



Notice of Independent Review Decision

[Date notice sent to all parties]:

February 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 80 hours (10 sessions)

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

REVIEW OUTCOME:

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

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- 11-17-11 Functional Capacity Evaluation.
 - 12-9-11 X-ray of the pelvic-lumbar and sacroiliac, MD.
 - 12-15-11 EMG-NCV performed by, MD.
 - 1-5-12 MRI of the lumbar spine performed by MD.
 - 8-23-12 Ph.D., office visit.
 - 8-30-12 DC., Medical Request.
 - Chronic Pain Management Program at Inc. on 10-31-12, 11-1-12, 11-5-12, 11-7-12, and 11-9-12.
 - 11-6-12 MD., Letter.
 - 11-13-12, Ph.D., office visit.
 - 11-19-12 Physical Therapy Evaluation.
 - 11-29-12 MD., Medical Review.
 - 12-20-12 Ph.D., Letter.
 - 12-20-12, MD., Medical Review.
 - 12-26-12, Ph.D., Letter.
 - 1-22-13, Ph.D., Letter.

PATIENT CLINICAL HISTORY [SUMMARY]:

11-17-11 Functional Capacity Evaluation shows the claimant is functioning at a Light PDL.

12-9-11 X-ray of the pelvic-lumbar and sacroiliac, MD., showed at the lumbar spine, the posterior longitudinal ligament appears sonographically increased in its thickness at the noted segments. This swelling is also accompanied by a moderate hyperechoic signal reflected at both the main body and the lateral extensions of the ligament. L1-2. There is a slight to moderate amount of swelling demonstrated sonographically about the erector spine muscle and the concurrent compartment of the scanned area of the lumbar spine. There are sonographic indications of joint

inflammation demonstrated by increased reflection signals at the lumbar joint planes bilaterally. L2-5. There is evidence of an early form of degenerative osteoarthritis of the lumbar spine. Sonographic evaluations of the sacroiliac joints are unremarkable for any frank pathology or swelling. Left and right side.

12-15-11 EMG-NCV performed by, MD., showed borderline latency of the right median meter at the wrist is relate dot mild entrapment neuropathy of the median nerve. No evidence of radiculopathy.

1-5-12 MRI of the lumbar spine performed by, MD., showed mild L5-S1 disc space narrowing with associated moderate disc desiccation and 2 mm circumferential disc bulge but without canal stenosis or neural foraminal narrowing. Signal abnormality within the inferior L5 and superior S1 compatible with bony edema. No compression fracture or spondylolisthesis. Mild bilateral L5-S1 facet arthropathy.

8-23-12 Ph.D., the claimant presents for a Psychological Evaluation. Diagnosis: Pain disorder associated with both psychological factors and a general medical condition, adjustment disorder, with mixed anxiety and depressed mood. Axis II: No diagnosis. Axis III: Hip, back, and shoulder contusions; lumbar radiculopathy. Axis IV: Psychosocial stressors: 3, moderate, persistent pain producing disruption of psychological functioning and lifestyle. Axis V: GAF = 59 (current). Plan: The evaluator recommended two weeks interdisciplinary pain management program (5 days a week 8 hours a day for 10 days).

8-30-12 DC., the evaluator noted that the claimant will benefit from a comprehensive physical rehabilitation program with a frequency of 5x-wk for duration of 2 weeks.

Chronic Pain Management Program from 10-31-12 through 11-9-12 (5 sessions)

11-6-12 MD., the evaluator noted that the claimant has recently completed an initial trial of 10 sessions of chronic pain management. The Official Disability Guidelines (2012) recommend interim evaluation for patients after completing 10 sessions of chronic pain management as follows: "Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains (emphasis added).... Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures (emphasis added) and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program." Therefore 1 hour of psychological testing (96101) is requested to perform follow-up testing and allow comparison to baseline measures of emotional status as well as pain coping skills, and validate the need for additional sessions, if indicated by follow-up testing. Please note the attached documentation

that supports this recommendation. The evaluator certified that psychological testing is of medical necessity and is reflected in the documentation presented.

11-13-12, Ph.D., the claimant presents for a Psychological Evaluation. Diagnosis: Adjustment disorder; pain disorder; hip, back, and shoulder contusions; lumbar radiculopathy. Plan: Additional interdisciplinary treatment is recommended to reinforce and increase levels of physical activity, eliminate additional emotional obstacles to return to work, and provide supervised application and reinforcement of chronic pain management strategies and techniques, thereby increasing her physical, emotional, and occupational functioning to a more optimal level despite persistent pain. The evaluator certified that participation in a Chronic Pain Management Program is of medical necessity and is reflected in the documentation presented.

11-19-12 Physical Therapy Evaluation.

11-29-12 MD., performed a Medical Review. It was his opinion that he does not recommend approval for the additional sessions of the chronic pain management program, after 10 sessions completed, for this female, status post stated injury when she is stated to have tripped on string-wire and fallen on xx/xx/xx, with mention of knee pain and back pain, treated with PT, medications, etc., with diagnoses of hip contusion, radiculopathy (not clearly documented), facet related pain, status post treatment with PT, medications, injections, etc., sessions of individual psychotherapy, for the following reasons: 1) The claimant has attended 10 sessions of chronic pain management, 2) Mention is made of a decrease in pain to 7-10, from 8 at the start, a day to day variation, 3) Psychosocial variables are not improved, 4) There is a decrease in Hydrocodone to 0 from only 2-3 per day, 5) The FCE, if examined closely, (note the graphs), is invalid, 6) the evaluator is unable to document any progress that would be beyond a day to day variation after 10 days in the program, 7) This would not be consistent with ODG, 2012.

12-20-12, Ph.D., this letter is written to request reconsideration of the Adverse Determination that was received via fax on 12-5-12, with regard to our recommendation that the claimant participate in a multidisciplinary Chronic Pain Management Program daily, 5 times per week 8 hours per day, consisting of 40 hours per week, for an additional 2 weeks. Given that the rationale for non-certification appears inaccurate and therefore fails to bear effectively on the question of medical necessity of treatment for the claimant, he would like to request reconsideration of our request in order to expedite medically necessary services for the claimant.

12-20-12 MD., performed a Medical Review. It was his opinion that clinical data submitted indicates the prior pre-certification review physician opined there has been minimal objective evidence of clinically significant therapeutic benefit as the

result of the first ten sessions of participation. The physician reviewer cited a decrease in Hydrocodone from only 2-3 per day to no more than one, often zero per day and a perceived pain level decrease of only one point. The evaluator also opined the mental health evaluation tools demonstrated a lack of clinically significant advancement, while the repeat functional capacity evaluation was determined, under close scrutiny, to fail to document clinically significant functional improvement. Additional information submitted reports that a computer problem caused the findings of 0 lbs during the FCE testing but that lifting tests yielded light PDL. The results in this evaluator's opinion continues to indicate inconsistency in the results and does not reveal that adequate benefit was derived from the initial trial of chronic pain management to support its continuation as is consistent with the recommendations from evidence based treatment guidelines.

12-26-12 Ph.D., the evaluator conferred with Dr. regarding the FCE dated 11-16-12, especially concerning the anomalous results on the claimant's lifting performance. Dr. stated that the claimant's functional capacity testing was interrupted due a computer malfunction on Friday afternoon and could not be completed until Monday morning. Unfortunately, the claimant suffered a muscle spasm on Sunday afternoon resulting in a fall and an episode of marked pain exacerbation. This resulted in inability to perform the static lifting task on Monday morning (0 lbs) despite excellent effort-lifting performance on Friday afternoon (20 lbs) on the dynamic lifting task. The claimant's overall performance, however, was significantly improved in comparison to her pre-program evaluation and this warranted a change in per measured Physical Demand Level from Sedentary to Light. Both pre- and post-program FCEs have been included for your perusal.

1-22-13 Ph.D., "this letter is written to request review by an Independent Review Organization of two Adverse Determinations, the first dated 12-5-12 and the second dated 12-26-12, with regard to our recommendation that the claimant continue to participate in a multidisciplinary Chronic Pain Management Program for an additional 10 sessions. Given that the rationale for non-certification appears inaccurate and therefore fails to bear effectively on the question of medical necessity of treatment for the claimant, he would like to request review of our request by an independent review organization in order to expedite medically necessary services for the claimant. The evaluator notes that the "reviewer states, Clinical data submitted indicates the prior pre-certification review physician opined that there has been minimal objective evidence of clinically significant therapeutic benefit as the result of the first ten sessions of participation. The physician reviewer cited a decrease in Hydrocodone from only 2-3 per day to no more than one, often zero per day and a perceived pain level decrease of only one point"; however, as performed ODG many patients experience an increase in pain after beginning chronic pain management due to increased activity levels; therefore, a decrease of even 1 point in average levels of pain is clinically significant, especially given that The claimant discontinued all use of narcotic medication during the same period of time. In addition, it should

be noted that many reviewers consider such a decrease in Hydrocodone not only a clinically significant improvement but also in itself sufficient progress to justify continuation of a chronic pain management program. The evaluator also notes that "the reviewer states, "The reviewer also opined the mental health evaluation tools demonstrated a lack of clinically significant advancement, while the repeat functional capacity evaluation was determined, under close scrutiny, to fail to document clinically significant functional improvement"; however, the claimant did report subjective reduction of emotional distress, and the main criterion for continuation of chronic pain management is functional improvement, rather than improved psychological test scores. The claimant demonstrated functional improvement given that she increased her functional capacity from a Sedentary up to Light Physical Demand Level, which together with weaning off narcotic medication, comprises sufficient progress to justify continuation of the program as per Official Disability Guidelines (2012). Given that the results of the FCE dated 11-16-12 were unfortunately compromised by a computer malfunction, however, a new FCE was conducted on 1-9-13 which more clearly demonstrates that the claimant has progressed from a Sedentary up to a Light Physical Demand Level. The evaluator notes that "The reviewer states, "The 11-12 FCE indicates NIOSH tasks show 0 lbs and does not support that claimant can perform at light PDL. It also indicates a red flag as to veracity of test/effort of claimant"; however, again given that the results of the FCE dated 11-16-12 were unfortunately compromised by a computer malfunction and not the fault of the patient, a new FCE was conducted on 1-9-13 which clearly demonstrates that The claimant has improved from a Sedentary up to a Light Physical Demand Level, The reviewer states, "Additional information submitted reports that a computer problem caused the findings of 0 lbs during the FCE testing but that lifting tests yielded a light PDL. The results in this reviewers opinion continues to indicate inconsistencies in the results and does not reveal that adequate benefit was derived from the initial trial of chronic pain management to support its continuation"; however, again given that the results of the FCE dated 11-16-12 were unfortunately compromised by a computer malfunction and not the fault of the patient, a new FCE was conducted on 1-9-13 which clearly demonstrates that The claimant has improved from a Sedentary up to a Light Physical Demand Level. The claimant requires interdisciplinary intervention that is medically necessary as per Chapter 408.021 of the Texas Labor Code, which states: "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment." As outlined below, all three definitions of medical necessity included in the Labor Code are met, even though only one is required to establish entitlement to health care services, i.e., 1) The claimant continues to require treatment to relieve chronic pain that has naturally resulted directly from her compensable injury and is interfering with recovery, 2) additional interdisciplinary treatment is likely to continue to promote

recovery as it has been proven to do in so many other patients with chronic pain (e.g., Sanders, S., Harden, R & Vicente, R, 2005. Evidence-Based Clinical Practice Guideline For interdisciplinary Rehabilitation Of Chronic Non-Malignant Pain Syndrome Patients), and 3) The claimant is entitled to psychological intervention to reduce fear and avoidance of activity as well as to improve pain coping skills, thereby enhancing her ability to recover and return to full time employment, which she strongly desires. The claimant would benefit significantly from additional sessions of interdisciplinary chronic pain management program to continue improve objective functional capacity, continue to reduce average pain levels, prevent relapse with regard to reliance on narcotic medication, and continue to improve pain coping skills. She requires additional sessions of chronic pain management in order to achieve the goal of successfully returning to work without further difficulty or incident. The recommended treatment will increase her emotional, social, and occupational functioning to a more optimal level and facilitate appropriate recommendations for further treatment, if necessary to reduce emotional symptoms and functional impairment. He certified that interdisciplinary intervention is of medical necessity and that the need for interdisciplinary services is reflected in the documentation presented."

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

Based on the records provided, this claimant has undergone 10 sessions of a chronic pain management program. However, the documentation provided fails to provide any significant objective evidence of measurable pain improvement or functional responses. Per ODG, treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. Therefore, based on the data provided, Chronic Pain Management Program 80 hours (10 sessions) would not be reasonable or medically necessary.

PER ODG 2013 CHRONIC PAIN MANAGEMENT PROGRAM: Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery." There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), the research remains ongoing as to (1) what

is considered the “gold-standard” content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) See Biopsychosocial model of chronic pain.

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

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

(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)

(b) Multidisciplinary pain clinics

(c) Pain clinics

(d) Modality-oriented clinics

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

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d)

psychosocial care; (e) vocational rehabilitation and training; and (f) education.

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

Outcomes (in terms of body parts)

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

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

Intensive multidisciplinary rehabilitation of chronic low back pain: The most recent Cochrane study was withdrawn from the Cochrane (3/06) as the last literature search was performed in 1998. Studies selected included a physical dimension

treatment and at least one other treatment dimension (psychological, social, or occupational). Back schools were not included unless they included the above criteria. There was strong evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improved function when compared to inpatient or outpatient nonmultidisciplinary rehabilitation. Intensive (> 100 hours), daily interdisciplinary rehabilitation was moderately superior to noninterdisciplinary rehabilitation or usual care for short- and long-term functional status (standardized mean differences, -0.40 to -0.90 at 3 to 4 months, and -0.56 to -1.07 at 60 months). There was moderate evidence of pain reduction. There was contradictory evidence regarding vocational outcome. Less intensive programs did not show improvements in pain, function, or vocational outcomes. It was suggested that patients should not be referred to multidisciplinary biopsychosocial rehabilitation without knowing the actual content of the program. ([Guzman, 2001](#)) ([Guzman-Cochrane, 2002](#)) ([van Geen, 2007](#)) ([Bendix, 1997](#)) ([Bendix, 1998](#)) ([Bendix2, 1998](#)) ([Bendix, 2000](#)) ([Frost, 1998](#)) ([Harkapaa, 1990](#)) ([Skouen, 2002](#)) ([Mellin, 1990](#)) ([Haldorsen, 2002](#))

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

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

Role of comorbid psych illness: Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. ([Dersh, 2007](#)) The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability. ([Polshuck, 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) (Gatchel2, 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](#).

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.

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

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