Changes in OHP Coverage for Back Conditions

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- I have nothing to disclose.

WHY?

Size of the problem:

Oregon 2013: 8% of OHP members saw provider for back pain

Over one-half received opioid medications

Evidence:

Lack of good evidence that surgeries and opioids improve lives.

Focus:

Functional improvement

Bio-psycho-social treatment model

New Structure for OHP Back Pain Coverage

1. Increase coverage for conservative treatments
   - Includes coverage for previously non-funded “symptom” codes

2. Cover surgery for urgent indications

3. Limit surgery without urgent indications

4. Limit opioid prescribing for conditions of back and spine

Line 407 – Non-Surgical Treatments

- All diagnoses previously covered
  - Plus Symptom Codes: sciatica, lumbago, cervicalgia…
- Assess for risk
  - Low risk:
    - 4 therapy visits, NSAIDS, acetaminophen and muscle relaxants, limited opioids
  - High risk:
    - 30 therapy visits, NSAIDS, acetaminophen and muscle relaxants, limited opioids
    - Cognitive Behavioral Therapy
    - Massage, Yoga, Interdisciplinary Programs, Supervised Exercise “if available”

START Back Screening Tool

- Nine items:
  - Items 1-4: **Physical limitations** related to symptoms
  - Items 5-8: **Emotional effects** of pain
  - Item 9: How “bothersome” is pain? (point for very much or extremely)
- Scoring
  - Scoring:
  - Low risk –3 or less
  - Medium risk - 4 or more, including **0-3 of the emotional measures**
  - High risk – 4 or more, including **all 4 emotional measures**

Keele University 2007 (Arthritis Research UK)

Covered Therapies

- Physical Therapy
- Occupational Therapy
- Osteopathic Manipulation
- Chiropractic
- Acupuncture
- Possible: Yoga, Massage, Interdisciplinary Programs, Supervised Exercise

Surgical Line 351 – Urgent Surgical Indication

GOOD EVIDENCE THAT SURGERY IS EFFECTIVE TREATMENT

- Cauda Equina
- Myelopathies
- Spondylolisthesis
  - Only with spinal stenosis resulting neurogenic claudication
- Spinal Stenosis
  - MRI evidence of moderate to severe central or foraminal stenosis AND
  - History of neurogenic claudication OR exam evidence of radiculopathy
  - Only decompression surgery

Surgical Line 532 – Without Urgent Surgical Indication

- NON-FUNDED LINE
- Indications on current surgery line, minus Urgent Indications
- Includes radiculopathy and spondylosis diagnoses, but …
  - Without good evidence of effectiveness of surgical treatment
  - Evidence that surgery is equally effective to non-surgical treatment
  - Evidence that surgery is equally effective, but with greater cost and/or risk

Epidural Steroids for Low Back Pain

- **NON-COVERED**

- Current guidelines:
  - Lumbar only – epidural and foraminal only
  - Only for radiculopathy related to herniated disc

    (Excludes facet joint, medial branch block, sacroiliac, intradiscal and specific ablation techniques.)

Guideline Note 60
Opioid Prescribing for Conditions of the Back

Acute Injury, acute flare of chronic pain, after surgery

- First six weeks:
  - Each Rx limited to 7 days of treatment
  - Short-acting opioids only
  - After trial/failure or contraindication to NSAIDS, acetaminophen, muscle relaxants
  - Plan for physical activity
  - No current or prior opioid misuse or abuse

Guideline Note 60
Opioid Prescribing for Conditions of the Back

Acute injury, acute flare of chronic pain, after surgery

- **Six weeks to 90 days:**
  - Documented **improvement of 30%**
  - Prescribed **in conjunction with therapies**
  - Verification that patient is not high risk for opioid misuse or abuse
    - PDMP, screening instrument, UDS
  - Each prescription limited to 7 days and for short acting opioids only
- **After 90 days:**
  - Only with significant change in status
  - Maximum additional 7 days (28 days in exceptional cases)

Guideline Note 60
Opioid Prescribing for Conditions of the Back

Patients with chronic pain currently treated with long-term opioids.

- Opioids must be tapered off over one year.
  - Recommend 10% per week
- Substance abuse treatment if needed.

Alternatives to Opioids – Trillium

- Currently, PT referral is not restricted to funded diagnosis and does not require PA
- Additional coverage for chiropractic, osteopathic, acupuncture
- Behavioral therapy benefits: depression, CBT, Substance Abuse
- Living Well with Chronic Back Pain program
- Barriers to new opioid, long term opioids through pharmacy benefit
- Ongoing coverage for buprenorphine
- Naloxone for intranasal atomization is covered.
- Support to community for additional interventions.

Buprenorphine/Naloxone

- For Diagnosis of Opioid Dependence
  - Requires DEA number or “X”
  - Can be approved for up to 90 tablets per month for one year
  - Renewal requires documentation of UDS

- For Diagnosis of Pain
  - Requires a covered condition
  - Requires trial/failure of MS Contin
  - Can be approved for up to 90 tablets per month for up to 2 years

- Prescriber can call to request override for 30 day supply for induction.

Diagnostic Guideline Note D4
Advanced Imaging for Low Back Pain

RED FLAGS:

- Cancer
- Spinal column infection
- Cauda equina syndrome
- Myelopathy

Spinal stenosis symptoms, more than 1 month

Diagnostic Guideline Note D4
Advanced Imaging for Low Back Pain

Nerve Compression/Herniated Disc with Radiculopathy:

- Markedly abnormal reflexes
- Segmental muscle weakness
- Segmental sensory loss
- EMG or NCV evidence of nerve root impingement

Present for greater than one month, candidate for surgery (or ESI)

Consider therapies first