Chronic Pain Programs

- Clinical Policy Bulletins
- Medical Clinical Policy Bulletins

Number: 0237

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Policy

Scope of Policy

This Clinical Policy Bulletin addresses chronic pain programs.

1. **Medical Necessity**

   Aetna considers the following interventions medically necessary:

   1. Aetna considers a screening examination medically necessary for members who are being considered for admission into a chronic pain program.;
   2. Aetna considers outpatient multi-disciplinary pain management programs medically necessary when *all* of the following criteria are met:
      1. If a surgical procedure or acute medical treatment is indicated, it has been performed prior to entry into the pain program; *and*
      2. Member has experienced chronic non-malignant pain (not cancer pain) for 6 months or more; *and*
      3. Member has failed conventional methods of treatment; *and*
      4. Member has undergone a mental health evaluation, and any primary psychiatric conditions have been treated, where indicated; *and*
      5. Member's work or lifestyle has been significantly impaired due to chronic pain; *and*
      6. Referral for entry has been made by the primary care physician/attending physician; *and*
      7. The cause of the member's pain is unknown or attributable to a physical cause, i.e., not purely psychogenic in origin.

      Note: Pain is considered chronic if it results from a chronic pathological process, has recurred periodically over months or years, or persists longer than expected after an illness or injury. Typically, pain is considered chronic if it has persisted for 6 months or more.

      Note: Dependence on narcotics or other controlled substances is frequently part of the presentation of a person with chronic pain. In persons with moderate to severe substance use disorders, detoxification must be considered and evaluated prior to enrollment into a pain management program. Refer to an Addiction Medicine specialist should be strongly considered in these persons.

   3. Aetna considers entry into an outpatient multi-disciplinary chronic pain program not medically necessary for members with *any* of the following contraindications:
      1. Member exhibits aggressive and/or violent behavior; *or*
      2. Member exhibits imminently suicidal tendencies; *or*
      3. Member has previously failed an adequate multi-disciplinary (e.g., Commission on Accreditation of Rehabilitation Facilities (CARF) accredited) chronic pain management program; *or*
      4. Member has unrealistic expectations of what can be accomplished from the program (i.e., member expects an immediate cure); *or*
      5. Member is medically unstable (e.g., due to uncontrollable high blood pressure, unstable congestive heart failure, or other medical conditions); *or*
      6. Member is unable to understand and carry out instructions.

4. Aetna considers entry into an inpatient multi-disciplinary pain management program for up to 21 days medically necessary when members meet the above criteria for entry into an outpatient pain management program as well as all of the following criteria:
    1. Member has major functional disabilities; *and*
    2. Member needs extensive psychological or behavioral therapy; *and*
    3. Member needs temporary removal from a detrimental home situation to re-focus their lives away from the pain; *and*
    4. The pain has caused extensive disruption in family functioning.

5. The following limitations apply to inpatient chronic pain treatment programs:
    1. Most inpatient chronic pain treatment programs require both medical and psychological evaluations before admission into the program. These evaluations should be performed on an outpatient basis; inpatient admission for these evaluations is considered not medically necessary.
    2. Participation in inpatient pain management programs for more than 21 days is subject to medical necessity review.
    3. Continued inpatient chronic pain treatment is considered not medically necessary for members who are not participating (e.g., failure to attend scheduled treatment sessions) in the program.
    4. An inpatient chronic pain management program is considered not medically necessary for persons who have failed a prior adequate multi-disciplinary (e.g., CARF accredited) chronic pain management program.

6. Modality-oriented pain clinics and single disciplinary pain clinics are considered not medically necessary and inappropriate for comprehensive treatment of members with chronic pain.

7. Neuropsychological evaluation/testing is not medically necessary for members with chronic pain being considered for treatment solely with narcotic pain medication. See CPB 0158 - Neuropsychological and Psychological Testing.

2. **Experimental, Investigational, or Unproven**

The following interventions are considered experimental, investigational, or unproven because the effectiveness of these approaches has not been established:

1. Foundation PISM (Ethos Laboratories) functional biomarker urine test panel for chronic pain management and for all other indications.;
2. NeuroFlow (remote monitoring physiologic parameters) for monitoring individuals in pain management and for all other indications.

3. **Related Policies**

- CPB 0158 - Neuropsychological and Psychological Testing

CPT Codes / HCPCS Codes / ICD-10 Codes

CPT codes not covered for indications listed in the CPB:

Code	Code Description
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain
96132 - 96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

Code	Code Description
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

Other CPT codes related to the CPB:

64553 - 64595	Neurostimulators
90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832 - 90838	Psychotherapy
90845 - 90853	Psychotherapy for crisis
96156 - 96171	Health behavior assessment, or re-assessment and intervention
97010 - 97546	Therapeutic procedures

ICD-10 codes not covered for indications listed in the CPB:

G89.21 - G89.3	Chronic pain, not elsewhere classified
G89.4	Chronic pain syndrome

Background

Pain is considered chronic if it persists longer than expected after an illness or injury, if it is associated with a chronic pathological process, or if it flares up periodically over months to years. Typically, pain is considered chronic if it has lasted 6 months or more. Chronic pain may be caused by physical, psychological, and environmental factors. It can be categorized as malignant or non-malignant in etiology. Chronic non-malignant pain encompasses many painful disorders such as back pain, migraine headaches, diabetic neuropathy, dental and orofacial pain, arthritic pain and pain due to musculo-skeletal/rheumatic disorders.

Pain rehabilitation programs are a relatively new and innovative approach to the treatment of chronic, intractable non-malignant pain. The goal of such programs is to give patients the tools to manage and control their pain and thereby improve their ability to function independently. Comprehensive treatment of chronic pain must address both physical and psychological aspects; thus, inter-disciplinary approaches to pain management involve medical management, physical therapy, occupational therapy, biofeedback, vocational and recreational therapy, and psychological counseling. Collaboration among therapists, psychologists, and other supportive resources is important to delivering effective pain treatments.

Chronic pain patients often have psychological problems that accompany or stem from physical pain. Hence, it is appropriate to include psychological treatment in the multi-disciplinary approach to pain management. However, patients whose pain results solely or primarily from psychiatric disorders rather than physical conditions generally can not be successfully treated in a pain rehabilitation program.

Hospital-level pain rehabilitation programs use coordinated multi-disciplinary teams to deliver, in a controlled environment, a concentrated program to modify pain behavior, which addresses physiological, psychological, and social factors that may contribute to the patient's pain. Such programs generally include diagnostic testing, skilled nursing, psychotherapy, structured progressive withdrawal from pain medications, physical therapy and occupational therapy to restore physical fitness (mobility and endurance) to a maximal level within the constraints of a patient's physical disability, and the use of mechanical devices and/or activities to relieve pain or modify a patient's reaction to it (e.g., nerve stimulation, hydrotherapy, massage, ice, systemic muscle relaxation training, and diversional activities). The program's day-to-day activities are under the general supervision and, as needed, direct supervision of a physician.

The literature suggests that generally up to 3 weeks of inpatient care may be required to modify pain behavior. Any chronic pain rehabilitation that may be needed after that can usually be effectively provided on an outpatient basis. Although many multi-disciplinary pain facilities have both inpatient and outpatient treatment programs, there is little evidence that inpatient programs are more effective than outpatient programs. Outpatient pain rehabilitation programs frequently provide services in group settings, even though these services are being furnished pursuant to each patient's individualized plan of treatment.

There is sufficient evidence that multi-disciplinary pain treatment clinics/centers are effective for the management of appropriately selected patients with chronic non-malignant pain. Studies have shown that chronic pain patients who have completed these programs have lasting reductions in pain and psychological distress. These studies have demonstrated improvements both in subjective ratings of pain and in objective measures such as reduced use of narcotic pain medications, increased rates of return-to-work, and decreased utilization of the health care system.

A systematic evidence review by the Swedish Council on Technology Assessment in Health Care (SBU, 2006) concluded that "rehabilitation programs, referred to as multimodal rehabilitation (usually a combination of psychological interventions and physical activity, physical exercise or physical therapy) is that pain decreases more, a greater number of people return to work and sick leaves are shorter than with passive control and/or limited, separate interventions." The SBU assessment also found that multi-modal rehabilitation improves long-term functional ability in fibromyalgia patients more effectively than passive control or limited, separate interventions.

An assessment of multidisciplinary pain programs for chronic non-cancer pain, preparted for the Agency for Healthcare Research and Quality (Jeffery, et al, 2011) found that multidisciplinary pain programs have been extensively documented in the standard medical literature. The 183 papers considered in the AHRQ assessment followed a biopsychosocial model of chronic pain, including treatment components in each of four areas: medical, behavioral, physical reconditioning, and education. Most of the studies considered in the AHRQ assessment were observational before-after designs. Although several different clinical conditions were studied, 90 percent of the studies included chronic back pain, the most frequent condition addressed in the literature. The report noted that differences were apparent between studies based in the United States and those in Europe; recent European studies were more likely than U.S. studies to include inpatient delivery of multidisciplinary pain program treatment. Declining access to multidisciplinary pain program treatment in the United States is highlighted as a key issue faced by those in the community of chronic pain sufferers and researchers.

Heutink et al (2012) evaluated a multi-disciplinary cognitive behavioral treatment program for persons with chronic neuropathic pain after spinal cord injury (SCI). The intervention consisted of educational, cognitive, and behavioral elements. A total of 61 people were randomized to either the intervention group or the waiting list control group in 4 Dutch rehabilitation centers. Primary outcomes were pain intensity and pain-related disability (Chronic Pain Grade questionnaire), and secondary outcomes were mood (Hospital Anxiety and Depression Scale), participation in activities (Utrecht Activities List), and life satisfaction (Life Satisfaction Questionnaire). Measurements were performed at baseline, and at 3, and 6 months follow-up. The primary statistical technique was random co-efficient analysis. The analyses showed significant changes over time on both primary (t1 - t2), and 2 out of 4 secondary outcomes (both t1-t2 and t1-t3). Significant intervention effects (Time*Group interactions) were found for anxiety and participation in activities, but not for the primary outcomes. Subsequent paired-t tests showed significant changes in the intervention group that were not seen in the control group: decrease of pain intensity, pain-related disability, anxiety, and increase of participation in activities. The authors concluded that these findings implied that a multi-disciplinary cognitive behavioral program might have beneficial effects on people with chronic neuropathic SCI pain.

Foundation PI℠

Foundation PI℠ is a urine test analysis by liquid chromatography tandem mass spectrometry (LCM/MS) of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5- hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3- hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid). Results of an algorithm are reported as a pain-index score that is intended to indicate the likelihood of atypical biochemical function associated with pain. There is a lack of evidence in the peer-reviewed published medical literature of the clinical validity and utility of this test.

Gunn, et al. (2020) reported on a retrospective observational study to determine and evaluate the prevalence of abnormal biomarker findings in a population of patients with chronic pain. Investigators employed a pain-specific biomarker test panel that evaluates biomarkers of systemic inflammation, oxidative stress, neurotransmitter turnover, and micronutrient status to determine the prevalence of abnormal findings in 17,834 unique patient samples analyzed at a national reference laboratory (Ethos Laboratories, Newport, KY). Patient biomarker results were considered abnormal if they were outside of the 95% confidence interval reference ranges established using a healthy population of donors who had no history of chronic pain or opioid use. The investigators found that 77% of patients with chronic pain exhibited at least one abnormal biomarker result (n = 13,765). The most common abnormal biomarker finding was elevated quinolinic acid, which was observed in 29% of patients (n = 5,107). Elevated pyroglutamate, indicative of glutathione depletion, was observed in 19% of patients (n = 3,314). Elevated xanthurenic acid, indicative of vitamin B6 insufficiency, was observed in 17% of patients (3,025). Elevated levels of the acrolein metabolite 3-hydroxypropyl mercapturic acid were observed in 21% of patients (n = 3,667). Elevated methylmalonic acid, indicative of a vitamin B12 deficiency, was observed in 10% of patients (n = 1,827), whereas abnormally low levels of neurotransmitter metabolites were observed in 8% of patients (n = 1,456). The investigators noted that a limitation of this study was that medications and conditions other than those associated with chronic pain were not evaluated as potential causes of abnormal biomarker findings.

McGeary et al (2022) examined the effects of inter-disciplinary pain management on pain-related disability and opioid reduction in poly-morbid pain patients with 2 or more co-morbid psychiatric conditions. This study was a 2-arm, randomized controlled trial (RCT) examining a 3-week intervention with assessments at pre-treatment, post-treatment, 6-month, and 12-month follow-

up. A total of 103 military veterans with moderate (or worse) levels of pain-related disability, depression, anxiety, and/or post-traumatic stress disorder (PTSD) were randomly assigned to usual care (n = 53) and inter-disciplinary pain management (n = 50). All subjects reported recent persistent opioid use. Trial participants had high levels of co-morbid medical as well as mental health conditions. Interventions entailed the experimental arm -- a 3-week, inter-disciplinary pain management program guided by a structured manual; and the comparison arm -- treatment as usual (TAU) in a large Department of Veterans Affairs medical facility. Main outcome measures included Oswestry Disability Index (ODI; pain disability); Timeline Follow-back Interview and Medication Event Monitoring System (opioid use). Analysis used generalized linear mixed model with all post-treatment observations (post-treatment, 6-month follow-up, 12-month follow-up) entered simultaneously to create a single post-treatment effect. Veterans with poly-morbid pain randomized to the inter-disciplinary pain program reported significantly greater decreases in pain-related disability compared to veterans randomized to TAU at post-treatment, 6-month, and 12-month follow-up. Aggregated mean pain disability scores (i.e., a summary effect of all post-treatment observations) for the inter-disciplinary pain program were -9.1 (95 % CI: -14.4 to -3.7, p = 0.001) points lower than TAU. There was no difference between groups in the proportion of subjects who resumed opioid use during trial participation (32 % in both arms). The authors concluded that these findings offered the 1st evidence of short-term and long-term inter-disciplinary pain management effectiveness in poly-morbid pain patients; however, further investigation is needed to examine how to decrease opioid use in this population.

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Policy History

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- Review History
- Definitions

Additional Information

- Clinical Policy Bulletin Notes