



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 6-1-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 10 sessions

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

Psychologist

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

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PATIENT CLINICAL HISTORY [SUMMARY]:

On xxxx, the claimant underwent surgery performed by MD. Right knee partial medial and lateral meniscectomy, removal of loose bodies, chondroplasty of the chondral injury of the patella, chondroplasty of the medial and lateral compartment, irrigation and injection of Lidocaine and Marcaine.

Follow up with Dr. on 8-10-09 noted the evaluator continued to recommend the claimant for a chronic pain management program as the claimant's behavioral pattern continues to demonstrate moderate anxiety related to her condition. She will undergo the recommended bone scan as requested by the Designated Doctor Evaluation.

On 8-27-09 Three phase bone scan showed right knee arthritis with some mild inflammatory component. The evaluator did not believe the claimant's knee is infected. The activity in the right mid thoracic spine, right L4-L5, and AC joint is probably degenerative in origin. The activity in the alveolar ridges is probably periodontal in etiology.

On 12-22-09, the claimant underwent surgery performed by MD., diagnostic arthroscopy, abrasion chondroplasty of the patellofemoral joint, medial femoral condyle and lateral femoral condyle, removal of loose body in the anterior intercondylar notch and from the lateral gutter. Tricompartmental synovectomy with extensive lysis of adhesions in the anteromedial, anterolateral and suprapatellar pouch. Partial and medial and lateral meniscectomy.

On 1-8-10, DC., performed an Impairment rating evaluation. He certified the claimant had reached statutory MMI and awarded the claimant 4% impairment rating based on partial and lateral meniscectomy.

Re-evaluation performed by DC., on 1-28-10 noted the claimant complains of some weakness in the right knee. The claimant has completed approximately 11 sessions of postop rehabilitation. On exam, the claimant his moderately tender to touch especially at the regions of previous surgical lacerations. There is mild swelling. Apley's compression was positive for increased pain in the right knee with external rotation in the knee. The patellar grind test is positive for increased pain. The evaluator recommended the claimant continue with her postop rehabilitation program.

On 3-30-10, , MD., performed a Peer Review. It was his ongoing that ongoing chiropractic treatment is not reasonable or medically necessary for the accident or injury of record in this case. The claimant in this case has undergone an excessive

course of chiropractic care, physical therapy care, psychological counseling, work hardening, and post-operative physical therapy care with no substantive objective observable benefit. The claimant in this case has undergone 56 visits of physical therapy, work hardening, and chiropractic care over the past 27 months and the functional capacity evaluations conducted over the course of care revealed that, despite the measures utilized in this- case (chiropractic, therapy, medications, injections, sympathetic blocks, 2 surgeries, work hardening, chronic pain management, and psychological counseling) the claimant never attained functional abilities above the Light physical demand level. The amount of care rendered thus far has exceeded ODG guidelines and the continuation of chiropractic care is not clinically justifiable or medically reasonable or necessary in this case. Further diagnostics are not medically necessary for the compensable injury in this case. The claimant has undergone x-rays, two MRI studies and a bone scan, which have well defined the injury and the extent of pre-existing conditions affecting the right knee in this case. The claimant does not require any form of chiropractic treatment in this case. The injury was limited to the right knee and there is no need for any manipulation-based treatments or manual therapy treatments in this case rendered by a chiropractor. The maximum therapeutic benefits associated with chiropractic care are realized in the first few weeks of treatment and chiropractic literature indicates that no observable benefit is noted after 2 months. Thus, there would be no need for chiropractic treatments on an ongoing basis, as over 27 months have elapsed since the date of injury and the time period for the utilization of chiropractic care was reached two years ago. Periodic chiropractic office visits are not reasonable or medically necessary. The chiropractor has little to offer the claimant in this case, as all measures utilized to date have not resulted in significant functional improvement.

Follow up with Dr. on 4-20-10 noted due to her persisting pain and depression and anxiety related to her pain, the evaluator recommended the claimant undergo a chronic pain management program.

4-20-10 MA, LPC., After completion of approved individual psychotherapy sessions, the evaluator was recommending that this patient participate in our Multidisciplinary Chronic Pain Management program to aid the patient in dealing with depression, anxiety, and pain symptoms associated to both psychological factors and a general medical condition, and chronic pain. Patient has completed approved group sessions of work hardening unfortunately, patient was noted making minimal progress, due on large part to poor coping skills, anxiety, depression, and pain complaints. Patient has been compliant with our clinic's treatment guidelines and has demonstrated minimal progress. Please consider this as a request for 10 sessions of Multidisciplinary Chronic Pain Management Treatment, thus awarding this patient the opportunity to participate in a program that will enable her to make a successful transition to a higher level of functioning, and return to work. The pain resulting from her injury has severely impacted normal functioning physically and interpersonally. Patient reports frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. Pain has reported high stress resulting in all major life areas. The patient will benefit from a course of pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning. Patient should be treated daily in a pain management program with both

behavioral and physical modalities as well as medication monitoring. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consists of, but is not limited to daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting, and returning to a higher level of functioning as possible.

Follow up with Dr. on 4-26-10 notes the claimant reported mild pain and soreness. The pain is located at the lateral side. On exam, the claimant has pain which is moderate to palpation, positive apprehension test. The claimant had tenderness over the medial and lateral joint line. Motor exam is 4/5 bilaterally. The claimant is sensitive to light touch. The claimant has an antalgic gait. The evaluator felt the claimant had made progress from her preoperative state. The evaluator reported she is nearing MMI. He recommended Synvisc series and an unloader orthosis to treat her post traumatic osteoarthritis. The claimant was continued on Lyrica, Voltaren gel and she was given a prescription for Lidoderm patches. The claimant will be sent to Dr. to check the nerve for ablation.

A Physical Performance Evaluation dated 4-29-10 noted the claimant was functioning at a Light PDL.

A Required Medical Evaluation performed on 4-30-10 performed by, MD., noted ongoing medical treatment is no longer reasonable nor necessary for this claim. The findings on her arthroscopy are not consistent with the mechanism of injury. She has had significant and severe preexisting degenerative arthrosis that was diagnosed prior to the first arthroscopy on the MRI. At this time she is suffering from the natural progression of the arthritis, unrelated to the slip-and-fall of December 21, 2007. The evaluator did not believe that ongoing orthopedic or pain management care is necessary or appropriate. The evaluator believed that her current symptoms are in excess of the objective findings, and they are related to the degenerative condition that was preexisting this slip-and-fall. The ODG does not endorse the ongoing use of anti-inflammatory medications for the knee contusion she suffered in December 2007. She has used ibuprofen, Voltaren and Celebrex at times for this injury. While she may require anti-inflammatory medications for the underlying degenerative changes, they are not related to the injury of December 2007. There is no evidence of neuropathic pain for which Lyrica would be reasonable or necessary. In his opinion, the patient is now three months later her last surgery, and she would not require the ongoing use of pain medications as a direct result of surgery. At this time the diagnosis is quite clear. She is preexistent degenerative changes created by the injuries of 2004 and 2006. The slip-and-fall in 2007 did not materially change the condition within her knee. Should she require further treatment in the future, she would have acquired this treatment regardless of the slip-and-fall of 2007. She does not require diagnostic injections, physical therapy, durable medical equipment, chiropractic care, work-hardening (The patient has already been through a tertiary program and it did not improve hex functional level), or a pain management program. There is no evidence of depression or other psychological condition that occurred as a direct result of the injury. A TENS unit, neuromuscular stimulator or a spinal cord stimulator are not required for this claimant.

The claimant would benefit from a home exercise program to include stretching and strengthening. At the current time the claimant does not require ongoing visits in regards to the injury. While she may have subjective pain complaints, they are unrelated to the injury in questions. Further office visits are neither reasonable nor necessary.

On 5-7-10, , DC., performed a Utilization Review. The evaluator reported he spoke to the doctor on 5-6-10, they discussed the current request. The recent psych evaluation indicates the claimant has minimal depression and anxiety, neither of which is significant to support or warrant the current request. An RME was performed on 4-30-10 which states she has already completed a tertiary care program which did not improve her functional abilities. The RME also indicates there was no evidence of psych issues as it relates to the original work injury. The claimant has completed individual psych sessions which were very effective at reducing the depression and anxiety levels. Prior treatments have been successful at treating this claimant. A recent FCE indicated the claimant is capable of static and dynamic lifts from 20 to 31 lbs, which falls into the Medium PDL. This claimant does not meet the ODG Criteria for the requested program. This claimant does not have a significant loss of function. She is capable of dynamic and static lifts in the medium PDL and she was capable of completing a work hardening program. Based on the submitted information, she is capable of her normal work duties. She has already completed a work hardening program. Re-enrollment in the same or similar program for the same work injury is not supported. There is no evidence that the prior treatments have been unsuccessful. The prior treatments with individual psych were very effective at reducing the depression and anxiety. This claimant does not meet the ODG Criteria for the current request. Based on the documentation provided, objective and subjective findings this request is not medically reasonable and necessary.

On 5-10-19, DC., provided a request for reconsideration. The evaluator reported the claimant exhausted all lower levels of care and is pending no additional procedures. Official Disability Guidelines from the Work Loss Data Institute consider tertiary chronic interdisciplinary pain programs as the standard of treatment, The results of an outcome study performed by Proctor, Mayer, Theodore, and Gatchel demonstrated that patients who do not complete a chronic pain program are 7 times more likely to have post-rehabilitation surgery in the same area and nearly 7 times more likely to have more than 30 visits to a new health provider in persistent healthcare-seeking efforts. The study also demonstrated that patients who do not complete a chronic pain program had only half the rates of work return and work retention, being 9.7 times less likely to have returned to any type of work, and 7 times less likely to have retained work at the end of the year. Therefore, a chronic interdisciplinary pain program is the recommended course of treatment to help an injured worker return to work and is considered the treatment of choice by the national standards cited above. Ms. Pena meets the criteria for the general use of multidisciplinary pain management program, according to Official Disability Guidelines.

On 5-17-10 DC., performed a Utilization Review. The evaluator reported he discussed the request at length with Dr. at 2:15pm CST on 5-13-10. The previous reviewer noted the claimant has completed a work hardening program yet has failed to return back to work duties. The job description on the functional capacity evaluation dated 4-29-10 indicated the claimant performs clerical tasks such as making copies, ordering supplies,

basic storeroom activities. The claimant was stated as having to lift a box of paper weighing 30 pounds, which would place her in the Light physical demand level. The FCE dated 4-30-10 determined the claimant was able to safely lift at the Light level. There was no job description from the employer. The claimant's BAI was 14 and the BDI was only 10. It was not clear why the claimant would require additional supervised therapy given the FCE and behavioral findings. The RME dated 4-30-10 opined that no additional treatment was required. Given the submitted documentation and the peer to peer with Dr. recommend non-approval of requested chronic pain management program

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

The available information has been reviewed. The patient has an injury date of xx/xx/xx She has had diagnostics, physical therapy, a bone scan, surgeries, chiropractic treatment, medications, individual psychotherapy, and a Work Hardening program. She reportedly made progress in IT and continued to demonstrate decreased anxiety and depression following IT with her current symptoms within the normal range. She progressed in WH to a light PDL; however, on some measures, she reportedly is able to function at a medium PDL and she has a required PDL of medium. It was determined on 1/08/10 that she was at statutory MMI with a 4% impairment rating. A Peer Review on 3/30/10 notes that no further treatment would be reasonable or necessary for the patient given the injury and treatment to date. An RME on 4-30-10 notes that ongoing medical treatment is not reasonable or necessary. CPMP was requested and denied two times. The patient reportedly did not attempt to return to work in any capacity following the Work Hardening program. According to the available records, this patient has had extensive treatment to date and has made little progress overall with the exception of decreasing anxiety and depressive symptoms. The patient is reportedly close to her required PDL but her return to work plans are unclear. It is noted in the documentation that she is very fearful of having to have additional surgeries but it is also stated that no further surgeries will be recommended. Notes from 4/10 from her doctor indicate conflicting information about her presentation of depression and anxiety. Without having attempted to return to work at light duty, particularly after a Work Hardening program, and with minimal psychological symptoms of distress noted, there is insufficient information to establish necessity of CPMP. The patient has had an opportunity to participate in a return to work program with little progress noted. Based on the available information, the necessity for CPMP does not appear to be reasonable and necessary.

ODG-TWC, last update 5-28-10 Occupational Disorders Pain – 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. (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. (Karijalainen, 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) (Gatchel2, 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 (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. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(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)