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Notice of Independent Review Decision

DATE: June 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management 5 x per Week x 2 Weeks for 8 Hours/Day

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

This physician is a Board Certified Pain Management Physician with over 40 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:

03/16/11: MRI of the Lumbar Spine without Contrast interpreted by, MD with One Step Diagnostic

06/27/11: Consultation by, MD with Neurology, Headache & Pain, PA

08/08/11: Weekly Summary from Rehab

08/15/11: Followup Visit by, MD

08/23/11: Orthopedic Consult by, MD with Orthopedics

09/23/11: Orthopedic Report by, MD and, PA-C

11/08/11: Orthopedic Report by, MD and, PA-C

12/15/11: Operative Report by, MD

12/23/11: Orthopedic Report by, MD

01/12/12: Followup Visit by, MD

01/31/12: Treatment Note from Healthcare Center

03/26/12: Treatment Note from Healthcare Center

04/19/12: Designated Doctor Evaluation Amendment to Report by, MD with Medical Management Solutions

04/25/12: Letter of Medical Referral by Dr. with Health Care Center

04/30/12: Treatment Note from Healthcare Center

05/09/12: Letter of Treatment Recommendation by with Rehabilitation Management Rehab Center
05/14/12: UR performed by, MD
05/24/12: Letter from, PT with Rehab Center
05/29/12: Treatment Note from Healthcare Center
06/01/12: UR performed by, DO
06/13/12: Letter from Insurance Company
06/13/12: Prescription History from Scripnet

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a work-related injury to his low back on xx/xx/xx.

03/16/11: MRI of the Lumbar Spine without Contrast interpreted by, MD with One Step Diagnostic. IMPRESSION: Lumbar lordosis is straightened. The appearance could reflect positioning, posture, or spasm. Please correlate clinically. No other abnormalities are seen.

06/27/11: The claimant was evaluated by, MD who noted that he had an on-the-job injury on 12/20/10 when a pipe was rolling against him and he fell backwards landing on the ground. He described constant, aching pain over the right side with slight radiation into the hip since the injury. Dr. noted that the claimant had been seen by a surgeon but no surgery was suggested. He had received Lorcet and was undergoing physical therapy with some improvement. Current medications included Lorcet 10 mg q.d. On physical exam, muscle strength was 5/5 and symmetrical throughout. Muscle tone and bulk were normal. Sensation was intact. Romberg sign was negative. Finger-nose testing was normal. Muscle stretch reflexes were normal, 2/2, and symmetrical throughout. Extremities showed full range of motion. Muscle spasm along the right lumbar spine and over the gluteus maximus. It was Dr.'s impression that his "neurological exam was normal." He was diagnosed with muscle sprain. He was given prescriptions for Lyrica and Lorcet with a follow up visit in one month.

08/08/11: The claimant attended Bay Rehab for work hardening, which he started on 08/01/11. , DC noted that he started work hardening and initial program goal settings were set and proper body mechanics were taught. He was noted to have plateaued and was claiming to get worse after one week of work hardening. He was requesting to do every other day of work hardening because of increased pain levels. He was referred to Dr. for psychological evaluation. It was noted that he had decreased muscle strength and flexibility and demonstrated poor posture and body mechanics. It was noted that he had some psychological barriers that needed to be addressed during the program. It was documented that the claimant "claims to have regressed and will not continue Work Hardening at this time. Patient is referred to Dr. for orthopedic consult at this time."

08/15/11: The claimant was evaluated by, MD who noted that he reported much more pain across the back and that Lyrica did not seem to help him. He returned

asking for pain medication. On physical exam, finger-nose testing was normal and fine motor movements were normal. Muscle stretch reflexes were normal 2/2 and symmetrical throughout. He was given prescriptions for Ambien and Lorcet and was to be seen again in one month.

08/23/11: The claimant was evaluated by, MD who noted that he had approximately 4-6 weeks of physical therapy and chiropractic manipulation. He complained of 8/10 lumbar pain. He noted that his pain was aggravated by driving and walking. Medications included Lorcet and muscle relaxers. On physical exam, there was significant guarding that interfered with proper range of motion examination. He had a positive Faber test and a posterior sheer. His lower extremity motor strength and sensation were intact in all motor groups and dermatomes tested. His reflexes were symmetric. IMPRESSION: Bilateral sacroiliac strain, right worse than left. PLAN OF TREATMENT: 1. We are going to track down Dr. reports. 2. Based on the patient's clinical exam and MRI, I do not believe the patient has a spine problem but rather a sacroiliac joint problem. We are going to treat him with an oral anti-inflammatory, which he currently does not have. 3. We are going to track down the MRI films and review those at next visit. 4. The patient may be a candidate for a sacroiliac injection.

09/23/11: The claimant was seen in followup by, MD and, PA-C. It was noted that he presented with low back pain he rated as 8/10 with discomfort with side-to-side movement, soreness, and stiffness. On physical exam, there was severe tenderness below his L5 disc level, right side greater than left. He had tenderness in his right SI joint region. He had a positive Faber, positive Flamingo, and positive Fortin finger test, right side greater than left. His motor strength and sensation were intact in his lower extremities, and his reflexes were 2+ in his patellae and 2+ in his Achilles. His gait was unremarkable. He was able to heel-to-toe walk, walk on toes, and walk on heels with discomfort in his low back. MRI film and report revealed no disc bulges or protrusions. There was no foraminal stenosis present. IMPRESSION: Bilateral SI joint strain, right side greater than left. PLAN OF TREATMENT: 1. The patient continues to remain symptomatic. He has exhausted physical therapy and oral anti-inflammatories with temporary relief. The patient has maximum pain below his L5 disc level. He has more pain in his right SI joint than his left SI joint region. We are recommending a right SI joint injection to help with his persistent pain. The patient meets all indications and has positive tendency for SI joint strain on physical examination. We believe the patient would benefit well. We will do this in conjunction with post-injection physical therapy. 2. The patient will continue his oral anti-inflammatories as prescribed.

11/08/11: The claimant was reevaluated by, MD and, PA-C who noted that since his last visit, he underwent a right SI joint injection on 10/28/11 with significant relief on the right side of his low back area and SI joint space. He complained of a left-sided pain rated as 8/10 with discomfort with various movements, soreness, and stiffness. On physical exam, he had severe tenderness below his L5 disc level. At that time, his left side was greater than right. He continued to have

tenderness in his left SI joint region. There were no other changes to physical exam when compared to previous visit on 09/23/11. IMPRESSION: Bilateral SI joint strain, left side greater than right. PLAN OF TREATMENT: 1. The patient continues to remain symptomatic on his left SI joint space. He had significant relief following his right SI joint injection. We will proceed with a left SI joint inject once approved by his insurance carrier. 2. The patient will continue his oral anti-inflammatories as prescribed.

12/15/11: Operative Report by, MD. Postoperative Diagnosis: Left Sacroiliac joint strain. Procedures: 1. Left Sacroiliac joint injection. 2. Fluoroscopic interpretation of SI arthrogram with needle localization.

12/23/11: The claimant was seen in followup by, MD who noted that he still complained of 8/10 lumbar pain. He stated that the left SI joint injection did not help and in fact made it a little worse. On physical exam, he had left sacroiliac tenderness and painful decreased lumbar range of motion. His lower extremity motor strength and sensation were intact. IMPRESSION: Back pain. PLAN OF TREATMENT: 1. The patient has a normal lumbar MRI and there is no change with his sacroiliac pain after the injection, not even temporarily. At this point, I think the patient would be a candidate for a chronic pain program. 2. The patient should follow up with Dr. Al-Sahli. 3. The patient can return on an as-needed basis.

01/12/12: The claimant was reevaluated by, MD who noted that he returned asking for pain medication. On physical exam, finger-to-nose and fine motor movements were normal. Muscle stretch reflexes were normal 2/2 and symmetrical throughout. IMPRESSION: He has had no major change. Patient is wanting narcotic. CONCLUSION: 1. Since the patient has been getting medication from another physician, I decided not to continue prescribing narcotic at this time. I offered the patient other medications, which are not narcotic, however patient refused.

01/31/12: A note from Healthcare Center does not list the name of the treatment provider. The claimant received manipulation to the lumbar region at Healthcare Center where he described acute back pain and acute low back stiffness. Palpation of the lumbosacral region revealed acute muscle hypertonicity. Palpation of the lumbosacral region elicited acute reduced motion. ASSESSMENT: In my clinical opinion the patient is feeling somewhat better. PLAN OF ACTION: Antonio will be following a schedule of one visit per week.

03/26/12: The claimant returned to NBC Healthcare Center with no changes on report given, which did not list the name of the treating provider.

04/19/12: Designated Doctor Evaluation Amendment to Report by, MD with Medical Management Solutions. RATIONALE: 1. Recommend chronic pain management and continued physical therapy. 2. Claimant is unable to return to work of any sort. He demonstrates inability to stand or walk for short period of

time or any lengthy period of time required to work. This would best be evaluated with a functional capacity evaluation exam. 3. Candidate for work retraining/reconditioning.

04/30/12: The claimant returned to Health Center (name of treating provider not listed) with symptoms of acute back pain, slightly better since the last treatment. He reported symptoms acute low back stiffness with minimal improvement over his previous visit. He described symptoms of acute stabbing pain in the low back, no different than the last visit. Manipulation was administered to the lumbar region. ASSESSMENT: It is my opinion that Antonio is feeling a little better. PLAN OF ACTION: One visit per week will be scheduled for Antonio.

05/09/12: Letter from with Rehabilitation Management Rehab Center indicates that the claimant had been recommended by Dr. and Dr. to participate in a multidisciplinary chronic pain management program.

05/14/12: UR Performed by, MD. REVIEWER COMMENTS: This request is for chronic pain management five times per week for two weeks at eight hours per day. There was no clinical documentation provided from the requesting physician regarding a recent patient assessment addressing in detail the necessity of the proposed services. Submitted clinical documentation does not include objective evidence that previous methods of treating the patient's chronic pain have been unsuccessful. The functional objective response through VAS pain scales, as well as physical therapy and psychotherapy progress notes was not provided. It is not clear if there is an absence of other options likely to result in significant clinical improvement and that the patient is not a candidate for further diagnostic, injection(s), or other invasive or surgical procedure. Based on these grounds, the medical necessity of the requested service in this patient has not been established.

05/29/12: The claimant returned to Health Center (name of treating provider not listed) with reported symptoms of acute back pain, which was the same as the last visit. He also reported indications of acute low back stiffness, the same as last visit, and symptoms of acute stabbing pain in the low back, the same level of pain as last visit. The treatment included manipulation t the lumbar region. ASSESSMENT: In my clinical opinion, he is feeling somewhat better. PLAN: One visit per week will be scheduled for this patient.

06/01/12: UR performed by DO. REVIEWER COMMENTS: This is an appeal request for the medical necessity of chronic pain management five times a week for two weeks, eight hours a day. The previous request was non-certified because there was not recent provider's examination, no documentation indicating that previous methods of treatment were unsuccessful, and no mention regarding absence of other options likely to result in significant clinical improvement. Updated documentation submitted for this appeal still did not address the aforementioned issues. A recent medical report from the requesting provider documenting subjective and objective clinical findings was still not

provided in the records. Such evaluation is necessary to determine the patient's current functional status and provided direction for further management. In addition, while it is noted that the patient has previously utilized a number of conservative treatment modalities, objective documentation through VAS pain scales and PT progress notes were still not provided to indicate the patient's functional response and the appropriateness and adequacy of the strategies used. Likewise, there was no mention if the patient has been evaluated with regard to other concomitant medical issues and if such issues have been addressed. Radiologist's reports of recent diagnostic imaging examinations to rule out other pain generators were likewise not provided for review. Moreover, negative predictors of success were not noted to have been identified and subsequently addressed. Evidence that the patient is aware that successful treatment may change compensation and/or other secondary gains was not noted. Furthermore, documentation of an adequate psychological testing using a validated instrument was not provided. Documentation that the patient has motivation to change, and the will to change medication regimen was also not indicated. Based on these grounds, the medical necessity of this request is not substantiated, and the previous non-certification is upheld.

06/13/12: A letter from Insurance Company indicates that the injured worker has completed 7 sessions of Work Hardening between 08/01/11 and 08/08/11 and that he had a designated doctor report that was amended on 04/19/12 releasing him to light duty. It was noted that the injured worker did not fill any medications between 02/28/12 and 06/05/12.

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

The previous adverse decisions are upheld. The information given supports a diagnosis of this compensable injury sustained on xx/xx/xx, as a lumbar sprain and strain and bilateral sacroiliac sprain and strain. He has received appropriate diagnostic studies (MRI of the lumbar spine on March 16, 2011 interpreted by, MD. Impression: Straightened lordotic curve. No other significant abnormalities). He has also received significant and over-abundance of physical therapy with no apparent long term benefit. He has had a right sacroiliac injection on October 28, 2011 with definite pain relief and a left sacroiliac injection on December 15, 2011 with no relief and possibly some worsening of his pain symptoms. All of this exceeds ODG recommended treatment listed for sprain and strain of the lumbar spine and bilateral sacroiliac joints.

In addition, he has requested pain medication, including narcotics, from multiple providers and has stopped a work hardening program partially through the program.

This request is for Chronic Pain Management, 5 times per week x 2 weeks for 8 hours per day. There is insufficient documentation of a psychological evaluation stating that he would take full advantage of such a program or would be an appropriate candidate for it. Also, it has not been presented to this reviewer that a

concise, neurological examination has been performed recently to justify the program. Therefore, this reviewer concurs with the two prior reviewers, , M.D. and, D.O., that the adverse decision should be upheld.

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 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> <p>(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)</p> <p>(b) Multidisciplinary pain clinics</p> <p>(c) Pain clinics</p> <p>(d) Modality-oriented clinics</p> <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</p>
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	<p>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><i>Outcomes (in terms of body parts)</i></p> <p><i>Neck and Shoulder:</i> 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><i>Multidisciplinary back training:</i> (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)</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</p>
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	<p>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>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)</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</p>
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	<p>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). 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</p>
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	<p>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 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;</p> <p>(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</p>
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	<p>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> <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>
Chronic pain	Recommended depending on identification of patients that may benefit from early

<p>programs, early intervention</p>	<p>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> <p>(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.</p>
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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
- AHCP- 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)