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DATE OF REVIEW: 11-18-08

IRO CASE #:

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Medical Rehabilitation times 20 sessions

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is an employee of xx years who sustained an industrial injury to the left shoulder in xxxx for which she underwent successful rotator cuff surgery in February 2006 and was released to full duty work in January 2006. The patient incurred a second injury in xxxx to the cervical spine, right shoulder, right knee and lumbar spine and re-injury to the left shoulder. Secondly, she suffered damage to the upper GI and was diagnosed with depression and chronic pain syndrome. The patient is described as 5' 6" and 300 pounds and smokes up to 1 pack of cigarettes daily.

According to the provider's medical report of January 3, 2006 the patient demonstrated excellent left shoulder range of motion and strength following her left shoulder surgery and rehabilitation. No additional treatment was needed and the patient could continue working normal duties. She might benefit from some spinal and rib adjustments.

The patient sustained a second industrial injury on xx/xx/xx when she slipped on a large oily area in the copy room at work. She landed on her right side. The patient was subsequently treated for injury to the neck, right shoulder, right knee, low back and re-injury of the left shoulder.

Per the provider's report of October 10, 2006 the patient began using a cane in March 2006 for fear of falling. Cervical MRI of March 2006 reportedly shows multiple levels of spondylosis and significant degenerative disc disease at C5-6 but no neurocompressive lesions.

According to the IME report of May 10, 2006 the use of a DRX-9000 cervical decompression machine has been recommended for the patient. At this examination, right and left shoulder range of motion were symmetrical. The diagnosis provided was rule-out labral tear/SLAP lesion right shoulder and work-related exacerbation of cervical spondylosis and lumbar spondylosis. Recommendation was for MR Arthrogram of the right shoulder, functional physical therapy for the neck and low back. The DRX treatment may be worthwhile for her cervical spine on a trial basis, although it was noted that support in the literature is weak for

this device. Imaging showed a labral tear on the right and the follow-up IME report of June 8, 2006 recommended arthroscopic intervention.

The patient was provided 18 sessions of cervical mechanical axial traction with the DRX 9000 during the period of April 25, 2006 through June 2, 2006 without benefit.

The patient was provided an internal medicine consultation on August 22, 2006 following an episode of hematemesis associated with dysphagia and chest pain and subsequent identification of an MRSA soft tissue infection of her anterior abdominal wall. The patient's medical history is significant for "diabetes, hypertension, high cholesterol and a fatty liver." The patient was noted to have GI distress secondary to overprescription of NSAIDS. The patient underwent intervention on that visit to visualize the esophagus and expand a tight Schatzki ring.

Following extensive workup for the left shoulder, her surgeon did not believe that there is a structural problem and reported that surgery is not indicated. The provider is in agreement per the report of October 12, 2006. The provider states "the patient will be referred for a work hardening program. The goal is within a one-month time frame to be able to return to work. The patient is committed in this goal."

On October 25, 2006 the patient underwent a psychological evaluation and consultation. The patient was returned to full duties following her 2005 left shoulder injury although in reality she could only lift 5 pounds. Following the second injury of xx/xxxx the patient reported pain in many areas. Decompression treatment to the neck was not helpful. She has been doing lighter duty office work. She had no physical therapy until August 2006. She was seen in emergency in July 2006 for GI problems and has been off work since that time. She is anxious to return to her usual job and desires work hardening. Her health conditions include glucose intolerance and high blood pressure. She smokes about 2 packs of cigarettes daily. Her husband died in a MVA in 1990. Her mother passed away one month prior. She reports depression and anxiety but showed no evidence of psychotic symptoms. Her testing profile indicate "a high probability that the outcome of traditional medical program to address her pain will be poor...she is likely at heightened risk for having an adverse negative reaction to stressful or invasive medical procedures." and there is a risk of medication misuse. She could benefit from psychological interventions. She has Major Depressive Disorder, Adjustment Disorder and Mental Disorder.

From October 25, 2006 through November 22, 2006 the patient participated in 13 sessions of a Work Hardening program. On November 22, 2006 the patient was reported to be progressing. She is looking into xx jobs not requiring as much physical demand as her prior xx duties. Program notes of day 10 state the patient has fallen again and has scuffed forearms. On day 11 the notes state 'exaggerated pain behaviors with reports of pain inconsistent with prior reports and observed behaviors in AM, likely due to Dr. and I again indicating [the program is] maximum 4 weeks.' Staff notes from week 3 of the program state "she has completed day 13 today. Continues to improve significantly from a physical and functional standpoint. Psychosocial issues complicate recovery with periodic slips." Additional notes indicate the patient has distractions of moving her residence, illnesses and court hearings which interrupt her participation in the work hardening program. The patient was to have an FCE upon completion and then reenter the workforce.

On December 13 2006 the patient underwent examination for impairment rating. The patient has been "working light duty" in regard to her 2005 left shoulder injury. She uses Neurontin for residual left shoulder pain. She has right shoulder pain in a patchy pattern. MRI/arthrogram was performed and her surgeon does not believe surgery is needed for the right shoulder. She has been treated for lumbar and lower extremity conditions. She has fallen several times recently and uses a cane for stability. She participated in a work hardening program that included psychological support. She is neurologically intact. She is MMI. She can work light duties.

According to the patient's primary provider's report of December 14, 2006 the patient is not yet MMI but should be by July 2007. Left shoulder MRI was performed and shows no evidence of a full thickness rotator cuff tear. There is supraspinatus tendinopathy and capsular hypertrophy at the acromioclavicular joint. There is evidence for anterior capsular injury. The patient cannot yet return to work.

According to the medical report of February 15, 2007 the patient was started on a trial of methadone.

The Designated Doctor examination of April 11, 2008 indicated the patient's weight was 285 pounds. Shoulder range of motion was complete. The patient was able to heel and toe walk. The patient is not yet MMI. During April 2007 the patient has increased blood pressure problems for which she is afforded care by her private physician.

The patient was examined for impairment rating on May 31, 2007. The report of June 14, 2007 indicates the patient's depression is industrial while her esophageal condition is non-industrial.

On June 15, 2007 the surgeon determined that the patient had failed conservative treatment to the right shoulder. The patient desires to proceed with arthroscopy for right shoulder impingement. However, on June 26, 2007 the patient was not cleared for shoulder surgery due to multiple medical problems including GI problems and "possible seizure disorder." The patient is noted to be taking 17 medications, including methadone.

On June 26, 2007 the patient was examined for pre-op right rotator cuff surgery and WAS NOT cleared for surgery.

Lower extremity electrodiagnostic studies of July 10, 2007 show diabetic peripheral neuropathy consistent with "the patient's history of diabetes."

MRI of July 22, 2007 shows a meniscus tear at the medial right knee.

The patient returned to the designated doctor for evaluation on August 1, 2007. The patient's weight is 269 pounds. She is reported to have "not worked since the accident." Orthopedic testing of the shoulder is normal. The patient is unable to heel and toe walk. She has right shoulder impingement, trauma to the right shoulder and trauma to the lumbar area. MMI is anticipated for January 2008.

Dr. provided an examination to assess the patient's right knee on October 1, 2007. The patient has grade IV chondromalacia secondary to knee arthroscopy of 2003. She does not desire injections. She desires a surgical solution if medical clearance can be realized. Surgery was subsequently scheduled for right knee arthroscopy on November 19, 2007.

The patient underwent Impairment Evaluation on February 19, 2008. The patient is in the process of changing primary treating physicians and is also seeking a second opinion to assess thoracic outlet syndrome. Her shoulder surgeon has recommended right shoulder surgery to repair a rotator cuff and labrum tear which has not been authorized. Although she had preexisting depression she also has industrial depression. The GI problems are also industrial. She does not have a left hip contracture. The cause of her falls needs additional neurological assessment. She is not MMI. The right shoulder has not been fully addressed and she could benefit from a chronic pain management program.

On June 3, June 17 and June 22, 2008 the patient underwent a Required Medical Examination which included psychiatric/neuropsychiatric testing and interview. The patient reports she was terminated from her LVN position in January 2007. Her history includes rotator cuff repair in January 2005 and right knee meniscus repair in November 2007. Her treatment has included work conditioning, multidisciplinary pain managements, trigger point injections and cervical traction with the DRC 9000c. She states she has fallen and hit her head. She states she has been verbally abused by the adjuster. She reports low back, neck and bilateral arm pain.

A Functional Capacity Evaluation of September 2006 showed she was over reactive and exhibited inappropriate behavior. Work hardening was provided and her provider deemed her MMI in December 2006 with 11% impairment. Left shoulder MRI of December 2006 showed no full thickness tear and her surgeon opined that he did not want to see her any more and there was no explanation for the reported pathology. Another opinion by a clinician of April 2007 determined she was not yet MMI. A subacromial injection was provided in April 2007. She requested right knee arthroscopy in October 2007. She reports pain aggravated by movement and numbness in multi body regions. The adjuster told her she is bipolar. She states on the form that she has a lot of mental disease. Much of her intake form is illegible. She is 5' 6" and 292 pounds with blood pressure of 162/104. Her examination is unremarkable with exception of tenderness to palpation in the lumbar region. There are positive Waddell tests. The subjective complains are out of proportion to the objective findings. She has 8 out of 8 positive W addell Signs "which is positive for symptom magnification." She reports auditory or visual hallucinations over the last 6 months. She sees and talks with ghosts. She sits in a chair and talks to herself. The patient is not diagnosed with malingering. Her diagnosis is Bipolar disorder/delusional disorder, Personality disorder, hypertension along with diabetes, obesity, hypothyroidism, reflux and gastrointestinal ulcers. Cervical strain, lumbar strain, left shoulder sprain/strain resolved. Severity -catastrophic mental illness with 50% of global functioning. Her cervical, lumbar and left shoulder sprain/strain injuries have resolved. No additional treatment is indicated relative to the work injury. Examinee has significant comorbid, psychiatric pathology, complicating physical symptom validity. She has had sufficient formal therapy and should be engaged in a home exercise program. Her provider is correct regarding MMI as of December 13 2006 although impairment should be zero and not 11% because the examinee did not provide consistent physiologic effort with the examination process.

On xx/xx/xx the patient presented at a hospital emergency room. Her blood pressure is noted to be 105/50. She has multiple complaints. She reported a fall of xx/xx/xx and is concerned about a neck fracture. The "patient has rambling speech, constantly talking about numerous complaints...reports syncopal episodes, urinary incontinence for one week." Her history includes hypertension and bipolar disease. The patient reported "being unable to raise her bilateral arms above her chest but is seen lying in bed with her hands clasped, resting behind her head." The patient was advised to see her neurologist at discharge.

A Functional Capacity Evaluation was performed on August 6, 2008. The patient has been provided treatment of physical therapy, injections and work hardening with short-term relief. She has been using narcotic medications for over 2 years, including methadone and hydrocodone as well as antidepressants, sleep medications, over-the-counter drugs and has esophageal erosion secondary to prescription of NSAIDS. She is more depressed about functional limitations than just pain levels. Her future outlook and returning to an active member of society appears to hinge more on functional restoration and behavioral modification than merely intense psychological reprogramming as indicated by the recent IME impression of "catastrophic mental illness." She feels that if she could restore stamina, endurance and strength levels needed to lift at least 50 pounds safely, she felt she could find employment in the healthcare sector that did not require Heavy PDL/Work Category as her previous job did. She is only age 43 and should be a viable person in the community. Out patient medical rehabilitation is recommended. The patient's lifting capacity was tested to be 10 pounds floor to table times three.

According to a pre-authorization request of August 27, 2008 the patient would begin the OPMR program on a half-day basis and then step up to an 8 hour a day program when she could tolerate such. It is stated that individual counseling to address psychological stressors is part of the program.

On August 29, 2008 the provider reiterates that the patient is not, in his opinion, at MMI and may yet undergo rotator cuff surgery in the future. "We have performed 19 successful CPM/OPMR programs since 2001 with a 100% return to work record."

The patient was seen on September 5, 2008 for a designated doctor evaluation and impairment rating. She has not worked since July 2006. Her neck x-ray of February 2006 is essentially negative. MRI of March 2006 did not show a neurocompressive lesion in the cervical spine. CT scan of the brain and neck in October 2006 were essentially unremarkable. Left shoulder MRI of December 2006 showed the prior surgery but no rotator cuff tear. A partial thickness tear was found in the right shoulder. Lumbar MRI of July 2007 did not show a focal neurocompressive lesion. She underwent right knee arthroscopy in November 2007. She has a cervical strain/sprain, lumbar sprain/strain, right shoulder partial rotator cuff tear and right knee strain. She is MMI as of August 5, 2008 with zero impairment in the cervicothoracic regions. For the lumbar spine she has a 5% whole person impairment.

The patient was reevaluated by her provider on September 2, 2008. Her treatment was summarized and she was recommended to participate in an "out-patient medical rehabilitation program," after which she could find work in a sedentary to light medium work category in the healthcare field.

The patient was provided an initial pain management evaluation on September 8, 2008. Her primary pain complaint includes generalized arm, hand, and leg pain, associated with swelling, temperature changes, sensitivity to touch, independent spasms and twitches. She has signs of reactive depression and anxiety. "Partial rotator cuff tear on the right (sic) was surgically treated." She participated in a chronic work hardening program with little sustained benefit. Following examination, a diagnosis was provided of: Generalized chronic pain syndrome in an obese smoker having failed conservative rehabilitation and surgical treatments. Most probable complex regional pain syndrome disseminated throughout the upper and lower extremities as evidenced by persistent pain associated with edema, hyperesthesia, allodynia and vasomotor changes. Costochondritis of the left anterior chest wall. Chronic myofascial pain syndrome associated with chronic pain state. Moderate to severe reactive depression, anxiety and generalized deconditioning is a chronic pain patient. She understands a lifestyle change is needed. Also, Wellbutrin will help her depression. Restoril will help her sleep. Her prognosis is fair-poor. At follow-up on September 15, 2008 the patient was in an improved mood. Lyrica was given as a sample. It is imperative that she continue the physical therapy and chronic pain program.

Request for 20 sessions of outpatient medical rehabilitation (OPMR) was not certified in review on September 3, 2008 with rationale that the patient "is a surgical candidate" and has tried and completed prior attempts at physical therapy, rehabilitation and work hardening and it is unlikely that additional rehabilitation protocols will result in a net gain for the patient. Given that the patient is dependent on narcotic medications and has evidence of depression, a mental health evaluation would be reasonable.

Request for reconsideration for 4 weeks (20 sessions) of OPMR was not certified in review on October 10, 2008 with rationale that the supporting documentation lacked individualized treatment plan and goals and the treatment plan exceeds appropriate trial levels based on evidence based guidelines.

Case summary and arguments put forth for the applicant for the request can be summarized as follows: The patient underwent psychological evaluation on October 4, 2008 to assess her candidacy for OPMR and to clarify her levels of psychogenic pain, anxiety and depression. The patient was initially recommended for physical therapy but cervical mechanical traction was provided instead. The cervical decompression caused her condition to worsen and was discontinued. She changed providers in July of 2006 and was overprescribed NSAIDs resulting in esophagitis, strept throat and esophageal strept. The patient then participated in 10 sessions of physical therapy described as primarily passive treatments. Per psychological assessment of October 2006 she has major depression, adjustment disorder with mixed depression and anxiety being injury related and general mental disorder affecting medical condition. She attended work hardening which was completed in November 2006 which she related was not helpful due to the level of her shoulder and knee pain which limited strengthening and rehabilitation. Her surgeon had the work hardening discontinued as she had re-injury of the left shoulder and a labral tear in the right shoulder. She was then given an impairment of only 11 % in December 2006. She was terminated from her work position as they could no longer accommodate her restrictions. Her provider initiated methadone in February 2007. She underwent right knee surgery in November 2007 with no additional follow-up or rehabilitation. The patient has a new provider since February 2008. She is seen monthly for medication management only. In July 2008 her provider referred her for chronic pain management. In August 2008 she was recommended for admission to OPMR. Based on Independent/RME opinions of August 2008, all prescription and narcotic medications were cut-off for the patient and the patient was forced to turn to a county hospital for short-term medication refills. Following testing it was opined that her pain appears to be both psychogenic and neuropathic. Despite her depression, she is very confident that with proper physical rehabilitation and psychological counseling she will be able to return to a high functioning state and become a self-sufficient person again. It is stated that the patient "is not diabetic."

Summary and arguments put forth against the request can be summarized as follows: The Official Disability Guidelines does not reference "outpatient medical rehabilitation" (CPT code 97799-MR). The request should be considered under Interdisciplinary rehabilitation program guidelines. The claimant has had prior physical therapy rehabilitation and work hardening and "was still a surgical candidate." This program lacks "an individualized treatment plan and goals." This request exceeds the appropriate trial level of two weeks and the claimant is more than xx years post injury. In July 2006 the claimant was told her neck was clear and she did not need anything else done to it.' She was released from care of her neurosurgeon. In September 2006 the claimant was over-reactive and exhibited inappropriate behavior during an FCE. In October 2006 the claimant's provider was concerned with discrepancies in the claimant's subjective and objective complaints and referred the patient for a psychosocial evaluation. Left upper extremity EMG/NCV was normal. The claimant was opined to have a severe major depressive disorder. The examination of December 2006 was mostly unremarkable and the claimant was deemed MMI by her provider with 11% impairment. In January 2007 the claimant is concerned about her left shoulder while her surgeon was unable to find any pathology to account for her symptoms and advises he can offer nothing further. In June 2007 the claimant decides to proceed with a shoulder surgery but she was not cleared medically. EMG studies show evidence of moderate diabetic peripheral lower extremity neuropathy consistent with her history of diabetes. In November 2007 the claimant undergoes right knee arthroscopy.

The claimant has repeated falling incidents and goes to the emergency room but is discharged repeatedly in good condition and encouraged to follow up with a neurologist. The claimant has a sedentary PDL per FCE. In June 2008 a required medical examiner determined the claimant's strain injuries had resolved with no disability and no need for additional treatment. The patient continues to fall down and present to emergency rooms. X-rays rule out acute injury and she is asked to follow up with her neurologist. The claimant's diagnoses were cervical sprain/strain, lumbar sprain/strain, right shoulder partial rotator cuff repair and right knee sprain. The most current designated doctor examination of September 2008 determined the claimant was MMI in August 2008 with 5% whole person impairment. Her shoulder range of motion deficits were not found to be valid due guarding and significant voluntary restriction. The requested treatment does not have an individualized treatment plan.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

According to the TDI-DWC physical medicine ground rules regarding Out-Patient Medical Rehabilitation the goal of such programs is to improve the functional level of persons who have severe functional limitations of recent onset or recent regression or lack of progression or have not had prior sufficient exposure of rehabilitation. Entrance is for persons who are likely to benefit, whose functioning is severely impaired and require intensive rehabilitation. An individualized plan of treatment shall be supervised by a doctor for about 50% of the program; the rest of the time will be spent under the direct care of one of the members of the interdisciplinary team. While the OPMR program requested is described to include individual counseling to address psychological stressors, it is not clarified that the patient will have individual supervision for 50% of the time. We shall consider whether or not the patient has severe functional limitations of recent onset or recent regression or lack of progression or has not had prior sufficient exposure of rehabilitation.

ODG guides that these programs are for patients with chronic disabling occupational musculoskeletal disorders. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. It has been noted that a 4-week program is requested for this patient. This does not necessarily disqualify the patient as all programs are required to assess patients at least biweekly and provide progress reports. So in effect, no patient would continue past two weeks without documentation of progress.

Guidelines state the following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. According to the reviewed records the patient demonstrates at least 5 of these 9 variables for negative outcome, namely, numbers 4,6,7,8,and 9.

ODG also state, outpatient pain rehabilitation programs may be considered medically necessary when ALL of the 11 criteria cited below in the guidelines are met. According to the medical records, the patient does not meet the following criteria: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit.

Prior reviewers opined that the patient does not qualify for entrance to the requested program because 1) She is a surgical candidate, 2) has failed prior rehab attempts, 3) the treatment plan exceeds trial levels, 4) there is lack of an individualized treatment plan. The patient was not cleared medically for right shoulder surgery and it has been reported that more recently it "has not been authorized by the carrier." The records do not indicate the patient is currently anticipating a surgery. On the other hand, the patient cannot be considered to have realized the goals of the prior multidisciplinary program. During the four-week work hardening program of October-November 2006 the patient had significant psychological barriers to maintaining full participation. Her mood appears to have changed almost hourly. Following that program the patient was anticipated to return to the work force in a light duty job. The patient did not return to employment. Since completion of the multidisciplinary program the patient has continued to be seen evaluated, tested, and treated with no sign of return to work in sight. Participation in a similar multidisciplinary program two years later would not be anticipated to have a different result. Or, as a prior reviewer noted, "it is unlikely that additional rehabilitation protocols will result in a net gain for the patient." Although the request "exceeds trial levels" recommended by The Official Disability Guidelines, as noted above, the patient would not continue past 2 weeks without documentation of improvements. "Lack of individualized treatment plan" is a fair rationale for non-certification as the program description does not clarify 50% individual management, although it does include "individual counseling."

The primary barriers to a successful outcome for this patient are: The duration of pre-disability referral time which is longer than the 2 years recommended by guidelines and, the patient is a smoker and uses opioids on a chronic basis and has high levels of psychosocial distress. Unfortunately, ODG state that "ALL of the 11 criteria cited below in the guidelines must be met." As all of the criteria for entrance to the requested program have not been met, there is no choice but to agree with the prior determinations. It is also noted that the patient's lifting capacity was tested to be 10 pounds floor to table times three and she would need to increase this capability times 5 to be able to perform even work that does not require Heavy PDL/Work Category. Additionally, the patient's psychological condition of "bipolar disorder" and her neurological condition of "possible seizure disorder" do not appear to be well controlled. It is also noted that the patient's blood pressure has been noted as high as 162/104 (September 2006) and as low as 105/50 (July 2008), which indicates her medications are not well managed or medication compliance is poor. The patient may be falling down due non-industrial vasovagal syncope and/or hypostatic orthotension. The patient can fall down at any time based on history and create new aggravations and setbacks. As recommended in the past, the patient needs a lifestyle change. Overall, the patient does not meet the guideline requirements for the requested program. Therefore, my determination is to agree with the previous non-certification of the request for Outpatient Medical Rehabilitation

times 20 sessions.

The IRO's decision is consistent with the following guidelines:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

The Official Disability Guidelines -- 11-4-08: Functional restoration Programs

Recommended for selected patients with low back pain and chronic disabling back pain, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. The evidence base in other conditions is unclear. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see Chronic pain programs), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. (Bendix, 1998) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see Chronic pain programs.

The Official Disability Guidelines - 11-4-08: Chronic Pain Programs:

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain

rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):

(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

- (a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)
- (b) Multidisciplinary pain clinics
- (c) Pain clinics
- (d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005)

Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs.

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;
- (2) The patient has a significant loss of ability to function independently resulting from the chronic pain;
- (3) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;
- (4) The patient is not a candidate for further diagnostics, injections or other invasive procedure candidate, surgery or other treatments including therapy that would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided);
- (5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement;
- (6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;
- (7) Negative predictors of success above have been addressed;
- (8) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit;
- (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains

may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program;

(10) Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function;

(11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach.

(BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs

The Official Disability Guidelines - 11-4-08: Work Hardening / Work Conditioning

Recommended as an option, depending on the availability of quality programs. [NOTE: See specific body part chapters for detailed information on Work conditioning & work hardening.] See especially the Low Back Chapter, for more information and references.

Criteria for admission to a Work Hardening Program:

- (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA).
- (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.
- (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function.
- (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
- (5) A defined return to work goal agreed to by the employer & employee:
 - (a) A documented specific job to return to with job demands that exceed abilities, OR
 - (b) Documented on-the-job training
- (6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program.
- (7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit.
- (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less.
- (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities.
- (10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Physical Therapy Guidelines - Work Conditioning

10 visits over 8 weeks

See also Physical therapy for general PT guidelines.

And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.