

# Managing Functional Recovery

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- 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

# Chronic Pain Medical Treatment Guidelines

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A CA hybrid, consisting of:

- **Introduction** (written by MEEAC)
  - Medical Evidence Evaluation Advisory Committee
- **ODG CP Guideline** (10/08 version, revised, alphabetical list of available treatments and evidence-based recommendations)

# Introduction to CP Guideline

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- Presents definitions, mechanisms
  - DWC Definition: Any pain that persists beyond the anticipated time of healing
- Attempts to establish an updated conceptual framework for understanding and treating chronic pain

# Introduction to CP Guideline

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- Compares and contrasts models of care, underscoring shortcomings of the traditional biomedical model and suggests a biopsychosocial 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 Guidelines

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- 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 MTUS CP Guidelines

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- 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

# Biomedical Model

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- Explains pain through etiologic factors (e.g., injury) or disease whose pathophysiology results in pain  
**Cause →→ Effect**
- This classic biomedical approach to understanding and treating pain is incomplete
- Its exclusive application can result in unrealistic expectations on the part of the physician and patient, inadequate pain relief, and excessive disability in those with pain that persists well after the original injury has healed



# Biopsychosocial Model

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- Recognizes that pain is ultimately the result of the pathophysiology plus the psychological state, cultural background/belief system, and relationship/interactions with the environment (workplace, home, disability system, and health care providers)

# Biomedical vs. Biopsychosocial Model

<b>Biomedical model</b>	<b>Biopsychosocial model</b>
Most appropriate for acute pain conditions	More useful for those with chronic pain conditions
Emphasizes peripheral nociception	Recognizes the role that central mechanisms play in modulating peripheral nociception or generating the experience of pain in the absence of nociception
Focus on physical disease mechanisms	Recognizes the importance of illness behavior including cognitive and emotional responses to pain
Reductionistic approach to understanding and treating pain	Multidimensional systems approach to understanding and treating pain
Reliance on medical management approaches	Utilization of self-management approaches

# Functional Restoration

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“...the process by which the individual acquires the skills, knowledge and behavioral change necessary to achieve maximal functional abilities (reengage in life activities), 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

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- Utilizes multiple, goal-oriented treatment approaches, such as,
  - Pharmacologic,
  - Interventional,
  - Psychosocial,
  - Cognitive behavioral, and
  - Physical/Occupational Therapies

# Emphasis

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- Achieving maximum functional independence, rather than elimination/reduction of pain

# Delayed Recovery

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- A distinct subpopulation of injured workers
- An estimated minimum **10%** of CA WC cases, consuming **75+%** of medical/indemnity resources
- Traditional treatment often not successful

# Characteristics of DR

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- 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

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



# Characteristics of At-Risk Patients

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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

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- When Physicians:
  - 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 it with surgery
- Many physicians and lay people do not understand the relationship between **impairment** and **disability**

# Dynamics of DR

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- 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

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- 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

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

# Early Identification

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- 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)

# FRP Treatment Goals

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- 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

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- 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 or chronic pain functional restoration



# The Answer

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- Incentivize
- Educate
- Communicate
- Understand and use the MTUS Chronic Pain Treatment Pain Guidelines

# Conclusions

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- While biologic mechanisms play a role in the perception of pain, it is also important to recognize that psychological and environmental factors are important

# Conclusions

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- Recognition of these factors will allow the physician to better
  - treat the injured patient,
  - identify the “at risk” patient, and
  - refer the patient with delayed recovery and an impending chronic pain condition to the appropriate resources

# Conclusions

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- Therapy for chronic pain ranges from single modality approaches for the straightforward patient to comprehensive interdisciplinary care for the more challenging patient
- Therapeutic components such as pharmacologic, interventional, psychological and physical have been found to be most effective when performed in an integrated functional restoration manner
- All therapies are focused on the goal of functional restoration rather than merely the elimination of pain

# Conclusions

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- Typically, with increased function comes a perceived reduction in pain and increased perception of its control
- This ultimately leads to an improvement in the patient's quality of life and a reduction of pain's impact on the individual and society

# Getting to Yes with UR

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- Wordsmithing / Jiu-Jitsu Medicine
- Conservative care to date ineffective
- Request supported by MTUS
- Will result in increased function, less reliance on medications, early return to work, and P&S status

# Epidural

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- An ESI will reduce pain and inflammation, restore range of motion and thereby facilitate progress in a more active treatment program with the hope of avoiding surgery
- There is documented radiculopathy by physical examination corroborated by imaging studies and/or electrodiagnostic testing
- This patient has been unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)