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Vanila M. Singh, M.D., MACM
Chair, Pain Management Best Practices Inter-Agency Task Force
Chief Medical Officer
Department of Health and Human Services
Office of the Assistant Secretary for Health
200 Independence Ave., S.W., Room 736E
Washington, DC 20201

Dear Dr. Singh and Task Force Members:

On behalf of the National Association of Specialty Health Organizations (NASHO) and the Physical Medicine Management Alliance (PMMA) please accept these comments on the Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations. We agree with the identified gaps and support the recommendations outlined in the report. PMMA also appreciates the opportunity to provide our feedback on the report.

2. Clinical Best Practices

2.1.1 Acute Pain

PMMA's focus is on non-pharmacologic, non-surgical options to pain management for musculoskeletal disorders (MSDs). Our members provide support through evidence and advocacy for non-pharmacologic, non-surgical approaches, when clinically indicated, such as acupuncture, chiropractic care, physical therapy, massage therapy, and exercise therapy. We agree with the report that multi-modal, non-opioid therapies are underutilized; however, we believe this goes beyond the perioperative setting. The focus on the perioperative period puts the entire focus on surgery while we believe an increased use of integrative healthcare (IH) providers who specialize in physical medicine and musculoskeletal care can provide a safer alternative to both opioids and other higher risk medical procedures, such as surgery. The Centers for Disease Control and Prevention, the National Institutes of Health, the Joint Commission, and American College of Physicians all support primary conservative care incorporating exercise and movement, chiropractic care, physical therapy, massage therapy, and acupuncture which have all been proven effective at mitigating pain and treating musculoskeletal conditions without the risks and expense associated with prescription drugs and invasive procedures. The Joint Commission found that acupuncture was recommended as a

first-line treatment in lower back pain by the American College of Physicians.[1] They also found that massage therapy has shown to be effective in adult and pediatric populations with minimal risk of side effects.[2]

2.3 Restorative Therapies

PMMA has a few points of clarification for this section of the report. While this section of the report includes a discussion on therapeutic exercise, it predominantly focuses on passive therapies which do not require energy expenditure on the part of the patient, whereas physical therapists, occupational therapists and chiropractors form a treatment plan around active therapy where the patient needs to complete specific exercises or tasks. Integrative healthcare providers incorporate these modalities. PMMA recommends the inclusion of osteopathic manipulative therapies under this section. Chiropractic and osteopathic manipulation can help restore structural balance, improve joint mobility, and provides functional improvement.

For Recommendation 1b, we would like to point out that physical therapy and occupational therapy are not modalities. They are forms of treatment and the professionals that provide this treatment use the various modalities outlined in the section to that end.

2.6 Complementary and Integrative Health

PMMA generally supports this section of the report but would suggest the inclusion of language around chiropractic care. The section briefly mentions chiropractic manipulation. We ask you to consider including a separate section for chiropractic care. We suggest using the following language:

> Chiropractic doctors, as point of entry providers, focuses on pain management of musculoskeletal disorders, and the effects of these disorders on general health. As a first-line treatment for managing pain, chiropractors can diagnose and triage as indicated for a team-based, patient specific case management. Chiropractic services are used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, pain in the joints of the arms or legs, and headaches.[3] In a comparative-effectiveness trial, 94 percent of manual-thrust manipulation (chiropractic) recipients experienced a 30 percent reduction in their pain, compared with only 54 percent of medical care recipients.[4] Spinal manipulation has shown improvement in pain for patients with chronic lower back pain, shoulder pain, and migraines.[5]

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[1] The Joint Commission; Non-pharmacologic and non-opioid solutions for pain management; Quick Safety; Issue 44; August 2018.
[2] Ibid
[3] American Chiropractic Association; https://www.acatoday.org/Patients/Why-Choose-Chiropractic/What-is-Chiropractic
[4] Schneider M et. al. Comparison of spinal manipulation methods and usual medical care for acute and subacute low back pain. *Spine* 2015; 40(4):209-217.
[5] Ibid

3. Cross-Cutting Clinical and Policy Best Practices

3.2.1 Public Education

PMMA supports public education campaigns to inform the public about the non-pharmalogical, non-surgical approaches to address pain such as acupuncture, chiropractic care, physical therapy, massage therapy, and exercise therapy. We suggest that the report includes language that reflects this and provides an avenue for the public to receive more detailed information.

3.2.2 Patient Education

PMMA supports the early treatment of musculoskeletal conditions by engaging acute care evidence-based treatment sooner in an effort to educate patients and reduce chronic pain progression. We also support the inclusion of language on pain neuroscience education which is used by physical therapists and chiropractic doctors to educate pain patients about the biological and physiological processes involved in their pain experience.[6,7,8] This has been shown to decrease pain ratings, dysfunctions, fear-avoidance, and pain catastrophization. [9,10]

3.2.3 Provider Education

PMMA supports the inclusion of additional language regarding integrative health and the importance of early acute care treatment and patient education to reduce chronic pain progression. We recommend further education of non-pharmacologic, non-surgical approaches to addressing pain. In Recommendation 1B we support the use of language that would direct the use of non-pharmacologic treatment options as first-line therapy to address pain management.

3.3.3 Insurance Coverage for Complex Management Situations

PMMA appreciates the section that outlines the barriers patients face as they try to access non-pharmacologic, non-surgical approaches to pain. We recommend the report could go one step further and include an additional recommendation that aligns with the Centers for Medicare &

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[6]Moseley L. Combined physiotherapy and education is efficacious for chronic low back pain. The Australian journal of physiotherapy. 2002;48(4):297-302.

[7] Moseley GL, Hodges PW, Nicholas MK. A randomized controlled trial of intensive neurophysiology education in chronic low back pain. *Clinical Journal of Pain.* 2004;20:324-330.

[8] Meeus M, Nijs J, Van Oosterwijck J, Van Alsenoy V, Truijen S. Pain Physiology Education Improves Pain Beliefs in Patients With Chronic Fatigue Syndrome Compared With Pacing and Self-Management Education: A Double-Blind Randomized Controlled Trial. *Arch Phys Med Rehabil.* Aug 2010;91(8):1153-1159.

[9] Louw A, Diener I, Butler DS, Puentedura EJ. The effect of neuroscience education on pain, disability, anxiety, and stress in chronic musculoskeletal pain. *Archives of physical medicine and rehabilitation.* Dec 2011;92(12):2041-2056.

[10] Louw A, Zimney K, Puentedura EJ, Diener I. The efficacy of pain neuroscience education on musculoskeletal pain: A systematic review of the literature. *Physiother Theory Pract.* Jun 28 2016:1-24.

Medicaid Services and commercial payers allowing primary-based musculoskeletal providers as the patient point-of-entry for back pain management. This would eliminate or reduce risk of prescription drug abuse/addiction and other comorbidities, increase speed to evaluation, minimize fragmentation, avoid unnecessary surgery, and lower total episode costs. Thousands of Americans suffering from MSDs have been caught up in the nation's opioid epidemic because they were not offered non-pharmacologic treatment options as first-line therapy. PMMA supports changes to Medicare and Medicaid that can help achieve these goals.

As we stated in our comments to the Task Force, traditional Medicare plans limit access to IH providers by only providing coverage for chiropractic physicians. This is further constrained by limiting the diagnoses (spine-related only) and scope of services (manipulation only) included in this benefit, leaving out much of what a chiropractor can typically offer patients within their licensure and typical scope of practice. This is in contrast to medical and osteopathic physicians who provide similar services to a patient population with musculoskeletal conditions that are also commonly seen by chiropractic physicians. Medical and osteopathic physicians are also allowed to opt out of Medicare if they so choose in contrast to chiropractic physicians who may not opt out. PMMA supports giving Medicare beneficiaries greater access to a variety of IH providers and services which would provide greater choice, could result in lower health care costs, and can lessen the number of opioid prescriptions. CMS could use its demonstration authority to experiment with coverage for alternative treatments to address pain for those with musculoskeletal disorders.

We also support expanding the Medicaid benefit to require the inclusion of evidence-based IH services at the state level. Eliminating the barrier to reimbursement for those on Medicaid would help beneficiaries access conservative, evidence-based, non-pharmacologic, non-surgical pain management services.

Finally, to ensure a balanced perspective and since a multi-modal, integrated approach to managing pain is essential, PMMA would like to propose that the Task Force consider adding a representative from the consolidated, multidisciplinary practitioner groups who provide non-drug, non-surgical treatment modalities.

NASHO was founded to advance and evolve specialty health care delivery in the United States. Its mission is to enhance and promote the value proposition of specialty health organizations. PMMA consists of organizations representing care management companies who specialize in physical medicine/musculoskeletal care and wellness. PMMA members partner with provider specialists to facilitate care delivered via specialty services that include, but are not limited to, Physical and Occupational Therapy, Chiropractic Care, Acupuncture, Massage Therapy, and other Complementary and Integrative Healthcare services.

PMMA thanks the Task Force for their work on the Draft Report on Pain Management Best Practices. We appreciate the opportunity to provide feedback on the report. If you have any questions regarding our comments, please contact Julian Roberts at jroberts@nasho.org or 404-634-8911.

Sincerely,

Julian Roberts
Executive Director, NASHO/PMMA
3774 LaVista Rd, Suite 101
Tucker, GA 30084
Phone: 404-634-8911
Email: jroberts@nasho.org