^{115TH CONGRESS} ^{2D SESSION} **S. 3008**

AUTHENTICATED U.S. GOVERNMENT INFORMATION

> To direct the Secretary of Health and Human Services to conduct a study and submit to Congress a report containing recommendation on how to improve the use of non-opioid treatments for acute and chronic pain management for individuals entitled to benefits under part A or enrolled under part B of the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 6, 2018

Mr. YOUNG (for himself and Mr. DONNELLY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

- To direct the Secretary of Health and Human Services to conduct a study and submit to Congress a report containing recommendation on how to improve the use of non-opioid treatments for acute and chronic pain management for individuals entitled to benefits under part A or enrolled under part B of the Medicare program, and for other purposes.
 - 1 Be it enacted by the Senate and House of Representa-
 - 2 tives of the United States of America in Congress assembled,

3 SECTION 1. SHORT TITLE.

- 4 This Act may be cited as the "Dr. Todd Graham Pain
- 5 Management Improvement Act of 2018".

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1 SEC. 2. PAIN MANAGEMENT STUDY.

2 (a) IN GENERAL.—Not later than 1 year after the 3 date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the "Sec-4 5 retary") shall conduct a study and submit to the Committee on Ways and Means and the Committee on Energy 6 7 and Commerce of the House of Representatives and the 8 Committee on Finance of the Senate a report containing 9 recommendations on whether and how reimbursement to providers and suppliers of services, coverage, and coding 10 policies related to the use of multi-disciplinary, evidence-11 based, non-opioid treatments for acute and chronic pain 12 13 management for individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social 14 Security Act should be revised. The Secretary shall make 15 16 such report available on the public website of the Centers for Medicare & Medicaid Services. 17

(b) CONSULTATION.—In developing the report described in subsection (a), the Secretary shall consult
with—

21 (1) relevant agencies within the Department of22 Health and Human Services;

(2) licensed and practicing osteopathic and
allopathic physicians, physician assistants, nurse
practitioners, dentists, and pharmacists;

1	(3) hospitals and other medical facilities, in-
2	cluding acute care hospitals, cancer hospitals, psy-
3	chiatric hospitals, hospital emergency departments,
4	facilities furnishing urgent care services, ambulatory
5	surgical centers, and post-acute care and long-term
6	care facilities (such as skilled nursing facilities, inpa-
7	tient rehabilitation facilities, long-term care hos-
8	pitals, and home health agencies);
9	(4) substance abuse and mental health profes-
10	sional organizations;
11	(5) pain management professional organizations
12	and advocacy entities, including individuals who per-
13	sonally suffer chronic pain;
14	(6) medical professional organizations and med-
15	ical specialty organizations;
16	(7) licensed health care providers who furnish
17	alternative pain management services;
18	(8) organizations with expertise in the develop-
19	ment of innovative medical technologies for pain
20	management;
21	(9) beneficiary advocacy organizations; and
22	(10) other organizations with expertise in the
23	assessment, diagnosis, treatment, and management
24	of pain, as determined appropriate by the Secretary.

1	(c) CONTENTS.—The report described in subsection
2	(a) shall include the following:
3	(1) The recommendations described in sub-
4	section (d).
5	(2) The impact analysis described in subsection
6	(e).
7	(3) An assessment of pain management guid-
8	ance published by the Federal Government that may
9	be relevant to coverage determinations or other cov-
10	erage requirements under title XVIII of the Social
11	Security Act.
12	(4) Recommendations for updating, including
13	expanding, the "CDC Guideline for Prescribing
14	Opioids for Chronic Pain—United States, 2016"
15	published in March 2016 by the Centers for Disease
16	Control and Prevention, including for purposes of
17	management of pain. Such recommendations shall—
18	(A) consider incorporating relevant ele-
19	ments of the "Va/DoD Clinical Practice Guide-
20	line for Opioid Therapy for Chronic Pain" pub-
21	lished in February 2017 by the Department of
22	Veterans Affairs and Department of Defense,
23	including adoption of elements of the Depart-
24	ment of Defense and Veterans Administration
25	pain rating scale; and

1	(B) include recommendations on how the
2	"CDC Guideline for Prescribing Opioids for
3	Chronic Pain—United States, 2016", as so up-
4	dated, could be adopted by health care pro-
5	viders across clinical settings.
6	(5) An evaluation of the following:
7	(A) Barriers inhibiting individuals entitled
8	to benefits under part A or enrolled under part
9	B of such title from accessing treatments and
10	technologies described in subparagraphs (A)
11	through (C) of paragraph (6).
12	(B) Potential legislative and administrative
13	changes under such title to improve individuals'
14	access to items and services currently covered
15	under such title and used for the treatment of
16	pain, such as cognitive behavioral interventions,
17	physical therapy, occupational therapy, physical
18	medicine, biofeedback therapy, and chiropractic
19	therapy, and other pain treatments services fur-
20	nished in a hospital or post-acute care setting.
21	(C) Costs and benefits associated with po-
22	tential expansion of coverage under such title to
23	include items and services not covered under
24	such title that may be used for the treatment
25	of pain, such as acupuncture, therapeutic mas-

1	sage, and items and services furnished by inte-
2	grated pain management programs.
3	(6) An analysis on reimbursement, coverage,
4	and coding policies (including DRG classification,
5	CPT, HCPCS, NDC, and other applicable codes)
6	under title XVIII of the Social Security Act with re-
7	spect to the following:
8	(A) Non-opioid based treatments and tech-
9	nologies for chronic or acute pain, including
10	such treatments that are covered, not covered,
11	or have limited coverage under such title.
12	(B) Non-opioid based treatments and tech-
13	nologies that monitor substance use withdrawal
14	and prevent overdoses of opioids.
15	(C) Non-opioid based treatments and tech-
16	nologies that treat substance use disorders.
17	(D) Items and services furnished by practi-
18	tioners through a multi-disciplinary treatment
19	model for pain management.
20	(E) Medical devices, non-opioid based
21	drugs, and other therapies (including inter-
22	ventional and integrative pain therapies) ap-
23	proved or cleared by the Food and Drug Ad-
24	ministration for the treatment of pain.

1 (F) Items and services furnished to bene-2 ficiaries with psychiatric disorders, substance 3 use disorders, or who are at risk of suicide, or 4 have comorbidities and require consultation or 5 management of pain with one or more special-6 ists in pain management, mental health, or ad-7 diction treatment.

8 (d) RECOMMENDATIONS.—The recommendations de-9 scribed in this subsection are, with respect to individuals 10 entitled to benefits under part A or enrolled under part 11 B of title XVIII of the Social Security Act, legislative and 12 administrative recommendations on the following:

(1) Options for additional coverage of pain
management therapies without the use of opioids, including interventional pain therapies, and options to
augment opioid therapy with other clinical and complementary, integrative health services to minimize
the risk of substance use disorder, including in a
hospital setting.

20 (2) Options for coverage and reimbursement
21 modifications of medical devices and non-opioid
22 based pharmacological and non-pharmacological
23 therapies (including interventional and integrative
24 pain therapies) approved or cleared by the Food and

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1	Drug Administration for the treatment of pain as an
2	alternative or augment to opioid therapy.
3	(3) Treatment strategies for beneficiaries with
4	psychiatric disorders, substance use disorders, or
5	who are at risk of suicide, and treatment strategies
6	to address health disparities related to opioid use
7	and opioid abuse treatment.
8	(4) Treatment strategies for beneficiaries with
9	comorbidities who require a consultation or co-
10	management of pain with one or more specialists in
11	pain management, mental health, or addiction treat-
12	ment, including in a hospital setting.
13	(5) Coadministration of opioids and other
14	drugs, particularly benzodiazepines.
15	(6) Appropriate case management for bene-
16	ficiaries who transition between inpatient and out-
17	patient hospital settings, or between opioid therapy
18	to non-opioid therapy, which may include the use of
19	care transition plans.
20	(7) Outreach activities designed to educate pro-
21	viders of services and suppliers under the Medicare
22	program and individuals entitled to benefits under
23	part A or under part B of such title on alternative,
24	non-opioid therapies to manage and treat acute and
25	chronic pain.

(8) Creation of a beneficiary education tool on
 alternatives to opioids for chronic pain management.
 (e) IMPACT ANALYSIS.—The impact analysis de scribed in this subsection consists of an analysis of any
 potential effects implementing the recommendations de scribed in subsection (d) would have—
 (1) on expenditures under the Medicare pro-

7 (1) on expenditures under the Medicare pro-8 gram; and

9 (2) on preventing or reducing opioid addiction
10 for individuals receiving benefits under the Medicare
11 program.

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