
- Average co-payment of greater than $20 was assigned to ‘d) **High Co-pay’**

VHC Standard Plans & Co-Pay (CP) Level

	Chiropractic	PCP
Bronze plan:	Deductible then $85	Deductible then $35
Silver plan:	$50	$25
Gold plan:	$25	$15
Platinum:	$20	$10

All current co-pays in Vermont Health Connect (VHC) plans are considered 'high co-pay levels'.

Will Lowering The Chiropractic Co-Payment Amounts Increase Overall Insurance Costs?

COST OF CARE FOR COMMON BACK PAIN CONDITIONS INITIATED WITH CHIROPRACTIC DOCTOR VS MEDICAL DOCTOR/DOCTOR OF OSTEOPATHY AS FIRST PHYSICIAN:

EXPERIENCE OF ONE TENNESSEE-BASED GENERAL HEALTH INSURER

Richard L. Liliedahl, MD, Michael D. Finch, PhD, David V. Axene, FSA, FCA, MAAA, and Christine M. Goertz, DC, PhD

Objective: The primary aim of this study was to determine if there are differences in the cost of low back pain care when a patient is able to choose a course of treatment with a medical doctor (MD) versus a doctor of chiropractic (DC), given that his/her insurance provides equal access to both provider types.

Methods: A retrospective claims analysis was performed on Blue Cross Blue Shield of Tennessee's intermediate and large group fully insured population between October 1, 2004 and September 30, 2006. **The insured study population had open access to MDs and DCs through self-referral without any limit to the number of visits or differences in copays to these two provider types.** Our analysis was based on episodes of care for low back pain. An episode was defined as all reimbursed care delivered between the first and last encounter with a health care provider for low back pain.

CONCLUSIONS(cont.):

Paid costs for episodes of care initiated with a DC were almost 40% less than episodes initiated with an MD. Even after risk adjusting each patient's costs, we found that episodes of care initiated with a DC are 20% less expensive than episodes initiated with an MD.

Our results suggest that insurance companies that restrict access to chiropractic care for LBP may, inadvertently, be paying more for care than they would if they removed these restrictions

Societal costs of prescription opioid abuse, dependence, and misuse in the United States.

Birnbaum HG[1], White AG, Schiller M, Waldman T, Cleveland JM, Roland CL.

- "Focusing specifically on the health care component, White et al. found that during **1998–2002**, the excess (i.e., relative to matched controls) annual health care costs **per opioid abuse patient** in a privately insured population were $17,768."
- Health care costs are estimated at only 45% of the total US societal costs.

Three Basic Questions

- Is there any evidence to suggest increased utilization of chiropractic services will have any effect on the usage of opioids? **YES**
- Is there any evidence that lowering co-payment amounts for chiropractic physicians visits will result in increased utilization of chiropractic services? **YES**
- Will lowering co-payments increase insurance costs? **Maybe yes, maybe no. Penny wise, pound foolish?**