



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 5-4-09 (AMENDED 5-13-09)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program x 10 days

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

American Board of Anesthesiology and Pain Medicine

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 5-23-08 MRI of the lumbar spine and left knee.
- 12-11-08 Initial Behavioral Medicine Consultation performed by, MS, LPC.
- 1-24-09 DO., performed a consultation.
- 1-24-09 Functional Capacity Evaluation.
- 2-25-09, MS, LPC, CRC., performed a Chronic Pain Management Program evaluation.
- 3-2-09, DO., determination for Chronic Pain Management Program x 10 sessions.
- 3-24-09, MS, LPC, CRC., Request for Reconsideration.
- 3-31-09, PhD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine dated 5-23-08 shows L1-L2, L2-L3 and L4-L5; 5-6 mm anterior innerspaces marginal bony osteophytes only. L2-L3 and L4-L5: Minimal symmetric annular bulges, reduced innerspaces widths by approximately 50%, drying of disc substance and 4.5 mm anterior marginal bony osteophytes. L5-S1 4-5 mm posterior central discal substance protrusion. Substance mildly indents expected (thecal sac contours, mild degree of central axial stenosis results as there is also posterior bony elements hypertrophy.

MRI of the left knee dated 5-23-08 showed a small to small-moderate volume joint effusion of posttraumatic or inflammatory origin. Moderate degree patellofemoral arthrosis. Mild degree posteromedial meniscus degenerative thinning. No inner fluid signal tear.

12-11-08 Initial Behavioral Medicine Consultation performed by, MS, LPC., notes the claimant was referred to assess his emotional status and relationship to the work accident. Diagnosis: Axis I: 30928, Adjustment Disorder, with mixed anxiety and depressed mood, secondary to the work injury. Axis II: V71.09, no diagnosis. Axis III: Left wrist and forearm (sprain and contusion only), disputed: Lower back, Left leg, knee. Axis IV: Primary support group, social environment, economic, and occupational issues Axis V: GAF: current 55; Estimated pre-injury: 90±. The initial evaluation that we completed in the office suggests that the claimant would greatly benefit from a brief course of individual psychotherapeutic intervention using CBT approaches and basic self-management strategies coupled with autogenic exercises to facilitate a healthy adjustment and improve his coping with his overall condition. This should assist him in

developing tools and skills for the management of his injury-related disturbances in mood and sleep. The claimant should receive immediate authorization for participation in a low level of individual psychotherapy for a minimum of 6 weeks. Further, the healthcare team should work to reduce disturbances in mood and resolve psychosocial stressors by providing the appropriate community resource referrals.

1-24-09, DO., performed a consultation. The claimant was involved in a work-related injury on xx-xx-xx. He was involved in some physical training that is required for his job. While hitting a punching bag, he injured his left hand and wrist. He says that he was evaluated and told he had 2 tendons torn in his wrist. He also has had an evaluation by a hand surgeon who was unable to provide any surgical treatment, presumably for insurance reasons, but this is unclear. The patient also has a herniated disk in his back at L5-S1 and has had back and leg pain causing him to fall. He also has knee pain due to torn cartilage. At this point, his only compensable injury is his left wrist and forearm. At this time, he is complaining of pain in all three of the above areas. On exam, the claimant has difficulty getting up from the seated position. He has mild gait disorder due to both knee and back pain. He has paravertebral muscle spasm throughout the lumbar spine and generalized pain to palpation. His left wrist area is examined. He has inability to touch his fingertips to his thumb on his left hand, although he can easily do this on the right hand. He has generalized pain to palpation over the MTP joints with some discomfort with range of motion. He has some hand discomfort with range of motion of his left knee. Impression: Left hand injury previously diagnosed as damaged tendons, lumbar herniated nucleus pulposus by history with radiculopathy, left knee pain with possible internal derangement. The evaluator placed the claimant on Elavil 150 mg, which he is currently taking for sleep and put him on some Darvocet for pain in his wrist. He needs further evaluation for his back and knee, but these are not compensable at this time. The claimant is a good candidate for a chronic pain program as he seems to have exhausted all of his ability to get any further medical treatment. He may need to be further evaluated by a hand surgeon to determine if he has a surgical correctable lesion with the tendons of the left hand.

1-24-09 Functional Capacity Evaluation showed the claimant was functioning at a Medium PDL. He required a Medium PDL to perform his job.

2-25-09, MS, LPC, CRC., performed a Chronic Pain Management Program evaluation. The evaluator reported that prior treatment modalities have failed to stabilize the claimant's psychosocial distress, increase his engagement in activities of daily living or enhance his physical functioning such that he could safely return to Work. He endorses his pain as chronic, inflatable, and persistent at 8/10. Conservative care has failed to extinguish his pain or increase functioning such that he could make a successful return to work. He has expressed a strong motivation to return to work, control his pain, and move toward case closure. He describes a severely disabled self-identity. He has developed a chronic pain syndrome. The treatment of choice is participation in an interdisciplinary pain rehabilitation program. The claimant's treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. He is not a surgical candidate. This intensive level of care is

needed to reduce this patient's pain experience, develop self regulation skills, facilitate a timely return to the work force, and medical case closure. Thus, authorization for an initial 10 day trial in a Chronic Pain Management Program appears reasonable and medically necessary for any lasting management of his pain symptoms and related psychosocial problems, as it is the recommended treatment of choice for patients with chronic pain syndrome..

3-2-09, DO., Adverse determination for Chronic Pain Management Program x 10 sessions. The evaluator noted the claimant is a 64-year-old male with an injury from 1-24-08 to the left wrist while performing training duties a security officer. The medical records indicate that he injured his knee, his leg and his back also but it was not reported until several days later. He apparently saw an orthopedic surgeon on only one or two occasions and then started treating with a chiropractic physician Dr. It appears that he has had only six sessions of physical therapy and six sessions of individual psychotherapy. Dr. recommended a trial of Pain Program, Medications include Darvocet-N 100 and Elavil. Darvocet-N 100 four times a day and Elavil 150 mg at bedtime. There are no accompanying medical records indicating any specific functional impairment. The claimant states he is able to stand according to the lifestyle alterations sent from the Pain Management Program. He is able to stand only five to 10 minutes and sit and drive only five to ten minutes. He is able to lift only 3 to 5 pounds. Has difficulty buttoning and zipping his pants, putting on shoes, brushing his teeth, combing his hair. There are no medical records from any of his treating physicians that are not related to the Pain Management Program. There is no indication of treatment from any orthopedic surgeons or what the diagnoses were. An MRI of the left knee taken on 5-23-08 revealed mild patellofemoral arthrosis, mild posteromedial meniscus degeneration and mild effusion. MRI of the low back on 5-23-08 indicated mild degenerative arthritis at L5-S1. There was a 4 to 5 mm posterior central disc protrusion, which appeared to be degenerative in nature. There was no evidence of acute nerve root compression. In reviewing the medical records, it appears that the use of narcotics has not been at maximum or upper limits of recommended dosages. There are no concurrent analgesics, neuromodulators being used. There has never been any evidence of interventional blocks or specific treatments for his back or knee. There has never been an indication that he has failed physical therapy. There is no indication that he has had appropriate physical therapy. There is no indication that he has had appropriate injection therapy. There are no functional impairments indicating household maintenance deficiencies, sleep or wake dysfunction. There is no indication of inability to maintain hygiene or loss of emotional control. There are numerous exaggerated responses such as shaking of the entire body, which is not physiologic in a Functional Capacity Evaluation dated 2-16-09. Also reviewing Functional Capacity Evaluation it appears that the claimant put out significantly less than best effort. It does not appear that the injured worker is a candidate for an Interdisciplinary Pain Management Program. The claimant has certainly not exhausted all lower levels of care.

3-24-09, MS, LPC, CRC., Request for Reconsideration - The evaluator noted that the first issue raised by Dr. is the fact that "there is no indication of treatment from any orthopedic surgeons or what the diagnoses were." In response, it is noted that the

carrier has only accepted a left wrist sprain/strain and forearm contusion as compensable. The patient has been unable to receive an orthopedic consultation because the accepted conditions on his claim would not be operable. That is, the carrier has denied these consultations. Next, Dr. states that, "it appears that the use of narcotics has not been at maximum or upper limits of recommended dosages. There are no concurrent analgesics, neuromodulators being used." This is clearly false. Mr. is currently taking both Darvocet N-100 and Elavil 150mg. That aside, even if the patient were not taking narcotics at all, ODG would not exclude a patient's participation in a CPMP for this reason. Dr. notes that "there has never been any evidence of interventional blocks or specific treatments for his back or knee." Again, as iterated above, the low back and left knee are disputed by the insurance carrier and not considered compensable. Therefore, treatment would not be approved to those body parts. Dr. continues with, "there has never been an indication that he has failed physical therapy. There is no indication that he has had appropriate physical therapy." This is contradictory to Dr. prior notation that, "it appears that he has had only six sessions of physical therapy..." The amount of physical therapy had would be near the upper limits of ODG's recommendation for a sprain/strain of the wrist.

Next, Dr. states, "there is no indication that he has had appropriate injection therapy." I would note that beside the fact that injections only offer temporary relief of injections, again, the only accepted injury at this time is a wrist sprain/strain and forearm contusion, neither of which have indications for an injection procedure. The next concern raised by Dr. that, "there are no functional impairments indicating household maintenance deficiencies, sleep or wake dysfunction. There is no indication of inability to maintain hygiene or loss of emotional control." These are not ODG criteria for participation in a CPMP, therefore they are irrelevant. Despite this, the patient does have many functional impairments and rates sleep problems as 9/10 on a VAS, with 10 being the worst. Also, he requires assistance with hygiene, though it is unclear what Dr. means by "loss of emotional control." Clearly, his psychosocial issues are affecting his condition. Further, Dr. suggestion that, "there are numerous exaggerated responses such as shaking of the entire body which is not physiologic," is incorrect. A man who has multiple areas of injury (including his low back for which he has not received treatment) and is highly deconditioned would be expected to have a pain and fatigue response such as this. This was not noted to be an exaggerated motion on the patient's part and non-organic features have never been shown to be positive in this gentleman. Finally, Dr. states that, "reviewing Functional Capacity Evaluation it does not appear that the claimant put out significantly less than best effort." I would begin by noting that out evaluation system uses a COV measure (Coefficient of Variance) to assess maximal effort. That said, it is noted that "values greater than 15% may be an indicator of submaximal effort." In this case, only two tests (Static Left Hip Flexion Strength, the COV of which was 15.6%, and the High Near Lift, the COV of which was 16.0%) had a COV over 15%, and these were minimally above 15%- There is no indication by the evaluator that the patient gave inconsistent effort. Overall, it appears that Dr. has used several points to deny this request that he has verbatim spelled out in denials on other two other recent cases reviewed by Dr.. These were both later overturned on appeal. Clearly, the points raised are not valid and the claimant should be authorized to participate in this level of care.

3-31-09, PhD., noted that the recommended denial of pre-authorization for chronic pain management program was upheld. The evaluator reported that pre-authorization was medically not necessary or appropriate with regard to injured workers ongoing discomfort to the left wrist and hand. The current medical documentation regarding the left wrist and hand is inadequate to make a diagnosis as to the current pathology and the ongoing pain generators. There is no indication as to what treatment has been rendered and what treatment is necessary to resolve the injured worker's ongoing complaints with regard to the left wrist and hand and the request for Interdisciplinary Program is premature at this time.

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

The severe pain of 8/10 that persists, the mechanism of injury and recent physical exam of the left hand presented, as well as the lack of diagnostics and investigation of pain generators, all point to as yet, an unclear or inaccurate diagnosis. Multiple consults have been mentioned: possible injury or rupture, tears, but nowhere is there a documented investigation and diagnosis proposed by a hand specialist. A diagnosis, prognosis and appropriate therapy for the compensable injured part, have not been submitted by the appropriate specialty. A pain program is premature at this time and inappropriate without addressing the possible existence of anatomical pathology. Therefore, non-certification is provided.

ODG-TWC, last update 4-30-09 Pain - Chronic Pain Management Program:

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 have resulted in "Delayed recovery." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), 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) 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) See Biopsychosocial model of chronic pain.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. These pain rehabilitation programs (as described below) combine multiple treatments, and at the least, include psychological care along with physical and/or occupational therapy (including an active exercise component as opposed to passive modalities). 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.

Outcomes measured: Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to “demedicalize” treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all. (See Opioids for chronic pain.)

Outcomes (in terms of body parts)

Neck and Shoulder: There are limited studies about the efficacy of chronic pain programs for neck, shoulder, or upper extremity musculoskeletal disorders.

(Karjalainen, 2003) This may be because rates of cervical claims are only 20-25% of the rates of lumbar claims. In addition, little is known as to chronicity of outcomes.

Researchers using PRIDE Program (Progressive Rehabilitation Institute of Dallas for Ergonomics) data compared a cohort of patients with cervical spine disorders to those with lumbar spine disorders from 1990-1995 and found that they had similar outcomes. Cervical patients were statistically less likely to have undergone pre-rehabilitative surgery. (Wright, 1999)

Multidisciplinary back training: (involvement of psychologists, physiotherapists, occupational therapists, and/or medical specialists). The training program is partly based on physical training and partly on behavioral cognitive training. Physical training is performed according to the "graded activity" principle. The main goal is to restore daily function. A recent review of randomized controlled studies of at least a year's duration found that this treatment modality produced a positive effect on work participation and possibly on quality of life. There was no long-term effect on experienced pain or functional status (this result may be secondary to the instrument used for outcome measure). Intensity of training had no substantial influence on the effectiveness of the treatment. (van Geen, 2007) (Bendix, 1997) (Bendix, 1998) (Bendix2, 1998) (Bendix, 2000) (Frost, 1998) (Harkapaa, 1990) (Skouen, 2002) (Mellin, 1990) (Haldorsen, 2002)

Intensive multidisciplinary rehabilitation of chronic low back pain: The most recent Cochrane study was withdrawn from the Cochrane (3/06) as the last literature search was performed in 1998. Studies selected included a physical dimension treatment and at least one other treatment dimension (psychological, social, or occupational). Back schools were not included unless they included the above criteria. There was strong evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improved function when compared to inpatient or outpatient nonmultidisciplinary rehabilitation. Intensive (> 100 hours), daily interdisciplinary rehabilitation was moderately superior to noninterdisciplinary rehabilitation or usual care for short- and long-term functional status (standardized mean differences, -0.40 to -0.90 at 3 to 4 months, and -0.56 to -1.07 at 60 months). There was moderate evidence of pain reduction. There was contradictory evidence regarding vocational outcome. Less intensive programs did not show improvements in pain, function, or vocational outcomes. It was suggested that patients should not be referred to multidisciplinary biopsychosocial rehabilitation without knowing the actual content of the program. (Guzman, 2001) (Guzman-Cochrane, 2002) (van Geen, 2007) (Bendix, 1997) (Bendix, 1998) (Bendix2, 1998) (Bendix, 2000) (Frost, 1998) (Harkapaa, 1990) (Skouen, 2002) (Mellin, 1990) (Haldorsen, 2002)

Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults: The programs described had to include a physical component plus either a psychological, social and/or vocational intervention. There was moderate evidence of positive effectiveness for multidisciplinary rehabilitation for subacute low back pain and that a workplace visit increases effectiveness. The trials included had methodological shortcomings, and further research was suggested. (Karjalainen, 2003)

Role of opioid use: See Chronic pain programs, opioids.

Role of comorbid psych illness: Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of

injury. (Dersh, 2007) The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability. (Poleshuck, 2009) (Bair, 2008)

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) There is need for research in terms of necessity and/or effectiveness of counseling for patients considered to be "at-risk" for post-discharge problems. (Proctor, 2004) 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) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) (Dersh, 2007)

Role of duration of disability: There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).

Studies supporting programs for patients with long-term disability: Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals. (Jordan, 1998)

Studies suggesting limited results in patients with long-term disability: While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. (Gallagher, 1989) (Beals, 1972) (Krause, 1994) Washington State

studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a "treated group" for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included Psych/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N=963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the "treated patient" was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that modest goals (improvement, not cure) be introduced. (Robinson, 2004) (Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]

Timing of use: Intervention as early as 3 to 6 months post-injury may be recommended depending on identification of patients that may benefit from a multidisciplinary approach (from programs with documented positive outcomes). See Chronic pain programs, early intervention.

Role of post-treatment care (as an outcome): Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a "new provider" is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that

did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed. (Proctor, 2004)

See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention.

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

- (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.
- (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.
- (3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or

diagnoses that would better be addressed using other treatment should be performed;
(d) An evaluation of social and vocational issues that require assessment.

(4) 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) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery.

(10) 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 they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) 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 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

(13) At the conclusion and subsequently, neither re-enrollment in 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 (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

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. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program).

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**