

- MD., office visits on 3-21-10, 4-19-10, 5-10-10, 6-7-10, 7-12-10, 8-23-10, 9-20-



Notice of Independent Review Decision-WC

DATE OF REVIEW: 4-27-11

CLAIMS EVAL

*Utilization Review and
Peer Review Services*

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 10 days
Start date: 3/14/11 End Date: 8/26/11

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

Chiropractor

REVIEW OUTCOME

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

- Upheld
- (Agree) Overturned
- (Disagree) Partially Overturned

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

PATIENT CLINICAL HISTORY [SUMMARY]:

3-24-09 MRI of the left knee showed myxoid degeneration throughout the medial meniscus with subtle inferior articular extension along the posterior horn. Lateral meniscal myxoid degeneration without a tear. Mild proximal patellar tendinopathy with prepatellar subcutaneous edema.

6-3-09 X-rays of the left pelvis shows no acute bony abnormality.

6-3-09 X-rays of the left knee shows a normal knee.

6-3-09 X-rays of the left knee was normal.

6-3-09 X-rays of the lumbar spine appeared unremarkable with no acute bony abnormality.

6-15-09 MRI of the lumbar spine shows diffuse disc bulge, right paracentral superior disc extrusion and facet arthrosis at L5-S1 cause severe bilateral neural foraminal narrowing. Disc material contacts both exiting L5 nerve roots.

On 6-16-09 MD., the claimant reports ankle, knee and hip pain. The knee has persisted and is the most bothersome. The claimant was provided with an injection into the knee. The claimant was continued off work.

Physical therapy on 6-26-09, 7-1-09.

On 7-21-09, MD., the claimant was seen for follow up of the left knee and hip. The claimant reports he is better the claimant reports he is better. On exam, the claimant has some discomfort with range of motion of the knee. He is stable on varus, valgus and Lachman's stress. The evaluator talked about treatment options. The claimant will be sent for a second opinion.

On 7-31-09, the claimant was evaluated by DO., notes the claimant reported that a chain from the hoist wrapped around his left lower extremity and jerked him upside down hanging in the air from his left lower extremity. He injured his knee and lumbar spine. He will most likely be going through surgery for his knee but he was there for the lumbar spine. On exam, he is able to heel and toe walk with some difficulty regarding balance.rom of the lumbar spine was significantly decreased. He had a mildly positive right SLR. He has decreased sensation at the right lateral lower extremity. Strength was normal. DTR were normal. Plan: pursue a lumbar epidural steroid injection.

8-28-09 Lumbar epidural steroid injection at L5-S1 performed by Dr.

Medical records reflect the claimant underwent a second knee opinion performed by Dr. on 8-31-09. It was his opinion that the claimant was a non surgical candidate. He reported the knee brace was not necessary. The evaluator recommended weight loss.

Follow up with Dr. on 9-14-09 notes the claimant had an epidural steroid injection done on 8-28-09. He reported the claimant was doing significantly better. He reports that his knee symptoms are almost resolved. The claimant was released to full duty.

9-18-09 MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 10-30-09 as the date of MMI.

Follow up with Dr. on 9-28-09 notes the claimant has some increased back pain but no symptoms to the lower extremities. The evaluator recommended physical therapy for the lumbar spine. He was continued at work with his same duty.

Physical therapy on 9-29-09.

On 11-2-09, Dr. evaluated the claimant recommended physical therapy for the lumbar spine and epidural steroid injection at L5-S1.

On 12-1-09 DO., evaluated the claimant. The claimant has a L5-S1 herniation. However, he is not having radicular symptoms. The evaluator reported that the claimant needs to be treated and not the film. The evaluator strongly recommended against any type of surgical evaluation. The evaluator recommended a Functional Capacity Evaluation.

On 12-3-09, MD., performed a Designated Doctor Evaluation. He felt the claimant had reached MMI and awarded the claimant 2% for range of motion loss of the left hip, 0% for the left knee, and 5% for the lumbar spine, for a total of 7% impairment rating.

On 3-21-10, the claimant was seen by MD., with complaints of low back pain, left knee and left ankle pain. The claimant was started on Ultram and continued on Zanaflex. The evaluator reported that because he has failed conservative care, it was medically warranted for the claimant to undergo bilateral lumbar facet medial branch blocks at L4 and L5.

Physical Performance Exam on 3-24-10 notes the claimant is functioning at a Light/Medium PDL. His job requires a Heavy PDL.

Physical therapy on 4-15-10, 4-19-10, 4-20-10, 4-22-10, 9-16-10, 9-17-10, 9-20-10, 9-21-10, 9-22-10, 9-27-10, 9-29-10, 9-30-10, 10-4-10, 10-5-10, 10-6-10, 10-11-10.

Follow up with Dr. on 4-19-10 notes the claimant is doing the same. His current medications include Ultram and Zanaflex. He has good pain control with current regimen. The evaluator recommended EMG/NCS and refill medications. The claimant is to advance with physical therapy program.

An EMG/NCS of the lower extremities performed by MD., on 4-21-10 was normal.

4-28-10 Work Conditioning program Functional Capacity Evaluation shows the claimant is functioning at a Light/Medium PDL.

Follow up with Dr. on 5-10-10 notes the continued recommendation for bilateral medial branch blocks at L4-L5.

On 6-3-10, the claimant was seen by MD., who recommended L5-S1 facet injections.

Follow up with Dr. on 7-12-10 notes the claimant is having knee surgery soon. His medications include Ultram and Zanaflex. The claimant is to advance with physical therapy.

On 7-22-10, the claimant underwent left knee arthroscopy with ACL and PCL augmentation, partial medial and lateral meniscectomy, complete synovectomy, abrasion arthroplasty medial femoral condyle, removal of adhesions, and injection of platelet rich plasma. Procedure performed by MD.

8-11-10 Functional Capacity Evaluation shows the claimant is functioning at a Sedentary/Light to Light/Medium PDL.

Follow up with Dr. on 9-20-10 notes the claimant just started physical therapy. He is doing better. He is to advance with supervised exercise program.

8-24-10 MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI. He reported the claimant had not received adequate care for the low back, left knee and left hip injuries. He estimated 1-24-11 as the date of MMI.

10-6-10 Post Surgical PPE shows the claimant is functioning at a Light to Light/Medium PDL.

Physical therapy on 11-3-10, 11-4-10, 11-5-10, 11-8-10, 11-9-10, 11-11-10, 11-16-10, 11-17-10, 11-18-10, 11-22-10, 11-23-10, 11-29-10.

On 11-8-10 MD., performed a Peer Review. The patient has had an extensive amount of treatment well beyond what one would normally expect for an ankle/knee sprain, hip sprain, and/or possible lumbar sprain. The first record available for my review was on June 3, 2009, some x months post the actual injury itself. Therefore, he could not state with any certainty as to what his initial findings were. It subsequently has been stated that the patient was accepted as a knee strain, hip strain, and lumbar strain. The MRI initially did not show evidence of a significant meniscal tear nor was there evidence of a significant internal derangement to the patient's knee. It was also noted months after the accident, the patient continued to improve with his knee and was seen for a second opinion relative to surgery by Dr. on August 3, 2009, who felt that he did not need additional surgery. In fact, on September 14, 2009, the patient was noted to be not wearing a knee brace because he said his knee pain was almost resolved at that point. It appears the patient then changed treating physicians and started down another course of chronic pain management and treatment and subsequently underwent an extensive arthroscopic surgical procedure to his knee. At this point in time, he may continue to have symptoms secondary to the actual surgical procedure itself. Likewise, early on, the patient had what appeared to be a right-sided disc herniation but never early on was documented to have any significant radicular component to his pain; therefore, not clearly documented that he had a symptomatic disc herniation from that perspective. Certainly, within a three to four month period of time, one would normally respond to conservative measures from that perspective. The patient has had extensive treatments, multiple injection therapy beyond which what would be normally recommended by the ODG protocols, with no clear cut change in the patient's objective response. The patient will need to be followed up for at least a six-month period post his knee arthroscopy since it was only carried out on July 22, 2010. It

would be his opinion, by this point in time, the patient should be transitioned predominantly to a self-directed home-based program of exercise relative to his lumbar spine, and it is unlikely that additional invasive treatments and injections will change his subjective complaints of pain. At this point in time, it is not clear what medications the patient is on. In August, he was on a short-term Hydrocodone and this was in the postoperative period. He was subsequently, in September, placed on Ultram, Zanaflex, and Hydrocodone. Based on the ODG guidelines, there would not be a recommendation for continued use of a muscle relaxant this far post lumbar strain. The use of Ultram for breakthrough pain as a non-narcotic medication is reasonable at this point in time as it relates to any knee pain. The continued use of Hydrocodone at this point in time for chronic lumbar spine complaints is not recommended by the ODG guidelines on a long-term basis. There is no documentation as to how frequently he is taking that or how much and most likely it would not need to be an extended period of weaning since I cannot find that he has been on it for an extended period of time. The patient has had an extensive amount of therapy at this point in time. It is my opinion there is no clear cut indication that the patient should continue to require an extensive amount of ongoing active medical care, other than followups for his knee arthroscopy. Generally, by this point in time, followup on an every two-month basis, for up to six months post his surgery, should be sufficient. If he is doing satisfactory at that time, with no evidence of significant complications from the surgery, then additional followup would generally not be required. As previously stated, by this point in time, the patient should have been transitioned to a primarily home-based program of exercise as it relates to his lumbar spine. If he has been on more extended use of a narcotic medication than is evident by the present records, the patient may benefit from a true multidisciplinary pain management program over a two to three-week period of time, with the primary goal being to detoxify him off of any narcotic medications or muscle relaxants and in to a more functional status with appropriate psychological support in trying to return him to a more active functional status. There is no indication that additional diagnostic studies or injection therapy or any type of surgical intervention would change this individual's outcome, nor does it appear to be indicated at this point in time. There is nothing to indicate that the patient would require the use of durable medical equipment at this point.

On 11-12-10, the claimant underwent left lumbar facet rhizotomy at L3, L4 and L5.

On 11-24-10, the claimant underwent right lumbar facet rhizotomy at L3, L4 and L5.

A Clinical Interview on 12-1-10 notes the claimant is experiencing psychological distress due to concerns over his health as a result of his injury. The evaluator recommended 4 sessions of cognitive behavioral therapy.

Individual psychotherapy from 12-7-10 through 1-21-11.

On 1-13-11 MD., performed a Doctor Selected by Treating Doctor. He certified the claimant had reached MMI on this date with a 9% impairment rating based a 5%

impairment rating due to the lumbar spine combined with 4% for the left knee, for a total of 9% impairment rating.

On 1-21-11, MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on this date and awarded the claimant 6% impairment rating based on 5% for the lumbar spine combined with 1% for the left knee, for a total of 6% whole person.

Follow up with Dr. on 2-28-11 notes the claimant has increased pain with physical therapy. His medications include Ultram and Zanaflex. The medications are helpful for this claimant. On exam, he has increased paraspinal tenderness. Negative motor deficits, negative sensory deficits. The evaluator provided the claimant with a refill of medications. He evaluator felt that a chronic pain management program would be beneficial for this claimant.

3-2-11 Chronic Pain Management evaluation shows the claimant is functioning at a Sedentary/Light to Light/Medium capacity. His job requires a Heavy PDL.

DC., DWC-73: off work on 3-23-11 and 4-6-11.

3-14-11 MA, LPC, LMSW., the claimant was last seen during an approved psychotherapy session on January 21, 2011. As part of the last approved session of psychotherapy, the patient completed assessments to help determine progress made in therapy and to ascertain the appropriateness for appropriateness for a multidisciplinary chronic pain management program. The results of the assessment are based upon the assumption that the patient provided accurate data during the appointment. The report is to be used by professionals who are familiar with this case. It can also be used as an adjunct to other assessment procedures already completed. Regarding psychiatric treatment history, the patient denies any past mental health treatment history. The patient denies any issues related to drug or alcohol abuse likely to interfere with his treatment progress. He states that his current symptomatology began at its current severity shortly after the injury and is directly related to the injury and associated difficulties. His primary coping mechanism is talking with his sister and friend. The claimant has attended a total of 4 approved sessions of cognitive behavioral therapy from December 3, 2010 to January 21, 2011. He has been compliant with treatment recommendations, including all homework assignments, Cognitive behavioral therapy and stress management techniques were utilized in an attempt to reduce the patient's psychological distress associated with his work related injury. To date, the patient has shown some improvement in mental and emotional states through therapy although he is still very anxious. The claimant endorses some depressive symptomology as a result of his injury and was administered the Beck Depression Inventory-II (BDI-II) which is a subjective, self-report measure that provides the patient the opportunity to acknowledge current coping difficulties and report the nature and extent of depressive symptoms which have been recently problematic. The patient obtained a score of 11, which categorizes him in the minimal range for depression. The patient self-rates himself as an 8/10 in reference to his ongoing depression. He complains of memory problems,

anhedonia, fatigue, sadness, crying episodes, and isolation. He reports losing confidence in himself, feeling useless, experiencing a lack of control, and feeling disappointed in himself as he can no longer support his family. Although he has benefitted from sleep hygiene training, he is still sleeping anywhere from 5-6 hours per night. The claimant currently endorses some anxious symptomology as a result of her injury and was administered the Beck Anxiety Inventory (BAD which is a questionnaire that indicates how much the patient has been bothered by each symptom during the past week, including the day of the test. The patient obtained the score of 19, which categorizes the patient in the moderate range for anxiety. The patient self-reports his anxiety as a 7/10 at this time. He reports mood swings, excessive worry over his health, recurrent thoughts related to injury, nervousness and being unable to relax. He reports that the tension in his body increases his perception of pain. The patient also reports that he has been experiencing notable interpersonal disturbance and increased stress since the time of the injury including withdrawal from family and friends, feeling lonely, ignored, and misunderstood and experiencing daily headaches, He currently self-rates his stress level as a 6/10. At this time, the patient is reporting psychological distress in the form, of symptoms of anxiety and perceived disability which revolve around a strong dissatisfaction and concern over his current level of functioning. His current distress is directly related to his persistent pain and functional limitations and he demonstrates limited skills to cope with current psychological stressors. Specifically, his symptoms are manifested by his continued inability to return to work. He identifies himself as a worker in order to fulfill his role as provider of the family. Throughout the assessment the patient endorsed marked and excessive reliance on passive or avoidant pain management behaviors, and also exhibits a high level of perceived disability. Such issues are likely to hinder his quality of life and/or his return to employment unless adequately addressed. Since being treated for his injuries, the claimant has not returned to his previous level of functioning nor has he responded well to such treatments or the process of rehabilitation as would be expected. In summary, the patient has not experienced significant improvement in most areas of psychological disturbance through psychotherapy. This however, is not surprising. Based upon what has been learned from his interviewing and the therapeutic process, the claimant could be described as suffering from Chronic Pain Syndrome and appropriate for a Chronic Pain Management Program. In light of the assessment results, in order to help this patient manage his current level of subjective distress and pain behavior, the patient would appear to be an appropriate candidate for participation in a Chronic Pain Management program. He will be involved in group pain management therapy aimed at increasing his resources and skills to adequately cope with his pain and distress. The program will also include a monitored, individualized plan of physical therapy and pharmacological intervention in which only one doctor will provide the pain/psychotropic medication necessary in fitting with the patient's particular needs. The professionals involved in each of these fields will communicate with each other in order to provide the proper care for the patient, and the treatment should begin as soon as possible, The patient is at a tertiary level of care and no further invasive procedures are planned.

3-17-11 DC., performed a Utilization Review. It was her opinion that the current clinical information reveals that the patient is and status post work related knee and low back

injury as of xx/xx/xx. The patient underwent left knee surgery 7/22/10 which included ACL repair. The patient completed 24 post operative PT visits. The providers FCE dated 3/2/11 reports that the patient is capable of sedentary / light physical demand levels. The psych narrative report dated 3/14/11 states that the patient reported BDI of 11, and BAI 19. The patient is reported to have completed a trial of individual psych sessions and demonstrated improvement. Given the improvement with lower levels of care the request for chronic pain management is not supported as necessary.

3-28-11 Letter for reconsideration request for CPMP provided by LPC/ LMSW., notes " This letter is in response to a non-certification decision for the patient, to be approved for 10 days in the Chronic Pain Program. The initial request was non-certified on the date of 03/17/11 by D.C. following a peer-to-peer discussion concerning our request for the patient to be approved for 10 days in the CPP. Dr. stated reasons for non-certification include:

- The patient is capable of sedentary/light physical demand levels.
- The psych narrative report dated 03/14/11 states the patient reported a BDI of 11 and a BAI of 19.
- The patient is reported to have completed a trial of individual psych sessions and demonstrated improvement.

In my peer to peer review with Dr, I asked him to review page 4 of our request titled "Chronic Pain Program Goal Sheet". I pointed out to Dr. that the claimant continues to present with medical, psychological, and physical deficits which are preventing him from returning to gainful employment. The claimant is complaining of high levels of chronic pain (7-9 on the Visual Pain Index Scale) and is taking high doses of narcotic medication (Hydrocodone 7.5/500 q.i.d. and Ultram 500 mg t.i.d.). On his psychometric testing, he presents with high levels of functional complaints and anxiety as measured by the In addition, the patient has high levels of fear avoidance as measured by the Fear Avoidance Behavioral Questionnaire and perceives himself to be severely disabled as measured by the Oswestry Disability Index. In addition, he has become severely deconditioned as can be noted from his functional capacity evaluation. The claimant's current PDL is sedentary-light and he will require a heavy PDL if he is to return to the workforce. I should note that Dr. is a chiropractor and may not understand the significance of the high scores on the patient's psychometric testing. Peer reviews are usually conducted between professionals who have a similar background and licensure. The fact that the claimant underwent a brief trial of psychotherapy with demonstrated improvement does not mean that he is at Maximum Medical Improvement. As can be gleaned from our in-depth request (36 pages) and the patient's goal chart, this patient presents with significant deficits that only a multidisciplinary program can address. I would welcome the opportunity to review our request with a professional of a similar background. In summation, a denial of services was issued because the reviewing peer professional did not understand reasoning/criteria for approval of the patient to enter a multidisciplinary program. As can be clearly seen in the documentation provided, the patient has significant deficits; medically, psychologically, and physically which are impeding his return to the workforce. Therefore, I will thank you in advance for your reconsideration that the patient, be approved for 10 days in the comprehensive pain management program."

On 4-5-11, MD., performed a Utilization Review. This is a male patient s/p injury xx/xx/xx. Subjective findings include constant pain which significantly interferes with his normal daily activities and recreational, social and family activities, He is fearful that he will not be able to return to work because of his high levels of pain. Objective findings include minimal range for depression, moderate range for anxiety, and a significantly high degree of fear avoidance beliefs. Oswestry Low Back Pain Disability Questionnaire revealed severe disability. Negative Predictors were identified and addressed. Treatment goals were identified. Conservative treatment includes medication, physical therapy, and cognitive behavioral therapy. Evidence based guidelines necessitate documentation of the following indications [The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months; Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; An adequate and thorough multidisciplinary evaluation has been made; A treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed; 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); Negative predictors of success should be identified and if present, the pre-program goals should indicate how these will be addressed to support the medical necessity of an outpatient pain rehabilitation program. Within the medical information available for review, the patient has not exhausted other options likely to result in significant clinical improvement and the patient does not have motivation to change, or is willing to change their medication regimen. Therefore, the request is not certified.

4-13-11 MA, LPC/, LMSW., provided a Treatment Summary. Based on the findings of an initial behavioral health assessment, the claimant was certified for 6 sessions of individual psychotherapy for issues directly related to his work injury he sustained on xx/xx/xx. To date, the claimant has completed all approved sessions and appears to be acting in good faith in regards to his rehabilitation and return to work. Treatment focused on decreasing his depression, anxiety, and fear/avoidance. Objectives met include 1) decreasing the patient's pain behaviors 2) increasing the patient's motivation to become involved in the treatment process and 3) introducing behavioral techniques to help the patient manage his pain instead of using narcotics. He also began work on a resume with the assistance of his vocational counselor and was able to contact DARS to determine if he is a candidate for vocational retraining. The claimant continues to present with medical, psychological, and physical deficits which are preventing him from, returning to gainful employment. The claimant is complaining of high levels of chronic pain (7-9 on the Visual Pain Index Scale) and is taking large doses of narcotic medication (Hydrocodone 7.5/500 q.i.d. and Ultram 500 mg t.i.d.). On his psychometric testing, he presents with multiple functional complaints and anxiety as measured by the BBHI-II. In addition, the patient has high levels of fear avoidance as measured by the Fear Avoidance Behavioral Questionnaire and perceives himself to be severely disabled as measured by the Oswestry Disability Index. He has become severely deconditioned and will require a structured exercise program as can be noted

from his functional capacity evaluation. The claimant's current PDL is sedentary-light and he will require a heavy PDL if he is to return to the workforce. He will benefit from vocational counseling as well as cognitive/behavioral therapy within the confines of a multidisciplinary program. Given his current emotional state, functional impairment, and failure to respond to lower levels of treatment, he is a likely candidate for multidisciplinary treatment. The patient is at a tertiary level of care and no further invasive procedures are planned. While in the program Dr. will supervise a scheduled decrease in the patient's narcotic medication which the patient has agreed to. The claimant is highly motivated to participate in a multidisciplinary program and has in fact been working out on his own to prepare himself for a successful outcome.

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

FILE REVIEW SHOWS CLAIMANT HAS HAD EXTENSIVE THERAPY AND INTERVENTIONS IN THE xx MONTHS SINCE INJURY, INCLUDING PHYSICAL THERAPY, SURGERY, INJECTIONS, AND MEDICATIONS. CURRENTLY, THE CLAIMANT HAS BEEN DESCRIBED TO HAVE A CHRONIC PAIN SYNDROME AND RECOMMENDED TO ATTEND A MULTI-DISCIPLINARY CHRONIC PAIN MANAGEMENT PROGRAM IN ORDER TO ADDRESS PHYSICAL AND PSYCHOLOGICAL DEFICIENCIES, AS WELL AS PHARMACOLOGIC INTERVENTION.

DOCUMENTS SHOW THE CLAIMANT TO HAVE BEEN RELATIVELY RECENTLY DETERMINED TO BE AT MMI AND HAD UNDERGONE AT LEAST FIVE DIFFERENT PHYSICAL PERFORMANCE EXAMINATIONS IN THE LAST YEAR. LITTLE CHANGE IN THE CLAIMANT'S FUNCTIONAL CAPACITY WAS DEMONSTRATED OVER THE PAST 12 MONTHS, DESPITE SURGERY, PHYSICAL REHABILITATION, PRESUMED HOME EXERCISE PROGRAM, INJECTIONS AND INDIVIDUAL PSYCHOTHERAPY. OVER THIS YEAR, THE CLAIMANT NEVER ACHIEVED GREATER THAN A LIGHT/MEDIUM FUNCTIONAL CAPACITY, AND REMAINS NOW AT A SEDENTARY/LIGHT TO LIGHT/MEDIUM LEVEL. THE CLAIMANT ALSO ATTENDED FOUR APPROVED SESSIONS OF INDIVIDUAL PSYCHOTHERAPY, WHICH APPEAR TO HAVE BEEN SOMEWHAT EFFECTIVE IN REGARD TO DEPRESSION SCORES, THOUGH NO CHANGE WAS NOTED IN ANXIETY OR FEAR AVOIDANCE MEASURES, THE LATTER BEING EXCEEDINGLY SEVERE. THE CLAIMANT'S SUBJECTIVE PAIN SCORES REMAIN HIGH.

EVIDENCE-BASED GUIDELINES, SPECIFICALLY THE ODG, NOTE THAT PATIENT SELECTION IS IMPORTANT IN RESOURCE-HEAVY PROGRAMS SUCH AS THESE, AND NEGATIVE PREDICTORS OF A SUCCESSFUL OUTCOME SHOULD BE ADDRESSED PRIOR TO ENTRY. ALL EVIDENCE IN THIS CASE INDICATES THAT THE LACK OF PHYSICAL PROGRESSION IN THIS CLAIMANT IS NOT DUE TO SIMPLE DECONDITIONING, AS THERE HAS BEEN AMPLE OPPORTUNITY TO MAKE MEASURABLE PROGRESS AND GAINS. SOME PROGRESS HAS BEEN MADE WITH THE INITIAL FOUR SESSIONS OF INDIVIDUAL PSYCHOTHERAPY. ADDITIONALLY, THERE IS NO CLEAR INDICATION THAT ATTEMPTS AT

NARCOTIC WITHDRAWAL HAVE BEEN TRIED AND FAILED. GIVEN THIS, LOWER LEVELS OF CARE HAVE CLEARLY NOT BEEN EXHAUSTED AND ENTRY TO A CHRONIC PAIN MANAGEMENT PROGRAM CANNOT BE SUPPORTED BY GUIDELINES AT THIS TIME.

ODG-TWC, last update 4-18-11 Occupational Disorders - 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) (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). See Chronic pain programs, opioids; Functional restoration programs.

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 KNOWLEDGBASE
- 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)