



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 2-13-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management 5 x week x 2 weeks 80 hours lumbar 97799

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 5-25-11 MD., office visit.
- 6-24-11 MD., office visit.
- 8-3-11 MD., office visit.
- 8-31-11 MD., office visit.
- 10-3-11 MD., office visit.
- 11-18-11 MD., office visit.
- 12-16-11 MD., office visit.
- 12-20-11 Chronic pain management note.
- 1-3-12 UR performed by DO.
- 1-4-12 MD., office visit.
- 1-13-12 UR performed by MD.
- 1-20-12 MD., office visit.

PATIENT CLINICAL HISTORY [SUMMARY]:

5-25-11 MD., the claimant is a employee of the, who sustained a low back injury on xx/xx/xx during the course of his employment as a. The patient was carrying 65-pound box of yearbooks to the office when he felt a sudden onset of low back pain. The patient had no time loss other than seven initial days and returned to work on light duty. He ended up having additional time loss related to surgeries 6 months in March 2010 and 4 weeks for second surgery. The patient has been working in his usual occupation ever since. The patient is currently earning xxx per year as a. He has no previous history of low back or workmen's compensation claims. He has 10-year work history, 7 years in the longest job. He has 17 years for formal education with a xxx. As a result of these injuries, under the care of Dr., the patient underwent a lumbar microdiscectomy at L4-L5

in October 2009 with a repeat surgery in March 2010. The patient was seen in his office in early 2011 and underwent epidural steroid injection x 2 with some benefit. The patient has had electrodiagnostic testing in January which documented evidence of radiculitis. The patient has completed 4 weeks of 3 times per week physical therapy (12 visits) without long-term success. He is currently using LYRICA and LEXAPRO for symptom control. Pain level is 4-5/10. It is worse with sitting, bending forward, lifting, standing, and bending backward. The pain improves with physical therapy and pain medication. The patient lifts up to 30 pounds (his son) on a regular basis. He has had to limit yard work, housework, and walking as a result of his symptoms. The patient currently spends 10 of 24 hours reclining. On physical examination, Lumbar spine alignment is Intact. Lumbar lordosis is well maintained. Iliac crests are level. A well-healed surgical scar is present in the midline. Lumbar motion is moderately restricted in forward flexion (50°) and more severely restricted in extension (10°), and bilateral side bending (80). There is evidence of segmental rigidity at the L4-L5 and L5-S1 facet segments with most the lumbar side bending occurring above the level of L4. There is no sciatic notch or piriformis muscle or greater trochanteric tenderness. Full range of motion is present at the hips, knees, and ankles. Straight leg raise is negative for radicular symptomatology today in both supine and seated position. No lower extremity edema, erythema, or lymphadenopathy is appreciated. Neurologically, deep tendon reflexes are 2/4 and symmetric at the patella, Achilles, and medial hamstrings tendons. Motor power is 5/5 and symmetric in the bilateral lower extremity muscle distributions. There is no evidence of circumferential atrophy in the lower extremities. Sensation is well preserved in lower extremities. Tandem gait is smooth and symmetric. Clinical Impression: Chronic low back pain after L4-L5 microdiscectomy x2. Recommendations: The patient has tried and failed routine conservative care and has not demonstrated significant progress with outpatient physical therapy, injection management, medications, or surgery. We, therefore, would like to complete an evaluation over the next several days to include PT, OT, and Disability Assessment as well as a Mental Health Evaluation for consideration of a functional restoration program at our facility. This was discussed at length with the patient who is in agreement with proceeding. Once the evaluation is complete, we will see the patient back in the office to review those findings and formulate a management plan.

6-24-11 MD., the claimant returns today having completed his full functional evaluation here at . He is extremely motivated and was quite pleased with what he saw. He has got a good job to go back to and is hopeful that with short-course of treatment he will be able to return to work full time, full duty in his usual occupation. Formal functional testing documented a number of activities of daily living with which the patient had significant difficulties. Lumbar spine range of motion was noted to be severely deficient with extremely deficient strength. Biodex lifting was severely deficient. PILE testing was moderately deficient. Gait was within normal limits, but aerobic fitness remained low. Pain level varied between 2 and 7 on a scale 0-10 and consistency of effort was noted to be variable throughout testing. He was unable to meet the initial job demands for stooping, walking, climbing stairs, and twisting. On psychosocial basis, the patient demonstrated severe loss of function (GAF=48) with moderate stressor (PSS=3). There are moderate-to-severe depressive symptoms described both by the patient (BDI=23)

and the therapist (IDS=24). The patient is already on LEXAPRO, which has been recommended to continue. Additional psychosocial issues which may impact care include symptoms of anxiety or agitation, symptoms of depression, suicidal ideation, disrupted thought processes, psychophysiological correlates of affect and stress, sleep disturbance, current use of narcotics, muscle relaxants, tranquilizers or sedative-hypnotic medications, reports of increased family dysfunction or discord secondary to injury-related stresses, social isolation and/or disruption in the quality of interpersonal relationships, difficulty fulfilling premorbid family and/or social obligations, Inability to engage in premorbid recreational activities, patient with pain extending beyond the primary intervention phase (0-3 months) with continued significant impairment In daily function, failure to return to work and/or progress adequately in healthcare treatments. He had an opportunity to meet with the treatment team and discuss treatment options. This patient is felt to be an excellent candidate for trial of functional restoration. He has a good Job to go back to and Is unable to continue to work well at work site because of persistent pain after his surgery. His prognosis for recovery is excellent. We would recommend a course of 20 visits of functional restoration (160 total hours). Our goals of treatment will be return to full duty work, prevent recurrent injury by increasing functional capacity, decrease excessive healthcare utilization, achieve claim resolution after patient reaches Maximum Medical Improvement, and psychosocial goals decrease anxiety/stress symptoms, decrease depression symptoms, decrease sleep disturbance, increase independent pain management skills. Additional factors for determining care include only inhibition of physical function. The patient is felt to be a good candidate for treatment and he felt that he will be an excellent patient. We will first request a preauthorization for treatment. I will plan to see him back in the office upon initiation of treatment to ensure that he settling in well and coming along nicely. Once authorized, this patient will begin in the PRIDE Functional Restoration program (as recommended in ODG and ACOEM guidelines) with additional evaluation and increasing frequency and intensity. The first 10 visits (or 80 hours, whichever is greater) are requested (per the guidelines) to allow Concurrent Review to determine attendance, compliance and progress. If program continuation is warranted at that time, an individualized treatment plan (duration, visits and hours) will be submitted. This patient will return for reassessment in 2-3 weeks. In the course of this evaluation, the potential risks and benefits of a progressive exercise program were discussed with the patient. These risks include, but are not limited to, increased muscle tightness, joint irritation, overuse and pain. It was emphasized that reactivation of muscles, connective tissue and joints following a period of inactivity and/or postoperative recovery may be associated with an exacerbation of some symptoms, which generally does not constitute an injury. The sports medicine approach to regaining function and decreasing pain through treatment was reviewed and the patient's questions and concerns were addressed.

8-3-11 MD., the claimant has current complaints of low back pain. The patient was injured on xx/xx/xx working for where he had worked for 7 years. The patient has had 2 surgeries for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 6'2" In height and weighs 205 pounds. The claimant returns today for follow-up of his low back pain. He is

scheduled to start school next week. He has now been denied twice for the functional restoration program, The last physician stated that as his job description required no lifting, there was no reason for him to complete a functional restoration program. This does not make intuitive sense to me as the patient actually was Injured lifting a 60-pound box of books. Certainly a standard approach for teacher would be that there would be no lifting involved, however, common sense would tell us that this job involves significant functional movements and lifting. Nevertheless the claimant has elected to move forward with an IRO which we whole heartedly support. He wrote a letter of support last week. On examination today, this is a well-developed and well-nourished male appearing his stated age and in moderate distress. He is oriented to person, place, time, and situation. Mood and affect are appropriate. Lumbar spine alignment is intact. Lumbar lordosis is well maintained. Iliac crests are level. Lumbar motion is moderately restricted in flexion, extension, rotation, and side bending. There is minimal posterior lumbar tenderness and no overt paraspinal muscle spasm. Neurologically, deep tendon reflexes are 2/4 and symmetric at the patella, medial hamstrings, and Achilles tendons. Motor power is 5/5 and symmetric between myotomes L3 and S1. Moderate posterior lumbar motion restriction is noted particularly in extension. Recommendations: The patient will move forward with an IRO regarding functional restoration. The patient may continue to work in his usual occupation when school starts

8-31-11 MD., the claimant has current complaints of low back pain. The patient was injured on xx/xx/xx working for where he had worked for 7 years. The patient has had 2 surgeries for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 6'2" In height and weighs 205 pounds. The claimant returns today for follow-up of his chronic low back pain. He has won his IRO and is ready to begin treatment. Unfortunately, now the school year has started again and we have to work on scheduling issues. The claimant is still having some back pain. He has returned to the classroom, however, and is doing reasonably well partly because he is at a new job with new responsibilities. On examination today, this is a well-developed and well-nourished Caucasian male appearing his stated age and in moderate distress. He is oriented to person, place, time, and situation. Mood and affect are appropriate. Lumbar spine alignment is intact. Lumbar lordosis is well maintained. Iliac crests are level. Lumbar motion is moderately restricted In all planes of motion. There is minimal posterior lumbar tenderness and no overt paraspinal muscle spasm. Clinical impression: Chronic low back pain, pending functional restoration. Recommendations: He will refill DOXEPIN and LEXAPRO for the patient today. Follow up with his office will be upon initiation of treatment.

10-3-11 MD., the claimant has current complaints of low back pain. The patient was injured on xx/xx/xx working for where he had worked for 7 years. The patient has had 2 surgeries far this Injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 6'2" in height and weighs 205 pounds. The claimant returns today for follow-up to ensure stability at the

initiation of functional restoration program. He has now completed 2 of 10 authorized visits (14 hours). He is tolerating this well and has settled in nicely. He finds that he is already improving both from standpoint of pain and strength. So far, he is able to work around his new job schedule reasonably well. On examination today, this is a well-developed and well-nourished male appearing his stated age. He is in moderate distress. He is oriented to person, place, time and situation. Mood and affect are appropriate. Lumbar spine alignment is intact. Lumbar lordosis is well maintained. Iliac crests are level. Lumbar motion is moderately restricted in flexion, extension, rotation and side bending. There is moderate posterior lumbar tenderness. No overt paraspinal muscle spasm. Recommendations: Continue his treatment.

11-18-11 MD., the claimant was Injured xx/xx/xx working for where he had worked for 7 years, The patient has had 2 surgeries for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 6'2" in height and weighs 205 pounds. The claimant returns today for follow-up of his chronic low back pain. He has now completed 4 of 10 initially scheduled visits of functional restoration here at PRIDE. He is moving slowly only because he is working full time, full duty and working around his work schedule. He is making good forward progress nevertheless and is scheduled to come in next week Monday and Tuesday while he is off for the holiday. The patient remains on LEXAPRO 20 mg p.o. q.d., NAPROXEN 500 mg p.o. q.d., and LYRICA 150 mg p.o. b.i.d. This combination of medication is offering good clinical success and he is able to work full time, full duty in his new position. On examination today, this is a well-developed and well-nourished Caucasian male appearing his stated age and in no acute distress. He is oriented to person, place, time, and situation. His mood and affect are appropriate. Lumbar spine alignment is intact. Lumbar lordosis is well maintained. Iliac crests are level. Lumbar motion is moderately restricted in flexion, extension, rotation, and side bending. There is minimal posterior lumbar tenderness. No overt paraspinal muscle spasm. Recommendations: Continue to proceed through the program. A 1-month supply of each medication was given with 2 refills.

12-16-11 MD., the claimant has current complaints of low back pain. The patient was Injured xx/xx/xx working for where he had worked for 7 years. The patient has had 2 surgeries for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 6'2" in height and weighs 205 pounds. The claimant returns today for medication check and follow-up of status, He has completed 6 of 10 outpatient visits of PRIDE and at school finished today, He is scheduling for 4 visits next week. The patient is reporting significant side effects with the LEXAPRO, which he is unable to tolerate. On physical examination, this is an alert and cooperative male appearing his stated age. He is in no acute distress, He is oriented to person, place, time, and situation, His mood and affect are appropriate. Lumbar spine alignment is intact. Lumbar lordosis is well maintained. Iliac crests are level. Lumbar motion is moderately restricted with mild tenderness. Clinical Impression: Chronic low back pain. Recommendations: Continue outpatient functional restoration

program around work schedule. He will change the LEXAPRO to WELLBUTRIN 150 mg p.o. b.i.d.

12-20-11 Chronic pain management note.

1-3-12 UR performed by, DO., noted the patient is a male with a reported injury on xx/xx/xx. The patient is noted to have persistent lower back pain and had participated in several conservative care measures and subsequently was referred to a chronic pain management program. It is noted that the patient has completed approximately 80 hours of the chronic pain management program to-date. It is noted that the patient's starting pain level was a 6/10 and the current pain level is a 3/10 to 5/10. It is noted that the patients prescribed pain medication was Hydrocodone 7.5 mg as needed and Lyrica 300 mg. After completion of the initial 80 hours of chronic pain management, the medication has remained unchanged. Furthermore, the patients initial BDI-II was 23, and there is no repeat BDI score to now the patient's depressive symptomatology has decreased objectively. The guidelines state that treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. The documentation submitted for review lacks clinical documentation of objective functional gains in the initial 80 hours of chronic pain management in terms of increased range of motion, decreased pain, and decreased medication use. Also there is lack of documentation noting the patient's depressive and anxiety symptomatology has decreased due to the initial chronic pain management program. As such, the request for additional chronic pain management 5 times a week x2 weeks, 80 hours, lumbar 97799, is non-certified. Determination: Non-Certified.

1-4-12 MD., noted he was in receipt of an adverse determination regarding the request to perform 80 additional hours of functional restoration for your patient,. The reviewing physician, , indicated that our request was denied because "no repeat BDI was submitted and lack of documentation noting the patient's depressive and anxiety symptomatology has decreased due to initial CPMP." This peer call was actually an inappropriate peer call in that the doctor called at 3:45 p.m. on January 3, 2012. The peer doctor was not available at that time and the office staff stated he would call back before 5 p.m. and never did. Nevertheless, the case was rendered a denial despite no peer consultation. Furthermore, the documentation clearly indicated that BDI has dropped from 23 to 13 through the first 80 hours of treatment This was noted on the concurrent review as well as the patient's Improved mood, sleep, and interest in activities. Less irritability was also documented. These are all reasons to approve and not deny treatment and the patient has been extremely compliant with care and has worked hard with his treatment. Pain decreased from an average of 7/10 to an average of 4/10. He has struggled to maintain his current working status, but is continuing to do so. He would respectfully request reconsideration based upon these grounds. The Texas DWC/TDI Disability Management Rule 137.1 specifies ODG is to be used as a guideline for pre-authorization. ODG utilizes evidence-based medicine where good evidence is available, and best practices otherwise. In determining pre-auth for a chronic pain management and/or functional restoration program (CPMP/FRP), the

overriding principle guiding all specific criteria is that such programs are recommended only for CPMP/FRP facilities with proven outcomes. The FRP discussed above, in contrast to many others, has specific, objective outcomes for work-related injuries on critical issues such as RTW and future healthcare utilization, published in high-quality peer-reviewed journals. These references provide medical evidence for treatment efficacy at PRIDE in many situations including: a) spinal and other musculoskeletal disorders; b) patients with cervical diagnoses; 5" c) extremity Injuries; 7 d) spinal surgery cases (including fusion); and e) working patients for early intervention, those with disability extending beyond 2 years, or older age patients. These, and other outcome studies derived from PRIDE's prospectively-collected database of chronic pain/disability patient care, currently represents the major source of information on objective, socioeconomically-relevant treatment outcomes in the workers' compensation setting. These studies are highly relevant to the pre-auth decision In this case.

1-13-12 UR performed by MD., noted this is an appeal for additional chronic pain management program. It is noted that the patient has received prior authorization for 80 hours in the program. He discussed the case with (case manager, authorized to conduct peer for Dr.), Mr. stated that the patient has done well with the first functional restoration program/chronic pain management program whereby he was able to reduce his narcotic intake of Hydrocodone 7.5mg/325mg to periodically, not daily. The patient continues to work as a teacher, and at times there may be increased in the activities that he needs to perform from a physical standpoint. The goal for the additional request of hours for the chronic pain management program is to help increase his strength, increase lumbar range duration with bending, and increase his physical demand level to a medium/medium heavy level for better tolerance at his job. However, clarification is needed as to the total number of hours the patient has attended as the integrative summary report dated 12/20/11 included dates from 9/25/11 to 12/15/11. It is also noted that the patient gained improvements with participation in the program. However, there was no documentation of the patient's current physical demand level (PDL) as his return-to-work requirement is medium PDL. As per 12/20/2011 report, patient has attended the treatment sessions while working full time as a. Additionally, there was no documentation of suggestions for treatment post-program. Hence, the previous non-certification is upheld. Determination: Non-certified.

1-20-12 MD., the claimant complains of low back pain. The patient was injured on xx/xx/xx working for where he had worked for 7 years. The patient has had 2 surgeries for this injury. He has had appropriate diagnostic testing and therapeutic procedures up to the present. The patient denies medication allergies. Review of systems, past, family and social history are unchanged. The patient is 6'2" in height and weighs 205 pounds. He met with Mr. Burns and am disappointed to see that we have a "double denial" of a request for the remaining 80 hours of his functional restoration program. Our case manager, , MS, CRC will call you to discuss a possible override of this second denial in hopes of avoiding a submission to an IRO for dispute resolution. As you may recall, the initial 80 hours of treatment was overturned and approved at the IRO level. The patient has already completed a letter to the IRO, but we have asked him to hold It pending further discussion with you. Although, he had summarized much of this In previous

dictations, the rationale for the treatment here and the ODG criteria that are met include: 3 1/2 years of partial/total disability, the patient has demonstrated his motivation by remaining at work for most of the time since his date of injury, but still needs to strengthen lumbar for job retention, the patient still has deficits in climbing stairs, ability to stand continuously, and overall endurance, trial of non-operative care and testing, but no prior trial of functional restoration or chronic pain management.

Undated hand written letter from the claimant.

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

BASED ON THE NOTES AND RECORDS FROM DR. I FEEL ADDITIONAL 2 WEEKS (80 HRS) IS WARRANTED. ODG SUPPORTS THE ADDITIONAL 10 DAYS BASED ON HIS COMPLIANCE, SEVERITY OF THE INJURY AND FAVORABLE RESPONSE SO FAR. THEREFORE, THE REQUEST FOR CHRONIC PAIN MANGEMENT 5 X WEEK X 2 WEEKS (80 HRS) LUMBAR 97799 IS REASONABLE AND MEDICALLY NECESSARY.

ODG-TWC, last update 1-20-12 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) The latest AHRQ Comparative Effectiveness Research supports the ODG recommendations. (AHRQ, 2011) 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

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)**