

CHRONIC PAIN MANAGEMENT PROGRAM

Eligibility Requirements

To provide chronic pain management program services to workers, the provider must be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The term interdisciplinary describes the type of program and not the practice skills of staff members. Providers of chronic pain management program services must work within the scope of practice for their specialty and/or be appropriately certified or licensed for the field in which they work.

Providers must maintain CARF accreditation and provide L&I with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed for administrative reasons.

When a CARF Accredited Provider is not Reasonably Available

In certain circumstances, a CARF accredited provider may not be reasonably available for workers who have moved out of Washington State. In those circumstances, a provider with CARF-like credentials may provide chronic pain management program services to the worker.

For outpatient services, these CARF-like credentials include:

- Patient prescreening is conducted by a physician, a psychiatrist/psychologist, and a physical/occupational therapist. Vocational rehabilitation may be added if the claim manager determines vocational assessment is needed.
- Regular interface occurs between a physician and the worker on a frequent, if not daily basis during treatment
- Treatment includes, at a minimum, medical management, psychiatric testing and/or counseling, physical and occupational therapy, and, if indicated, vocational rehabilitation services with return to work goals as indicated
- Follow-up includes remedial treatment or status checks to determine how well the worker is coping following completion of their treatment

For inpatient services, these CARF-like credentials include:

- The outpatient services credentials listed above and
- Affiliation with a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited hospital.

CARF-like providers will be required to comply with the chronic pain management program policies and fee schedule as well as meet the same reporting requirements as CARF accredited programs. CARF-like providers must also obtain an L&I provider account number. The provider account number for CARF-like providers will be activated for only 9 months.

When to Refer an Injured Worker for a Chronic Pain Management Evaluation

When the attending provider requests a referral to a chronic pain management program, the claim manager may authorize an evaluation if the worker has chronic pain, is not a surgical candidate and meets 1 of the following criteria:

- Has received conservative treatment for approximately 6 months:
 - without significant improvement,
 - has a perceived degree of pain, and
 - has not returned to work, or
- Has not significantly improved or has not returned to work due to pain within 6 months following authorized surgery or
- Has a significant pain medication abuse problem or
- Has returned to work but needs help with chronic pain management.

Chronic Pain Management Phases

A chronic pain management program has an interdisciplinary team that provides appropriate services to rehabilitate persons with chronic pain. Multiple modalities address the psychosocial and cognitive aspects of chronic pain behavior together with physical rehabilitation.

A chronic pain management program consists of three phases with a separate fee for each phase.

The chronic pain management program phases are defined as:

- **Evaluation Phase**
 - This phase consists of an initial evaluation including at a minimum a medical examination, and a psychological evaluation
 - A vocational assessment will be included in the initial evaluation if requested by the claim manager
 - A summary evaluation report is required and must include information from each discipline participating in the evaluation and a return to work action plan if indicated
 - This phase lasts 1 to 2 days
- **Treatment Phase**
 - At a minimum, this phase consists of medical management, psychiatric testing and/or counseling, and physical therapy/occupational therapy
 - Vocational rehabilitation services with return to work goals will be part of this phase if requested by the claim manager
 - Other services provided in this phase may vary as required by the needs of the worker
 - A discharge report is required and must include the findings of each discipline involved in the treatment phase and must list the outcome of the treatment
 - The maximum duration of this phase is 18 treatment days. The 18 treatment days are consecutive (excluding weekends and holidays). Each treatment day lasts 6-8 hours.
- **Follow Up Phase**
 - This phase consists of remedial treatment or status checks as needed to determine how well the worker is coping following completion of the treatment phase. The goal is to extend and reinforce the gains made during the treatment phase. This phase is not a substitute for and cannot serve as a second treatment phase.
 - A follow up report is required including the findings of all disciplines involved in providing the follow up services
 - This phase will last for no more than a total of 5 follow up days during the 3 months immediately following completion of the treatment phase or treatment phase extension (information about the treatment phase extension is provided under the *Treatment Phase Extension Criteria* heading next in this subsection)

The reports required for each phase must be sent to the insurer and to the attending physician. When requested, other reports may be required.

The fee schedule and procedure codes for these phases are listed in the [Fees](#) section on page [185](#). This fee schedule applies to workers in either an outpatient or inpatient program.

Treatment Phase Extension Criteria

The claim manager can authorize up to 10 additional days of treatment for the worker.

Before the claim manager authorizes the treatment phase extension, 1 or both of the following criteria must be documented in the extension request:

- Treatment is steadily progressing toward achievement of a treatment goal and how the extension supports the meeting of the specific treatment goal
- The worker is nearing completion of treatment and needs a few more sessions to achieve the treatment goal

The following factors will be applied when evaluating a request for extending treatment:

- The treatment phase extension is limited to a 1 time basis per referral
- The extension should be on an outpatient basis. Extension of inpatient services will require concurrence of an L&I ONC or self insurer based on their review of the extension request and claim file.
- Extensions are not granted for either the evaluation or follow up phases
- The extension is limited to a specific number of treatment days not to exceed a maximum of 10 consecutive treatment days (excluding weekends and holidays). The start and end dates must be defined prior to start of the treatment phase extension.
- The treatment phase extension request must be based on specific issues requiring further treatment. The request must be supported by documentation of progress made to date in the program.
- The request must clearly state the goals of the treatment phase extension and time needed to meet those goals

RETURN TO WORK ACTION PLAN

If the worker needs assistance in returning to work or becoming employable, the claim manager will authorize admission to the chronic pain management program for treatment after:

- A vocational counselor has been assigned by the claim manager
- The chronic pain management program vocational specialist (program counselor) and the insurer assigned vocational rehabilitation counselor have agreed upon a return to work action plan with a return to work goal acceptable to the insurer and
- The attending provider and the worker approve the return to work action plan with a return to work goal.

The return to work action plan is to provide the focus for vocational services during a workers' participation in a chronic pain management program. The insurer assigned vocational provider will facilitate the review, revision, and approval of the return to work action plan by the attending provider and the worker.

The return to work action plan may be modified or adjusted during the treatment or follow up phase as needed. At the end of the program the listed return to work action plan outcomes must be included with the treatment discharge report.

FEES

Non-Hospital Based Programs

Outpatient chronic pain management programs must bill using the local codes listed in the following table on a CMS-1500 form.

Description	Local Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	2010M	Conducted over 1-2 days	\$1,106.63
Pain Clinic Treatment Phase	2011M	Not to exceed 18 treatment days	\$708.82 per day
Pain Clinic Treatment Extension Phase	2012M	Not to exceed 10 treatment days	\$708.82 per day
Pain Clinic Follow-Up Phase	2013M	Not to exceed 5 follow-up days	\$304.69 per day

Hospital Based Programs

Facility based chronic pain management programs will bill using the revenue codes listed in the following table on a CMS-1450 (UB-04) form.

Description	Revenue Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	0011	Conducted over 1-2 days	\$1,106.63
Pain Clinic Treatment Phase	0012	Not to exceed 18 treatment days	\$708.82 per day
Pain Clinic Treatment Extension Phase	0017	Not to exceed 10 treatment days	\$708.82 per day
Pain Clinic Follow-Up Phase	0013	Not to exceed 5 follow-up days	\$304.69 per day

Inpatient Room And Board Fees

There are occasions when the chronic pain management program evaluation indicates a need for the worker to be treated on an inpatient basis. All inpatient admissions will require **prior authorization**. All State Fund inpatient admissions also require utilization review.

Utilization review for L&I is provided by Qualis Health. Eligible providers will contact Qualis Health at 1-800-541-2894 or fax their request to 1-877-665-0383. Qualis Health will compare the workers' clinical information to established criteria and make a recommendation to approve or deny the inpatient admission request to the claim manager.

For authorization procedures on a self insured claim, contact the self insurer directly.

The claim manager will make the final authorization decision. When the claim manager authorizes treatment on an inpatient basis, the provider will be paid up to \$503.31 per day for room and board costs. These costs should be billed using either revenue code 0129 (semiprivate) or 0149 (private).

An acceptable return to work action plan is a one-page statement included with the chronic pain management program's vocational evaluation report that contains:

- The workers' current vocational status with the employer of injury
- The workers' current level of physical function
- The appropriate U.S. Department of Labor Dictionary of Occupational Titles (DOT) number and physical demands of the job goal common to the immediate labor market
- The actions, timelines, and people responsible for achieving the return to work action plan goal

BILLING FOR PARTIAL DAYS IN TREATMENT OR FOLLOW-UP PHASES

It is expected that the worker will attend the full 6-8 hours each treatment day during the treatment phase. If the worker is unable to complete a full day of treatment due to an emergency or unforeseen circumstance, the provider should bill for that portion of the treatment day completed by the worker.

Example 1: Clinic A requires the worker to be in attendance for 8 hours for each treatment day. The worker had an unforeseen emergency and had to leave the clinic after 2 hours (25% of the treatment day) on one treatment day. The clinic would bill L&I for that day as follows: $\$708.82 \times 25\% = \177.21

For the follow up phase, the provider should bill for that portion of the follow up day that the worker is in attendance.

Example 2: Clinic B scheduled the worker for 3 hours of follow-up services. Clinic B's normal hours of attendance for the worker is 6 hours. Clinic B would bill L&I for those 3 hours of follow-up services as follows: $\$304.69 \times 50\% = \152.35