

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/05/09

**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 chronic pain management program (CPMP) five (5) times a week for two (2) weeks (10 sessions/hours) as related to the neck and back

### **REVIEW OUTCOME**

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

Upheld (Agree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 10-10-06 EMG/NCV from Dr.
- o 10-14-06 Evoked potential study from Dr.
- o 12-27-06 Chest film study read by Dr.
- o 01-17-07 Chest film read by Dr.
- o 01-17-07 Lumbar x-rays read by Dr.
- o 01-17-07 Operative report, revision cervical surgery from Dr.
- o 01-18-07 Lumbar x-ray read by Dr.
- o 03-16-07 Lumbar x-rays read by Dr.
- o 05-15-07 Chest film read by Dr.
- o 06-21-07 Lumbar x-rays read by Dr.
- o 06-27-09 Lumbar CT scan read by Dr.
- o 07-11-07 Cervical MRI read by Dr.
- o 08-01-07 EMG/NCV BUE from Dr.
- o 08-27-07 BUE evoked potential study from Dr.
- o 11-16-07 Discogram report from Dr.
- o 12-05-07 Cervical x-rays read by Dr.
- o 01-19-08 Discharge Summary from Dr.
- o 02-15-08 Medical report and radiographic reading from Dr.
- o 03-04-08 Consultation report from Dr.
- o 03-04-08 Chest films read by Dr.

- o 03-11-08 Cardiolute stress test results from Dr.
- o 03-19-08 Internal Medicine Consultation from Dr.
- o 03-19-08 Lab report, path lab, from Dr.
- o 03-21-08 Operative report 3-level ACDF from Sr.
- o 03-21-08 Cervical x-rays read by Dr.
- o 04-01-08 Medical report and radiographic reading from Dr.
- o 04-16-08 Cervical x-rays read by Dr.
- o 04-18-09 Medical report from Dr.
- o 05-15-08 Medical report from Dr.
- o 06-12-08 Cervical x-rays read by Dr
- o 07-15-08 Cervical x-rays read by Dr.
- o 08-15-08 Medical report and radiographic reading from Dr.
- o 09-10-08 EMG/NCV lower extremities read by Dr.
- o 09-15-08 Cervical x-ray report from Dr.
- o 09-19-08 Medical report from Dr.
- o 10-15-08 Medical Report - Plate Block procedure - from Dr.
- o 12-02-08 Medical report and Radiographic reading from Dr.
- o 12-15-08 Functional Capacity Evaluation from Dr.
- o 12-15-08 Psychological Impact Screens, unsigned
- o 01-12-09 Lumbar MRI read by Dr.
- o 05-11-09 Initial Diagnostic Screening from Dr.
- o 06-18-09 Treatment note from Dr.
- o 06-26-09 MRI cervical spine read by Dr.
- o 07-01-09 Treatment note from Dr.
- o 07-23-09 Treatment note from Dr.
- o 07-23-09 EMG/NCV read by Dr.
- o 07-27-09 Treatment Progress Report from Dr.
- o 07-31-09 Medical report from Dr.
- o 08-03-09 Notice of utilization review findings - initial denial - from
- o 08-13-09 Medical report from Dr.
- o 08-13-09 Radiographic reading from Dr.
- o 08-11-09 Letter of Medical Necessity from Dr.
- o 08-21-09 Response to Denial Letter from Dr.
- o 08-21-09 Patient treatment goals and objectives of the CPMP
- o 08-24-09 Request for appeal from Dr.
- o 08-27-09 Notice of utilization review findings - reconsideration – from
- o 09-15-09 Request for IRO from the Claimant
- o 09-15-09 Lower EMG/NCV study from Dr.
- o 09-16-09 Confirmation of Receipt of IRO
- o 09-17-09 Case Assignment of IRO

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is an employee who reported neck and low back pain when he tripped, fell and rolled down an embankment while working on xx/xx/xx. His prior history included a lumbar fusion in 1996 at L4-5 with pedicle screw and posterior plate fixation L4-S1. He developed low back pain with radiation to the bilateral legs with numbness on the right. Electrophysiologic studies of October 2006 revealed acute irritability of the bilateral L4 and L5 and to a lesser extent, S1 nerves.

The patient underwent a revision posterior lumbar surgery with fusion redo and laminectomies on January 17, 2007 for failed back syndrome and radiculopathy complicated by a broken Songer cable L4-5. Extensive disc material was removed along with a partial corpectomy. A PEEK cage and BMP was used and pedicle bolts were placed on the L4-5 pedicles on the left and L4 and S1 pedicles on the right. Per CT scan of July 2007 the pedicle screws remained secure.

The patient also developed neck pain. MRI of July 2007 revealed degenerative disc disease, spondylosis and spinal stenosis C4-T1. A focal neurocompressive lesion was not described. Nerve studies of August 2007 indicated radiculopathic changes bilaterally at C6 and C7 and mild involvement of C5. Cervical discogram of November 2007 was interpreted to show disruption of disc architecture C3-4, C4-5, C5-6 and C6-7 with concordant pain response at C4-5 and C5-6.

The medical report of February 15, 2008 notes the patient is 5' 8" and 256 pounds. He is being treated for neck, mid back and low back pain. Recommendation was for ACDF with anterior plate at C4-5 and C5-6.

The patient was examined pre-surgically on March 4, 2008. Due history of hypertension, dyspnea with exertion and chest pain he was scheduled for a Cardiolute stress test, chest x-rays and lab work. He passed these tests and was cleared for surgery which was performed on March 19, 2008 and described as anterior cervical discectomy and fusion with cage/plate device at C4-5, C5-6 and C6-7. PEEK cages and BMP were used.

Per the patient's orthopedic provider on April 1, 2008 the patient has done well with the surgery but reports some occasional tingling and numbness in his right hand. He has breathing problems and is using his sister's CPAP machine. He is a former boxer and has had multiple fractures of his nose and septal defects. He was also hit by a truck at age 10 and had surgery on his

nasal area. X-rays show good positioning of the cage and screws. In April 2008 the patient's breathing problem is much better using a nasal separator. In May 2008 the patient initiated PT. He has persisting neck pain and breathing problems. He is using Ambien, Genahist and Cymbalta.

Radiographs taken in July 2008 note little movement in the cervical spine but no instability. The patient reports significant upper and lower extremity conditions in August 2008 but radiographs do not show any significant findings. He was recommended for a lumbar hardware block. Nerve studies were done in September 2008. Lower extremity nerve studies were also done in September 2008 for bilateral hip and left heel pain. The nerve studies showed improvement in the L4 and L5 motor nerves but some worsening of the acute irritability of the S1 nerve roots. A plate block was administered on October 15, 2009 with pain reduction noted of 9/10 to 7/10 that day. On December 2, 2008 the patient reported his pain was 7-8/10 pre-block and 6/10 post-block with pain of 8-9/10 since. He appears to have some mild plate impingement syndrome. X-rays revealed posterior translation of L3 on L4 of 8 mm and MRI and repeat nerve studies were recommended.

The patient underwent an FCE on December 15, 2008. Mild motor weakness is noted in the left hip, knee and ankle muscles. All cervical motor groups are 4/5 or 4+/5. The patient reports thoracic and lumbar pain with all lifts. He can lift a 20-pound weight knuckle level to shoulder level 17 times at the third attempt. Isometric strength testing indicates a mean leg lift of 83.3, Torso lift of 88.3, Arm lift of 62.7 and High near lift of 72.7 pounds. Per the summary, most of his psychological impact scores were high. He is unable to return to his employment. He has difficulty even with simple household chores. He was recommended to participate in a chronic pain management program.

The patient was assessed psychologically and considered for individual psychotherapy on May 11, 2009. He has worked in his job for more than 20 years. He is married and has a good support system. He reports his work related injury has worsened. He does not smoke. He is at retirement age and is applying for retirement and has no educational goals at this time. His provider has noted mood disturbances, anxiety disorder, sleep disorder, vocational concerns, psychosocial stressors, significant mental stress and sleep disturbance. He is focused on his pain which is significant. He has moderately severe depression per testing. He has sleep difficulty. Impression is Adjustment Disorder with Mixed Anxiety and Depression, Pain Disorder, Sleep Disorder and Occupational Problem. Six sessions of Cognitive Behavioral therapy (CBT) were recommended and psychiatric medications. A treatment note of July 23, 2009 indicates the patient is doing HEP but fearful of re-injury. There is a conflict regarding impairment at this time.

Upper extremity nerve studies were performed on July 23, 2009 and revealed significant improvement in the cervical radiculopathy previously noted and some progression of slowing across the wrists and elbows which may represent a form of mixed polyneuropathy. A cervical MRI of July 23, 2009 was essentially interpreted as unremarkable with post-surgical changes noted.

A lengthy psychological progress report was submitted on July 27, 2009. The patient's depression score was reduced from 29 to 16. His anxiety score was reduced from 23 to 15. His sleep score was reduced from 59 to 48. Goals include vocational planning. His treatment should include a conservative course of multidisciplinary treatment. He would benefit from participating in a chronic pain management program (CPMP) to help him cope with his feelings attributed to his work related injury, feelings of depression, anxiety and ongoing physical complaints. He is recommended for a 5x/week program of 10 days (2 weeks).

Request for participation in a CPMP was considered in review on August 3, 2009 with recommendation made for non-certification. Rationale included recent participation in 6 sessions of CBT with noted improvement in all areas of assessment. All lower levels of care do not appear to have been exhausted. It was the reviewing physician's opinion that the request is not reasonable and does not meet current Official Disability Guidelines criteria as all lower levels of care have not been exhausted.

Request for reconsideration and rationale for the medical necessity of a CPMP was submitted dated August 11, 2009. Since his injury the patient has been provided treatment of rest, PT, diagnostic testing, epidural steroid injections, hospital care, surgeries and ongoing medical management. He is currently attending follow-up visits with his orthopedic provider and pain management provider and using hydrocodone 5/500. He continues to suffer from chronic pain on a daily basis. He is unable to return to work. All primary and secondary levels of treatment have failed. He meets 4 criteria as required by guidelines-only 2 need be met to participate in a CPMP. He scored 35 on a GANT PAO Readiness Assessment for CPM. He consistently reports a pain level of 8/10. His revised Oswestry Low Back Pain Disability score is 74%. Per the FCE he does not qualify for his pre-injury job. A multidisciplinary pain management program would be beneficial for this patient. A list of treatment goals is attached.

On August 13, 2009 the patient reports only slight cervical pain when driving. He continues to have lumbar pain that radiates to the entire left leg to include below-the-knee. He reports some left ankle swelling. He reports a pain level of 8/10. He uses a cane when taking a long walk. He is using hydrocodone 5/500 mg up to 6 daily as needed. He will be referred for a lumbar epidural injection at L3-4 bilaterally.

An appeal letter was submitted dated August 21, 2009 from the patient's psychological provider. The orthopedic provider has indicated that all surgical intervention and secondary care to address pain and functional loss have been exhausted and he is

recommending multidisciplinary intervention to address functional restoration deficits. According to a recent Physical Performance Evaluation the patient is not able to return to work. He is motivated. A chart is provided demonstrating progress with anxiety, depression and sleep. Criteria for multidisciplinary pain management programs are reviewed.

Request for CPM program was considered in review on August 27, 2009 on appeal and recommendation made for non-certification. The patient is 4.5 years post injury. He is only using hydrocodone. The most recent FCE is December 2008 with no current physical objective physical assessment, The FCE says he is sedentary but isometric lifting was 72-88 pounds, so this is questionable. He does not have a return to work plan as he is contemplating retirement. He has completed 6 sessions of CBT with noted improvements. Given the above, he does not meet the Official Disability Guidelines criteria for a CPMP (2,3,6,7,9). Continued individual care with gradually increasing exercise would be sufficient to meet his goals. The 15 criteria for CPMP of The Official Disability Guidelines are cited (see guidelines below).

Lower extremity nerve studies were conducted on September 15, 2009 and provided impression: "There is significant change from his last study in that there now appears to be some irritability in both the L3 and L4 motor roots, left greater than right, whereas the previous irritability noted in the S1 distribution has resolved. There is a greater involvement of the lower sacral S2-4 motor roots than previously noted with more pattern decreases and polyphasicity and he has some perirectal numbness on the left and has had two episodes of bowel incontinence. Because of the change in condition will request repeat extremity dermatomal SEPS for further evaluation and comparison."

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

Per The Official Disability Guidelines, there is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).

The Official Disability Guidelines provides 15 criteria to aid the provider in determining if a patient is a good candidate for a CPMP. The criteria are closely reviewed. Criteria 10-15 do not apply at this time but would apply to a successful candidate for a CPMP. Criteria 1-9 are considered presently. Criteria #1 has been met: The patient has a chronic pain syndrome and use of a prescription pain medication that may result in tolerance. Criteria #2 has not been met: Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. The patient has done quite well with just 6 sessions of CBT and additional improvements could be realized with this treatment. Criteria #3 has not been met: An adequate and thorough multidisciplinary evaluation has been not been completed. The patient was assessed psychologically in May and July 2009 but has not been thoroughly assessed physically since the FCE of December 2008. Criteria #4 does not apply as a surgery is not planned. Criteria #5 has not been met as substance abuse is not a concern. The patient is using only hydrocodone and no medication issues have been reported. Criteria #6 and #7 can be said to have been met as the content and goals of the CPMP have been clarified and the patient appears to be motivated for improvements. Criteria #8 and #9 have not been met: Identification and addressing the negative factors of success have not been clarified. The patient is 4.5 years post injury which is a negative factor for success and this has not been addressed.

The patient could be said to have met 3 of the first 9 criteria. Criteria 10-15 apply only to successful CPMP candidates. According to the provider, the patient meets 4 criteria as required by guidelines-only 2 need be met to participate in a CPMP. This is not found in the guidelines. Additionally, on August 13, 2009 the patient was planned to have a lumbar epidural injection and the results are pending. On September 15, 2009, due a change in the patient's condition repeat extremity dermatomal SEPS are planned for further evaluation and comparison. The patient appears to be a candidate for additional CBT. Clearly, all primary and secondary levels of treatment cannot be said to have been exhausted. In any case the patient is at retirement and does not appear to have a return to work plan or interest in additional training or education for work. Overall, considering the patient is 4.5 years post injury and planning retirement versus seeking work and considering how well he has done with CBT, it would appear additional CBT would be a more appropriate treatment plan versus initiating an extended multidisciplinary program. Therefore, my recommendation is to agree with the previous non-certification for outpatient chronic pain management program (CPMP) five (5) times a week for two (2) weeks (10 sessions/hours) as related to the neck and back.

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 -Pain Chapter (9-9-2009) 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 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.

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.

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

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.

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.

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.

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.

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.

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. 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 Pysch/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).

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.

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 (80 hours) 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. 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).