



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

**January 25, 2012**

**DATE OF REVIEW: 1-25-12**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

80 hrs/units initial trial Pain management program for lumbar spine, as an outpatient

**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**

- 6-20-11 X-rays of the lumbosacral spine.
- 7-29-11 Initial Behavioral Medicine Consultation.
- Individual psychotherapy note on 10-11-11.
- 10-11-11 PPE.
- 10-11-11 CPMP Goals of treatment.
- 10-12-11 DO., office visit.
- 10-14-11 Psychological assessment performed by PsyD.
- 11-15-11 Chronic Pain Management Program pre-authorization request.
- 11-28-11 UR review performed by MD.
- Chronic Pain Management Program request 80 hours /unit initial trial - out patient. Provided by PsyD.
- 12-5-11 UR performed by PhD.

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

6-20-11 X-rays of the lumbosacral spine shows on dynamic lateral flexion-extension views the spine looks stable. The height of the intervertebral disc spaces appears to be well maintained. Vertebral bodies appear adequate in density. AP pelvis with lumbosacral spine: Alignment is good, vertebral bodies appear of adequate density, sacroiliac joints look good, joint spaces are well maintained.

7-29-11 Initial Behavioral Medicine Consultation. The claimant reportedly sustained a work-related injury on xx/xx/xx in the course of completing his customary duties. Since that time, he has had passive and active physical therapy. He continues to struggle with moderate pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. The patient's treating doctor is recommending participation in a Work Hardening Program to advance the patient's physical condition and functioning and support the patient's desire to return to work and resumption of other major role obligations. Given the information gathered in this intake, the patient would be an excellent candidate for the Work Hardening Program and his psychosocial problems may be effectively addressed in didactic group therapy services offered in this program.

Individual psychotherapy note on 10-11-11 MULTIAXIAL DIAGNOSIS:

Axis 307.89 Pain Disorder associated with both psychological factors and a general medical condition

Axis II: V71.09 No diagnosis

Axis III: Injury to Lumbar — see medical records.

Axis IV: Problems related to primary support group, social, economic, environment, and occupational Axis V: GAF = 63 (current) Estimated Pre-Injury GAF = 85+

TREATMENT PLAN RECOMMENDATIONS: The client was very open to treatment and grateful for the assistance being able to find the treatment to be beneficial for him in reducing some of the negative emotionality caused by the on the job injury. He has participated in physical therapy, failed ten days in a Work Hardening Program, and is now eager to begin participating in the Chronic Pain Management Program as he has exhausted conservative treatment, yet is negatively impacted by pain, emotional distress, and reduced functioning across activities of daily living, in which monomodal therapy has not been enough to address this patients' distress. The patient requires a more intensive intervention that would provide professional assistance with physical and vocational rehabilitation to propel him safely and successfully back to work. The patient is motivated and relates a lack of knowledge of how to improve his physical condition without supervision and guidance. He is eager to begin participating in the Chronic Pain Management Program to improve his physical functioning, tolerance for activity, and to regain his confidence in performing job simulation activities. Thus, it is recommended that the claimant be approved for participation in the Chronic Pain Management Program in order to increase his physical and functional tolerances and to facilitate a safe return to work and medical case closure.

10-11-11 PPE notes the recommendation for the claimant to participate in a Chronic Pain Management Program to further address mental and psychological issues that are complication the claimant's regress in his treatment program and ultimately their return to gainful employment. The claimant has been participated in a work hardening program for the last several weeks and has shown some improvement in their area of injury. The CPMP is recommended to further address mental and psychological issues that are complicating the claimant's progress in the work hardening program and ultimately his return to gainful employment.

10-11-11 CPMP Goals of treatment. MULTIAXIAL DIAGNOSIS:

Axis 307.89 Pain Disorder associated with both psychological factors and a general medical condition

Axis II: V71.09 No diagnosis

Axis III: Injury to Lumbar — see medical records.

Axis IV: Problems related to primary support group, social, economic, environment, and occupational Axis V: GAF = 63 (current) Estimated Pre-Injury GAF = 85+

TREATMENT PLAN RECOMMENDATIONS: The client was very open to treatment and grateful for the assistance being able to find the treatment to be beneficial for him in reducing some of the negative emotionality caused by the on the job injury. He has participated in physical therapy, failed ten days in a Work Hardening Program, and is now eager to begin participating in the Chronic Pain Management Program as, he has exhausted conservative treatment, yet is negatively impacted by pain, emotional distress, and reduced functioning across activities of daily living, in which monomodal therapy has not been enough to address this patients' distress. The patient requires a more intensive intervention that would provide professional assistance with physical and vocational rehabilitation to propel him safely and successfully back to work. The patient is motivated and relates a lack of knowledge of how to improve his physical condition without supervision and guidance. He is eager to begin participating in the Chronic Pain Management Program to improve his physical functioning, tolerance for activity, and to regain his confidence in performing job simulation activities. Thus, it is recommended that the claimant be approved for participation in the Chronic Pain Management Program in order to increase his physical and functional tolerances and to facilitate a safe return to work and medical case closure.

10-12-11 DO., the claimant was pushing/pulling a pallet jack when he had acute onset of low back pain. He was treated at. He had epidural steroid injection with Dr. Perl. He completed rehab and has done work hardening. He was referred for a return to work program and presents for evaluation. On exam, the claimant has full range of motion with pain. Strength is decreased. ADL limitations in lifting and bending. He has + SLR bilaterally. Assessment: Lumbar strain/sprain, coccydynia. Recommendations. Chronic Pain Management Program.

10-14-11 Psychological assessment performed by PsyD., notes

11-15-11 Chronic Pain Management Program pre-authorization request - His treating physician, Dr. D.O., has prescribed CPM treatment as warranted and medically necessary. Based on available documentation, they concurred that he would be an excellent candidate for interdisciplinary care to increase his functional tolerances for safe/successful return to work while reducing perceived disability. Physically and functionally, the claimant reported the following changes in his daily functioning as a result of injury to his low back. He reports that he is able to perform all aspects of dressing and hygiene/grooming without assistance. Per report, home exercise program is limited to stretching for 5-10 minutes, walking for 1 hour, cardio exercises for 1 hour; he avoids resistance training. He relates that he is able to open jars/cans, prepare food,

and he cooks every day. He reports that he is able to accomplish all household chores to include: wash/dry/put away dishes, vacuum/sweep/mop, laundry, dusting, throwing out trash, and make beds. He relates that he does water plants but avoids all other yard work to include mow/edge yard and plant/prune. He lists his driving as being limited to 1 hour. The claimant relates that he socializes with family daily and does not socialize with friends at all. He notes that he avoids all previously enjoyed recreational activity. The claimant sustained a work-related injury to his low back on xx/xx/xx while performing his customary duties as a Truck Driver for xx. He plans to return to the same employer in the same position once he has reached the ability to work without restrictions. Dr. has evaluated the claimant and noted that he is an appropriate candidate for progression to a chronic pain program. Based upon available records, prescription from his referring doctor, information gathered across assessment periods, and limited response to low-level treatment, the claimant is a suitable candidate for a tertiary level of care. Conservative care has not been sufficiently intensive to help this patient increase his physical functioning capacity or reduce psychological distress. He requires a daily, intensive, team-oriented program that will stabilize active symptoms on a long-term basis and assist him with return to work options. He meets the following criteria, which are among those considered appropriate benchmarks for referral to a multidisciplinary chronic Pain Management Program. First, the claimant's presenting problems are consistent with a diagnosis of chronic pain syndrome as outlined by the American Medical Association (AMA), the American Academy of Pain Management (AAPM), American Academy of Physical Medicine and Rehabilitation (AAPMR), the chronic pain literature, standards of practice in the chronic pain treatment community, and the former Texas Workers' Compensation Mental Health Treatment Guidelines effective March 1, 1995, (pg. 67-68). Second, the National Guideline Clearinghouse [(in the article "Clinical practice for chronic non-malignant pain syndrome patients II: An evidence-based approach" in the Journal of Back and Musculoskeletal Rehabilitation (1999, pg. 13;47-58)] notes that, "it is recommended that CPM patients be accepted for treatment if there is reasonable chance of showing significant improvement in at least 3 of the 7 program goals. Third, the treatment of choice to promote the claimant's recovery is participation in an interdisciplinary chronic pain program. Thus, 10 days in a chronic pain program is requested. This request is in accord with the standards of practice set forth by the American College of Occupational and Environmental Medicine (ACOEM), The National Guideline Clearinghouse, and DWC guidelines for treatment of patients with chronic pain syndrome. Moreover, The American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines 2nd Edition (2004) noted that the "The treatment of chronic pain requires specialized knowledge, substantial time, and access to multidisciplinary care. Judicious involvement of other professionals, including psychologists, exercise and physical therapists, and other healthcare professionals who can offer extra physical or mental therapy while the physician continues to orchestrate the whole therapeutic process can be helpful." (Chapter 6 pg. 109). Our chronic pain program includes these components. SUMMARY: Please recall that prior treatment modalities have failed to stabilize Mr. psychosocial distress, increase his engagement in activities of daily living, or enhance his physical functioning such that he could safely return to work. The claimant is approximately 9 months status post injury. His pain is chronic, persistent, and intractable at 5-7/10, depending on his

level of activity. Conservative care has not been sufficient to extinguish his pain or increase his functional tolerances such that he could successfully return to his previous position. He describes limited functioning within daily, job, and familial activities. He has developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary pain rehabilitation program. The claimant's treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary.

11-28-11 UR review performed by MD., notes the claimant sustained a low back injury on xx/xx/xx. The evaluator had a Peer to Peer with Dr. on 11-21-11. He noted that the claimant has persistent pain in the lumbar spine. He has already undergone orthopedic evaluation, lumbar injection and 10 days of a work hardening program as well as four individual psychological therapy sessions. He has also been on additional therapy and has been on medications. He has persistent pain in the lumbar spine. However, current documentation does not indicate the current pathology in his lumbar spine and does not indicate the persistent pain generator in his lumbar spine and whether it is amenable to other interventions or not. Based on the lack of adequate documentation of conservative care and medical rationale to support the request, the request recommended is denial of preauthorization as medically not necessary or appropriate.

Chronic Pain Management Program request 80 hours /unit initial trial - out patient. Provided by Adami Gabriel PsyD., notes the claimant has exhausted low level of care and has being recommended by his treating doctor for 10 days of the Chronic Pain Management Program.

12-5-11 UR performed by, PhD., notes that the submitted documentation notes the claimant had a PPE dated 10-11-11, signed by DC. Few problems with sleep, sex life, personal care, emotional contact or interpersonal relationships were reported. There is no prescription of pharmaceutical treatment. There is no indication that conservative evidence based treatment has been exhausted. The recommendation is made, consistent with the original consideration that Chronic Pain Management Program not be preauthorized.

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

THE PATHOLOGY INDICATED IN THE DOCUMENTATION PROVIDED FOR REVIEW DOES NOT WARRANT A CPMP. THEREFORE, THE REQUEST FOR 80 HRS/UNITS INITIAL TRIAL PAIN MANAGEMENT PROGRAM FOR LUMBAR SPINE, AS AN OUTPATIENT IS NOT REASONABLE OR MEDICALLY NECESSARY.

**ODG-TWC, last update 1-20-12 Occupational Disorders - Pain - CPMP:**

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery." There should be evidence that a complete diagnostic

assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) See Biopsychosocial model of chronic pain.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. These pain rehabilitation programs (as described below) combine multiple treatments, and at the least, include psychological care along with physical and/or occupational therapy (including an active exercise component as opposed to passive modalities). The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):

(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

- (a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)
- (b) Multidisciplinary pain clinics
- (c) Pain clinics
- (d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

Outcomes measured: Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to "demedicalize" treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional

restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all. (See [Opioids for chronic pain.](#))

Outcomes (in terms of body parts)

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

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

Researchers using PRIDE Program (Progressive Rehabilitation Institute of Dallas for Ergonomics) data compared a cohort of patients with cervical spine disorders to those with lumbar spine disorders from 1990-1995 and found that they had similar outcomes.

Cervical patients were statistically less likely to have undergone pre-rehabilitative surgery. ([Wright, 1999](#))

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

([Bendix2, 1998](#)) ([Bendix, 2000](#)) ([Frost, 1998](#)) ([Harkapaa, 1990](#)) ([Skouen, 2002](#)) ([Mellin, 1990](#)) ([Haldorsen, 2002](#))

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

([Guzman, 2001](#)) ([Guzman-Cochrane, 2002](#)) ([van Geen, 2007](#)) ([Bendix, 1997](#)) ([Bendix, 1998](#)) ([Bendix2, 1998](#)) ([Bendix, 2000](#)) ([Frost, 1998](#)) ([Harkapaa, 1990](#)) ([Skouen, 2002](#)) ([Mellin, 1990](#)) ([Haldorsen, 2002](#))

Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults: The programs described had to include a physical component plus

either a psychological, social and/or vocational intervention. There was moderate evidence of positive effectiveness for multidisciplinary rehabilitation for subacute low back pain and that a workplace visit increases effectiveness. The trials included had methodological shortcomings, and further research was suggested. (Karjalainen, 2003)  
Role of opioid use: See Chronic pain programs, opioids.

Role of comorbid psych illness: Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. (Dersh, 2007)  
The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability. (Poleshuck, 2009)  
(Bair, 2008)

Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) There is need for research in terms of necessity and/or effectiveness of counseling for patients considered to be "at-risk" for post-discharge problems. (Proctor, 2004) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) (Dersh, 2007)

Role of duration of disability: There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).  
Studies supporting programs for patients with long-term disability: Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention

at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals. (Jordan, 1998)

Studies suggesting limited results in patients with long-term disability: While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. (Gallagher, 1989) (Beals, 1972) (Krause, 1994) Washington State studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a “treated group” for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included Psych/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N=963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the “treated patient” was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that modest goals (improvement, not cure) be introduced. (Robinson, 2004) (Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]

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

Role of post-treatment care (as an outcome): Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking

care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a “new provider” is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed. (Proctor, 2004) 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 /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program).

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)