INLAND EMPIRE HEALTH PLAN

# IEHP UM Subcommittee Approved Authorization Guidelines
## *Referrals to Pain Management Specialists*

**IEHP Policy:**
Based on a review of the currently available literature and community standards of practice, the IEHP UM Subcommittee will consider referrals to Pain Management Specialists medically necessary and appropriate under the following three criteria (1, 2, or 3).

****Note: 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.**

**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.**

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)
    c. Evidence of significant psychiatric co-morbidities that are being exacerbated by chronic pain (for example, major depression, bipolar disorder )
    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
   (1) Acetaminophen
   (2) Opioids
   (3) Muscle relaxants
   (4) Anti-depressants (SSRI's, tri-cyclics etc…)Anti-epileptic drugs (gabapentin, pregabalin etc…)

AND

ii. Failure of at least one physical treatment modality including any of the following:
   (1) Ice, rest and activity modification
   (2) Bracing, taping or other immobilization
   (3) Physical and/or occupational therapy
   (4) Chiropractic Care (for eligible Medicare and Medi-Cal members)
   (5) 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:
      (1) For nociceptive pain: x-ray, ultrasound, or other initial imaging test to rule out the presence of structural lesions and/or significant anatomical pathology.
      (2) 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

**Apollo Guidelines 2013 [1]:**

According to these guidelines, pain management services (including medications, interventional techniques, behavioral methods, and physical treatments) may be covered when there is "persistent pain > 3 months that is unresponsive to active management by the primary care physician or in-plan specialists evidenced by adjustment/escalation in medication management and failure of other appropriate conservative modalities".

**National Institute for Health and Care Excellence (NICE) [2]:**

Consider referring the person to a specialist pain service and/or a condition-specific service at any stage, including at initial presentation and at the regular clinical reviews if:

- They have severe pain
- Their pain significantly limits their lifestyle, daily activities (including sleep disturbance) and participation OR
- Their underlying health condition has deteriorated

**Department of Veterans Affairs/Department of Defense (VA/DOD) [3]:**

Consider referral to a Pain Management Specialist in the following situations:

- Patient with complex pain conditions or polytrauma
- Patient with significant medical comorbidities that may negatively impact opioid therapy
- Patient who is unable to tolerate increased pain or physical withdrawal symptoms arising from opioid tapering when opioid therapy is being discontinued

- Opioid induced hyperalgesia or opioid tolerance is suspected
- High dose of medication (>200mg/day morphine equivalent) provides no further improvement in function
- Patient requiring management beyond the expertise of the primary provider

**National Guideline Clearinghouse: University of Michigan Health System [4]:**

Referral to pain management specialist should be considered for:

- Failure to achieve treatment goals
- Intolerance of therapies
- Need for interventional management
- Need for multidisciplinary treatment
- Need for excessive opioid doses
- Suspicion of addiction or opioid misuse

**Partnership Health Plan of California [5]:**

- Prior to Pain Management Specialist referral, the Primary Care Physician should:
    - Perform a thorough history and physical to determine the nature of the pain.
    - Assess for possible depression, anxiety, substance abuse and secondary gain.
    - Treatable underlying causes of pain have been addressed by the PCP and other specialists
- Referral to a Pain Management Specialist should be considered for the following:
    - Complex pain syndrome where the diagnosis is unclear or the condition is unresponsive to usual conservative therapy for at least 3-6 months.
    - Complex pain syndromes compromised by severe functional impairment.
    - Complex pain syndromes complicated by mental health conditions or substance abuse unresponsive to usual therapy and referral to an appropriate behavioral health specialist.
    - For performance of procedures done by Pain Management Specialists (RFA, ESI, etc…).

**Health Plan of Nevada[6]:**

In general, a Pain Management referral should be made when:

- Pain has lasted > 6 months despite conservative therapy, or
- Pain is from an acute event that may benefit from early intervention (i.e. acute disc herniation)
- Provider feels there is a specific intervention that Pain Management can offer (i.e. procedure)
- Surgery is contemplated or eliminated as option by appropriate specialist
- Recommendations sought for medication management

**State of Colorado Department of Labor and Employment [7]:**

"Consultation or referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated."

**Research Review and Summary [8]:**

According to the ECRI Institute's September 2014 Health Technology Assessment Information Service Hotline Response: Criteria for Referring Patients to Pain Management Specialists and Programs, which was based on an extensive search of numerous sources (including PubMed, the Cochrane Library, and selected web-based documents) and included a review of abstracts published between January 1, 2009 and September 10, 2014; a total of 6 studies and 13 clinical practice guidelines were found. Among these documents, those which specifically addressed the criteria for referral of patients to pain management specialists by primary care physicians were included in the current IEHP UM Subcommittee Guideline.

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| **Revised:** |
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**Bibliography:**

1. Apollo Guidelines 2013: Medical Review Criteria Guidelines for Managed Care: Pain Management, p. 56.
2. National Institute of Health and Care Excellence (NICE). The pharmacological management of neuropathic pain in adults in non-specialist settings. NICE clinical guideline 173. Issued: November 2013.
3. Department of Veterans Affairs, Department of Defense (VA/DOD). VA/DOD clinical practice guideline for management of opioid therapy for chronic pain. 2010 May.
4. National Guideline Clearinghouse: Managing chronic non-terminal pain in adults including prescribing controlled substances. University of Michigan Health System. Ann Arbor (MI). 2011 Jan. 36 p.
5. Partnership HealthPlan of California: Policy Title: Clinical Practice Guideline: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing. Revision Date: 1/15/14. Policy Number: MPXG5008.
6. Health Plan of Nevada. 2012 HPN Southern Nevada Provider Summary Guide. 12.12: Pain Management Referral Guidelines.
7. Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, pg. 56
8. Criteria for Referring Patients to Pain Management Specialists or Programs. *ECRI Institute Health Technology Assessment Information Service Hotline Response*. September 2014.
9. California State Senate Bill 833, Section 14, effective July 1, 2016.

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