



Notice of Independent Review Decision - WC

DATE OF REVIEW: 07/12/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening Program 80 Hours

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

Clinical Psychologist
Member American Academy of 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.

Work Hardening Program 80 Hours – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Multidisciplinary Work Hardening Plan & Goals of Treatment, Injury 1, 03/02/11
- Functional Capacity Evaluation (FCE), Center, 04/30/12
- Initial Behavioral Medicine Consultation, Injury 1, 05/07/12
- History & Physical for WHP, M.D., 05/17/12
- Work Hardening Pre-Authorization Request, Injury 1, 05/30/12, 06/11/12

- Denial Letter, SRS, 06/04/12, 06/18/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury on xx/xx/xx. The FCE done on 04/30/12 placed the patient at the Medium physical demand level (PDL) of 25 pounds, with patient's job requiring function at a Medium PDL of 50 pounds. The Initial Behavioral Medicine Consultation by L.P.C. of 05/07/12 states that "The patient sustained a work related injury to his neck, low back, and right knee...while performing his customary duties as for for whom he had worked for over 3 years at the time of the injury." The reason for referral was noted as a "behavioral medicine consultation at the directive of his treating doctor, Dr. to assess his emotional status and to determine his suitability for some level of behavioral medicine treatment and/or a return to work program".

Psychometric testing showed that the patient scored a 49 on the BDI, a 50 on the BAI, a 42 on the FABQ-W, a 22 on the FABQ-PA, and rated his pain at a 8/10. Patient also reported severe sleep disturbance, averaging 2-4 fragmented hours per night. Patient self-rated his irritability, frustration, and depression at an 8/10, his anxiety at a 9/10, and his sleep problems and muscle tension at a 10/10. Mental status exam showed patient's mood to be dysthymic and patient verbalized suicidal ideation with no current plan or intent. Patient was recommended for psychotropic med management evaluation. Patient was diagnosed with 296.23 Major Depressive Disorder, severe without psychotic features, and 307.89 Pain Disorder. Current GAF was 50 and previous GAF was estimated at 80+. Treatment recommendation was that "the patient would be an excellent candidate for the Work Hardening Program".

On the 05/17/12 med visit, Dr. diagnosed the patient with lumbar, cervical, and right knee sprain and referred him for a Work Hardening program. Treatment to date was reported as MRI of the lumbar spine, 2 physical therapy sessions, and medication management, to include Norco, Lyrica, and Metformin, per his treating physician Dr..

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

Per the Behavioral Med Consult of 05/07/12, the patient was exhibiting overall severe symptomatology across all measures, and noted suicidal ideation on mental status examination. However, instead of being referred for any individual therapy sessions, as is reasonable and recommended under ODG, patient is instead referred for a work hardening program, which notably is contraindicated in patients with this level of psychological distress. It is also important to note that a recommendation was made for AD med check on 05/07/12, but the physician visit on 05/17/12 did not address this. Also, ODG states that previous physical therapy which shows improvement followed by plateau is a necessary precondition that could not have happened in this case, as only two physical therapy sessions were administered. The reason for this is not explicated. The patient is also more than xx post-injury, and may need a more intensive return to work program that work hardening. The more immediate need is for a stepped-care approach

to psychological treatment of his severe MDD along with a referral for psychotropic medication management. With these contraindications, medical necessity for a Work Hardening Program cannot be established at this time.

WH/WC: Recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker back to work is with a modified duty RTW program (see [ODG Capabilities & Activity Modifications for Restricted Work](#)), rather than a work hardening/conditioning program, but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful. See also [Return to work](#), where the evidence presented for “real” work is far stronger than the evidence for “simulated” work. Also see [Exercise](#), where there is strong evidence for all types of exercise, especially progressive physical training including milestones of progress, but a lack of evidence to suggest that the exercise needs to be specific to the job. Physical conditioning programs that include a cognitive-behavioral approach plus intensive physical training (specific to the job or not) that includes aerobic capacity, muscle strength and endurance, and coordination; are in some way work-related; and are given and supervised by a physical therapy provider or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with chronic back pain, when compared to usual care. However, there is no evidence of their efficacy for acute back pain. These programs should only be utilized for select patients with substantially lower capabilities than their job requires. ([Schonstein-Cochrane, 2003](#)) See also [Chronic pain programs](#) (functional restoration programs), where there is strong evidence for selective use of programs offering comprehensive interdisciplinary/ multidisciplinary treatment, beyond just work hardening. Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). ([Lang, 2003](#)) Work Conditioning should restore the client’s physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual’s measured tolerances. Work conditioning and work hardening are not intended for sequential use. They may be considered in the subacute stage when it appears that exercise therapy alone is not working and a biopsychosocial approach may be needed, but single discipline programs like work conditioning may be less likely to be effective than work hardening or [interdisciplinary programs](#). ([CARF, 2006](#)) ([Washington, 2006](#)) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable [functional improvement](#) should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. ([Schonstein-Cochrane, 2008](#)) Use of Functional Capacity Evaluations (FCEs) to evaluate return-to-work require validated tests. See the [Fitness For Duty Chapter](#).

Other established guidelines: High quality prospective studies are lacking for Work Conditioning and Work Hardening, but there are consensus guidelines used by providers of these programs. The term “work hardening” was first introduced in the late 1970s ([Matheson, 1985](#)), with a description as a “work-oriented treatment program” with an outcome of improvement in productivity. An assessment is necessary, and activities include real or simulated work activities. ([Lechner, 1994](#)) The first guidelines for work hardening were introduced in 1986 by the American Occupational Therapy Association Commission on Practice. ([AOTA, 1986](#)) In 1988 the Commission for Accreditation of Rehabilitation Facilities (CARF) addressed standards, suggesting that the programs must be “highly structured and goal oriented.” Services provided by a single practitioner were excluded from CARF accreditation for work hardening. ([CARF, 1988](#)) As CARF accreditation includes extensive administrative and organization standards, the Industrial Rehabilitation Advisory Committee of the American Physical Therapy Association (APTA) developed the Guidelines for Programs in Industrial Rehabilitation. ([Helm-Williams, 1993](#)) This was primarily to offer more flexibility. Types of programs in these guidelines are outlined below:

Single-Discipline Exercise Approaches: Approaches or programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, and typically called Work Conditioning (WC). Single-discipline approaches, like WC, may be considered in the subacute stage when it appears that physical rehabilitation alone is not working. For users of ODG, WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. It is an intermediate level of nonoperative therapy between acute PT and interdisciplinary/ multidisciplinary programs, according to the number of visits outlined in the WC/PT guidelines, which appear below the ODG WH criteria.

Interdisciplinary Work-Related Exercise Approaches Adding Psychological Support: These approaches, called Work Hardening (WH) programs, feature exercise therapy combined with some elements of psychological support (education, cognitive behavioral therapy, fear avoidance, belief training, stress management, etc.) that deal with mild-to-moderate psychological overlay accompanying the subacute pain/disability, not severe enough to meet criteria for chronic pain management or functional restoration programs. (Hoffman, 2007) See also Chronic pain programs (functional restoration programs). There has been some suggestion that WH should be aimed at individuals who have been out of work for 2-3 months, or who have failed to transition back to full-duty after a more extended period of time, and that have evidence of more complex psychosocial problems in addition to physical and vocational barriers to successful return to work. Types of issues that are commonly addressed include anger at employer, fear of injury, fear of return to work, and interpersonal issues with co-workers or supervisors. The ODG WH criteria are outlined below.

Criteria for admission to a Work Hardening (WH) Program:

(1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.

(2) Screening Documentation: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.

(3) Job demands: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).

(4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.

(5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

(6) Rule out surgery: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).

(7) *Healing: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.*

(8) *Other contraindications: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.*

(9) *RTW plan: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.*

(10) *Drug problems: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.*

(11) *Program documentation: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.*

(12) *Further mental health evaluation: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.*

(13) *Supervision: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.*

(14) *Trial: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.*

(15) *Concurrently working: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.*

(16) *Conferences: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.*

(17) *Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.*

(18) *Post-injury cap: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see [Chronic pain programs](#)).*

(19) *Program timelines: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.*

(20) *Discharge documentation:* At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) *Repetition:* Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

Comorbid psychiatric disorders: Recommend screening for psychiatric disorders. Comorbid psychiatric disorders commonly occur in chronic pain patients. In a study of chronic disabling occupational spinal disorders in a large tertiary referral center, the overall prevalence of psychiatric disorders was 65% (not including pain disorder) compared to 15% in the general population. These included major depressive disorder (56%), substance abuse disorder (14%), anxiety disorders (11%), and axis II personality disorders (70%). ([Dersh, 2006](#)) When examined more specifically in an earlier study, results showed that 83% of major depression cases and 90% of opioid abuse cases developed after the musculoskeletal injury. On the other hand, 74% of substance abuse disorders and most anxiety disorders developed before the injury. This topic was also studied using the National Comorbidity Survey Replication (NCS-R), a national face-to-face household survey. ([Dersh, 2002](#)) See also [Psychological evaluations](#).

Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested:

Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.

Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also [Multi-disciplinary pain programs](#). See also [ODG Cognitive Behavioral Therapy \(CBT\) Guidelines for low back problems](#). ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))

Criteria for the general use of multidisciplinary pain management programs Pain Chapter:

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 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.

(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities).

[\(Sanders, 2005\)](#) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. [\(Keel, 1998\)](#) [\(Kool, 2005\)](#) [\(Buchner, 2006\)](#) [\(Kool, 2007\)](#) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See [Chronic pain programs, opioids; Functional restoration programs](#)

Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. [\(WCRI, 2005\)](#) [\(Joling, 2006\)](#) [\(PERI, 2005\)](#) [\(Smith, 2001\)](#) [\(Stover, 2007\)](#) Delayed recovery has been associated with delayed referral to nurse case management. [\(Pransky, 2006\)](#)

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**