

Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

Notice of Independent Review Decision

September 30, 2014
Amended Date: October 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Program x 80 Hours

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

The Reviewer is Board Certified in the area of Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was struck by another vehicle on xx/xx/xx. She sustained injuries to her mid to lower back by thrusting forward and twisting during impact.

Xx/xx/xx: Office Notes. **Assessment:** Thoracic strain, Lumbar Strain, Abdominal wall strain, abdominal pain, Urinary incontinence. **Plan: Medications:** 600mg ibuprofen, Cyclobenzaprine 10mg. Lumbar ROM is decreased to all planes with pain. Palpation is positive for tenderness over L1 through L5 and paraspinal area bilaterally. The patient has a musculoskeletal injury for which a structured PT program is medically necessary due to limited ROM, functional deficits and clinically relevant pain.

10/30/2012: PT Notes. **Assessment:** The patient examination is consistent with the medical diagnosis of thoracolumbar. The patient is good candidate for therapy intervention and demonstrates good prognosis for improvement. The impairments identified during the examination prevent the patient from performing their standard ADL's. Goals to be met in 12 visits. **Plan:** Frequency: Three times a week duration: two weeks.

11/05/2012: Progress Notes. **PE: Musculoskeletal:** ROM of the trunk is slightly decreased to all planes with mild pain. Palpation of the spine is positive for mild tenderness, over T4 through T10. Cervical ROM is normal. Lumbar: Lumbar ROM is slightly decreased. Palpation is positive for mild tenderness over L1 through L5 and the paraspinous area bilaterally.

11/14/2012: PT Notes. Visit number: 6. . **Impairment Goals:** AROM bilateral thoracic flexion: Current 80%. Progressing slower than anticipate per protocol. AROM bilateral lumbar flexion: 80%. Progressing slower than anticipated. AROM bilateral lumbar extension: 80%. Progressing slower than anticipated per protocol. AROM bilateral lumbar lateral flexion: 80%. Progressing slower than anticipated per protocol. AROM bilateral lumbar rotation: 80%. Progressing slower than anticipated per protocol. **Subjective:** The patient reports that back is feeling better today and she has less pain.

11/20/2012: Progress Notes. **HPI:** The patient states that she has been working within her duty restrictions and tolerating the work. She has been taking her medication and feels that it is helping to relieve her pain. She has had 6 sessions of physical therapy and is making progress. She has seen an urologist and states that he told her that her urinary incontinence could be treated with medication. She states that she feels that she is ready to return to her regular job duties. **Musculoskeletal:** Gross exam of the thoracic spine is normal. ROM of the trunk is within normal limits to all planes without pain. Palpation of the spine is negative for tenderness. Cervical ROM is normal. Lumbar: Lumbar ROM is within normal limits to all planes without pain. Palpation is negative for tenderness. **Plan:** Continue Ibuprofen 600mg. Activity status: Regular duty, release from care today.

04/25/2013: Progress Notes. The patient states that she has been working her regular duty and experiencing persistent low back pain. She has been taking her OTC medication and has gotten minimal relief from her pain. She was released from care 11/26/12, but at the time of her release she stated that she continued to have back pain. Her pain had otherwise revolved. She advised that her back pain has become unbearable. **Musculoskeletal:** Gross exam of the thoracic spine reveals that the patient is unable to stand upright without pain. ROM of the truck is decreased to all planes with pain. Palpation of the spine is positive for tenderness over the spine and paraspinous muscles of the thoracic and lumbar spine. Straight leg rising is positive bilaterally. **Plan:** I would recommend that the patient return for additional treatment.

05/21/2013: MRI of Lumbar Spine. **Impression:** 1. Posterior and leftward disc herniation measuring 10mm at L5-S1 as described above.

05/29/2013: Progress Notes. Patient stated that she has not been working. Has been taking her medication and has gotten some relief from her pain. was referred to an Orthopaedic spine surgeon for evaluation and treatment of her back injury.

06/06/2013: Consultation. **Musculoskeletal:** She has pain in the back in the buttock. Her strength to lower extremity reveals 4+/5 strength bilaterally in her hip flexors, but otherwise 5/5 strength in the lower extremities. She has intact sensation throughout the lower extremities. She has 2+ reflexes of the bilateral lower extremity. She has a positive straight leg raise on the left. **Imaging:** X-rays of the lumbar spine revealed mild degenerative disk disease at L4-5 and L5-S1. An MRI of the lumbar spine was reviewed. This is from 05/21/2013. This shows a large posterior left root sub ligamentous disk herniation measuring approximately 1cm at L5-S1. **Impression:** A female with low back and left leg pain with left L5-S1 herniated nucleus pulposus. **Plan:** Given the patient has continued to have pain despite physical therapy and oral medications; we will recommend a left-sided L5-S1 transformational epidural steroid injection for her herniated disk.

06/18/2013: Operative Report. 1. Left L5-S1 transformational epidural steroid injection with fluoroscopic image guidance. 2. Use of intraoperative fluoroscopy for spinal needle injection.

06/27/2013: Progress Notes. **Plan:** Patient has had approximately 50% relief of pain with 1 injection. I would recommend a second left sided L5-S1 transformational ESI for her large L5-S1 herniated nucleus pulposus. She can also begin some more PT to help with her back pain.

07/03/2013: Evaluation. Visit number: 7. Lumbar AROM: Flexion 70% painful. Extension: 50% hinges at L3 segment. Lateral Flexion left, Right: 50% B/L hinges at L3 segment. Rotation: Left, right: 50% B/L hinges at L3 segment. Manual muscle testing: 3+/5. Myotomes Left, Right: L2 hip flexion: 4+/5, 4+/5. L3 Quadriceps: 5/5, 5/5. L4 Tibialis Anterior: 5/5, 5/5. L5 Extensor Hallucis Longus: 5/5, 5/5. S1 Gastroc/Soleus: 5/5, 5/5. Passive Intervertebral Accessory Motion: Increased mobility L3, L4, L5 segments into extension, SB and flexion. PPIVMS: hypermobility noted L3, L4, L5 segment right and left facets. Deep Tendon Reflexes left and right: Patellar: +1, +1. Achilles: +1, +1. **Assessment:** Patient present with signs and symptoms of nerve root irritation as evidenced with SLR seated and supine and slump test. Patient verbalizes increased pain with prolonged sitting which correlated with positive slump test. This impedes patient's ability to perform her regular duty job as her duties, includes sitting longer than 40 minutes. Overall progress: Slower than Expected. **Impairment Goals:** AROM bilateral thoracic flexion: Current 70%. Progressing slower than anticipated per protocol. AROM bilateral lumbar flexion: 70%. Progressing slower than anticipated. AROM bilateral lumbar extension: 70%. Progressing slower than

anticipated per protocol. AROM bilateral lumbar lateral flexion: 70%. Progressing slower than anticipated per protocol. AROM bilateral lumbar rotation: 70%. Progressing slower than anticipated per protocol. **Plan:** Two times a week duration: six weeks.

07/11/2013: Behavioral Evaluation Report. In conclusion, based on the criteria set fourth by the ACOEM, ODG, and TWCC guidelines is a candidate for a Multi-Disciplinary Pain Management Program. It is recommended that Ms. participate in 80 hours of a multidisciplinary chronic pain program to insure her medical benefits that she is entitled and as a con-current evaluation to assess her compliance and therapeutic response to treatment. It is in good faith that this request is being submitted for consideration of certification of these services.

07/16/2013: Operative Report. 1. Left L5-S1 transformational epidural steroid injection with fluoroscopic image guidance. 2. Use of intraoperative fluoroscopy for spinal needle injection.

08/12/2013: Visit Notes, Supervising: . **Pain Level:** 7. **PE:** On examination of lumbar spine, Active ROM is restricted in. Restricted flexion 50/95 with pain. Restricted extension 10/35 with pain. There is tenderness on palpation over L4, L5 and S1. Pain radiates through the left foot. Toe walk S1 test is positive on the left side of lumbar region. Heel walk L4/5 test is negative on both the side of lumbar region. Minor's sign is positive on both sides of lumbar region. Straight leg raise test is positive on the left side 50 degree of lumbar region. DTRs +1 4/5 motor on L Plantars. **Plan:** MRI confirms 10mm HNP

08/21/2013: Functional Capacity Assessment. The patient's occupational demand requires a Medium PDL. According to the results of the evaluation Ms. is currently performing at a Light PDL, which indicates a moderate functional deficit.

09/19/2013: Muscle Strength Testing. **PE:** Flexion was 25 degrees. She had pain with straight-leg raising on the left side at 30 degrees, but she had no pain on the right side. She had tenderness in the left sciatic notch. There was normal strength in the iliopsoas, quadriceps, and tibialis anterior, but there was weakness in the left extensor hallucis longus, gastrocnemius, and soleus group. There was atrophy of the left calf, which measured 3.5 cm. The left ankle reflex was reduced. **Plan:** The claimant has failed no operative management. She clearly has a symptomatic disc herniation with neurologic symptoms and findings. The lumbar disc herniation is part of her compensable injury. In my opinion, she is an excellent candidate for surgery, and we will put in a request for an L5-S1 discectomy on the left side.

10/04/2013: Post Designated Doctor's Required Medical Examination. Based on the available documentation and today's evaluation, the injury of xx/xx/xx resulted in thoracic sprain/strain and lumbar sprain /strain. The subligamentous disc herniation at L5-S1 observed on the MRI does not correlate with the claimant's clinical findings; and hence, it reflects preexisting degenerative disc disease and it is not related to the compensable work injury. In conclusion, the above facts rule

out causal relationship between the MRI findings and the xx/xx/xx injury based on reasonable medical probability.

10/29/2013: Functional Capacity Evaluation. The patient's occupational demand requires a Medium PDL. According to the results of the evaluation Ms. is currently performing at a Sedentary-Light PDL, which indicates a moderate functional deficit.

02/13/2014: Letter. This is a short note to let you know was seen back in the office on February 13, 2014. I reviewed the court order, which opined the L5-S1 disc herniation is part of her compensable injury. This lady continued to have pain in her back with radiation down her left leg. She has failed non operative management, including therapy, medication, and epidural steroid injections. Examination today showed 30 degrees of forward flexion. She had tenderness in the left sciatic notch. She had pain with straight leg raising on the left side at 30 degrees in the supine and seated positions, but she had no pain on the right side. There was normal strength in the iliopsoas, quadriceps, and tibialis anterior; but there continued to be weakness in the left extensor hallucis longus, gastrocnemius, and soleus group. There continued to be atrophy of the left calf, which now measures 4 cm. Knee reflexes were normal. The left ankle reflex was absent. The lady is an excellent candidate for left L5-S1 discectomy, and we will schedule this as quickly as possible.

03/26/2014: X-Ray of chest. **Impression:** 1. No apparent acute infiltrate or pneumothorax.

04/01/2014: Operative Report. **Postoperative Diagnoses:** 1. Herniated nucleus pulposus, left side L5-S1. 2. Left S1 radiculopathy. **Procedure Performed:** 1. Laminotomy left side L5-S1. 2. Decompression left S1 nerve root. 3. Discectomy left side L5-S1.

04/15/2014: Letter. This is a short note to let you know was seen back in the office on April 15, 2014. She is two weeks out from the time of her discectomy, and she has done well. She has continued to have a little back pain, but the leg pain has improved. The incision was clean. The staples had been removed. There was no true nerve root tension signs. Strength and reflexes were normal. This lady has made an appointment with you to begin a therapy program.

04/21/2014: Office Notes: Claimant reported pain level as 8/10. She reports she had surgery on 04/01/2014, she states she is still having left leg pain, she describes it as achy and numbness. **PE:** Restricted flexion 45/95 with pain. Restricted extension 10/35 with pain. **Plan:** At this time I am going to request 12 visits of PT, which is in compliance with the ODG guidelines.

04/22/2014: Functional Capacity Evaluation. The patient's occupational demand requires a Medium PDL. According to the results of the evaluation is currently performing at a Sedentary PDL, which indicates a moderate functional deficit.

04/25/2014: PT Evaluation. Patient's signs and symptoms consistent s/p surgery; patient presenting with significant lumbar flexion/anterior pelvic tilt causing muscle guarding and hypertonicity of the iliopsoas/quadrants lumborum; patient presents with tenderness, pain with functional activities, limited lumbar ROM/flexibility, decreased core/LE strength/stability and poor postural awareness. Patient would benefit from skilled PT including appropriate strength/stretching exercises, modalities and manual techniques in order to minimize muscle guarding, tenderness, manage pain with functional activities, improve lumbar ROM/flexibility, increase core/LE strength/stability and improve postural awareness in order to maximize functional potential and enhance QoL.

06/02/2014: PT Re-Evaluation. **Functional Level Update: Lumbar ROM has improved:** Flexion 40 to **50 degrees**. Extension 15 to **20 degrees**. Lateral flexion (R) 10 to **30** (L) 15 to **30** degrees. Rotation (R) 20 to **25**, (L) **25** degrees. Strength of the spinal extensors is rated at **3/5**, initially rated at 3-/5. Abdominals rated at **3/5**, initially rated at 3-/5. Strength of the cervical musculature rated is 3+5, initially rated at 3-/5. Shoulder flexors (R) 4+ (L) initially rated at (R) 4 (L) 4/5. Shoulder Abductors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Shoulder Extensors (R) 4+ (L) 4 initially rated at (R) 4 (L) 4/5. Shoulder Internal Rotators (R) 4+ (L) 4 Initially rated at (R) 4 (L) 4/5. Shoulder External Rotators (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Elbow Flexors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Elbow Extensors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Hip Flexors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Hip Extensors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Hip Abductors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Hip External Rotators (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Hip Internal Rotators (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Supinators (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Pronators (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Wrist Flexors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Wrist Extensors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Wrist Ulnar Deviation (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Wrist Radial Deviation (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Ankle Dorsiflexors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Ankle Plantar flexors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Ankle Invertors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Toe Flexors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. Toe Extensors (R) 4+ (L) 4, initially rated at (R) 4 (L) 4/5. **Functionally, her transfers, mobility, ambulating and activities at home do increase pain although slightly less than before. Pain level is rated at 0-2/10 at rest and 3/10 with activity, which is decreased from last evaluation.**

Plan of treatment: Would recommend continuing skilled PT intervention utilizing heat/ice/electrical stimulation for treatment comfort, ultrasound to increase local circulation, manual therapy techniques to maximize pain free functional ROM, and therapeutic activities/procedures to increase activity tolerance and endurance.

06/30/2014: Initial Medical Report. **HPI:** The patient underwent lumbar surgery on 04/01/14. The patient attended postsurgical therapy. The patient reports of ongoing back pain. She states of numbness referred to her left leg and foot. The patient is referred here by her treating physician for evaluation for tertiary care. **Objective Clinical Findings:** There is tenderness of the lumbar par spinals on the left side. Tenderness is also noted of the left S1 joint. Lumbar ranges of

motion are restricted with increase in pain. Kemp's test is positive. There is decreased sensation of the left lower extremity. **Diagnosis:** Status post lumbar surgery, HNP of lumbar spine, lumbar radiculitis, lumbar sprain/strain. **Treatment Plan:** Refer for MHE, refer for FCE, Medications: Gream/gel ibuprofen 5%, ketoprofen 10%, piroxicam 10%.

07/11/2014: Behavioral Evaluation Report. In conclusion, based on the criteria set forth by ACOEM, ODG and TWCC guidelines is a candidate for Multi-Disciplinary Pain Management Program. It is recommended that Ms. participate in 80 hours of a multidisciplinary chronic pain program to insure her the medical benefits that she is entitled and as a con-current evaluation to assess her compliance and therapeutic response to treatment.

07/11/2014: Work Capacity Evaluation. The patient's occupational demand requires a Medium PDL. According to the results of the evaluation Ms. is currently performing at a Sedentary PDL, which indicates a moderate functional deficit.

07/24/2014: UR. Rationale for Denial: I spoke to for peer to peer. He reported she is taking Tramadol (50 mg, q.d.) and ibuprofen and Zoloft. I noted lack of lower level psychological or behavioral care for this injury as well as a lack of objective psychological testing such as MMPI-2 to validate her psychological symptoms. She is not taking narcotics and her average pain report is generally mild to moderate. Furthermore, the outlined treatment goals to reduce depression, anxiety by only -4 points on Beck Scales with such intensive intervention do not make sense. understood my rationale and that I believe CPMP is premature at this point. ODG criteria 2, 3, 6, and 8 are not met.

07/28/2014: Subsequent Medical Report. **Objective Medical Findings:** There is a well healed surgical incision at the dorsal aspect of the lumbar spine. There is tenderness of the lumbar paraspinals on the left side. Tenderness is also noted of the left SI joint. Lumbar ranges of motion are restricted with increase in pain. Kemp's test is positive. There is decreased sensation of the left lower extremity. **Plan:** pending chronic pain management program.

07/30/2014: Office Notes: Claimant describes her pain level as 3/10. **PE:** On examination of lumbar spine Active ROM is restricted. Restricted flexion 60/95. Restricted extension 20/35. There is tenderness on palpation over L4, L5, S1. Pain radiates through the left knee and not pain heaviness and numbness.

09/03/2014: UR. Rational for Denial: In this specific case, for the described medical situation, Official Disability Guidelines would not support this request to be one of medical necessity. Based upon the records presently available for review, it would not appear that all lesser levels of care have been exhausted. Additionally, it is documented that the claimant is approximately 5 months removed from undergoing surgical intervention to the lumbar spine region. The records available for review do not provide any data to indicate that the claimant has been released from the care of the physician who performed the surgical

intervention to the lumbar spine. The records available for review do not provide any data to indicate whether there is any consideration for any additional diagnostic testing and/or invasive procedures for the lumbar spine region. As such, presently, medical necessity for this request is not established in this specific case.

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

Determination: denial of 80 hrs chronic pain management is UPHELD/AGREED UPON since there is lack of information regarding lower levels of care. There is question regarding the number of post-operative PT visits, attendance, progress and compliance with treatment and home exercise program. There is question regarding release by the surgeon to pursue a physically aggressive rehabilitation program. There is question regarding Tramadol, how much currently taken, prescribed by whom and the planned weaning process. There is question regarding Sertaline, prescribed by whom, the duration, the effectiveness (especially given moderately high Beck Depression and Anxiety Indices), trial of any other psychotropic medication, any concomitant lower levels of psychological counseling, and plans regarding continuation. There are questions regarding return to work plans, whether job of injury is available and the claimant's motivation. Therefore, the request for 97799 Chronic Pain Program x 80 Hours is upheld.

PER ODG:

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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities.

([Sanders, 2005](#)) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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](#).

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)