MTUS: Delayed Recovery, Early Intervention & Functional Restoration

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The MTUS, MEEAC &
The Chronic Pain Guideline

January 1, 2004

- CA legislature charged the AD with adopting a Medical Treatment Utilization Schedule (MTUS)
- Presumed correct on extent and scope of treatment to cure or relieve

ACOEM "Guidelines"

Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery of Workers, 2004, 2nd edition

basis for MTUS until June 15, 2007

June 15, 2007

- MTUS in effect
- ACOEM "Guidelines" not same as MTUS
- Acupuncture Guidelines included
- Strength of evidence rating methodology
- Provisions for creation of MEEAC

A Problem……

- In CA, updates to external publications, such as the "Guidelines," **cannot be incorporated automatically or routinely** into the MTUS

(illegal delegation of authority to an external party)

…..A Solution

- Create Medical Evidence Evaluation Advisory Committee (MEEAC), and
- Deconstruct MTUS to facilitate timely updates (clinical topics format)

MEEAC

- Multidisciplinary, appointed members
- Responsible for ongoing evaluation of the EBM that supports the MTUS, and
- Advising AD on best practices and timely revisions of MTUS

MEEAC

Then,

- Adoption or rejection by AD, followed by
- public comment and rule-making, if adopted

The Current MTUS

Includes:

- Portions of ACOEM Treatment Guidelines, 2nd Ed.
- Acupuncture Guidelines (Colorado)

and…….

July 17, 2009

Effective:

- Post-Op Rehabilitation (New)
- Elbow (Updated)
- **Chronic Pain** (New, replaces ACOEM Ch. 6)

Chronic Pain Guideline

Another CA hybrid, consisting of:

- **Introduction** (written by MEEAC)
- **ODG CP Guideline** (10/08 version, revised, alphabetical list of available treatments and evidence-based recs)

Introduction to CP Guideline

- Presents definitions, mechanisms
- Attempts to establish an updated conceptual framework for understanding and treating chronic pain

Introduction to CP Guideline

- Compares and contrasts models of care, underscoring shortcomings of the biomedical model
- Reinforces role of "confounding psychosocial variables" in transition from acute to chronic pain
- Supports early identification and multidisciplinary treatment of those at risk

Introduction to CP Guideline

- Notes needless disability secondary to chronic pain is otherwise predictable and preventable
- Acknowledges the current evidence base supports, as most effective, a Functional Restoration approach to the management of chronic pain

The EB tells us that

- Effective clinical management of chronic pain is:
  - Timely (the earlier the better)
  - Multidisciplinary (addressing "variables")
  - Coordinated, and
  - Functionally goal-oriented, ensuring
  - Maximum independent self-management

Functional Restoration, Delayed Recovery & Early Intervention

Functional Restoration

"…the process by which the individual acquires the skills, knowledge and behavioral change necessary to avoid preventible complications and assume or re-assume primary responsibility ('locus of control') for his/her physical and emotional well-being post injury."

Functional Restoration

- Is used currently, across a spectrum, sometimes unknowingly, in
  - acute injury (eg sports medicine)
  - early intervention programs
  - post op rehabilitation
  - post TBI, stroke, burns, etc.
  - oncologic care
  - chronic pain

Functional Restoration

- Utilizes multiple, goal-oriented treatment approaches, such as,
  - pharmacologic,
  - interventional,
  - psychosocial,
  - Cognitive behavioral, and
  - physical/occupational therapies

Emphasis

- Achieving maximum functional independence, rather than elimination/reduction of pain
- Win-Win situation
  - IW returns to life activities including work, stabilized medically, and avoids iatrogenic complications
  - Employer avoids unnecessary costs and has return of able employee

Delayed Recovery

- A distinct subpopulation of IWs
- An estimated minimum **10%** of CA WC cases, consuming **75%** of medical/indemnity resources

Characteristics of DR

- Transfer of "locus of control"
- Functional decline, drug dependency, depression/anxiety and complaints of chronic pain
- ***Disability*** out of proportion to ***impairment***
- Largely preventable

Predictors of DR

- Include:
  - distress, depression, anxiety
  - excessive pain/disability behaviors
  - high pain ratings
  - fear-avoidance/maladaptive beliefs
  - focus on litigation
  - somatization
  - job dissatisfaction

Psychosocial Risk Factors

The elephant in the room!

Characteristics of At-Risk Patients

1. Unresponsive to conservative therapies demonstrated to be effective for specific diagnoses;
2. Significant psychosocial factors negatively impacting recovery;
3. Loss of employment or prolonged absence from work;
4. Previous history of delayed recovery or rehabilitation;
5. Lack of employer support to accommodate patient needs; and
6. A history of childhood abuse (verbal, physical, mental)

- Of these factors, lost time from work has the highest value in predicting those patients who will experience delayed recovery

Predictors of DR

- Physicians who:
  - Rely exclusively on traditional, biomedical model
  - Focus on pathology, not patient
  - Pursue pathology ("pain generator") and mask it with medications, obliterate it with procedures or remove with surgery
- Many physicians and lay people do not understand the relationship between **impairment** and **disability**

Dynamics of DR

- Most individuals accept some physical discomfort as a part of living, some cannot
- Psychologically and/or socially stressed individuals more frequently seek medical attention
- Those individuals can be "cure-focused," with a sense of entitlement

Dynamics of DR

- Those persons seek medical verification (a diagnosis) as an explanation of their distress (the process of "medicalization")
- A medically acceptable diagnosis permits sublimation of psychosocial issues, and transfer of the "locus of control" to the treater

Dynamics of DR

- The claimant becomes a high user of medical services, readily submitting to interventions offered
- Doctor shopping and drug seeking may follow

Early Identification

- Patients not responding to conservative therapy
- Those thought to be at risk for delayed recovery
- Consider simple screening devices to identify those at risk for delayed recovery
  - Örebro Musculoskeletal Pain Questionnaire
  - The Pain Disability Questionnaire (PDQ)

Treatment Goals

- Improve IW's sense of emotional well-being and physical capabilities
- Provide the knowledge, tools and skills that support independent self-management
- RTW

Current Situation

- Doctors don't recognize delayed recovery
- The norm is to refer for tests and procedures
- Most care is not coordinated, multidisciplinary or goal-oriented
- Payers don't want to pay for early intervention functional restoration

The Answer

- Incentivize
- Educate
- Communicate
- Understand and use the MTUS CP Guideline

Final Comments

The CA MTUS has an evidence-based point of view, that says:

- prevent needless work disability
- prevent delayed recovery where/when possible
- use a Functional Restoration approach in the treatment of chronic pain