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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 10/11/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management program x 10 sessions

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 03-19-10 Medical report from Dr.
- o 05-05-10 Lumbar MRI read by Dr.
- o 07-28-10 Follow-up Evaluation from Dr.
- o 08-04-10 Notice of Disputed Issues
- o 08-25-10 Follow-up Evaluation from Dr.
- o 08-26-10 Electrodiagnostic Consultation from Dr.
- o 08-27-10 Script for CPM from Dr.
- o 08-31-10 FCE from Acadiana Impairment
- o 09-02-10 Orthopedic Comprehensive Consultation from Dr.
- o 09-11-10 Designated Doctor Evaluation from Dr.
- o 09-21-10 Request for CPMP from Dr. with 09-07-10 Psych eval
- o 09-22-10 Medical Progress Notes from Dr.
- o 09-29-10 Initial Adverse Determination Letter
- o 09-29-10 Initial review
- o 09-30-10 Script for Vicoprofen from Dr.
- o 10-03-10 Letter for IRO request from Dr. (approximate date)
- o 10-04-10 Diagnostic Evaluation from Dr.
- o 10-11-10 Fax request for authorization CPMP 10 sessions from Dr.
- o 10-11-10 Appeal for CPMP from Dr. Accident and Injury
- o 10-14-10 Adverse Determination Letter on reconsideration CPMP
- o 10-15-10 Request for IRO from the Claimant

- o 10-15-10 Notice of Disputed Issues from the carrier
- o 10-21-10 Confirmation of Receipt of Request for IRO from TDI
- o 10-21-10 Notice to UR Agent of Case Assignment from TDI
- o 10-25-10 Fax note from Dr.
- o 10-27-10 Attorney letter

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the low back on xx/xx/xx associated with a fall. She fell onto her left side. She was seen in the ER where x-rays were taken.

General medical evaluation of notes pain centered at the coccyx that does not radiate. She had a normal neurologic exam. Modified work was assigned. She will use ibuprofen and Vicodin.

Lumbar MRI performed May 5, 2010 was given impression: 1. Mild multilevel spondylosis and degenerative disc disease as discussed. 2. Partially visualized right hemipelvic nonspecific cyst structure. Correlation with pelvic sonography suggested when patient is stable. Findings also note, no significant canal or neural foraminal stenosis at L4-5. No extrusion or canal stenosis at L5-S1. Possible ovarian cyst.

The patient was seen on July 28, 2010 for severe bilateral low back pain, stiffness and soreness. Her movements are slow, careful and painful. She barely gets 6 hours of sleep even with medication. Her activities are limited. She is 5' 1" and 150 pounds. She rates her pain as 6/10. Tenderness and soreness are noted in the lumbar region. Left nerve stretch tests are positive. Flexion is 60/60 and extension 18/25 degrees. Left lower extremity motor strength is 3/5. There is left hypoesthesia in the L5-S1 distribution on the left. She will have an orthopedic evaluation for signs of radiculitis and nerve studies.

On August 4, 2010 the carrier informed that the patient's degenerative disc disease is pre-existing and is not an extent of the work injury.

The patient was reevaluated on August 5, 2010 for marked pain with constant symptoms. She is restricted to one hour of sitting and standing due to pain. Tenderness and muscle spasm were noted. Left straight leg raise is positive. Lumbar ROM is slightly restricted. An FCE has been ordered and nerve testing and computerized ROM testing are pending.

Electrodiagnostic studies performed on August 26, 2010 were interpreted to show evidence of left L5 radiculopathy. Pretesting examination showed full motor strength and normal sensation.

FCE performed August 31, 2010 showed the patient to be working in a Sedentary to Sedentary-Light PDL while her job requires a Medium PDL. Recommendation was made for a CPMP. Heart Rate Profile indicated valid testing. Physical examination showed normal gait. Flexion was to 90 degrees and extension to 10 degrees. Reflexes and sensation were normal. Motor strength was not specific.

A comprehensive orthopedic assessment was provided on September 2, 2010. She slipped on a slippery floor and fell onto her buttocks. She returned to work after one day. She was taken off work in July 2010 due pain. She feels she has worsened since that time. Treatment has included PT x 9, lumbar belt, TENS unit and medications. She reports no lasting relief with treatments. She relates pain levels of 7-9/10. She describes pain down the back of her right thigh and into the front and back of her left calf into her foot with tingling and numbness. She sits on her right buttock. She is using Lyrica and hydrocodone. Flexion is to 40 degrees and extension to 20 degrees. Heel and toe rise were negative. Left ankle jerk is weaker than right. Left EHL strength is 4/5. Left L5-S1 sensation is hypoesthetic. Assessment is lumbar discogenic pain and lumbar radiculopathy affecting the L5 and S1 nerve roots, predominantly on the left. Recommendation is for flexion/extension x-rays, caudal ESI, return in 4 weeks.

Mental health evaluation of September 7, 2010 noted a BDI-II score of 8 (minimal depression) and a FABQ score of 29/10 and a pain level of 3-5/10. BAI and sleep difficulty were not reported.

A Designated Doctor examination was conducted on September 11, 2010. She is pending epidural injections. Her primary complaints are of leg/foot burning type pain. Palpation of the lumbar spine is normal with no spasm noted. Sensation is normal. Patellar and Achilles reflexes are both 2. Motor strength testing shows weak hip, leg and ankle flexion strength and weak ankle plantarflexion strength (method of testing not stated). She was able to heel and toes walk without difficulty. The patient was determined to be at MMI (basis for this opinion not clarified). WPI of zero was assigned.

Letter of Medical Necessity was submitted for a CPMP dated September 21, 2010. A CPMP is requested of 8 hours daily five day per week for a total of 10 sessions. After 2 months of light duty she was returned to full duty. She was unable to handle this and reported crying on the job due to low back pain. She was taken off work by her provider. She has had MRI and EMG. She is not surgical per an orthopedic specialist. She is using Lyrica and Vicoprofen. She is unable to return to work at this time and does not have a position to return to. She feels she has worsened. Her PDL has been noted. A psychological assessment was performed on September 7, 2010. She has a minimal level of depression. She wakes up at night due pain. Fear avoidance questionnaire showed she cannot do her regular work and feels she would not be able to return to work until her pain is treated. She is most concerned about re-injuring herself by returning to work. She has a psych diagnosis of Pain Disorder Associated with both

psychological factors and a general medical condition, Adjustment Disorder with Depression, very mild and transient. Global Assessment of Functioning is 65. She would benefit from participation in a CPMP. The goals are summarized.

Progress notes dated September 22, 2010 note complaint of moderate to severe low back pain with stiffness and soreness rated as 6/10. She is planning a follow up with pain management for an epidural injection. She is using Lyrica and Vicoprofen. Left straight leg raise is positive. Flexion is 65/60 and extension 19/30. Left EHL and FHL strength is 4/5

Request for 10 sessions of a chronic pain program was considered in review on September 29, 2010 with recommendation for non-certification. A peer discussion was conducted with the provider. No additional clinical information was obtained in the peer discussion. The patient has a diagnosis of lumbar strain. According to the report of September 21, 2010 the patient underwent a course of 10 sessions of PT. She failed return to work. She continues with fear avoidance behavior, chronic pain and medication usage. She is functioning at Sedentary-Light PDL per an FCE and her position requires a Medium PDL. Mental health evaluation of September 7, 2010 noted a BDI-II score of 8 (minimal depression) and a FABQ score of 29/10 and a pain level of 3-5/10. BAI and sleep difficulty were not reported. DD exam opined MMI as of 09/11/10 and zero percent W PI. The most recent office note of September 2, 2010 reported lumbar discogenic pain, radiculopathy of predominantly the left L5-S1 nerve roots with recommendation for lumbar ESI and stress radiographs. Rationale for denial states, the submitted documentation fails to meet all criteria for medical necessity. It is not established that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Additionally, there has not been an adequate and thorough multidisciplinary evaluation per ODG criteria (2). There was also no documentation that the patient was motivated to change and is willing to change their medication regimen per criteria (7). Negative predictors of success were not identified, and if present, how these will be addressed per criteria (8). And finally, it has not been objectively established that the patient has significant psychological barriers that necessitate this level of care. BDI-II was 8, minimal depression. There was no documentation of BAI, and there was minimal sleep disturbance.

A Diagnostic Evaluation was submitted dated October 4, 2010. She is using Vicoprofen and Cataflam. She does not smoke. She has gained 11 pounds in the last 3 months due decreased activity levels. She attempts to walk 3-4 times weekly. She takes care of her mother. Her children help her with chores. She has interest in further exploration of options in pursuing a real estate license or management/ownership of a thrift store. She is not receiving any worker's comp benefits. Testing shows elevated levels of fear of re-injury. Her clinical profile shows excessive sensory/physical, affective/emotional, and cognitive responses to her pain. She reports a pain level of 5/10. She scored 47 on the Pain Experience Scale, which indicates a mild level of emotional and worry response. The McGill Pain Questionnaire score of 17 puts her in the normal category. Her Oswestry score of 53% puts her in the severe category. In the interview, she was seen to have a standing tolerance of only 10 minutes and a sitting tolerance of only 15 minutes. While she reports having made her best efforts to improve (i.e. following all physician directives), she appears to be deteriorating across all major roles and environments, and appears to be at risk of becoming a further disabled individual. She does not have any negative predictors of efficacy of treatment in a CPMP. She will have 10 sessions with the counselor to address psychosocial issues in managing her emotional symptoms and pain levels. Goals include assistance with decreasing her medication dependence and increasing her PDL to Light-Medium.

Request for reconsideration 10 sessions of a chronic pain program was considered in review on October 14, 2010 with recommendation for non-certification. A peer discussion was realized. The recent clinical note of October 11, 2010 was discussed. The patient has left L5 radiculopathy per nerve studies. Her PDL is below her job requirement. She has had 9 sessions of PT, medications and uses a TENS unit. She has low back and left leg symptoms rates as 7/10. She has been recommended for an epidural injection. She has minimal depression per Beck Depression Index score. On 10/04/10 it was reported her BDI score is 5 (minimal) and her BAI score is 6 (minimal). Letter of appeal dated 10/11/10 again recommended the patient for a CPMP. This reviewer agrees with the prior denial on the basis of a lack of documentation to indicate the patient has exhausted all lower levels of care. The patient was noted to have radiographic and electrodiagnostic evidence of L5 radiculopathy. There is no indication that the patient has undergone any epidural injections as proposed by the consulting examiner on September 2, 2010. There are also no significant psychological barriers to warrant a multi-disciplinary program. The patient was noted to have normal levels of depression and anxiety. The patient was noted to have elevated fear avoidance beliefs; however, this could be attributed to the patient not meeting occupational requirements for physical demand. The clinical documentation does not support certification of the request.

An undated Letter for IRO Request has been reviewed: The psych evaluation of September 7, 2010 indeed did not contain the information required by ODG. Therefore, a new Diagnostic Screening was done which contains all the raw data and testing lacking in the first report. During the peer discussion the reviewer kept referring to the old psych report and was informed that a more comprehensive report was available. In regard to LESI, request for LESI on September 2, 2010 was denied by the carrier. In regard to psychological barriers, the patient has fear avoidance of 36 on the Work Sub Scale, a score of 47 on the Pain Experience Scale (mild) a score of 17 on the McGill Pain Questionnaire (normal). She did go on to state, the patient "describes her physical pain reactions as sharp, aching, stinging, and hurting. Her emotional reactions indicated the pain is exhausting, fearful, cruel and annoying. Her pain frequency is continuous and the severity is excruciating. She is in the severe category per the Revised Oswestry Low Back Disability Questionnaire. During the interview the patient showed a standing tolerance of 10 minutes and sitting tolerance of 15 minutes. It appears the patient is under reporting her physical limitations and tolerances as evidenced by this examiner and the treatment staff. Her Global Assessment of Functioning is moderate (score of 60) and she shows Moderate Symptoms and Psychosocial Stressors (PSS rating of 3-4). Her Beck Depression Inventory score of 5 indicates normal and her BAI score of 6 also indicates normal anxiety level. She scored 32 on the Sleep Questionnaire, which shows moderate to severe sleep difficulty. She is underreporting her levels on the tests as her report of Daily Living does not match nor does the pain

level she is experiencing while being observed match her testing. When she has completed her CPMP, she will be referred to DARS for retraining and return to the work force.

Request was made for an IRO.

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

Per ODG: 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. The specific criteria for chronic pain management programs are cited below. There should be a physical exam that rules out conditions that require treatment prior to initiating the program.

First line review rationale for denial notes the documentation fails to meet all criteria for medical necessity. It is not established that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Additionally, there has not been an adequate and thorough multidisciplinary evaluation per ODG criteria (2). There was also no documentation that the patient was motivated to change and is willing to change their medication regimen per criteria (7). Negative predictors of success were not identified, and if present, how these will be addressed per criteria (8). And finally, it has not been objectively established that the patient has significant psychological barriers that necessitate this level of care. BDI-II was 8, minimal depression. There was no documentation of BAI, and there was minimal sleep disturbance.

In appeal, the provider cited a more detailed psychological assessment and notes epidural injections have not been approved. The provider believes the patient is under reporting her physical limitations and tolerances as evidenced by this examiner and the treatment staff.

Second line review rationale for denial notes lack of documentation to indicate the patient has exhausted all lower levels of care (the recommended epidural injections). There are also no significant psychological issues to warrant a multi-disciplinary program. The patient was noted to have normal levels of depression and anxiety. The patient was noted to have elevated fear avoidance beliefs; however, this could be attributed to the patient not meeting occupational requirements for physical demand. Appeal report notes the patient appears to be under reporting her physical limitations and tolerances. Her Global Assessment of Functioning is moderate (score of 60) and she shows Moderate Symptoms and Psychosocial Stressors (PSS rating of 3-4). Her Beck Depression Inventory score of 5 indicates normal and her BAI score of 6 also indicates normal anxiety level. She scored 32 on the Sleep Questionnaire, which shows moderate to severe sleep difficulty.

The patient's pain generator has not been fully clarified. Imaging shows some pre-existing degenerative changes but does not show a focal neurocompressive lesion or any significant canal or neural foraminal stenosis. However, there were cystic findings suggestive of possible ovarian cyst and sonography was recommended. This has not been fully investigated. Nerve studies of August 2010 showed evidence of left L5 radiculopathy. However, pre-testing examination showed full motor strength and normal sensation. FCE examination also showed normal gait, flexion to 90 degrees, extension to 10 degrees, normal reflexes, normal sensation; motor strength was not specific. While there is occasional note of left hypoesthesia in the L5-S1 distribution, the Designated Doctor examination of September 2010 showed normal sensation and reflexes and some generalized motor weakness in hip, leg and ankle flexion strength and weak ankle plantarflexion strength. The patient is MMI since September 2010 with zero impairment. While it is appreciated that an epidural injection was planned but not approved, it remains relevant that treatment has been limited to 9 sessions of PT, medications and use of a TENS unit. The patient's compliance with PT, participation in HEP, and actual use of the TENS unit are not clarified and there is no report of any medication issues. The physical findings are not consistent with the imaging findings and the patient has no impairment per the MMI report. While the patient is quite stressed over caring for her mother and finances, it is not established that her psychological condition is sufficient to warrant a full multidisciplinary program versus individual counseling. As she is caring for her mother, she cannot be said to have an excessive dependence on health-care providers, spouse, or family. There are also no medication issues that would require a formal multidisciplinary program. Considering all these findings, a multidisciplinary program is not supported.

Therefore, my recommendation is to agree with the prior non-certification for Chronic Pain Management program x 10 sessions.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines 2010 Pain Chapter - Functional restoration/Pain Management Programs:

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. 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.

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.

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.

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).

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).

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.