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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 10/15/2010

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

Pain management 5 times a week times 2 weeks, left wrist, 97799, 80 hours.

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 03-10-08 Medical report (impairment) from Dr.
- o 05-13-08 Left wrist MRI read by Dr.
- o 06-26-08 Wrist MRI read by Dr.
- o 07-04-08 Physical therapy report(s) of poor copy from PT
- o 07-06-08 Physical therapy report from (rpt illegible-poor copy)
- o 08-07-08 Nerve studies interpreted by Dr.
- o 09-03-08 Operative report from Dr. (TFCC repair)
- o 02-10-09 Electrodiagnostic study LUE read by Dr. (?)
- o 03-10-09 Medical report from Dr. with SOAP notes
- o 11-16-09 Medical report from Dr.
- o 11-18-09 Progress report from Dr.
- o 01-06-10 Injection report from Dr. Expez(?) -poor copy
- o 04-30-10 Progress report from NP
- o 04-30-10 Medical report from NP
- o 05-06-10 Wrist X-ray report read by NP
- o 05-07-10 Referral form - pain management from Dr. .
- o 05-28-10 Examination Findings from Dr.
- o 05-28-10 Medication Contract from illegible
- o 05-28-10 Referral information and Medical History including FCE report from Dr.
- o 06-01-10 Evaluation for CPMP from, Ed.D.
- o 06-26-08 Left wrist MR arthrogram with and w/o contrast read by Dr.

- o 07-01-10 Pre-Certification Request from Ed.D and Dr. Dr.
- o 07-05-10 Fax request for 10 sessions of CPMP from Dr.
- o 07-08-10 Initial Adverse Determination letter from
- o 07-21-10 Progress report from Dr.
- o 07-28-10 Appeal for CPMP from Dr.
- o 08-11-10 TWC -73 work status report from JR(?)
- o 08-17-10 Adverse Determination letter for reconsideration from
- o 09-23-10 Request for IRO from the Claimant
- o 09-24-10 Confirmation of Receipt of Request for IRO from TDI
- o 09-27-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male laborer who sustained an industrial injury to the left wrist on xx/xx/xx when lifting a 60 pound bag of cement.

According to the impairment report of March 10, 2008, his hand and wrist became swollen and the next day he was sent to the doctor. Initial x-rays were read as normal. MRI of May 13, 2008 showed possible increase of the scapholunate space even though done on a clenched fist. X-rays had no gapping and the findings were inflammation and possible tear of the volar radial ulnar ligament. Further evaluation with MR arthrogram showed a perforation of the TFC. As symptoms did not resolve with a variety of treatments, he underwent surgery on September 3, 2008 with arthroscopy, debridement of the TFC tear. He had extensive post-op PT and was released with residuals of decreased ROM. Whole Person Impairment of 4% was assigned on March 10, 2008.

Left wrist MRI was performed on May 13, 2008 and interpreted to reveal wide scapholunate interspace, suspicious for an underlying schapholunate ligament tear. A conventional or MR arthrogram of the wrist would be required for accurate radiologic diagnosis if additional imaging is clinically required. Grade I strain versus mild tendinosis of the extensor carpi ulnaris tendon. Abnormal widening along the volar side of the distal radioulnar joint, suspicious for potential tearing of the volar radioulnar ligament. This could result in a sensation of subluxation or dislocation. MRI showed a TFC perforation which will be further assessed on post-arthrogram MRI scan.

Left wrist arthrogram was performed on June 26, 2008 and revealed a TFC perforation, which will be further assessed on post-arthrogram MRI scan.

Left wrist MRI with contrast was performed on June 26, 2008 and given impression: Mild tenosynovitis in the central carpal ulnaris tendon sheath. Evidence of a triangular fibrocartilage perforation as manifested by contrast that leaked into the joint from the distal radioulnar joint. That triangular fibrocartilage complex appears nearly normal although there is a question of a tiny rent in that structure on the initial T2 weighted images. Findings suggestive of a tiny ganglion cyst just dorsal to the four corners articulation of the mid carpal joint (articulation between the lunate, hamate, capitate and trapezium).

The patient attended PT during July 2008.

Bilateral upper extremity nerve studies performed on August 7, 2008 were interpreted to show: No electrophysiological evidence of cervical radiculopathy, brachial plexopathy, or distal mononeuropathy was recorded. The patient has left elbow and wrist pain and decreased sensation in the left 4th and 5th fingers. He smokes. He does not have diabetes.

Left wrist arthroscopy and debridement of triangular fibrocartilage tear was performed on September 3, 2008, followed by 64 sessions of post-operative PT.

EMG/NCV was performed on February 10, 2009 and interpreted to shows evidence of mild distal mononeuropathy at the level of the wrist (carpal tunnel). There is evidence of left distal ulnar mononeuropathy at the level of the wrist.

Progress report dated November 16, 2009 notes the patient has persisting left wrist pain with popping, especially with driving and lifting. He has not been improved with treatment. He is using Lyrica, Lidoderm patches, Mobic and Lortab. Tenderness and crepitus are noted on examination.

A left wrist injection was provided on January 6, 2010.

The patient reported an exacerbation of left wrist pain on April 30, 2010. Updated wrist x-rays were taken. He will wear a splint and use ice and return in one week. Tylenol will be added to his medications. X-rays were interpreted as negative.

The patient was examined for possible participation in a CPMP on May 28, 2010. Treatment has included x-rays, MRI, nerve studies, pre-operative PT 3 x 6, left wrist surgery and an impairment rating of 4%. The patient had left wrist surgery in September 2008 and complains of persisting wrist pain that varies from 2-10/10, worse with certain movements and relieved with rest. Focal muscle weakness is denied. He is using Lortab 7.500 every 6 hours (4 daily), Mobic 15 mg one daily, and Lidoderm patches, one daily for 12 hours. He smokes one pack weekly. He has normal neurologic function. Assessment is left wrist sprain. Recommendation is for participation in a multidisciplinary CPMP.

Referral information dated May 28, 2010 notes the patient is no longer employed as a by his company. He underwent a Physical Performance Evaluation this visit including dynamic box lifting, static NIOSH lifting, cardiovascular endurance testing and

ROM testing with inclinometers. Left wrist ROM is decreased in all planes. He was unable to perform the NIOSH lifts. He could lift 40 pounds floor to knuckles, 50 pounds waist to shoulder, 40 pounds waist to overhead and 60 pounds waist level carry lift, which places him in the Medium PDL. Left grip strength is 39-52% weaker than right as tested in 5 positions. Wrist flexion is 35% of normal and extension 24% of normal. Radial deviation is 78% of normal and ulnar deviation is 61% of normal (19/13/14/17). His lifting capacity is less than 10% of the average worker. Pinwheel examination noted hypersensitivity at the dermatome levels of left C5-C8 and T1. Psychological test scores are noted. Reasons/goals for the CPMP: Reduction in psychological test scores. Elevation scoring in: Depression and Pain Catastrophizing. A medication contract is included.

The patient was evaluated in psychology for a CPMP on June 1, 2010. He considers himself an excellent employee and likes his job. He is worried and sad that he is not working and supporting his family. X-rays showed a dislocated left wrist. He had an abnormal EMG. He had surgery in September 2008, PT and injections with a little better movement but continuing pain. He describes sharp, shooting and stabbing pain that radiates up to the inner elbow. Any type of movement or lifting aggravates the pain. Prior to medication his pain level is 5/10. Average daily pain level is 3/10. He tries to stay active and he uses his right hand for all activities. He smokes one cigarette daily and uses OTC Advil. He has not had any prior psychological treatment. He is married and lives with his pregnant wife. He gets 6 hours of sleep each night with interruption due pain. He appears to be depressed. His thought content includes worthlessness, helplessness, hopelessness, worry and recurring dream. Socially he reports a loss of interest and his avoidance is to activities, places and people. He has no suicidal or homicidal ideations. His BDI score is 15 (mild depression) and BAI is 6 (mild anxiety). His goals include decrease pain, be able to use his hands and wrist and be able to work without the wrist breaking. Axis I diagnosis is chronic pain disorder associated with both psychological features and general medical condition. He also has a fear of pain and fear of re-injury. His problems include chronic pain syndrome, difficulty dealing with negative emotions appropriately, distorted beliefs about the relationship between pain and disability, which can lead to withdrawal from normal and productive activities, inadequate coping skills, physical deconditioning, significant period of disability, symptoms of depression/anxiety and inability to return to work due to these problems. The time elapsed since the injury has been considered. The patient is recommended for a CPMP based on the following criteria: Patient is likely to benefit from the program. Excessive dependence on pain medication or treatment drugs. Patient has not responded to previous care and is further medical treatment is not expected to provide significant relief. Pain interferes with physical, psychological, social or vocational functioning. Pain continues well beyond expected tissue healing time. Risk for development of an excessively disabled lifestyle (as described). Inability or perceived inability to work. Chronic debilitating pain. The program content is summarized and treatment goals outlined. He has a good prognosis for clinical response and returning to work. BHI 2 test indicated the patient has a self-perception of having a very limited capacity for working and for performing activities of everyday life. He denied depressed or anxious thoughts or feelings.

On July 1, 2010 request was made for 8 sessions of CPMP (80 hours) for the period of July 6, 2010 to August 6, 2010. He has been managed with medications of Lortab 7.5/500, 4 daily and Lyrica 200 mg, twice daily, Mobic 15 mg, one daily and Lidoderm patches. Imaging findings were summarized. Treatment has included surgery on September 3, 2008 with arthroscopy and debridement of a TFC tear, PT x 18 sessions, injections, ultrasound, massage therapy, stretching, heat and topical analgesics. The patient is seriously deconditioned with limited ROM and a decrease in overall activities. He needs a CPMP in order to not completely deteriorate and not to have to continue to fully rely on the aid of family members. He is dependent on his spouse who is pregnant. He is currently unable to work. He demonstrated fear-avoidance of physical activity due pain. Socially he has a loss of interest and his avoidance is to activities places and people. He has a constant pain level of 5/10 and has been unable to return to work. He reports 6 hours of sleep per night and his quality of sleep is fair. There is a physical component to his psychological condition. He continues to use medications without evidence of improvement in function. Previous methods of treatment have not resolved his condition. A thorough evaluation has been performed. His BDI of 15 indicates moderate depression. His BAI of 6 indicates minimal anxiety. The BHI-2 concluded he has a relatively high level of functional disability. The recommended program is outlined and will include psychological treatment, physical treatment and medication management. He is willing to change his medication regimen. He signed a medication contract. Negative predictors of success were evaluated. He smokes 1 cigarette daily and will meet with an acupuncturist to discuss smoking cessation. He has been continuously disabled for more than 24 months (26 months) and so the outcomes are clearly defined as required. The psychological treatment goals are outlined. The physical treatment goals of the initial 10 days are outlined (such as increase lifting from floor to knuckles from 40 pounds to 50 pounds and increase ROM currently at 10%). He is a viable candidate for a 4-5 week CPMP as he meets the criteria for both ODG and ACOEM. A medication contract is attached that states the patient is willing to change their medication or completely be weaned off.

Request for pain management 5 times a week times 2 weeks left wrist 97799 80 hours was considered in review on July 8, 2010 with recommendation for non-certification. 84 pages of medical records were reviewed. A peer discussion was attempted but not realized. The patient is using Lortab, Lyrica, Mobic and Lidoderm patches. He underwent left wrist surgery on September 3, 2008. He was provided an intraarticular corticosteroid injection on January 6, 2010 (response not reported). Nerve studies of February 10, 2009 showed very mild left median neuropathy at the wrist. He has also had chiropractic treatment. A CPMP has been requested to improve physical functioning, decrease pain levels and address need for pain medication reduction and psychological issues. Per the reviewer, although records indicate that previous methods of chronic pain have been unsuccessful and there is an absence of other options likely to result in clinical improvement, submitted records did not include satisfactory that the patient is not recommended for further surgery. A medication weaning plan was not provided. Owing to insufficient supporting documentation, the medical necessity of the request was not established.

Reevaluation of July 21, 2010 noted decreased left wrist ROM with swelling noted. Phalen's and Tinel's were negative. The exam not consistent with carpal tunnel syndrome. The diagnosis is sprain of radiocarpal joint or ligament and closed dislocation of midcarpal joint of wrist. Plan is MRI of the wrist without contrast.

Appeal was submitted with date of July 28, 2010. The patient's medications are not currently planned for weaning as he is functioning well on these medications. ODG cites research that shows daily opioid use does not decrease the effectiveness of CPMP. Despite use of opioids he continues to struggle with management of his pain, and presents with both functional and psychological barriers as a result. Although there is no formal reduction protocol the CPMP will continue to have a primary goal of on opiate care and education on non-medical ways to manage pain and symptomatology. He is currently prescribed Lortab, Lyrica, Mobic and Lidoderm patches. Among the many reports submitted, there is no documentation of further surgical intervention recommended for this patient. He has exhausted numerous treatments. Recent FCE shows significant barriers to performing previous work duties. He is unable to lift over a Medium PDL. He is frustrated with his life and inability to work. His pain is constant and is affecting his daily functioning. He would benefit from the CBT component of the CPMP. As his previous position at work is not available, the program can provide vocational counseling services. He has a primary goal of returning to work.

Request for reconsideration pain management 5 times a week times 2 weeks left wrist 97799 80 hours was considered in review on August 17, 2010 with recommendation for non-certification. 84 pages of medical records were reviewed. The treatment is summarized as per the initial review. - (poor copy) Physical examination of July 21, 2010 showed decreased ROM of the left wrist and (poor copy) Request is for appeal, for 80 hours of CPMP. The case was discussed with an assistant who stated that the patient suffers from pain avoidance and uses rest to avoid wrist discomfort. PT has subjectively helped, but the PT notes are mostly illegible. It remains unknown if there has been objective improvement with PT.

Request was made for an IRO.

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

The ODG criteria for the general use of multidisciplinary pain management programs are outlined in the cited guidelines below. These programs are 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." 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.

The patient has a constant pain level of 3-5/10 at the left upper extremity and has been unable to return to work. The patient does have chronic pain and evidence of loss of function persisting beyond three months. He has not been returned to pre-injury function. Despite a surgery, there is evidence of a persisting triangular fibrocartilage perforation and mild carpal tunnel syndrome as well as distal ulnar mononeuropathy at the level of the wrist, conditions which have not been significantly improved with a substantial amount of conservative care including 64 post-operative visits of PT.

The patient does not have significant mood issue or medication issues. The provider reports further surgery to repair his left wrist condition is not planned at this time, although it is noted that the treatment plan of July 21, 2010 includes MRI of the left wrist without contrast (results pending). Given lack of progress after 64 post-operative physical therapy sessions with regard to advancing the patient's PDL due to his underlying persistent wrist pathology despite surgery, there is no indication that two weeks of a pain program will significantly improve his status, as there are no substantial mood or medication issues involved.

Given the amount of rehabilitation services already provided, a pain management program is not anticipated to significantly improve this patient's chronic pain and internal wrist derangement. It is reasonable to conclude that several weeks of a pain program will not make this patient sufficiently whole to return to medium or heavy PDL work. While, overall, he appears to meet many of the criteria for a CPMP, he is not realistically a good candidate for a CPMP at this time.

Therefore my recommendation is to agree with the previous non-certification for pain management 5 times a week times 2 weeks left wrist 97799 80 hours

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

ODG TWC 09-24-2010 Pain Chapter:

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.

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.