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Notice of Independent Review Decision

DATE: June 25, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 Sessions of the Chronic Pain Management Program (total 80 hours)

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

This physician is Board Certified by the American Board of Physical Medicine and Rehabilitation with over 18 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02/03/12: Designated Doctor's Examination by, MD
03/06/12: Functional Ability Evaluation by
04/11/12: Followup Office Visit by, DO, PA
04/25/12: Consultation by, M.Ed and, PhD, LPC-S
04/25/12: Followup Examination by, MD with Bone and Joint
04/26/12: Request for Authorization of Right Knee Injection by with Dr. at Bone and Joint
05/08/12: Followup Examination by, MD
05/09/12: Request for Pre-authorization of Chronic Pain Management Program by PhD, LPC-S
05/14/12: UR performed by, DC
05/24/12: Request for Reconsideration of Chronic Pain Management Program by, DC
05/30/12: UR performed by, PhD
06/11/12: Request for Independent Review by, PhD, LPC-S

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her right knee when she fell at work on xx/xx/xx. She is status post right knee extensive lateral meniscectomy, synovectomy of all three compartments, and arthroscopic lateral release.

02/03/12: Designated Doctor's Examination by, MD. Determine Maximum Medical Improvement: Claimant is not at MMI as adequate treatment of the back injury has not occurred. Further ESIs may be considered; however, a repeat MRI of the LS spine is necessary. She should be considered for limited exposure surgery if the findings are consistent. The lack of improvement of the knee symptoms may stem, in part, from instability due to muscle weakness, which may be related to the back injury.

04/11/12: The claimant was evaluated by, DO who indicated that she had a second ESI, from which she did not get significant relief. She reported predominantly low back pain as 75% of her symptoms and 25% intermittent right buttock and posterior thigh pain rated 6/10. Dr. noted that she was "in some sort of pain management program and does not appear to benefit presently from the counseling." On physical exam, she had tenderness to palpation in the paraspinous region and severe tenderness over the SI joint, worse on the right than the left. Lumbar spine forward flexion to 30 degrees, extension 5-10 degrees, rotation and side bending 5-10 degrees with moderate pain. SLR testing was negative bilaterally. DTRs +1 patellar bilaterally. Sensation was decreased in a nondermatomal pattern in the right lower extremity, intact in the left. She had some mild gastrocnemius/soleus weakness on the right at 4+/5. PLAN: She did not respond well to the second epidural injection. The majority of her low back pain seems to be isolated in the area of the SI joints, worse on the right than on the left. She is pending further treatment in her left knee to include physical therapy. I have read her designated doctor's report. We will send her for a repeat MRI of her lumbar spine, as well as I have recommended that she undergo a diagnostic right SI joint injection. We will see her back for recheck in four weeks.

04/25/12: The claimant was evaluated by, M.Ed. and PhD, LPC-S who noted that she reported that she had received several levels of treatment including x-rays, MRIs, physical therapy, pain injections, TENS unit, and surgery. It was documented that her current complaints pain primarily located in her right knee and left hip. She reported that medication and physical therapy decreased her level of pain. The Beck Depression Inventory II was scored at a 10, within the mild-moderate range of the assessment. The Beck Anxiety Inventory was scored at a 21, within the low range of the assessment. The Screener and Opioid Assessment for Patients in Pain-Revised (SOAPR-R) was scored at an 18, indicating a low risk for abuse of prescribed narcotic pain medications.

SUMMARY: The pain resulting from her injury has severely impacted normal functioning physically and interpersonally. Patient reports frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. Pain has reported high stress resulting in all major life areas. The patient

will benefit from a course of pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning. Patient should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consists of, but is not limited to, daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management, and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting, and returning to a higher level of functioning as possible.

04/25/12: The claimant was reevaluated by, MD who noted that she had knee pain and continued to buckle and give way. Knee pain was rated 6/10. Lumbar spine pain was 7/10. On physical exam of the lumbar spine, the lumbar spine showed point tenderness upon palpation of the lumbar paraspinal musculature. SLR was positive on the right. Achilles and patella reflexes were brisk being 2/4 bilaterally. Flexion and extension of the back caused pain to 60 degrees and 20 degrees. Positive Patrick's/Fabere test. Positive Yeoman's test. Positive Gaenslen's test/maneuver. Exam of the right knee demonstrated mild effusion. Range of motion was from 0-115 degrees. Positive medial joint line pain. Patella tracking was unremarkable and no tilting was noted. There was a negative grinding test and negative apprehension test. The knee was normal to varus and valgus stress testing, negative Lachman's test, negative anterior and posterior drawers, negative pivot-shift. Positive McMurray's test. Positive Apley test. RECOMMENDATION: 1. Obtain MR Arthrogram. 2. Continue followup and recommendations per Dr. for lumbar sprain pain. 3. Seek approval for steroid injection to the knee to reduce pain and swelling until we review the MR arthrogram and possible surgical intervention depending on the MR arthrogram findings. 4. Return with MR arthrogram. Patient will benefit from advancing physical therapy program and/or should participate in active care program.

05/08/12: The claimant was reevaluated by, MD for a steroid injection of the right knee. It was noted that right knee pain was 10/10. There was no change on physical exam when compared to exam on 4/25/12. RECOMMENDATION: I recommend and patient will start, if approved, post injection physical therapy/rehab up to six sessions. Reassess in two weeks. Review MR Arthrogram. Dr. performed a steroid injection to the right knee.

05/14/12: UR performed by, DC. Explanation of Findings: The medical evaluation performed on 05/08/12 revealed that the claimant was recommended for a trial of knee injections with a course of physiotherapeutics. An MRA was also proposed following the failure to reduce symptomology with the course of steroidal injections proposed. The behavioral evaluation completed on 04/25/12 revealed low range scores with psychosocial metrics and a requested 10 session trial of Chronic Pain Management. The orthopedic provider has proposed invasive pain modulation applications coupled with a potential course of invasive surgical applications and diagnostic imaging with the MRA. Thus, continued

application of invasive care coupled with the low range psychosocial metrics does not warrant the proposed 10 session trial of a chronic pain management program. 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. (ODG Treatment Integrated Treatment/Disability Guidelines Pain (Chronic)).

05/24/12: Request for Reconsideration of Chronic Pain Management Program by DC. Ms. has exhausted all lower levels of care and is pending no additional procedures. Official Disability Guidelines from the Work Loss Data Institute consider tertiary chronic interdisciplinary pain programs as the standard of treatment. The results of an outcome study performed by Proctor, Mayer, Theodore, and Gatchel demonstrated that patients who do not complete a chronic pain program are 7 times more likely to have post-rehabilitation surgery in the same area and nearly 7 times more likely to have more than 30 visits to a new health provider in persistent healthcare-seeking efforts. The study also demonstrated that patients who do not complete a chronic pain program had only half the rates of work return and work retention, being 9.7 times less likely to have returned to any type of work, and 7 times less likely to have retained work at the end of the year. Therefore, a chronic interdisciplinary pain program is the recommended course of treatment to help an injured worker return to work and is considered the treatment of choice by the national standards cited above. Ms. meets the criteria for the general use of multidisciplinary pain management program, according to Official Disability Guidelines, chronic pain chapter.

05/30/12: UR performed by, PhD. Explanation of Findings: The clinical documentation submitted for review indicates the patient continues with moderate complaints of pain to her right knee status post her work-related injury. The clinical documentation submitted for review indicates the patient was given a steroid injection to the right knee on 5/8/12 PT was recommended, presumably for strength and range of motion. The efficacy of that right knee injection has not been demonstrated. As such, the patient has not exhausted all lower levels of care for the right knee, as the efficacy of the steroid injection and PT has not been demonstrated. As such, the request is not considered reasonable and is not medically necessary.

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

The previous adverse decisions are upheld. The claimant's work injury occurred on xx/xx/xx. She has received nonsurgical and surgical treatment for her right knee injury and back injury. Notes dated 04/25/12 indicated that the claimant had

a positive Murray’s and Apley’s findings on the right knee exam, among other findings. Dr. noted “possible surgical intervention depending on the MR arthrogram findings”. On 05/08/12, Dr. performed a right knee steroid injection and prescribed additional physical therapy.

As per ODG’s guidelines and criteria regarding chronic pain programs, it states:

“that there is a place for interdisciplinary programs at a stage in treatment prior to the development of permanent disability, and this may be at a period of no later than 3 to 6 months after a disabling injury” ([Robinson, 2004](#)) ([Gatchel, 2003](#)) ([Jordan, 1998](#)).

Additionally, ODG cites

“[t]here is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).”

It should be noted that the claimant’s work injury occurred over 24 months ago. Furthermore, ODG states that, prior to a claimant participating in a chronic pain program, “[a]n 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.”

MRA findings and report were not available among documents included for this review. It is unclear if diagnostic or imaging studies have been performed to assess for lumbar instability which might contribute in part or cause the right knee buckling the claimant reports. Also, it is unclear from records submitted for review if claimant received physical therapy after her right knee injection listed above. The request for 10 Sessions of the Chronic Pain Management Program (total 80 hours) is not medically necessary and is non-certified.

ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>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</p>
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	<p>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.</p> <p>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):</p> <p>(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:</p> <ul style="list-style-type: none"> (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 <p>(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.</p> <p>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.</p> <p>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.)</p> <p>Outcomes (in terms of body parts)</p> <p>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)</p> <p>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</p>
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	<p>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)</p> <p><i>Intensive multidisciplinary rehabilitation of chronic low back pain:</i> 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)</p> <p><i>Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults:</i> 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)</p> <p><i>Role of opioid use:</i> See Chronic pain programs, opioids.</p> <p><i>Role of comorbid psych illness:</i> 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)</p> <p><i>Predictors of success and failure:</i> 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-</p>
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	<p>treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel2, 2005) (Dersh, 2007)</p> <p>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).</p> <p>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)</p> <p>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 Pysch/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N=963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the “treated patient” was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that modest goals (improvement, not cure) be introduced. (Robinson, 2004) (Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]</p> <p>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).</p>
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	<p>See Chronic pain programs, early intervention.</p> <p>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)</p> <p>See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention.</p> <p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the following circumstances:</p> <p>(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.</p> <p>(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.</p> <p>(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following:</p> <p>(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;</p> <p>(b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected;</p> <p>(c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not</p>
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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).</p>
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	<p>(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.</p> <p>(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.</p> <p>(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.</p> <p><u>Inpatient</u> pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don’t have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs.</p>
<p>Chronic pain programs, early intervention</p>	<p>Recommended depending on identification of patients that may benefit from early intervention via a multidisciplinary approach, as indicated below. The likelihood of return to work diminishes significantly after approximately 3 months of sick leave. It is now being suggested that there is a place for interdisciplinary programs at a stage in treatment prior to the development of permanent disability, and this may be at a period of no later than 3 to 6 months after a disabling injury. (Robinson, 2004) (Gatchel, 2003) (Jordan, 1998) Some early intervention programs have been referred to as “secondary treatment,” and differ from the more traditional, palliative care pain programs by not only the earlier onset of treatment, but by treatment intensity and level of medical supervision. (Mayer, 2003)</p> <p><i>Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:</i></p> <ul style="list-style-type: none"> (a) The patient’s response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) Risk factors are identified with available screening tools or there is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support or evidence of work organizational factors limiting return to work without interventions. (f) Evidence of psychosocial barriers that make return to work unlikely. (g) Loss of employment or evidence of partial disability involving ability to perform only “part-time” work or work with “light-duty” restrictions for greater than 4

	months. (Mayer, 2003) (Gatchel, 2003) For general information see Chronic pain programs .
Chronic pain programs, intensity	Recommend adjustment according to patient variables, as indicated below. Research is ongoing as to what treatments are most necessary as part of interdisciplinary treatment for patients with subacute and chronic pain, and how intense such delivery of care should be. The more traditional models of interdisciplinary pain management often provide what has been referred to as tertiary care; a more intensive, and often, more palliative treatment for chronic pain. Research as to the intensity of treatment that is required for earlier intervention remains ongoing (“secondary intervention” see Chronic pain programs, early intervention). Several examples show the difference in results based on intensity of treatment that occur based, in part, on variables such as gender, age, prognosis, diagnosis, and duration of pain. A recent study showed that for men with low back pain that had been “sick-listed” for an average of 3 months, there was no difference between extensive multidisciplinary treatment and usual care in terms of return to work. Significantly better results were found for men who received a “light treatment program” compared to usual care, and these results remained significant at 12, 18 and 24 months. (Skouen, 2002) On the other hand, an extensive program has been shown to be the most effective treatment modality for patients considered to be in categories of poor health, and poor prognosis who were “sick-listed” for the same period, although the effect tapers after one to two years. (Haldorsen, 2002) For general information see Chronic pain programs .

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM 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)