

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 14, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management x 80 hours

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

This physician is Board Certified in Anesthesiology with over 13 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 injured on the job on xx/xx/xx while cleaning a machine and pulling a bar from the machine, she heard a pop sound and had a sharp pain on lower back, radiating to the left leg and left shoulder. She was later evaluated at the hospital.

08-19-13: Visit Note. CC: While the claimant was bending forward cleaning at work, she tried to lift a heavy object and developed sudden pain that radiated to left hip and leg. Only less painful position is lying on her right lateral side, other positions trigger and aggravates pain. She presented with back pain located in the middle of the back area, described as aching and ongoing. In addition, she presented with leg pain located in left leg sciatica and left shoulder pain described as dull that as well started 5 days ago with injury. Current medications: Tramadol 37.5mg-acetaminophen 325mg PO TID PRN, Norco 5/325 PO TID PRN and oxaprozin 600mg PO BID. PE: Musculoskeletal: tender to palpation tense

muscle in lumbar spine and paraspinal area. DX: 847.2 lumbar sprain and strain, 953.2 injury to lumbar nerve root, 781.3 ataxia, and 997.91 HTN, NEC. Will add Flexeril 5mg PO TID x 10 days. Services performed: Ketorlac Tromethamine 15mg in a quantity of 4. Plan: return in 2 weeks. Note: In view of the severity of the painful condition and radiating to LLE, x-ray showing an area with decreased intervertebral space, recommend MRI L/S spine. For the mean time, will RX with muscle relaxants, NSAID, analgesic and PT. Claimant had significant difficulty secondary to pain to do basic movements; she will need to be off work under therapy until reassessed again in 2 weeks.

08-19-13: X-Ray Report. Lumbar x-ray findings: mild decrease in disc spacing is apparent at the L5-S1 level; however, vertebral body height is well maintained.

08-21-13: Physical Therapy Note. Claimant presented with severe sharp mid and low back pain which radiated down her left buttock and lateral thigh. All thoracic and lumbar ROM were restricted and aggravated pains were reported with most motions. An ataxic gait was visible favoring her left side. Palpable muscle spasms were present at the lumbar paraspinal musculature. On orthopedic examination, the claimant displayed positive SLR and Kemp's test to the left. Neurologically, pain was elicited along the S1 dermatome on the left side. Dx: 847.2, 953.2, 781.3, 997.91. Claimant prescribed the following medical supplies: TENS unit (30 day rental), lumbar brace/support, and 3oz Biofreeze. Recommend: PT to lumbar spine 3xwk x 2wks with unit modalities: massage, ultrasound, traction (mechanical) and electrical stimulation.

08-22-13: Daily Progress Note. Claimant stated she is worse today with aching, throbbing and sharp pain in back. PT: traction, myofascial, ultrasound and electrical stimulation for 15 minutes each. Continue plan.

08-23-13: Physical Therapy Note. Claimant given cane for assisted ambulation.

08-26-13: Visit Note. Claimant reported no change in severe, sharp bilateral LBP (L>R) with radiation pains at L buttocks and post lateral thigh to knee. Moderate to severe bilateral lumbar pain with muscle spasms palpable. Continue treatment plan. Mobilization done to the L spine following hands on muscle stretching to decrease spasms. DX: 847.2, 953.2, 781.3, 997.91. Claimant prescribed cane due to severe antalgic gait favoring L side. agreed to TX plan, but wished to deny lumbar MRI stating TX must be attempted first despite recommendation.

08-26-13: MRI Lumbar Spine without Contrast. Impression: 1. L5-S1 grade 1 retrolisthesis, uncovering of the intervertebral disc, and a superimposed disc protrusion (herniation) which mildly contacts bilateral S1 nerve roots in the lateral recesses, with canal stenosis. Associated mild right/moderate left neural foraminal stenosis. 2. L4-5 disc protrusion (herniation) contacts right L5 nerve roots in the lateral recess, without canal stenosis. Associated moderate right/mild left neural foraminal stenosis. 3. Moderate foraminal stenosis with contact on left L5 and tight L4 nerve roots in the foraminal spaces.

08-28-13: Visit Note. Claimant reported mild decrease in severity of radiating pains at LLE, moderate to severe, sharp bilateral LBP now travels to L buttocks and mid L thigh w/o pain at back of knee. Moderate bilateral lumbar palpable minimal paraspinal spasms. Continue TX plan. Claimant was unable to tolerate mobilization due to pain. DX: 847.2, 953.2, 781.3, 997.91.

09-03-13: Visit Note. Claimant reported no change in moderate to severe, sharp bilateral LBP with radiation pain at the LLE. Mild to moderate bilateral lumbar paraspinal muscle spasms palpable. Will suggest ortho referral as 6 visits of therapy have provided little relief. Claimant was unable to tolerate mobilization due to pain. DX: 847.2, 953.2, 781.3, 997.91.

09-05-13: Visit Note. CC: claimant c/o persistent LBP radiating down LLE. Claimant had some urinary incontinence due to severity of pain, inability to get to the restroom. She presented with leg pain/sciatica, described as aching and throbbing, back pain located in the left lower back area described as throbbing and discomfort. Current medications: Kristalose 20g PO QD, Ziac 5mg/6.25mg PO QAM, Norco 10/325 PO TID PRN, oxaprozin 600mg PO BID. PE: Musculoskeletal: no peripheral edema and musculoskeletal abnormality (tender to palpation tense muscle in lumbar spine and paraspinal area). DX: 724.4 lumbar radiculopathy, 847.2 lumbar sprain and strain, 953.2 injury to lumbar nerve root, 781.3 ataxia, 728.85 spasm of muscle, 997.91 HTN, NEC. Services performed: INJ Ketorolac 15mg in a quantity of 4. Plan: return visit in 2 weeks. Plan: refer to neurosurgeon, re: lumbar radiculopathy. Due to persistent severity of her condition will administer Ketorolac today, then up dose of analgesic and have her see neurosurgeon soon.

09-24-13: Functional Capacity Evaluation at Sovereign Evaluation. Notes/Recommendations/Restrictions: According to the subjective and objective findings from this evaluation: Muscle testing, ROM testing, dynamic task lifts, Pace/Endurance, work activities and work postures, claimant was determined to have a current PDL of less than sedentary both below and above the waist. She was unable to complete the dynamic task lifts portion of the evaluation determines the claimant's PDL leaving her with a sedentary PDL. She was also unable to complete the Push and Pull portion of the evaluation due to the same increase in pain. For this same reason she had difficulty both performing and completing nearly all of the tasks required of her during the evaluation. It is noted that the claimant did exhibit objective signs of severe pain such as increased heart rate and pupil dilation that coincided with her reported claims. This being said both the physical and psychological aspects of her pain issues will most likely need to be addressed at some time during the course of her treatment. These recommendations are based solely on the results of the FCE and can only be implemented with the permission of her treating doctor.

09-26-13: Office Visit. CC: claimant presented with back pain and leg pain located on the left side that has been going on for 1-3 months. She reported no significant relief from the pain medication or Flexeril or TENS unit or PT and reported she has not tried a HEP. Currently she complained of severe pain in her

left-sided lower back with radiation down the back of her leg and into her left lateral thigh. She denies any radiation of pain further down the leg. Record incomplete...

09-26-13: Physical Therapy Orders. DX: lumbar radiculopathy sciatica 722.1, 724.3. Goals: neurogenic low back rehabilitation. Physician's orders: back school, McKenzie and/or Williams exercise, progressive stabilization exercises, lower extremity flexibility, aerobic conditioning program, HEP. Frequency/duration: x2 times per week x4 weeks.

10-29-13: Office Note. Claimant refused any active exercises today when she arrived for her session stating pain had been too severe since last session on 10/24/13 where she performed up to 45 min of gentle stretches to low back, and mid low back strengthening. Advised claimant to seek out water therapy so that exercises could continue in an unweighted position in the water. Will discharge from care, unless her pain level will permit exercises on land.

10-29-13: Request for Physical Therapy. Recommend water therapy program 3x week for 3 weeks.

11-14-13: Office Visit. CC: low back and left leg pain. DX: lumbar strain, mild L4/5 and L5/S1 DDD, small L5/S1 disc bulge with contact of L L5 but no compression. Claimant stated her pain is worse and complained of severe low back pain rated 10/10 with radiation of the pain down the left lateral thigh to the level of the knee, also rated 10/10. She had no significant improvement with the Medrol Dosepak and has been taking Naprosyn BID w/o any improvement as well. There is quite a bit of delay getting her PT approved, and she finally had her evaluation by the therapist 2 days ago. She was recommended for continued therapy, but has not yet done any of these exercises, nor has she been tied any HEP yet. She continued to complain of severe difficulty with her ADLs and slow painful ambulation, requiring a cane. PE: Paravertebral muscles are tender bilateral, lumbar ROM is painful and restricted to the following: flexion is painful at 0% of normal; extension is painful at 0% of normal. Waddell's test shows non-specific tenderness, distraction: seated SLR, regional disturbances and overreaction present. Assessment: claimant with severe low back and left lower extremity pain, with very mild degenerative changes only seen in her lumbar spine. Plan: Discussed options. Explained that her pain in her back is likely soft tissue in origin, such as lumbar sprain or strain. Etiology discussed at length. N significant nerve root impingement seen in the lumbar spine that explains her severe pain in her back or legs. Additionally, there is no identifiable pathology which should restrict her motion to essentially 0 degrees of motion in each direction. It is believed that she should have some improvement in her symptoms with a prolonged course of physical therapy with an emphasis on active muscular conditioning and a HEP, although certain fear avoidance techniques and secondary gain may be complicating her recovery. Recommend no surgery or any further invasive techniques or treatment or ESI. 3 week off work to complete PT.

12-13-13: Office Visit. CC: chronic lower mid back pain. Water therapy was advised and has not gotten yet. Claimant lives upstairs and it is very painful to get up stairs, still in severe pain in back. Current medications: diclofenac sodium 75mg PO BID, Norco 10/325 PO TID PRN, Tramadol 37.5mg PO TID PRN, baclofen 20mg PO QHS. ROS: musculoskeletal: complained of back pain but denied myalgias. DX: 724.4 lumbar radiculopathy, 847.2 lumbar sprain and strain, 953.2 injury to lumbar nerve root, 781.3 ataxia, 997.91 hypertension nec. Plan: return in 10 days. Claimant needs referral for Accua Therapy ASAP, ref to pain management, refill medications for pain control, Biofreeze for back.

12-17-13: NCV, EMG & RNS. Diagnostic Impression: The is electrodiagnostic study of the lumbar spine and bilateral lower extremities showed EMG findings supportive of left L5 subacute lumbar radiculopathy with mild active denervation, there was no evidence suggestive of peripheral neuropathy, myopathy, neuromuscular junction disorder, or nerve entrapment of bilateral lower extremities.

01-29-14: Lumbar Myelogram. Preoperative diagnosis: lumbar radiculopathy 724.4 with nerve root dysfunction, Postoperative diagnosis: same.

01-29-14: Lumbar and Thoracic Myelogram. Preoperative diagnosis: lumbar radiculopathy 724.4, with nerve root dysfunction. Postoperative diagnosis: same.

01-29-14: CT Post CT Lumbar Myelogram. Impression: 1. A small central disc protrusion with mild spondylosis and moderate4 and disc bulging mildly narrow the lateral recess and central canal at the L5-S1 level. No compression of the traversing SI nerve roots are seen. The neural foramina L5-S1 are mildly stenote without compressing the exiting L5 nerve root sheaths. 2. No canal or foraminal stenosis at L1-2, L2-3, L3-4, or L4-5 is identified. 3. Subtle L5-S1 degenerative retrolisthesis is seen.

04-02-14: Exam Notes. CC: back pain. Medications: Gabapentin, Norco, and Tramadol. PE: Claimant has positive pain with compression of neck (+ Waddles' sign) additionally pain with any leg movement and symptoms inconsistent at one exam pain on right side and another exam pain on the left. Tenderness (excess or widespread reaction), SLR, Regional (widespread give-way or dysesthsia). DX: 847.2 lumbar sprain and strain. Assessment/Plan: Claimant has a lot of widespread pain and some left L5 type pain. Although she has some nonanatomical type pain, she has positive objective findings L>R L5 radiculopathy. This is consistent with CT Myelogram and EMG dated 12/13 and some PE findings. Recommend left LESI L4,5 since surgery was not recommended. Neurosurgery eval needed, will prescribe for short term Norco 7.5/325 BID PRN and Zanaflex 4mg 1-2 QHS and Gabapentin 300mg TID. Recommend Aqua therapy since claimant not able to tolerate land therapy. UDT today. F/U in 1 month or sooner for ESI.

04-16-14: Office Visit. recommended neurosurgery evaluation due to the fact that the claimant has documented radiculopathy. PE: tenderness and decreased

ROM in lumbar spine. DX: 724.4 c – lumbar radiculopathy, 847.2 c-lumbar sprain and strain, 728.85 c-spasm of muscle, 953.2 c-injury to lumbar nerve root, 781.3 c-ataxia. Plan: f/u in one month. Recommend to follow up with a designated doctor and neurosurgeon, continue with pain management and activity with restrictions to continue.

06-23-14: Office Visit. CC: claimant c/o persistent lower back pain that affected her with ADLs, pain located in the lumbar spine, described as aching and sharp. Episodes occur upon awakening with important triggers to include bending, twisting and activity with radiation to hip, severe. PE: musculoskeletal: some tenderness to LS spine. There appears to be magnification of her limited ROM of bilateral shoulders and lower extremities. DX: 724.4 lumbar radiculopathy, 953.2 injury to lumbar nerve root, 781.3 ataxia, 997.91 hypertension nec, 682.9 cellulitis & abscess, unspecified site (left axillary area). RX: Bactrim DS, lisinopril, Norco 7.5/325. Plan: return in 3 weeks, again recommend ortho or neurosurgeon referral and pain management, continue with same restrictions.

07-11-14: MMI. DX: lumbar strain/sprain, herniated nucleus pulposus at L4-S1. MMI: The claimant reached MMI on March 28, 2014. Neurological evaluation performed on 3/27/14 concluded that there is no objective evidence of damage or harm to the physical structure of the claimant's body secondary to her compensable injury. recommended no additional diagnostic studies, physical therapy, work hardening or durable medical equipment. He further stated that there is no objective abnormality that prevented the claimant from returning to full, unrestricted duty as of 3/28/14. On ROM measurements today, the claimant was able to flex to only 10 degrees, yet she was sitting comfortably at 90 degrees. Based primarily on neurological examination, the claimant reached MMI as of 3/28/14.

10-28-14: Progress Note. CC: back pain. Claimant complained of pain in the lower thoracic area and described it as intermittent in quality, aggravated by bending. Pain rated 10/10. PE: Back: there is back abnormality on palpation. Tenderness to palpation, mobility restricted, decreased ROM. Assessment and Plan: lumbar disc disease with radiculopathy 722.10. Plan: advised claimant to follow up with pain and rehab clinic to assess for other modalities of therapy, continue restrictions. Investigate if referral to back surgeon can still be done. ICD: sprain of lumbar region 847.2. RX: Tylenol with codeine #3, cyclobenzaprine 10 mg. F/U in one week.

10-31-14: Subsequent Medical Report. Claimant reported persistent back pain. The carrier is only accepting lumbar sp/st as compensable injury. She reported ongoing back pain with pain referred to the left posterior thigh. Objective Clinical Findings: Claimant ambulated with mild antalgic gait. Examination of the lumbar spine revealed tenderness of the lumbar paraspinals bilaterally. Lumbar ROM are restricted with increase in pain, SLR provoked low back pain. Treatment Plan: refer to MHE, refer to FCE, medications: Tylenol #3 and Flexeril, Work status: claimant is temporarily disabled due to ongoing pain and functional deficit, follow up in 4 weeks.

11-07-14: Behavioral Evaluation Report. Diagnostic Impressions: 307.89 Pain disorder associated with both psychological factors and a general medical condition, 296.22 major depression moderate (injury-related). Treatment Recommendation and Pre-authorization Request: In conclusion, based on the criteria set forth by the ACOEM, ODG, and TWCC guidelines, the claimant is a candidate for a multi-disciplinary pain management program. It is recommended that the claimant participate in 80 hours of a multidisciplinary chronic pain program to insure her the medical benefits that she is entitled and as a concurrent evaluation to assess her compliance and therapeutic response to treatment.

11-07-14: Work Capacity Evaluation. Summary: The claimant's occupational demand requires a Heavy PDL. According to the results of this evaluation, the claimant is currently performing at a Light-Medium PDL, which indicates a moderate functional deficit.

11-07-14: UR. Reason for denial: In this case data presented does not detail prior treatment and noted evaluation for this program does not explain physical findings. Diagnosis is a strain that should have fully resolved months ago and a physical reason for present pain is not presented. While psych treatment may be indicated based on attached, there are no indications based on attached for a multi-disciplinary program. Spoke to who went through the chart but did not clarify pertinent question as to availability of additional direct treatment options. Without additional data to resolve treatment issues and options, request cannot be approved. Spoke to who in turn did a peer to peer. The physician stated claimant had extensive prior PT and medication management but without significant improvement. Claimant has had injections without improvement. stated that claimant had imaging performed that noted discal protrusion at L5/S1 with neuro-compression. Claimant also had prior EMG noting radiculopathy. Claimant has been referred to ortho for consideration of surgery but consult was denied and there was no appeal. These records are not available to confirm all treatment options have indeed been exhausted and that claimant may indeed benefit from surgery. Without additional data to resolve claimant's clinical status and what options if any remain to be considered, cannot recommend a CPMP that does not treat directly the medical impairment.

11-10-14: Request for Preauthorization and Concurrent Review. The claimant suffered injury of the lumbar spine on 08/15/13. She has been treated with medications, therapy, physical rehabilitation, and injection therapy. She has chronic pain, functional deficits, and a secondary depressive reaction. She has been treated with anti-depressant medication. She does not have adequate pain and stress management skills. She needs specific pain and stress management skills. She needs specific pain and stress management training so that she will be more functional while dealing with her pain on a daily basis. She also needs to undergo significant vocational readjustment. Other treatment options have been exhausted. We have recommended that the claimant undergo chronic pain management program to address psychological component of her injury. She

understands that this is the final phase of her treatment, and that upon completion of the CPMP she will undergo evaluation for impairment and return to work. Conclusion: The claimant requires the medical services that are only available in a CPMP in order to treat the psychological component of her injury, achieve clinical MMI, return to gainful employment, and achieve case resolution. We therefore request 80 hours of the chronic pain management program for claimant.

11-20-14: Letter for Reschedule. The referral for the claimant was approved on 11/19/14 and she was scheduled for 11/20/14. Claimant called and cancelled her appointment. At this time the appointment has not been rescheduled.

11-26-14: UR. Reason for denial: First of all, a CPMP is a potential consideration when all other options have been exhausted for care. If there is an ortho appointment planned then one cannot state that there is an absence of other options likely to result in significant clinical improvement. This could imply that surgery is an option in this case. However, the provider did indicate that she is not interested in surgery. Second, the claimant only worked for 2 weeks on their job and despite having a reasonable physical capacity, per the FCE, is still not working 15.5 months post injury date. This FCE was also done 15 months post injury date and if there was deconditioning that would imply that she most likely was capable of returning to her job of injury yet for some reason did not do so. Third, there could be a motivational or other secondary gain issue that is occurring in this case. ODG notes that "There should be documentation that the claimant 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 claimant is aware that successful treatment may change compensation and/or other secondary gains." This person tested out at a light to medium level physical demand level yet did not work for unclear reasons. Not clear that the intensity of this program is needed with this level of functional ability (from a physical perspective) and psychological coping skills and other maneuvers can be taught outside of the scope of this program and the person certainly should be capable of building up their physical demand level (if needed) via home exercise program. Request denied.

01-02-15: Letter of Medical Necessity. Claimant requires the medical services that are only available in a CPMP in order to treat the psychological component of her injury, achieve clinical MMI, return to gainful employment, and achieve case resolution. The carrier has elected to deny our request. We, therefore, appeal the carrier's denial and request authorization of 80 hours of the chronic pain management program for the claimant.

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

Previous adverse determinations are upheld and agreed upon. Chronic pain management programs should be instituted when all other treatment options have been exhausted. It appears that this claimant has the potential for surgical interventional. Additionally, the claimant has not worked post injury despite an

FCE that showed reasonable physical capacity. Per ODG, a central component of CPMP is documented motivation to change, and willingness to change their medication dependence. “There should also be some documentation that the claimant is aware that successful treatment may change compensation and/or other secondary gains.” Given that the claimant did not work despite a clear FCE brings into question the claimant’s motivation for change and thereby the potential success of the CPMP. Therefore, after reviewing the medical records and documentation provided, the request for Chronic Pain Management x 80 hours is non-certified.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> 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</p>
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>
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	<p>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.</p> <p>(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.</p> <p>(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).</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p><u>Inpatient</u> 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</p>
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	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 .
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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)