March 14, 2019

Dear Dr. Singh:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants (PTAs), and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments in response to the Pain Management Best Practices Inter-Agency Task Force’s Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations.

2. Clinical Best Practices
2.1.1. Acute Pain: The report fails to fully address providers’ lack of understanding and education regarding the clinical indications and effective use of nonopioid medications and physical therapist management as part of acute and chronic pain management. A physical therapist initiates the management process by gathering information prior to or at the first meeting with the individual, and may use a combination of interventions to modulate the patient’s pain and maintain and restore motion and function. Early access to physical therapy holds the promise of reducing opioid use among patients with musculoskeletal pain. Researchers recently examined claims data to assess whether early physical therapy was associated with decreases in long-term opioid use. The results suggest that early physical therapy is associated with an approximate 10% reduction in the probability of any opioid use long term for patients with shoulder, neck, knee, and/or low back pain. For patients with low back, shoulder, and knee pain who did use opioids, early physical therapy was associated with a 5%-10% reduction in oral morphine milligram equivalent (MME). APTA recommends that the task force acknowledge in the final report that physical therapy is often initiated too late in the treatment of acute musculoskeletal pain. To facilitate early physical therapist management, we encourage the task force to advocate for reforms in nonpharmacological pain interventions for acute and chronic pain, including reduced copays, elimination of referral requirements, and expanded coverage.

2.2.1. Prescription Drug Monitoring Programs
Recommendation 1g: APTA strongly recommends that the task force incorporate within the recommendations the need to address interoperability for nonphysician providers, including physical therapists.

2.3 Restorative Therapies
Recommendation 1a: APTA recommends that the task force either define “pain syndrome” or not use the term at all. For example, neuropathic pain involves a sensitive peripheral nervous system distal to the dorsal horn. Nociplastic pain (formally referred to as central sensitization) is proximal to the dorsal horn. Both can be considered chronic or persistent pain, yet nociplastic pain tends to be more complex and should be treated more comprehensively using a multidisciplinary approach.

Recommendation 1b: Physical therapy is not a modality; it is a profession. The scope of practice for physical therapists is based on the profession's unique body of knowledge, supported by educational preparation, a body of evidence, and existing or emerging practice frameworks. To have physical therapy listed next to actual modalities is misleading and only leads to further misunderstandings about the value of physical therapy in the prevention and treatment of pain. We encourage the task force to be mindful not to categorize physical therapy as an “intervention.” Instead, diagnosis and treatment of pain conditions by physical therapists are interventions.

Recommendation 1c: APTA recommends that this recommendation be modified to read: “Make harm-free, self-management programs to support pain-management treatment plans.”

2.4 Interventional Procedures
Recommendation 1c: APTA recommends that the report include language specifying that these types of interventions should be utilized only if a patient has undergone a comprehensive course of nonpharmacological and noninvasive care or presents with a condition for which this care is clearly the appropriate first line of treatment. Numerous types of health care providers deliver interventional techniques to treat and manage patients with pain, including physical therapists. Additionally, we suggest modifying this recommendation by replacing the term “physician” with “licensed health care professional.” We also recommend that physical therapists be consulted prior to surgical interventions and that physical therapy be recommended prior and subsequent to nerve blocks, denervation, and surgeries for which mobility is expected to be limited and/or there is a significant need for rehabilitation.

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2.4.1 Perioperative Management of Chronic Pain Patients

**Recommendation 1a:** Preoperative Pain Neuroscience Education in an easy-to-understand context has been researched and proven to increase function and decrease health costs when implemented by a physical therapist prior to surgery and should strongly be considered in the management of perioperative chronic pain patients.\(^3\)

2.7 Special Populations

2.7.1 Unique Issues Related to Pediatric Pain Management

**Recommendation 2a:** APTA encourages the task force to clarify that these models are comprehensive, integrative pain management models that include biomedical, psychosocial, complementary health, spiritual care, and caregiver care/education; are person-centered; and focus on maximizing function and wellness.\(^4\)

2.7.2 Older Adults

**Recommendation 1c:** APTA strongly encourages the task force to modify this recommendation to ensure that pain management education is interprofessional. For example, in the Medicare population, Opioid Overuse Disorder (OUD) has the highest and fastest growing rate: 6 per 1,000 Medicare patients are at risk for OUD. Thus, we recommend that all providers who are involved in treating patients with acute or chronic pain receive education on the risks of opioid addiction, tolerance, adaption, and withdrawal and have strong working relationships and open communication with the prescribing physician.\(^5\)

2.7.3 Unique Issues Related to Pain Management in Women

**Recommendation 1b:** APTA recommends greater awareness among the public and in health care arenas regarding mobility issues and demands.

**Recommendation 2a:** APTA supports this recommendation but encourages the task force to clarify the definition of “multidisciplinary care teams” to ensure it comprises nonphysicians as well as physicians; moreover, it should be clear that patients’ needs will be addressed holistically through the use of multidisciplinary care teams.

2.7.5 Chronic Relapsing Pain Conditions

**Recommendation 1a:** APTA encourages the task force to modify this recommendation by specifically referencing physical therapy and cognitive and behavioral health services. APTA also recommends that the task force reference physical therapists within Gap 1 and Recommendation 1a.

2.7.6 Sickle Cell Disease

**Recommendation 1b:** APTA encourages the task force to modify this recommendation by specifically referencing physical therapy and cognitive and behavioral health services as nonpharmacological approaches.

2.7.7 Health Disparities in Racial and Ethnic Populations

**Recommendation 1a:** APTA has concerns that this section is extremely broad and includes inadequate recommendations. Programs that address access, insurance, discrimination, and all other barriers should be referenced, as well as research and education in these areas.

2.7.8 Military Personnel and Veterans

**Recommendation 2a:** APTA agrees with the importance of the integration of health systems and recommends that this sentiment be applied more broadly throughout the report.

3. Cross Cutting Clinical and Policy Best Practices

3.2.1 Public Education

**Recommendation 1a and Recommendation 1b:** APTA recommends that the public be better educated on risk and protective factors for chronic pain. Additionally, there is extensive research being conducted by physical therapists that examines the

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education of middle school-aged children (fifth-seventh graders) about the neuroscience of pain so they have a better understanding of what the pain experience really means. This is a proactive attempt at educating students (similar to the DARE program) to validate whether children understand pain at an earlier age and if that earlier education would reduce the risk of them developing chronic pain in the future. To date, the data illustrate that after 30-minute education sessions middle school-aged children demonstrate better understanding of the science of pain and ways of coping. The researchers plan to extend this endeavor into longitudinal studies and will follow these students into adulthood.  

3.2.2 Patient Education

**Recommendation 1b:** APTA recommends that the final report include a recommendation to educate the public to seek physical therapy and other nonpharmacological treatments early for the treatment of acute pain. Further, we note that in addition to rural areas, uninsured and underinsured individuals with low socioeconomic status have limited access to multimodal treatment. Additionally, we recommend the task force promote education that highlights supervised fitness via groups, online and other technology and physical therapist-supervised wellness centers, and/or medically oriented gyms, etc., as consumers must know where and how they safely can exercise and be active. 

**Recommendation 2c:** APTA supports this recommendation but encourages the task force to modify the terminology to ensure that it is applicable to all health care providers, as opposed to solely “physicians.”

**Recommendation 3b:** APTA strongly encourages the task force to change this recommendation to read “clinicians from multiple professions,” ensuring sufficient clarification that the term “clinician” includes physical therapists, psychologists, and other health care providers.

3.2.3 Provider Education

**Recommendation 1b:** APTA suggests expanding the recommendation to include health care professionals in addition to primary care physicians, such as mental health providers, physical therapists, occupational therapists, orthopedic surgeons, etc. We also recommend that the task force modify this recommendation to state: “…and early referral to physical therapy and to pain specialists.”

**Recommendation 1c:** APTA recommends that the task force include a recommendation to educate medical students, residents, and primary care physicians to refer patients with acute pain to a physical therapist or other provider who may deliver nonpharmacological treatments.

**Recommendation 2a:** APTA recommends greater recognition of chronic pain as a category of disease when the pain persists for more than the expected recovery time (3-6 months) despite appropriate treatment of the original injury or disease. Rather than focus on the expected recovery time, this recommendation should state: “…and when risk factors outweigh protective factors within the expected recovery time.”

**Recommendation 2b:** APTA recommends that the task force add interprofessional educational programming to this list.

3.3 Access to Pain Care

3.3.2 Insurance Coverage for Complex Management Situations

**Recommendation 1b:** APTA recommends that CMS and private payers more strongly promote payment models that emphasize group and interprofessional team-based care. There also is a significant need for payers to reimburse for patient education and care coordination.

**Recommendation 3a:** APTA recommends that the task force emphasize movement and mental health strategies in this section.

**Conclusion**

APTA thanks the task force for the opportunity to comment on the Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations. If you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

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