IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Referrals to Pain Management Specialists	**Guideline #**	UM_PAI 03
		Original Effective Date	11/12/2014
Section	Pain Management	**Revision Date**	08/30/22

COVERAGE POLICY

Pain management consultation referrals may be directed to a multidisciplinary team center especially when the center(s) offer other interdisciplinary and ancillary services that may further facilitate the management of a patient's care.

Referrals to Pain Management Specialists are medically necessary and appropriate under the following three criteria (1, 2 or 3):

1. Immediate referral to a Pain Management Specialist or other appropriate specialist may be considered under the following circumstances:
    A. Evidence of polytrauma
    B. Evidence of substance abuse, non-compliance and/or secondary gain (for example, opioid dose escalation, use of illicit substances, violations of pain contact, diversion of narcotic medications), with the substance use disorders already being managed by addiction specialists.
    C. Evidence of significant psychiatric co-morbidities that are being exacerbated by chronic pain (for example, major depression, bipolar disorder), with these co-morbidities already being managed by a Psychiatrist/Psychologist.
    D. Pain due to malignancy
    E. The presence of red flags including but not limited to: progressive motor weakness, sensory deficits, gait disturbances, bowel/bladder dysfunction, or unexplained weight loss.

2. The Member has chronic non-malignant (non cancer-related) pain lasting at least 3-6 months that meets the following criteria (A, B, C & D):
    A. The Member's pain is unresponsive to conservative care. Evidence of a failed trial of conservative care should include:
        i. Failure of at least 2-3 different classes of medications appropriate to the type of pain (i.e., nociceptive/somatic pain vs. neuropathic pain vs. psychogenic pain) including: NSAIDs
            a. Acetaminophen
            b. Opioids
            c. Muscle relaxants
            d. Anti-depressants (SSRI's, tri-cyclics etc.) Anti-epileptic drugs (gabapentin, pregabalin etc…)

    AND

        ii. Failure of ice, rest, bracing/taping, immobilization and at least one physical treatment modality including any of the following:

a. Physical and/or occupational therapy
b. Chiropractic Care (for eligible Medicare and Medi-Cal members)
c. Acupuncture (for eligible Medi-Cal members)

Note: Any contraindications to the above listed treatment modalities must be specifically documented in the patient's medical records.

B. An appropriate diagnostic work-up of the Member's pain has been performed. At a minimum, an appropriate diagnostic work-up should include documentation of the following:
   i. A complete and accurate history and physical exam have been performed.
   ii. Appropriate diagnostic testing has been done including, but not limited to, the following:
      a. For nociceptive pain: x-ray, ultrasound, or other initial imaging test to rule out the presence of structural lesions and/or significant anatomical pathology.
      b. For neuropathic pain with a radicular component: electrodiagnostic studies (EMG/NCS) and/or an MRI to differentiate between a peripheral entrapment neuropathy versus neural impingement at the spinal cord.

C. Treatable underlying causes of pain have been addressed by the PCP and the appropriate specialists. For example:
   i. Pain due to an autoimmune condition (for example, RA or SLE) or fibromyalgia should be assessed and treated by a rheumatologist.
   ii. Pain due to a neurological condition (Multiple Sclerosis, migraines, trigeminal neuralgia, spinal or brain lesion) should be addressed and treated by a neurologist and/or neurosurgeon.
   iii. Pain due to malignancy (tumors, sequelae of radiation/chemotherapy treatment) should be assessed and treated by a hematologist, oncologist, radiation oncologist or similar specialist.
   iv. Pain that is caused by and/or complicated by psychosocial conditions (anxiety, depression, secondary gain) or associated with substance abuse-should be assessed and treated by the appropriate mental health provider(s) including psychiatrists, psychologists, therapists and addiction medicine specialists.

D. There is documentation that the pain is causing the Member significant functional impairment (inability to perform usual activities of daily living) and/or is contributing to deterioration in their overall health.

OR

3. Once 3-6 months of conservative modalities have failed and an appropriate work-up has been completed, the patient's condition is determined to require interventional procedures not typically performed by PCP's or other specialists. Examples include:
   A. Radiofrequency Neurotomy (radiofrequency ablations)
   B. Epidural Steroid Injections
   C. Facet Blocks/Medial Branch Blocks
   D. Sacroiliac Injections
   E. Trigger Point Injections
   F. Sympathetic Ganglion Blocks

G. Peripheral Nerve Blocks
H. Spinal Cord Stimulator Placement
I. Intrathecal Pain Pump Placement

COVERAGE LIMITATIONS AND EXCLUSIONS

In using these criteria to make final determinations regarding the medical necessity of referrals to pain management specialists, IEHP reserves the right to take into consideration the specific circumstances of each Member's unique clinical condition.

ADDITIONAL INFORMATION

N/A

CLINICAL/REGULATORY RESOURCE

Medicare National Coverage Determination for Outpatient Hospital Pain Rehabilitation Programs

Coverage of services furnished under outpatient hospital pain rehabilitation programs, including services furnished in group settings under individualized plans of treatment, is available if the patient's pain is attributable to a physical cause, the usual methods of treatment have not been successful in alleviating it, and a significant loss of ability by the patient to function independently has resulted from the pain. If a patient meets these conditions and the program provides services of the types discussed in §10.3, the services provided under the program may be covered. Non-covered services (e.g., vocational counseling, meals for outpatients, or acupuncture) continue to be excluded from coverage, and A/B Medicare Administrative Contractors would not be precluded from finding, in the case of particular patients, that the pain rehabilitation program is not reasonable and necessary under §1862(a)(1) of the Social Security Act for the treatment of their conditions.

MCG Health Care Management Tools

Pain is a primary reason people seek healthcare and is associated with increased length of hospital stay, longer recovery time, and poorer patient outcomes. Pain is a multidimensional experience, with a variety of physiologic and psychosocial elements that can affect all aspects of an individual's life. The discomfort and distress associated with pain can last beyond the tissue-damaging experience.

Multidisciplinary multimodal approach for effective management, including:

1. Goal is to enhance ability to self-manage and modulate pain and to improve function with the pain that may persist.
2. Comprehensive pain history assessment (similar to history for acute pain)
3. Physical examination: directed to neurologic, musculoskeletal, and other systems as appropriate
4. Psychosocial factors evaluated for presence of anxiety, depression, psychiatric disorders, coping mechanisms, family support or issues, and vocational and legal issues
5. Treatment plan that may include medication, PT or rehabilitation, stress management or counseling, group support, and vocational counseling

Pain management interventions may include:

1. Nonpharmacologic therapeutic interventions (eg, massage, positioning, relaxation) and may also include
    A. Cognitive behavioral therapy
    B. Pain-management programs
    C. Support group participation:
2. Pharmacologic methods of pain management
    A. NSAIDs
    B. Opioids
    C. Antidepressants
    D. Anticonvulsants
    E. Topical agents (eg, diclofenac, lidocaine, capsaicin)
3. Invasive pain-management techniques
    A. Trigger point injections
    B. Peripheral nerve blocks
    C. Facet joint injections
    D. Sympathetic blocks
    E. Advanced neuromodulation
    F. Spinal cord stimulation
    G. Intrathecal drug administration

Apollo Medical Review Criteria Guidelines

Chronic pain symptoms are the most common cause of long-term disability in middle aged people. When chronic pain does not fully respond to treatment, patients may be referred to a comprehensive treatment program such as a Multidisciplinary Pain Program (MPP).

Department of Veterans Affairs/Department of Defense (VA/DOD)

Interdisciplinary care that addresses pain, substance use disorders and/or mental health problems for patients presenting with high risk and/or aberrant behavior is indicated.

American Academy of Pain Medicine (AAPM)

For the Primary Care Provider: When to Refer to a Pain Specialist- A recommendation statement intended to further enable primary care providers to improve the effectiveness and safety of the care they offer to their patients living with chronic pain.

DEFINITION OF TERMS

N/A

REFERENCES

1. Apollo Medical Review Criteria Guidelines, 17th edition, 2022. POS19-003 Pain Evaluation and Management.
2. Apollo Medical Review Criteria Guidelines, 17th edition, 2022. AN 105 Pain Management Resources- Overview.
3. Department of Veterans Affairs, Department of Defense (VA/DOD) 2017. VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, Version 3.0.

4. MCG Health Care Management Tools, 25th edition, 2021. CMT-0001 Pain Management.
5. Medicare National Coverage Determination (NCD) 10.4 Outpatient Hospital Pain Rehabilitation Programs.
6. https://painmed.org/for-the-primary-care-provider-when-to-refer-to-a-pain-specialist/. Accessed August 15, 2022.
7. UpToDate, Hauer MD, Julie and Jones PhD, MSW, Barbara L., Evaluation and Management of Pain in Children. Review current thru July 2022; last updated December 16, 2021.

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