

# Matutech, Inc

881 Rock Street  
New Braunfels, TX 78130  
Phone: 800-929-9078  
Fax: 800-570-9544

---

## Notice of Independent Review Decision

**Date: October 10, 2013**

**IRO CASE #:**

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

Chronic pain management x 10 sessions CPT 97799

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

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

**REVIEW OUTCOME:**

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Office visits (10/16/12 – 08/28/13)
- Diagnostics (11/23/12, 11/28/12)
- Utilization reviews (09/10/13, 09/19/13)
  
- Utilization reviews (09/10/13, 09/19/13)

**M.D.**

- Office visits (10/13/12 – 09/18/13)
- Diagnostics (10/15/12 – 11/28/12)
- Therapy (10/15/12 – 07/12/13)

**ODG Pain chapter criteria have been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on xx/xx/xx. He accidentally slipped on the stairs when his right knee, right ankle and mid-upper back twisted while trying to keep from falling.

**2012:** Following the injury, the patient was seen and noted to have limited range of motion (ROM) of the thoracic spine, right ankle and right knee. He was diagnosed with thoracic sprain/strain, right knee sprain/strain and right ankle sprain/strain; given prescription for pain medications including Zofran and ordered x-rays of the thoracic spine, right knee and right ankle.

On October 15, 2012, the patient was then seen for complaints of right knee and upper back pain which he rated at 8/10. The patient reported that the mid back pain worsened with bending. There were muscle spasms and back stiffness. The right knee joint pain increased with ROM and worsened with weightbearing. The pain increased with bending the knee. There was knee joint swelling on the right and intermittent locking of the knee. The knee got caught during movement. There was a clicking and a grating sensation in the knee. A popping sound was heard in the knee. The patient reported a shock-like sensation in the knee. The ankle joint pain also increased with motion and weightbearing. There was associated swelling and stiffness on the right ankle. The patient walked with a limp. Examination of the back revealed swelling and tenderness to palpation with associated muscle spasms. The thoracolumbar spine also demonstrated tenderness to palpation and there was pain elicited by motion. Examination of the right knee revealed tenderness on ambulation and muscle weakness. There was effusion present and tenderness on the anteromedial aspect and the lateral collateral ligament and pain with flexion and extension. Examination of the right ankle showed pain on dorsiflexion and plantarflexion and eversion and inversion. The active and passive ROM was decreased and there was weakness noted. diagnosed sprained right knee, sprain of the right ankle and thoracic strain; ordered x-rays of the thoracic spine, right ankle and right knee; prescribed Flexeril and naproxen and recommended elevation of the extremity, rest, reducing physical activities, ice/heat application, physical therapy (PT) for one month and ACE bandage.

The x-rays of the thoracic spine showed very minimal scoliosis. X-rays of the right knee and right ankle were unremarkable.

On October 16, 2012, the patient presented where, evaluated him. The patient reported immediate strong pain in the right ankle, right knee and upper back following the injury which continued to persist. He had sought evaluation and treatment who had obtained x-rays and had prescribed medications. On functional assessment, the patient reported increased pain in the right ankle and right knee rated at 7 to 8/10 with extended walking and weightbearing, climbing stairs/steps and difficulty kneeling and squatting. He also reported increased pain in the thoracic spine with reaching overhead, rotation and lateral bending of the upper back. The patient was off work and required prescription medications for pain/inflammation and noted limitations with home management due to his condition. Examination of the thoracic spine revealed moderately limited range of

motion (ROM) with pain, tenderness and muscle spasm noted in the mid-upper thoracic spine by palpation. Examination of the right knee revealed limited ROM (flexion 100 degrees, extension -10 degrees, internal rotation 5 degrees and external rotation 5 degrees) with pain elicited in all extremes of ROM. There was moderate-to-strong pain-tenderness noted in the medial and lateral aspects of the right knee by palpation with moderate to strong swelling-edema. Compression test and heel walk and toe walk tests on the right were positive. Examination of the right ankle revealed limited ROM (dorsiflexion 15 degrees, plantar flexion 20 degrees, inversion 15 degrees and eversion 10 degrees) with pain elicited in all ROMs (accentuated on inversion). There was moderate-to-strong pain-tenderness on the lateral aspect of the right ankle by palpation with moderate-to-strong swelling-edema. There was pain elicited in the right ankle on heel/toe walk. Motor function of the right knee and right ankle were 4/5 manually. diagnosed thoracic sprain/strain; right knee sprain/strain and right ankle sprain/strain and recommended initiating rehabilitative therapy three times a week for four weeks per prescription from his treating physician reported that while the patient was expected to see favorable improvement with rehabilitative therapy, his prognosis remained "guarded" pending completion of initial weeks.

October 17, 2012, gave prescription for a right ankle brace and application of Aloe Vera liniment to the affected area.

From October 19, 2012, through October 25, 2012, the patient attended therapy for six weeks consisting of hot/cold packs, massage, electrical muscle stimulation and therapeutic activities/exercises.

On October 22, 2012, recommended continuing the therapy and limiting physical activities.

On November 14, 2012, ordered magnetic resonance imaging (MRI) of the thoracic spine and right ankle as the patient continued to exhibit tenderness and muscle spasms of the middle back and tenderness of the right ankle with decreased ROM and weakness.

On November 23, 2012, magnetic resonance imaging (MRI) of the right ankle revealed sprain involving the posterior tibiofibular ligament and flexor hallucis longus tendon with fluid collection.

On November 28, 2012, MRI of the thoracic spine was unremarkable.

On November 28, 2012, recommended continuing the therapy.

On November 29, 2012, noted the patient had completed 12 sessions of active rehabilitation and requested additional PT sessions as the patient's prognosis was still guarded.

**2013:** On March 6, 2013, saw the patient for ongoing upper back pain which was on and off, right ankle joint pain which worsened with weightbearing and

associated swelling and stiffness of the right ankle. The patient was not working and was not attending therapy. Examination showed tenderness at the thoracic spine and at the right ankle. added Celebrex and recommended continuing analgesics, strengthening exercises, PT for one month and physical activity restrictions.

On April 12, 2013, requested maximum medical improvement (MMI) and impairment rating (IR).

On April 16, 2013, noted that the patient had completed 12 sessions of active rehabilitative therapy. He had returned to work on October 22, 2012, with restrictions of avoiding extended standing and extended walking and to lift no more than five pounds. This was not taken well by his employer. After being approved for additional 12 sessions of active rehabilitation, the patient was able to attend only two sessions as he had returned full-time work with no restrictions on November 29, 2012. He was required to work and was unable to get off during work-time in fear of losing his job. He continued to work and did not follow up with completing the approved rehabilitation as reported. However, on January 15, 2013, he was released from his job. The patient reported that he had not totally responded to the rehabilitative therapy and would need more treatment as he continued to have pain in the thoracic spine and right ankle. examined the patient and maintained the diagnosis of thoracic sprain/strain, right knee sprain/strain and right ankle sprain/strain and opined that the patient did not have ample opportunity to complete the prescribed and approved rehabilitation that could have possibly promoted full recovery. The patient continued to have strong pain and limited ROM of the thoracic spine and right ankle that was verified by examination. stated that the patient had not reached maximum medical improvement (MMI) and would require additional rehabilitative treatment to promote further recovery. He therefore, did not assign any impairment rating (IR).

On May 29, 2013, examined the patient and felt that he would benefit from four weeks of PT.

On June 3, 2013, examined the patient and noted that the right knee revealed normal ROM, but the right ankle still had limited and painful ROM in all planes, accentuated in inversion. There was strong tenderness in the lateral aspect of the right ankle with moderate swelling/edema. There was pain elicited in the right ankle on heel/toe walk. Examination of the thoracic spine revealed limited ROM with pain in the thoracic spinal muscles and muscle spasms. maintained the diagnoses of right knee sprain/strain, right ankle sprain/strain and thoracic sprain/strain and recommended additional rehabilitation therapy three times a week for four weeks.

From June 3, 2013, through July 12, 2013, the patient attended 12 sessions of PT consisting of hot/cold packs, electrical stimulation, joint mobilization, manipulation, massage and therapeutic activities/exercises.

On July 11, 2013, re-examined the patient and noted that the right knee revealed normal ROM with no pain on extremes of ROM. There was no tenderness in the right knee by palpation and no swelling-edema and no positive orthopedic tests were present. Examination of the right ankle revealed normal ROM with pain accentuated on inversion. There was moderate-to-strong pain tenderness on the lateral aspect of the right ankle by palpation with moderate swelling and edema. There was pain elicited on the right on heel/toe walk. Motor function of the right ankle test was 4/5 manually. Examination of the thoracic spine revealed limited ROM and flexion and extension with moderate-to-strong pain and muscle spasm elicited in the spinal muscles of the thoracic spine. reported that the patient had completed the prescribed and approved rehabilitation for thoracic spine, right knee and right ankle with continuing favorable improvement. However, he continued to report strong pain with limited ROM of the thoracic spine and right ankle that resulted in restrictions with extended walking, standing and lifting in heavy or strenuous work. He suggested completing an initial functional capacity evaluation (FCE) to assess the patient's current physical and functional status related to the physical demand level (PDL) requirements of his job and his ability to return to work. He advised the patient to follow-up with his treating physician for additional evaluation, recommendations and work status. further opined that the prognosis of the patient had improved and the progress with treatment-rehabilitation had not plateaued and his prognosis remained "guarded" pending completion of an initial FCE.

On July 19, 2013, felt that the patient needed to have a functional capacity evaluation (FCE) before the MMI/IR evaluation. He continued the analgesics and strengthening exercises.

On July 25, 2013, the patient underwent a psychological evaluation. His ongoing medications included naproxen, Flexeril and Aleve as needed. The patient was diagnosed with major depressive disorder, single episode; pain disorder associated with both psychological factors and a general medical condition, chronic; psychological factors interfering with recovery to a general medical condition, severe psychosocial stressors which included unemployment, financial, interpersonal and chronic pain and a global assessment of functioning where the current global assessment of functioning (GAF) score was 50 and prior to the injury was 90. Ms. opined that the patient reported suffering from chronic pain since the injury and the pain had been present despite conservative treatment for over six months. He further demonstrated symptoms of anxiety and depression and the pain that severely impacted the patient's normal physical, psychological, vocational and interpersonal functioning. The patient was positive for chronic pain syndrome and was required to participate in a full 20-day chronic pain management program (CPMP).

The same day, initial physical performance report indicated that the patient performed at the medium PDL. The evaluator recommended participating in an active physical therapy (PT) portion of the CPMP in order to increase his strength, endurance, stamina and flexibility.

On July 31, 2013, noted the patient was worried, anxious and concerned about his ability to work. He was utilizing Advil. The FCE showed that the patient needed to participate in work hardening program (WHP) before MMI.

On August 23, 2013, added tramadol and referred the patient for pain management.

On August 28, 2013, noted continued right knee and upper back pain. There was back stiffness and right ankle joint pain which worsened with weightbearing. There was moderate depression accompanied by persistent worry with feelings of hopelessness. His ongoing medications included Advil and tramadol. Examined the lower back and noted tenderness at the bilateral paraspinal regions. Thoracolumbar spine demonstrated tenderness at the thoracolumbar region by motion. Examination of the right ankle revealed decreased passive motion. strongly felt that the patient needed chronic pain management and hence requested for the same.

On September 10, 2013, the request for CPMP x10 sessions was denied with the following rationale: *"The date of injury is xx/xx/xx. The patient is a male. There is no medical necessity for this program when the only pathology was a soft tissue sprain that occurred almost a year ago and resolved fully a long time ago. These programs are not indicated for patients who had minor injuries and who have nothing physically "wrong" with them. I spoke with and the case was discussed. I asked why a CPMP is being requested now when she was requesting a work hardening program for this patient in August 2013? The response was that the CPMP was requested because the WH program was dented. She told me that liked to first request WH and then CPMP if the WH was denied. I pointed out the fact that a tertiary rehab program should be what the patient needs not what the provider wants. I asked what the patient's treatable and symptomatic pathology was, given that the injury was a strain that occurred. I asked how she knew if the patient was not simply malingering given that was the #1 diagnosis given the nature of this injury and claim history. She told me that it does not matter if the patient has somatization or is malingering or has a fictitious disorder if he endorses psychological symptoms. I disagree and so does ODG. These programs are not indicated when the injury was minimal and there is simply nothing physically wrong with the patient and when there is no pathology that explains the current physical and psychological complaints. This person had some sprains that resolved long ago. Most providers would reassure the patient that there is nothing physically wrong and discharge him from care."*

On September 18, 2013, that the patient continued to have upper and mid back pain with associated stiffness and right ankle joint pain which worsened with weightbearing. He was moderately depressed and anxious with feelings of hopeless and anhedonia. However, he had a desire to continue living. His ongoing medications included Advil and tramadol. The patient wanted to try working regular duty. recommended continuing analgesics, strengthening exercises and follow-up after one month.

On September 19, 2013, the reconsideration for CPMP x10 sessions was denied a psychiatrist, with the following rationale: *"I discussed the request. This worker has sprain injuries that he is requesting opiates to treat. It is the sense of the treatment center that his presenting complaints are a function of anger and irritability at his manager from being let go from his position, not a true orthopedic condition. I have offered several psychotherapy sessions in lieu of the requested services, however, that offer was rejected. There is insufficient data to support the request, and it is denied"*.

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

This patient has several negative predictors of success in the history and findings. Also, there is no documentation of motivation to return to pre-employment levels. The program is thus not appropriate or medically necessary per ODG guidelines.

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

#### **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Chronic pain programs (functional restoration programs)

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

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

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

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

(2) **Interdisciplinary pain programs:** Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is

emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See [Functional restoration programs](#).

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

**Outcomes measured:** Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to “demedicalize” treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all. (See [Opioids for chronic pain](#).)

**Outcomes (in terms of body parts)**

**Shoulder (and other upper extremity disorders):** This large cohort study concluded that an interdisciplinary functional restoration program (FRP) is equally effective for patients with chronic upper extremity disorders, including the elbow, shoulder and wrist/hand, as for patients with lumbar spine disorders, regardless of the injury type, site in the upper extremity, or the disparity in injury-specific and psychosocial factors identified before treatment. ([Howard, 2012](#))

**Neck (and cervical spine):** There are limited studies about the efficacy of chronic pain programs for neck disorders. ([Karjalainen, 2003](#)) This may be because rates of cervical claims are only 20-25% of the rates of lumbar claims. In addition, little is known as to chronicity of outcomes. Researchers using PRIDE Program (Progressive Rehabilitation Institute of Dallas for Ergonomics) data compared a cohort of patients with cervical spine disorders to those with lumbar spine disorders from 1990-1995 and found that they had similar outcomes. Cervical patients were statistically less likely to have undergone pre-rehabilitative surgery. ([Wright, 1999](#))

**Multidisciplinary back training:** (involvement of psychologists, physiotherapists, occupational therapists, and/or medical specialists). The training program is partly based on physical training and partly on behavioral cognitive training. Physical training is performed according to the “graded activity” principle. The main goal is to restore daily function. A recent review of randomized controlled studies of at least a year’s duration found that this treatment modality produced a positive effect on work participation and possibly on quality of life. There was no long-term effect on experienced pain or functional status (this result may be secondary to the instrument used for outcome measure). Intensity of training had no substantial influence on the effectiveness of the treatment. ([van Geen, 2007](#)) ([Bendix, 1997](#)) ([Bendix, 1998](#)) ([Bendix2, 1998](#)) ([Bendix, 2000](#)) ([Frost, 1998](#)) ([Harkapaa, 1990](#)) ([Skouen, 2002](#)) ([Mellin, 1990](#)) ([Haldorsen, 2002](#))

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

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

**Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults:** The programs described had to include a physical component plus either a psychological, social and/or vocational intervention. There was moderate evidence of positive effectiveness for multidisciplinary rehabilitation for subacute low back pain and that a workplace visit increases effectiveness. The trials included had methodological shortcomings, and further research was suggested. ([Karjalainen, 2003](#))

**Role of opioid use:** See [Chronic pain programs, opioids](#).

**Role of comorbid psych illness:** Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not

complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. (Dersh, 2007) The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability. (Poleshuck, 2009) (Bair, 2008)

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

***Role of duration of disability:*** There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).

***Studies supporting programs for patients with long-term disability:*** Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals. (Jordan, 1998)

***Studies suggesting limited results in patients with long-term disability:*** While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. (Gallagher, 1989) (Beals, 1972) (Krause, 1994) Washington State studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a “treated group” for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included 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.]

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

**Role of post-treatment care (as an outcome):** Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a “new provider” is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed. ([Proctor, 2004](#)) The latest AHRQ Comparative Effectiveness Research supports the ODG recommendations. ([AHRQ, 2011](#)) See also [Chronic pain programs, intensity](#); [Chronic pain programs, opioids](#); [Functional restoration programs](#); [Chronic pain programs, early intervention](#); [Progressive goal attainment program \(PGAP™\)](#).

#### **Criteria for the general use of multidisciplinary pain management programs:**

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

- (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.
- (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.
- (3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.
- (4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.
- (5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most

appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

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

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

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). ([Sanders, 2005](#)) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

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

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

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

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

approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See [Chronic pain programs, opioids](#); [Functional restoration programs](#).