1. **Purpose**

The purpose of this policy is to establish a provider and patient-centered approach in the assessment of tools and standardized scales through which to measure improvement in patient comfort and function.

2. **Statement of Policy**

2.1. The gold standard for assessing a patient’s response to care is measurement of comfort and function. These measures represent the fundamental agreement between provider and patient and their attainment is the primary reason why most patients present for care.

2.2. Many objective clinical indicators are used by providers to progressively evaluate a patient’s condition. While these are of value to the provider, their improvement is usually only valuable to the patient if they occur in conjunction with improvement in comfort and function. We believe that this defines “patient-centered care.”

2.3. When the primary clinical outcomes measures are patient reported function and comfort, Minimal Clinical Improvement is the reasonable progress towards full resolution as defined by the scales in use.

2.4. It is Triad Healthcare, Inc.’s (Triad) position that it is up to the provider to choose the most appropriate outcomes assessment tools from which to assess comfort and function. Once this assessment is made by the provider, Triad’s position is that it is reasonable and valid for the provider to represent his/her patient’s status on a set of easily reported, standardized scales. The scales used by Triad to measure improvement in patient comfort and function are as follows:

- Numeric Pain Severity Scale (ten unit scale)
- Pain Radiation (three unit scale)
- Functional Index/Restrictions of Daily Activity (ten unit scale)
- Work Capacity Scale (three unit scale)
- Patient Report of Improvement (ten unit scale).
2.5. Minimum Clinical Improvement is defined as a one unit improvement in a three unit scale, such as Work Capacity and a three unit improvement in a ten unit scale, such as Numeric Pain Rating Scale.

3. Discussion
Triad manages care for multiple allied specialties using a methodology that requires only one thing from the provider - to achieve reasonable progress towards resolution of pain and function using only the medically necessary duration, frequency and intensity of care. Our expectations, supported by the literature and by professional consensus, are that therapeutic care must produce minimal improvement in patient comfort and function of at least 30% within any thirty day period to be medically necessary. Some patients may improve more rapidly as is commonly communicated in the case and ethnographic studies in the professional chiropractic literature. Some patients may improve more slowly, but it is unusual that this rate of progress will yield lasting therapeutic benefit. Triad uses standard measures reported by the provider at a maximum of thirty day intervals to calculate minimal improvement against this expected minimum. Care failing to achieve minimal progress levels is denied for “insufficient progress.”

4. References
4.1. The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding the policy of minimal clinical progress and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


• Carreon LY, Glassman SD, Howard J. Fusion and nonsurgical treatment for symptomatic lumbar degenerative disease: a systematic review of Oswestry Disability Index and MOS Short Form-36 outcomes. *Spine J 2007 Nov 21*


• Copay AG, Glassman SD, Subach BR, Berven S, Schuler TC, Carreon LY. The minimum clinically important difference in lumbar spine surgery patients: a choice of methods using the Oswestry Disability Index, Medical Outcomes Study questionnaire Short Form 36, and Pain Scales. *Spine J 2008 Jan 15.*

• Copay AG, Subach BR, Glassman SD, Polly DW, Schuler TC. Understanding the minimum clinically important difference: a review of concepts and methods. *Spine J 2007 Apr 2.*


- Lauridsen HH, Hartvigsen J, Manniche C, Korsholm L, Grunnet-Nilsson N. Responsiveness and minimal clinically important difference for pain and disability


• Nyiendo J, Haas M, Goldberg B, Lloyd C. A descriptive study of medical and chiropractic patients with chronic low back pain and sciatica: management by physicians (practice activities) and patients (self-management). *J Manipulative Physiol Ther. 2001 Nov-Dec;24(9):543-51.*


• Rejas J, Pardo A, Ruiz MA. Standard error of measurement as a valid alternative to minimally important difference for evaluating the magnitude of changes in patient-reported outcomes measures. *J Clin Epidemiol 2008 Apr; 61(4):350-6.*


4.2. Related Triad Medical Policies:

- *TMMP 18 – Medical Necessity*

5. Attachments

5.1. *Provider Manual*

Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/07/2008</td>
<td>Level 1, 2, 3</td>
<td>Policy review and reformatting for Triad Policy Library. References added.</td>
</tr>
</tbody>
</table>