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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 01/17/2011

**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 doctor (Board Certified), 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 5 x 2 (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**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the neck and right shoulder on xx/xx/xx when a pole weighing more than 60 pounds fell on the back of his head, neck and right shoulder.

Progress report dated August 11, 2010 indicates the patient has persisting right-sided neck and right shoulder pain with some shooting pain and numbness into the right hand. He got severe gastric irritation with anti-inflammatory medications so he is using Vicodin 5/500 twice a day as needed. He states this controls his pain level. He is scheduled to see an orthopedic surgeon for shoulder evaluations and possible shoulder injections. He has tendinosis in the shoulder per MRI. Nerve studies are also planned. He is 5' 6" and 190 pounds (or 6' 1" and 205 pounds). He has a surgical scar at the right shoulder. His Vicodin was increased to 3 per day this visit.

The patient was seen by his chiropractic provider on August 13, 2010. He rates his pain as 5/10 and is using a TENS unit and Vicodin. He reports increased headaches and cervical muscle spasms. He is status post right rotator cuff repair with rotator cuff

syndrome and cervical radiculitis. Additional PT for the neck had been denied.

An independent medical examination was conducted on August 26, 2010. Review of medical records notes the following: 12 sessions of PT were recommended in August 2007. Shoulder MRI of August 2007 showed partial thickness undersurface tear of the supraspinatus tendon. Cervical MRI same date showed small disc protrusion C3-4 impinging on anterior thecal sac. EMG of November 2007 showed evidence of acute C4, C5 radiculopathy on the right. Right rotator cuff repair surgery was performed on December 3, 2007. Patient complains of right shoulder pain and swelling after PT on May 1, 2008. Cervical ESI was provided May and June 20, 2008. Patient is at MMI with zero impairment. Peer Review August 2008 - additional office visits are not medically indicated. He completed 24 visits of post-op PT. FCE showed inconsistent and submaximal efforts. He does not need the presently prescribed Vicodin 7.5 mg twice daily. Vicodin should be weaned. He has exhibited pain complaints consistently out of proportion to the objective physical findings. The EMG was interpreted by a chiropractor not a board-certified neurologist.

An IME was performed October 2008. There is no documentation of a major cervical spine injury (he was wearing a hat). Ongoing active care and/or a surgery is not indicated. In February 2009 1% WPI was assigned. DDE opinions August 2009, the only unequivocal diagnosis is a right cervical muscle strain and a right shoulder muscle strain. Initial orthopedic exam of December 4, 2009 noted he did not seem to be interested in getting better. MR arthrogram of March 25, 2010 showed no evidence of rotator cuff tear. There was supraspinatus, infraspinatus and subscapularis tendonosis. Arthrogram showed marked tendinosis and impingement. In May a pinched nerve in the neck was suspected and EMG requested. 10 sessions of PT were denied in August 2010. The IME noted medications as Vicodin. Spurling's is negative. IME diagnoses: Status post cervical strain; status post right shoulder strain; status post arthroscopic right RTC repair with acromioplasty; chronic cervical syndrome and chronic right shoulder pain. No additional medical treatment is needed. Additional use of narcotic medication is not indicated. Vicodin should be weaned over a 3-4 week period.

The patient was reevaluated by his chiropractic provider on October 11, 2010 for ongoing low back and left leg pain and weakness. A psychological consult is recommended as he has been considered for a surgery. His medical provider prescribed hydrocodone, Celebrex and portable TENS unit. He is 6' 1" and 205 pounds. Right straight leg raise is positive at 45 degrees. Left dorsiflexor/plantar flexor weakness of +4/5 was noted.

FCE was performed on November 8, 2010. He was working as an. His overall effort with testing was deemed to be reliable. He reports a pain level of 8/10 (at 10/10 an ambulance is needed). He showed strength deficits in the right upper extremity. Lift testing showed a sedentary level capacity. He complained of right shoulder pain after doing the lifting. Overall he is at a Sedentary PDL. Cardiovascular testing was discontinued due to fatigue, headache and altered gait. Muscle strength deficits were noted in the right shoulder and upper extremity.

Per provider notes of November 15, 2010 requested diagnostic studies were not approved. He reports flare-up of pain following the FCE of a week prior. He is an and needs to do very heavy lifting. Spurling's is positive on the right. Recommendation is for chronic pain management program (CPMP) to address poor coping regarding pain levels as well as dealing with change of vocation. He will continue to use Lidoderm patch (sic) and Vicodin. Medical reevaluation same date indicates prescriptions of Naprosyn 500 mg BID and Vicodin 5/500 BID.

A consultation was provided per report of November 19, 2010 to determine if mental health treatment would be appropriate for this patient and if his medications are appropriate. The opinions are based on an interview and a "mini-mental status examination." The report was prepared by an LPC-S Therapist. The patient relates having been provided a variety of treatments including TENS, chiropractic, surgery and medications without resolution of his pain to manageable levels. His psychological symptoms "appear to be" anergia, sadness, insomnia, frustration, anhedonia, motivation decrease, boredom, libido decrease, discouragement about the future, inability to relax, changes in appetite, muscle tension, difficulties adjusting to the injury, restlessness, fear of re-injury and increased concerns about physical health. He is using Naprosyn and Vicodin. He rates his neck and right shoulder/arm pain as 8/10. He sleeps 4 hours nightly. He has financial stress and difficulty with daily activities and relationships. BDI-II (self-report inventory) score is 31 within the range of severe depression. BAI score is 22 which in the moderate range for anxiety. SOAPP-R (for patients being considered for long-term opioid therapy) score was 48, indicating a high risk for abuse of prescribed narcotic pain medication. FABQ score was 42 for work scale and 24 for activity scale. As he has not become stabilized enough to enhance coping mechanisms to more effectively manage pain and achieve success in rehabilitation, request is for 10 sessions of a behavioral multidisciplinary CPMP. All lower levels of care have been exhausted and there are no additional treatment procedures pending.

Request for chronic pain management 5 x 2 (10 sessions) was considered in review on December 3, 2010 with recommendation for non-certification. Per the reviewer, current medications are reported as Vicodin, naprosyn and Lidoderm patches with no clarification of dosages or utilization. Lidoderm patches are not reported in the mental health evaluation. A peer discussion was conducted with the provider. The criteria for a chronic pain program are lacking. The mental health evaluation of 11/19/10 does not note any diagnostic impressions. The mental health evaluation is also inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments (limited to SOAPP-R, BAI, BDI, FABQ, the latter 3 not diagnostically valid for this presentation) are inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain the symptoms, and to help design and predict response to treatment, and there is no "thorough behavioral psychological examination" to provide a reasonable "manifest explanation for the etiology and maintenance of patients clinical problems" (i.e. pain complaint, behavior, and disability), to enable a "better understanding of the patient in their social environment," or to provide a "cogent explanation for the identified complaints and dysfunction." There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a CPMP. This is not addressed in the provider's last note of 11/15/10, in which he also suggests following up with orthopedic surgeon on the case for further recommendations. In addition, there are

limited studies about the efficacy of chronic pain programs for neck, shoulder, or upper extremity musculoskeletal disorders." Therefore, a more comprehensive analysis, from behavioral and psychometric perspectives, would be necessary to demonstrate that this patient manifests a chronic pain syndrome, is an appropriate candidate for the program, and is likely to benefit, thus constituting the requisite "adequate and thorough evaluation" of this problem for a CPMP.

A request for reconsideration dated December 7, 2010 was submitted by the patient's chiropractic provider. The patient was opined to meet the ODG criteria to participate in a CPMP. He is stated to not have any additional treatments pending.

Request for reconsideration chronic pain management 5 x 2 (10 sessions) was considered in review on December 7, 2010 with recommendation for non-certification. Per the reviewer, the patient was deemed MMI on 4/3/08 per a Required Medical Evaluation and was given a 1% impairment with note that "it is unlikely that further active treatment will result in sustained an industrial injury to the clinical improvement or change of functional level." The RME concluded, "it is my opinion that continued ongoing treatment is not indicated." Current medications are Naprosyn and Vicodin. A psychological evaluation of 11/19/10 indicates he is experiencing severe depressive symptoms and moderate symptoms of anxiety. Diagnostic impressions included Chronic Pain Syndrome. The request is inconsistent with ODG criteria for CPMP. In conclusion: There is no "adequate and thorough multidisciplinary evaluation" to determine the appropriateness of this request. There is no current "physical exam (by the physician associated with the CPMP) that rules out conditions that require treatment prior to initiating the program. There is no evidence provided to indicate that the treatment team has exhausted all appropriate treatments for this patient, a clinical indication for a CPMP. He has also been disabled for more than 24 months and the outcomes for the necessity of use are not clearly identified.

Request was made for an IRO.

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

ODG: 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. There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months). Criteria include:

(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.

Per IME of August 26, 2010 the patient is at MMI with zero impairment. No additional treatment is indicated and the patient should be weaned from Vicodin. EMG of November 2007 showed evidence of acute C4, C5 radiculopathy on the right; however, this study was reportedly interpreted by his chiropractic provider not a neurologist. Per the IME, he has exhibited pain complaints consistently out of proportion to the objective physical findings. He was wearing a hat at the time of injury and there is no documentation of a major cervical spine injury. He does appear to have residual right shoulder pain and occasional swelling but when provided an orthopedic consultation he did not appear to be motivated for improvement. Per Peer Review the FCE showed inconsistent and submaximal efforts and additional office visits are not medically indicated. The recommendation to wean Vicodin has not been realized. Otherwise there are no medication issues. The mental health assessment does not include a diagnosis and there has been no thorough multidisciplinary assessment indicating the patient has a significant loss of ability to function independently resulting from the chronic pain. The patient is 39 months post injury and has not been established as someone who would benefit from a CPMP. The ODG criteria for a chronic pain management program have not been met.

Therefore, my recommendation is to agree with the previous non-certification for Chronic Pain Management 5 x 2 (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 KNOWLEDGBASE

- 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 12-15-2010 Pain Chapter - Chronic pain programs (functional restoration 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.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. These pain rehabilitation programs (as described below) combine multiple treatments, and at the least, include psychological care along with physical and/or occupational therapy (including an active exercise component as opposed to passive modalities). The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):

(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

- (a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)
- (b) Multidisciplinary pain clinics
- (c) Pain clinics
- (d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

Multidisciplinary back training: (involvement of psychologists, physiotherapists, occupational therapists, and/or medical specialists). The training program is partly based on physical training and partly on behavioral cognitive training. Physical training is performed according to the "graded activity" principle. The main goal is to restore daily function. A recent review of randomized controlled studies of at least a year's duration found that this treatment modality produced a positive effect on work participation and possibly on quality of life. There was no long-term effect on experienced pain or functional status (this result may be secondary to the instrument used for outcome measure). Intensity of training had no substantial influence on the effectiveness of the treatment

**Role of comorbid psych illness:** Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability.

**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. 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. 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).

**Studies supporting programs for patients with long-term disability:** Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals.

**Studies suggesting limited results in patients with long-term disability:** While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. Washington State studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a "treated group" for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included Pysch/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N=963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the "treated patient" was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that modest goals (improvement, not cure) be introduced. (Robinson, 2004) (Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]

**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). See Chronic pain programs, early intervention.

**Role of post-treatment care (as an outcome):** Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a "new provider" is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed.

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.