



Claims Eval

Notice of Independent Review Decision

June 5, 2013

IRO CASE #:

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5 x wk x 2 wks x 80 hours 97799

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

Psychologist

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

xx-xx-xx, the claimant has a chief complaint of fall injury to right knee/leg. He fell 10 feet from ladder. Exam shows bony point tenderness. Impression: Comminuted tibial plateau fracture. Plan: Admitted.

xx-xx-xx X-rays of the right knee interpreted by showed severely comminuted displaced fracture of the proximal tibia extending into the knee joint. The distal fragment, including the fibula, is markedly adducted.

xx-xx-xx X-rays of the right leg interpreted by showed a comminuted intraarticular severely displaced fracture proximal tibia.

xx-xx-xx X-rays of the cervical spine interpreted by showed no evidence of injury or arthritis and appear normal.

xx-xx-xx X-rays of the right femur interpreted by showed no apparent injury and appear normal.

xx-xx-xx X-rays of the right knee interpreted by showed there has been a severely comminuted fracture of the proximal tibia including both tibial plateaus which has been reducing shows considerably better alignment than on the original films. The distal femur is intact. There appears to have been a small fracture of the tip of the head of the fibula.

xx-xx-xx CT of the right lower extremity interpreted by Hugo Isuani showed a markedly comminuted fracture of the lateral and medial tibial plateau with marked

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degree of separation of the lateral tibial plateau fragments and depression of the medial plateau. A cruciate ligament tear must be present.

xx-xx-xx, preoperative diagnosis: Right proximal tibial plateau fracture, Schatzker 6. Postoperative diagnosis: Right proximal tibial plateau fracture, Schatzker 6. Procedure: Transfixation and stabilization of the unstable tibial plateau fracture using external fixation device by Stryker.

Physical therapy on 3-13-09, 3-14-09, 3-26-09, 4-29-09, 5-1-09, 5-4-09, 5-6-09, 5-8-09, 5-12-09, 5-13-09, 5-18-09, 5-20-09, 5-21-09, 5-26-09, 5-27-09, 5-28-09, 6-9-09, 6-12-09, 6-15-09, 6-23-09, 6-26-09, and 6-29-09.

3-16-09, the claimant had surgery without complication. He was admitted to the floor for observation and soft tissue rest. He remained on the floor receiving wound care. He did well there. The skin continued to improve, but it was still not at a condition where it would be feasible to perform surgery on him. He was therefore discharged

home. Plan: Vicodin, Colace, and Lovenox. Follow up in the orthopedics clinic where he will preop'd for upcoming surgery.

3-23-09, preoperative diagnosis: Right proximal, tibial plateau fracture dislocation, type Schatzker VI with fibular head avulsion, and external fixator in place.

Postoperative diagnosis: Right proximal, tibial plateau fracture dislocation, type Schatzker VI with fibular head avulsion, and external fixator in place, and avulsion of the anterolateral capsule of the right knee joint, instability of the proximal fibula.

Procedure: Removal of external fixator. Open reduction internal fixation of the lateral plateau with plate and screws using 4.5 lateral plateau plate. Open reduction internal fixation of the medial plateau with two plates, one posterior and one more anteromedial. Approximation of the fibular head with suturing and fixation of the proximal fibula to the tibia with 6.5 screw with repair of the anterolateral capsule.

5-5-09, the claimant is almost 6 weeks after fixation of his fracture and dislocation of the right knee with tibial plateau Schatzker VI with the fibular head avulsion and proximal fibular instability and anterolateral joint instability. He is progressing and still has some pain. He has 3 more sessions of physical therapy left. Exam shows he keeps the knee about 10 degrees of flexion. He is able to lift it flexed like that and is able to do active extension and to hold it in the air at 10 degrees. Flexion sitting on the edge of the table is about 75 degrees. He does not have active dorsal extension of the foot. For that, he prescribed him an ankle/foot arthrosis. Plan: Non-weight bearing for at least 3 months. Do range of motion exercises. Vicodin and Colace were given.

5-18-09, discharge summary: SN to teach incisional wound care to spouse. Spouse proficient with care. Claimant admitted to hospital for ortho surgery.

Follow up on 6-19-09, the claimant is 3 months after fracture dislocation of proximal tibia plateau with planar palsy and still has pain. Plan: Allow to start putting weight on it and increase physical therapy as much as possible. Follow up 6 weeks for his nerve paralysis. See.

Physical therapy on 7-2-09, 7-7-09, 7-10-09, 7-20-09, 7-22-09, 7-24-09, 7-27-09, 7-29-09, 7-30-09, 8-5-09, 8-7-09, 8-10-09, 8-12-09, 8-17-09, 8-19-09, and 8-21-09.

8-3-09 EMG/NCV of the right lower extremity and left upper extremity, showed left upper extremity with evidence of a mild demyelinating motor neuropathy with some conduction block involving the left ulnar nerve and the wrist (Guyon's canal) with no evidence of any axonal loss or acute denervation at this time. There was no evidence of any left median neuropathy or diffuse peripheral neuropathy at this time. Right lower extremity revealing absent right sural, peroneal, and tibial latencies. The right tibial H reflexes also absent. The left sural and left peroneal and tibial H reflex is within normal limits'. Needle EMG of the right lower extremity reveals marked denervation in the tibialis anterior, gastrocnemius, and peroneus longus muscles, sparing the right biceps femoris (short head). There are no voluntary motor units in the tibialis anterior but the patient is able to recruit a few polyphasic motor unit

potentials in the right peroneus longus and his function of the right gastrocnemius muscles is also fair. Quadriceps muscle is normal. The above findings are consistent with a severe right peroneal greater than tibial neuropathy at the level of the popliteal fossa (most like).

8-14-09, the claimant follows up on right tibial fracture. Exam shows good range of motion from full extension to more than 90 degrees of flexion. However, he describes some tenderness over the midshaft of the tibia. There are no obvious signs of infection where he describes the pain. Impression: Right tibial plateau, healed with EMG studies suggestive of peroneal affection. Plan: Encouraged to weight bear. If he has severe pain he can back off for another 2 weeks. Prescribed Vicodin. Prescribed physical therapy. Follow up 6-8 weeks.

Occupational therapy evaluation on 8-19-09.

8-31-09, the claimant is being followed for a right common peroneal and left cubital tunnel nerve injury. Exam shows he is not able to dorsiflex his ankle or toes. Positive Tinel at the level of the fibular head on the right. Impression: Right common peroneal nerve injury, it appears to be a neural injury. Plan: Exploration and grafting of this nerve ASAP. Should address he left ulnar nerve once his surgery is taken care of on the right.

Physical therapy re-evaluation on 9-25-09.

10-19-09 the claimant has pain in the right lower leg and left hand. Hand written illegible notes.

10-27-09 preoperative diagnosis: Right peroneal nerve injury. Postoperative diagnosis: Right peroneal nerve injury. Procedure: Exploration of right peroneal nerve. Nerve transfer using interpositional nerve graft to re-elevate the tibialis anterior using the branches of the lateral head of the gastroc.

Physical therapy evaluation on 12-18-09.

Physical therapy evaluation on 1-13-10.

Physical therapy on 1-13-10, 1-22-10, 1-25-10, 1-26-10, 1-29-10, 2-1-10, 2-5-10, 2-8-10, 2-12-10, 2-15-10, 2-17-10, 2-18-10, 2-24-10, 2-26-10, 3-1-10, 3-3-10, 3-5-10, 4-23-10, 5-17-10, 5-20-10, 5-27-10, 6-1-10, 6-3-10, 7-7-10, 7-12-10, 7-14-10, 7-19-10, 7-22-10, 9-8-10, 9-10-10, 9-14-10, 9-15-10, 9-21-10, 9-24-10, 9-27-10, 9-28-10, 9-29-10, 10-12-10, 10-13-10, 10-14-10, 10-15-10, 10-20-10, 10-22-10, 10-26-10, and 10-27-10.

Follow up on 1-21-10, the claimant follows up on his grafting to address the right peroneal nerve injury and still has not received the AFO that was requested. Plan: Follow up regarding his knee. Follow up 3-4 months. Prescribed a crutch with a

platform walker to see if this will help alleviate the pressure in the hypothenar region of his hand to see if this will help alleviate the paresthesias he is experiencing.

Follow up on 2-19-10, the claimant is still having weakness of the right leg and the inability to dorsiflex the foot. Plan: He still has significant hypertrophy and weakness, but the knee is completely stable. He does not need the hinged knee brace any long. Will order a full brace. Weight bearing as tolerated. Follow up 3-4 months with right knee x-rays. Continue to see as scheduled.

Follow up on 3-18-10, the claimant is being followed for a right foot drop. WC has denied the brace. With regards to his left hand, he still continues to have difficulties. Therapy has been denied for his left hand. Plan: Request for left upper extremity therapy. Hold off on the AFO. He has now gone to a weight bearing status for his right lower extremity.

Follow up on 5-27-10, the claimant is being treated for a right common peroneal nerve palsy. Plan: Refer for EMG/NCV to evaluate the status of the ulnar nerve. Follow up 4-6 weeks.

6-15-performed a Designated Doctor Evaluation. He certified the claimant has not reached Maximum Medical Improvement but is expected to reach Maximum Medical Improvement on 9-15-10. DWC-73 shows the claimant was returned to work with restrictions on 6-15-10.

6-15-10 FCE shows the claimant is functioning at a Sedentary PDL.

Follow up on 7-9-10, the claimant follows up on right foot and right hand is doing well. Hand written illegible notes.

8-16-10, the claimant complains of right leg foot drop and left hand pain. He suffered a fall from 16 feet and landed on right leg. He rates his pain a 6/10. Exam shows weak right hamstrings, quadriceps, hip flexors and iliotibial band. Exam shows left wrist flexion is 55 degrees. Impression: Wrist sprain/strain. CTS. Knee or leg sprain/strain. Ankle/foot bursitis/tenosynovitis. Swelling of limb. Plan: Aquatic therapy 3 times a week for 3 weeks, 10 sessions. NMES unit, NMES supplies, and Biofreeze.

8-23-10 the claimant is s/p work injury fall and fracture right lower extremity. He rates his pain a 6/10. Hand written illegible notes. Impression: 842.00, 354.0, 844.9, 924.1, 727.06, 959.7. Plan: Pain meds. RTC 1 month.

8-25-10 FCE shows the claimant is functioning at a Light to Medium PDL.

Follow up on 8-31-10.

9-17-10, the claimant has a chief complaint of right knee, leg pain and left wrist pain. Exam shows he does have an ankle-foot orthosis to the right side. He has no active

dorsiflexion of the right ankle and his toes. Decreased sensory along the dorsal aspect of the foot and to the medial plantar aspect of the foot, as well as the dorsal medial aspect of his leg. He does have atrophy to the right quadriceps. He does have a large medial incision to the knee, as well as a large lateral incision, as well as a posterolateral incision from the apparent nerve exploration. His right knee has mild swelling, tenderness over the medial joint line. Range of motion is 0 degree to 140 degrees. Mild crepitus is noted. There are small incisions from the external fixator. Left arm demonstrates positive Tinel's sign to the ulnar nerve at the elbow. Decreased sensory to the ulnar nerve distribution. Diagnosis: Right tibial plateau fracture status post surgery with peroneal and tibial nerve injury. Internal derangement of right knee. Pain to the left arm consistent with left cubital tunnel neuropathy. Left cubital syndrome. Plan: Repeat EMG/NCV of the right lower extremity and left upper extremity. Bring medical records. Obtain right knee MRI to rule out meniscal injury. Follow up 4 weeks. DWC-73 shows the claimant was taken off work on 9-17-10.

Follow up on 9-24-10, the claimant follows up on right lower extremity pain that he rates a 9/10 and left hand pain 9/10. Exam shows RLE with decreased ROM with pain. Left hand with decreased strength, pain and tenderness. Plan: Continue meds. RTC 1 month.

Follow up on 10-11-10.

Team conference on 10-22-10.

10-25-10 performed a Designated Doctor Evaluation. He certified the claimant has reached Maximum Medical Improvement on 10-25-10 through 17% Impairment Rating. DWC-73 shows the claimant was returned to work with restrictions on 10-25-10.

Follow up on 11-1-10.

Follow up on 11-8-10, the claimant follows up on RLE pain that he rates a 5/10 and left hand pain 3/10. Plan: Continue meds. RTC 1 month.

Follow up on 11-15-10, the claimant states he is still waiting for the MRI and nerve study. He has been having tingling and numbness into the 3rd, 4th and 5th fingers. No surgery was recommended for the left upper extremity. Plan: Order EMG/NCV of the left upper extremity to rule out ulnar nerve lesion as well as an MRI of the right knee. Follow up 4 weeks. No work per

Mental Health evaluation on 11-15-10.

11-19-10 FCE shows the claimant is functioning at a Light PDL.

Follow up on 12-9-10, the claimant follows up on RLE pain that he rates a 5/10 and left hand pain 3/10. Exam shows decreased ROM in left wrist. Impression: 842.00, 354.0, 844.9. Plan: Add Neurontin. Continue meds. RTC 1 months.

Individual psychotherapy on 12-22-10, 1-5-11, 1-27-11, 3-2-11, and 3-21-11.

12-30-10 Right knee arthrogram interpreted showed right knee arthrogram without complications.

12-30-10 MR arthrogram of the right knee with intraarticular contrast interpreted by, showed greater than expected exam limitations related to internal fixation hardware at proximal tibia. If internal derangement is of clinical concern, CT knee arthrogram could be considered. Thin 0.5 cm medial plica. Possible ACL tear.

Follow up with on 1-6-11.

Follow up on 1-7-11, the claimant states he is still waiting on the EMG/NCV study. He is still having pain to the right knee and some numbness to the left hand. Exam shows left hand with decreased sensory to the ulnar nerve distribution. Right knee with tenderness to the medial aspect of the knee. Diagnosis: Internal derangement, right knee. Pain to the left arm consistent with cubital tunnel syndrome. Right tibial plateau fracture status post surgery with peroneal nerve injury. Plan: Await MRI of the knee and nerve study of the left upper extremity. Follow up in several weeks. No work per DWC-73 shows the claimant was taken off work.

Follow up on 1-24-11, the claimant follows up on RLE pain that he rates a 5/10 and left hand pain 3/10. Plan: Discontinue Neurontin. Add Norco. Continue meds. RTC 1 month.

Follow up, on 2-9-11.

2-18-11 FCE shows the claimant is functioning at a Light PDL.

Physical therapy on 2-21-11, 2-22-11, 2-14-11, 2-24-11, 2-25-11, 3-3-11, 3-4-11, 3-7-11, 3-8-11, 3-9-11, 3-10-11, 3-14-11, 3-16-11, 3-17-11, 3-18-11, 3-21-11, and 3-22-11.

Manual muscle testing and range of motion on 2-23-11.

Follow up on 3-4-11, the claimant follows up on RLE pain that he rates a 5/10 and left hand pain 3/10. Palpitations resolved. Plan: Continue meds. RTC 1 month.

Follow up on 3-9-11.

Manual muscle testing and range of motion on 3-16-11.

Follow up on 3-30-11.

Follow up on 4-4-11, the claimant follows up on RLE pain and left hand pain that he rates a 5/10. Plan: Continue meds. RTC 1 month.

Manual muscle testing and range of motion on 4-11-11.

4-22-11 PPE shows the claimant is functioning at a Light to Medium PDL.

Follow up on 4-27-11.

4-27-11 X-rays of the right knee and recommended a total knee replacement.

Manual muscle testing and range of motion on 4-27-11.

Follow up on 5-11-11.

5-16-11 EMG/NCV interpreted showed no evidence of left or right lumbar radiculopathies, focal left peroneal or tibial neuropathies in his knee or ankle segments, lower limb peripheral polyneuropathies, or myopathies.

Follow up on 5-23-11, the claimant rates his right knee pain a 5/10 and wrist 3/10. Plan: Continue meds. RTC 1 month. EMG results.

Follow up on 5-26-11.

Manual muscle testing and range of motion on 5-26-11.

Follow up on 6-13-11.

Manual muscle testing and range of motion on 6-13-11.

Follow up on 6-23-11, the claimant follows up on left wrist and right knee pain that he rates a 3-5/10. Impression: 9-29-11, 959.7, 729.81. Plan: Continue meds. EMG results.

Follow up on 6-28-11.

Manual muscle testing and range of motion on 7-13-11.

Follow up on 7-25-11, the claimant follows up on left wrist and right knee pain. Pain is unchanged. Plan: Add Skelaxin. Continue meds. RTC 1 month.

Manual muscle testing and range of motion on 7-28-11.

Follow up on 7-28-11.

Manual muscle testing and range of motion on 8-15-11.

Follow up on 8-15-11.

Follow up on 8-25-11, the claimant follows up on left wrist and right knee pain and is unchanged. He rates his knee a 5/10 and wrist 3/10. Plan: Wean off Norco. Continue meds. RTC 1 month. Urine tox.

Follow up on 9-13-11.

Manual muscle testing and range of motion on 9-13-11.

Follow up on 9-26-11, the claimant follows up on left wrist and right knee pain that he rates a 3/10. He is having back pain now more pronounced. Plan: Continue meds. RTC 1 month.

Follow up on 9-29-11.

10-3-11 performed a Designated Doctor Examination. Yes, his disability is because he fell off a ladder. He should qualify for those periods for his entitlement. Return to work status is outlined on the DWC-73 form. DWC-73 shows the claimant was returned to work with restrictions on 7-6-11 through 10-4-11.

Follow up on 10-18-11.

Manual muscle testing and range of motion on 10-18-11.

Follow up on 10-24-11, the claimant follows up on left wrist and right knee pain that is unchanged. Having more frequent pain in right knee that he rates a 5/10. Also still with lower back pain. Needs urine tox. Plan: Norco. Continue rest of meds. RTC 1 month. Repeat urine tox 1 month.

Follow up on 11-3-11.

Manual muscle testing and range of motion on 11-3-11.

Follow up on 11-21-11.

Follow up on 11-23-11, the claimant follows up on left wrist that he rates a 3/10 and right knee pain 5/10. He is still having back pain. Plan: Celebrex and Voltaren. RTC 1 month.

Follow up on 12-22-11, the claimant follows up on right knee that he rates a 5/10 and left wrist 3/10. Exam shows left wrist flexion 47 and extension 35. Right knee flexion 110 and extension 0. Impression: 924.1, 959.7. Plan: Refill meds. RTC 1 month.

Follow up on 1-2-12.

Manual muscle testing and range of motion on 1-3-12.

Follow up on 1-25-12, the claimant follows up on left wrist and knee pain that he rates a 3-5/10. He is having cramps again and back discomfort. Plan: Refill meds. RTC 1 month.

Follow up on 2-2-12.

Manual muscle testing and range of motion on 2-2-12.

2-3-12 performed a peer review. Not in my opinion. Current literature notes that there is little information available from trials to support the use of many physical medicine modalities for treating disorders of the ankle and foot. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. Without the data supporting the use and benefit of ultrasound for long term use and effectiveness, the request for a portable ultrasound unit would not be reasonable or necessary per ODG.

2-22-12 performed an Independent Medical Examination. This gentleman will not need any additional physical therapy. He will not need any pain management of a psychological basis. As to diagnostic testing, he may well need additional radiographs of his knee. It is likely in medical certainty that he will develop severe traumatic arthritis of the knee. The option for that in the future will be total knee replacement. As to his peroneal palsy in the right leg, it is unlikely that he will have any recovery as it has now been nearly x years since the date of injury. Therefore, he will need to continue with ankle/foot arthrosis or consider additional surgical options. As to his left elbow, he would recommend a repeat nerve conduction study by an independent expert. If it is determined that the ulnar neuropathy is from the cubital tunnel, an anterior transfer of the ulnar nerve would be an option. If it is felt that the entrapment or neuropathy is at the wrist (Guyon's canal) then decompression at that level would be an option. Certainly, he does not need any useless studies or testing such as manual muscle testing, grip strength and range of motion. That is, for this gentleman, in his humble opinion a waste of money and approaches a scam. This gentleman has had a devastating injury to the right leg and knee. He will have lifelong problems related to this. As to his medications, he would recommend cessation of the Celebrex. Obviously, the Celebrex is giving him some gastrointestinal problems as he is taking a medication for that. Therefore, he would suggest cessation of the Celebrex and the Omeprazole. He would recommend a non-narcotic analgesic such as Tramadol. If there are no contraindications, perhaps a medical such as Lyrica or Neurontin would help decrease perception of his neuropathic pain.

Follow up on 2-23-12, the claimant follows up on left wrist and right knee pain. He rates his knee a 5/10 and hand 3/10. He is having spasm and pain on lateral left foot. Plan: Discontinue Voltaren, Pennsaid solution, and Caleb. RTC 1 month.

Follow up on 3-5-12.

Follow up on 3-15-12, the claimant states he never had the MRI of the right knee. Exam shows right knee mild tenderness to the medial aspect of the knee. Diagnosis: Internal derangement of right knee. Pain to left arm with prior EMG/NCV indicating mild motor neuropathy consistent with left ulnar nerve lesion at the wrist. No median neuropathy was noted. Right tibial plateau fracture with peroneal nerve injury. Plan: Order MRI right knee. Off work. DWC-73 shows the claimant was taken off work on 3-15-12.

Follow up on 3-20-12.

3-22-12 MRI of the right knee showed limited study due to the ferromagnetic artifact.

Follow up on 3-28-12, the claimant follows up on left wrist and right knee pain that he rates a 3-5/10. Plan: Discontinue Pennsaid and Polar Freeze. Trial of Cymbalta. RTC 1 month.

Follow up on 3-29-12, the claimant states he is still having pain in his right knee. Plan: Order CT arthrogram of the knee. Refer to see whether he feels that removal of hardware from the tibial plateau fracture would be of any help. No work.

4-12-12 CT of the right knee showed somewhat limited exam due to inability to distend the joint with adequate volume of contrast due to claimant tolerance. Mildly thickened ACL without evidence for tear. This may be the sequela of prior injury or myxoid degeneration. Intact lateral meniscus with limited evaluation of the medial meniscus. Status post open reduction and internal fixation of comminuted proximal tibial fracture with most of the irregularity seen at the articular surface of the medial weight bearing compartment with probable associated cartilaginous abnormalities.

Follow up on 4-17-12, the claimant has a permanent drop foot and still has pain throughout the knee. This is present with walking. He is using crutches. Plan: Refer to see if removal of hardware is indicated. No work.

4-19-12, the claimant has a chief complaint of right knee pain. Exam shows mild obesity. He is using crutches. He has moderately antalgic gait. Knee ROM is quite good 0-110 degrees. Lachman's does reveal 1-2+ laxity. There is diffuse tenderness along the medial joint line, less so on the lateral joint line. Diagnosis: Posttraumatic arthritis, right knee. Plan: It is thought his hardware is not symptomatic at all. Removal will not give him any benefit. It is thought he needs an arthroscopic evaluation of his joint surfaces and see if there is anything to offer him in terms of cleaning up a torn meniscus perhaps versus performing a chondroplasty. A medial unloader brace may be of benefit. Consider a valgus osteotomy of his tibia as opposed to moving to a total knee replacement. X-rays of the right knee showed overall alignment at the limb is at 0 degrees as opposed to 7 degrees valgus. There appears to be relatively concentric reduction of his joint surface. No hardware in the

joint. There is moderate posttraumatic arthrosis noted. There is a non-united fragment on the lateral aspect of his knee, which he suspects may be from his fibular head as the fibular head looks a little odd in appearance. DWC-73 shows the claimant was taken off work on 4-19-12 through 5-19-12.

Follow up on 5-2-12, the claimant follows up on left wrist and right knee pain that is unchanged. Plan: Discontinue Cymbalta. Trial of Flector patches. Continue meds.

Follow up on 5-7-12.

Manual muscle strength exam on 5-7-12.

Follow up on 5-21-12, the claimant has a chief complaint of right knee pain. Plan: Request for knee arthroscopy versus total knee arthroscopy if the arthroscopic treatment of his knee pain fails.

Follow up on 6-6-12, the claimant follows up on left wrist, right knee and ankle pain. Still with GERD. He had spicy foods with exacerbation of pain 5/10 in knee and 3/10 in wrist. Exam shows left wrist flexion 42 and extension 34. Right knee -11 to 111. Impression: 924.1, 959.7, 729.81. Plan: Refill meds. RTC 1 month.

Follow up on 6-7-12.

Follow up on 6-20-12, the claimant has a chief complaint of right knee pain. Plan: The claimant is requesting a brace, but it is thought any brace is not going to make him better. This is not a stability problem. Continue meds. Follow up after surgery approval. Will appeal the average determination regarding the surgery.

6-25-12, the claimant complains of pain in the right leg and left arm. Exam shows diffuse tenderness to deep palpation in the lumbar spine with left paraspinal musculature involvement. Lumbar flexion to 30 degrees, extension limited secondary to pain, normal rotation, straight leg test positive bilaterally with severe radicular symptoms. Faber sign positive on the right, tenderness to palpation at posterior aspect of right SI joint, noted crepitation and pain on active range of motion, diffuse left upper extremity tenderness to palpation. Generalized tenderness to deep palpation in right lower extremity, orthotic device was removed for the evaluation. Range of motion decreased dorsiflexion and plantar flexion, limited inversion and eversion. Decreased sensation to light touch in stocking distribution of right lower extremity from distal thigh, decreased sensation to left upper extremity in distribution of C7-8, diffuse hyperesthesia in left upper extremity. Gait favoring left lower extremity, ambulation with crutches. Impression: Pain in joint, lower leg, right knee. Pain in joint, hand, left. Pain in joint, ankle and foot. Chronic pain syndrome. Unspecified neuralgia, neuritis, and radiculitis, left arm. Lumbago. Thoracic or lumbosacral neuritis or radiculopathy. Esophageal reflux. Encounter for long-term (current) use of other medications. Plan: Continue Celebrex Capsule, 200 MG. Continue Hydrocodone. Start Gabapentin 300 MG. Labs. UDS. Follow up 4 weeks.

Manual muscle strength exam on 7-9-12.

Follow up on 7-9-12.

Follow up on 7-11-12, the claimant follows up on left wrist and right knee pain. His GERD is improving. He rates his knee pain a 5/10 and wrist 3/10. Plan: RTC 1 month. Refill meds.

Follow up on 7-18-12, the claimant has a chief complaint of right knee pain. Plan: Inject knee today. He still has Celebrex. Get back into therapy. Diagnostic arthroscopy is indicated for potential preoperative planning. DWC-73 shows the claimant was taken off work on 7-18-12 through 8-18-12.

Follow up on 7-25-12, the claimant complains of pain in the right leg and left arm. Plan: Continue Celebrex, Gabapentin, and Hydrocodone. Follow up 4 weeks.

Follow up on 8-1-12, the claimant has a chief complaint of right knee pain. He is awaiting approval on surgery. Plan: If surgery is not approved, will get him into physical therapy.

8-2-12, the claimant indicates the pain is from the knee down to the foot on the right side and elbow to wrist on the left side. His pain varies from 3-5/10, 3 in the arm, and 5/10 in the right leg. Exam shows he walks with a right antalgic gait in a cane. He has an AFO. He has complete foot drop on the right. He has plantar flexion, but no dorsiflexion on the right. With the left arm, positive Tinel at the elbow. There is subjective decreased sensation and distribution in ulnar nerve. Diagnosis: Left ulnar neuropathy. Retained hardware from previous right tibial plateau fracture. Chronic peroneal neuropathy. Chronic pain syndrome. Plan: Recommended another EMG/NCV in the left extremity. Follow up regarding his knee. Try to obtain approval for arthroscopy. Continue. DWC-73 shows the claimant was taken off work on 8-2-12 through 9-2-12.

Follow up on 8-9-12.

Manual muscle strength exam on 8-9-12.

Follow up on 8-15-12, the claimant follows up on left wrist and right knee pain. Discontinue Celebrex. Refill meds.

Follow up on 8-22-12, the claimant complains of pain in the right leg and left arm. Plan: Continue Hydrocodone. Stop Celebrex and start Tramadol. Refill Gabapentin. Follow up 4 weeks.

8-31-12 Left EMG/NCV showed lesion of ulnar nerve.

9-4-12 X-ray of the chest showed no acute cardiopulmonary process.

Follow up on 9-6-12.

9-6-12, the claimant has a chief complaint of right knee pain. Exam shows a moderate antalgic gait. ROM of his knee is 0-110. Lachman's is 1-2+. Tender to palpation over the medial joint line, less so laterally. Absent dorsiflexion of his ankle and toes. Diagnosis: Posttraumatic arthritis right knee. Possible internal derangement of the right knee. Plan: Proceed with arthroscopic evaluation. Because the amount of metal he has in his knee, need to proceed with a diagnostic arthroscopy to confirm another internal derangement. Also at that time, proceed with arthroscopic evaluation of his knee for possible osteotomy rather than a knee replacement. He is on two crutches and has disability secondary to the knee.

9-13-12, preoperative diagnosis: Posttraumatic arthritis of the knee. Postoperative diagnosis: Knee arthrofibrosis, posttraumatic arthritis of the knee, chondromalacia of the trochlear groove of the knee. Procedure: Left knee arthroscopic major synovectomy of the medial, posteromedial, lateral, posterolateral, suprapatellar, infrapatellar and intercondylar notch compartments.

Follow up on 9-19-12, the claimant is status post right knee surgery on 9-13-12. He rates his pain a 7/10 in the knee and 3/10 in the wrist. Plan: Tramadol to Norco. Refill patch and Dunlop.

Follow up on 9-20-12.

Follow up on 9-21-12, the claimant complains of pain in left arm. His right knee pain has increased following surgery. He rates his pain a 7/10. Plan: Continue Hydrocodone. Stop Gabapentin. Start Lyrica. Follow up 4 weeks.

Follow up on 9-26-12, the claimant has a chief complaint of right knee pain. Plan: Physical therapy. Wean himself off his crutches. DWC-73 shows the claimant was taken off work on 9-26-12 through 10-26-12.

Physical therapy evaluation on 10-1-12.

Physical therapy on 10-3-12, 10-5-12, 10-8-12, 10-10-12, 10-12-12, 10-15-12, 10-17-12, 10-19-12, 10-22-12, 10-26-12, 10-29-12, 10-31-12, 11-14-12, 11-16-12, 11-19-12, 11-20-12, and 11-26-12.

Follow up on 10-4-12.

Follow up on 10-18-12, the claimant rates his pain a 5-7.5/10 in both joints. Plan: Continue meds. RTC 1 month.

Follow up on 10-19-12, the claimant complains of pain in the left arm. Plan: Continue Hydrocodone. Increase Lyrica. Start Xanax. Request left stellate ganglion steroid injection. He is requesting anxiety medication for the procedure. Follow up 4 weeks.

Follow up on 10-22-12.

Follow up on 10-24-12, DWC-73 shows the claimant was taken off work on 10-24-12 through 11-24-12.

Follow up on 11-5-12.

Follow up on 11-14-12, the claimant follows up on right knee pain that he rates a 6/10 and left wrist 3/10. Plan: Continue meds. RTC 1 month.

Follow up on 11-19-12.

Follow up on 11-21-12, the claimant has a chief complaint of right knee pain that he rates a 5/10. He is requiring use of his crutches. Exam shows foot drop is noted with gait and he does have a mild-to-moderately antalgic gait without crutches. He does indicate that he uses the crutches when he gets outside of the house, but inside the house, he does not. Diagnosis: Posttraumatic arthritis, right knee. Plan: He is going to eventually need a total knee replacement, but is 47 years old. Knee arthroplasty is not indicated. He is on disability. He could possibly get back to sedentary duty with a knee replacement. He is at MMI at this point. DWC-73 shows the claimant was taken off work on 11-21-12 through 12-21-12.

ROM & MMT evaluation on 11-28-12.

Follow up on 12-3-12.

12-6-12 PPE shows the claimant is functioning at a Medium PDL.

Follow up on 12-12-12, the claimant has crepitation increased right knee with locking and pain that he rates a 6/10. Still has stabbing and numbness in right leg knee to right foot with spasms. Impression: 924.1, 959.7, 729.81. Continue meds. RTC 1 month.

Work conditioning on 12-12-12, 12-13-12, 12-14-12, 12-17-12, 12-18-12, 12-19-12, 12-21-12, 1-10-13, 1-11-13, 1-17-13, 1-18-13, 1-21-13, 1-22-13, 1-23-13, 1-24-13, and 1-25-13.

Follow up on 12-18-12.

Follow up on 1-7-13.

Follow up on 1-17-13, the claimant follows up on right knee and left wrist pain. He rates his knee a 5/10 and wrist 3/10. Plan: Refill meds. Follow up. RTC 1 month.

1-24-13 Request for 10 sessions of CPMP- The pain resulting from his injury has severely impacted, normal functioning physically and interpersonally. Patient reports

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

Follow up on 2-7-13.

Follow up on 2-26-13, the claimant is having new pain on dorsal right foot that is sharp moderate to severe. He is having urinary incontinence issues. Left wrist and right knee pain is unchanged that he rates a 3-5/10. Plan: Follow up Refill meds. RTC 1 month.

2-27-13 PPE shows the claimant is functioning at a Medium PDL.

Follow up on 3-4-13.

3-15-13 Request for CPMP 5 x a week for 2 weeks.

Follow up on 3-19-13, the claimant rates his right foot and right knee a 5/10 and 3/10 in left wrist with numbness and tingling. Impression: 924.1, 959.7, 729.81. Plan: Refill meds. RTC 1 month. Follow up.

3-20-13 PhD., UR denial for CPMP 5 x week for 2 weeks. The request for chronic pain management program 5 x wk x 2 wks is not recommended as medically necessary. The patient's date of injury is approximately 4 years old. Current evidence based guidelines generally do not support chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period.

Follow up with, on 4-4-13.

4-16-13 Request for reconsideration for CPMP, the claimant has exhausted all lower levels of care and is pending no additional procedures. Official Disability Guidelines from the Work Loss Data Institute consider tertiary chronic interdisciplinary pain programs as the standard of treatment. The results of an outcome study performed by, and demonstrated that patients who do not complete a chronic pain program are 7 times more likely to have post-rehabilitation surgery in the same area and nearly 7 times more likely to have more than 30 visits to a new health provider in persistent

health care-seeking efforts. The study also demonstrated that patients who do not complete a chronic pain program had only half the rates of work return and work retention, being 9.7 times less likely to have returned to any type of work, and 7 times less likely to have retained work at the end of the year. Therefore, a chronic interdisciplinary pain program is the recommended course of treatment to help an injured worker return to work and is considered the treatment of choice by the national standards cited above. Mr. meets the criteria for the general use of multidisciplinary pain management program, according to Official Disability Guidelines, chronic pain chapter.

Follow up on 4-18-13, the claimant rates his right knee pain a 5/10 and left wrist 3/10 with numbness and tingling. Plan: RTC 1 month. The claimant is to follow up. He is to discontinue Lyrica.

4-23-13 performed an Independent Medical Examination. This gentleman's care for this severe injury has been more or less appropriate. It is his opinion that up to this point all treatments, diagnostics, and medications have been appropriate. Because of the marked severity of the injury, the length and frequency is appropriate. He would recommend transitioning from the Hydrocodone to a non-narcotic medication such as Tramadol or Tylenol. This gentleman is likely to have discomfort for a long period of time, and as such he would not continue narcotic analgesia. Weaning may be indicated for the Hydrocodone. The Lyrica can be continued for the decreased perception of neuropathic pain. He did not know the reasoning behind the Flector patch and this should be discontinued. He is taking a generic form of Protonix which is used to treat gastric reflux disease. He states this was due to medication he had taken in the past. However, he is taking no anti-inflammatory medications, and this medication from a work compensation issue should be discontinued. No weaning is indicated. He could transfer to over-the-counter Prilosec if desired. This gentleman will eventually be a candidate for a total knee replacement. However, he is fairly young for that procedure. As to the knee, because of some instability from quadriceps weakness as well as the peroneal injury, a hinged knee brace might be appropriate. This can be an over-the-counter type brace. As to his drop foot, it is totally unlikely he will have any return of function. Therefore, one must now consider operative intervention. This can be done by tendon transfers. Another option would be ankle arthrodesis. He would recommend from a medicine standpoint the use of Tramadol and continued use of Lyrica. These would be the only medications indicated at this time. He will have no benefit from any additional arthroscopic procedures to the knee. For the time being, he should utilize the knee brace. The lubricant injections if not given might be appropriate. It is unclear whether or not he had a reaction to that, or to corticosteroids. He will be a candidate for total knee replacement in the future. The request for the left custom-molded AFO is not only required and reasonable, but absolutely essential for this gentleman. This complete peroneal palsy is a result of the effects of the injury to the proximal tibial plateau.

4-23-13 UR Appeal for CPMP non certified.

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

The claimant has an injury date of xx/xx/xx. He was injured when he fell from a ladder. The claimant has had multiple treatment interventions to include diagnostics, physical therapy, medications, OT, surgery in 3/09, psychotherapy in 2010 to 2011, an arthrogram, surgery in 9/12, and Work Conditioning. A chronic pain management program has been denied x 2. An IME. dated 4/23/13 which is after the IME date, notes that surgery should be considered among other interventions, suggesting not all treatment may have been exhausted. The claimant was released to go to work but has not worked since his last surgery. Therefore, without evidence that all lower levels of medical care have been exhausted, the request for Chronic Pain Management Program 5 x wk x 2 wks x 80 hours 97799 is not 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)

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) (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; 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, outpatient 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.

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)**