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”

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.......
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

“...the process by which the individual acquires the skills, knowledge and behavioral change necessary to avoid preventable 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