AccuReview

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[Date notice sent to all parties]: April 7, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 Hours/Units of Chronic Pain Management Program to include CPT Code 97799

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 14 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]:
XX/XX/XX: Emergency Room Visit. CC: GLF injury 2 hours PTA, with stiffness and throbbing to upper shoulders and back region. Claimant stated she fell after slipping on water on the floor, landing on her back. She complained of back pain, right hip pain and left first toe pain. DX: Sprain/Strain to cervical/thoracic/lumbar region, follow up with PCP.

XX/XX/XX: CT Pelvis. Impression: No evidence of acute injury to the pelvis.

XX/XX/XX: CT C-Spine. Impression: 1. No acute osseous abnormality of the cervical spine. 2. No severe degenerative changes within the cervical spine.

XX/XX/XX: CT L-Spine & T-Spine. Impression: No evidence of acute process involving the osseous thoracic or lumbar spine. Degenerative changes as annotated above.

XX/XX/XX: X-Ray L Foot. Impression: No radiographic evidence of an acute osseous abnormality.

XX/XX/XX: Office Visit. CC: back pain that is worsened with bending and twisting. PE: palpation to cervical spine is moderate to severe tenderness with hypertonicity and myospasms seen in musculature, Spurling's testing is provocative for localized neck pain, and cervical ROM is restricted in all planes. The claimant has trouble sitting for duration of the examination due to pain as well as difficulty lying down in supine position. Movements are guarded and minor pain when rising from seated position. Palpation: moderate to severe tenderness was present in all planes. Assessment: Cervical Strain, Lumbar Strain. Plan: Recommend active care to help restore lumbar ROM, mobility, stability and overall functional mechanics by the means of therapeutic exercises and activities as recommended by the ODG.

XX/XX/XX: Cervical Spine, 3 views. Impression: Straightening of usual cervical lordosis suggestive of muscle spasms. Small bilateral C7 cervical ribs noted.

XX/XX/XX: Lumbar Spine, 3 views. Impression: Mild disc space narrowing at L5-S1 along with mild straightening of the usual lumbar lordosis suggestive of muscle spasm.

XX/XX/XX: Office Visit. CC: neck and LBP. Pain is dull and achy at the left shoulder that is aggravated when the arm is raised above the head. Symptoms are persistent and worsening despite conservative management (rest, chiro/PT, analgesics), ADL are significantly limited. The claimant currently depends on analgesics for pain relief. Current medications: Metformin HCL, ibuprofen. PE: neurological exam: palpable tenderness noted at the mid-line of the C/L spine and at left shoulder. Weakness of left arm, 4/5 strength, decreased ROM left shoulder with limited ROM above 90 degrees and pain on ROM of cervical and lumbar spine. Pain 4-6/10. + Neer's on the left, + Hawkin's on Left, and + Empty can's test on left. Assessment: Claimant presented with persistent and worsening symptoms of neck pain, LBP, and left shoulder pain s/p work-related injury. These injuries and symptoms are as a result of incident as patient was free of these injuries and symptoms prior to the incident. Claimant is currently receiveing conservative therapy with chiro/PT; therefore, will plan to continue with additional conservative therapy. Re-eval in 4 weeks and consider interventions if symptoms persist. Plan: conservative management, pain cream prescribed and RX for Mobic, continue chiro/PT for 4-6 weeks, re-evaluation 4 weeks.

XX/XX/XX: Office Visit. CC: neck, left shoulder pain and LBP. Symptoms are persistent and ADL is still limited. The claimant currently depends on analgesics for pain relief. Current medications: Metformin HCL, ibuprofen. PE: neurological exam: palpable tenderness noted at the mid-line of the C/L spine and at left shoulder. Weakness of left arm, 4/5 strength, decreased ROM left shoulder with Lt shoulder abduction <60 degrees with severe pain, Pain 2-8/10. + Neer's on the left, + Hawkin's on Left, and + Empty can's test on left. Assessment: Traumatic arthropathy, shoulder region 716.11, Pain in joint, ankle and foot 719.47, rotator cuff sprain and strain 840.4, and plantar fascial fibromatosis 728.71. Claimant presented with persistent neck pain, LBP, and left shoulder pain with injuries suspected. Therefore, will recommend MRI of Left Shoulder without contrast, Norco and Zanaflex, UDS for med compliance and continue PT for next 4-6 weeks, RTC in 2 weeks.

XX/XX/XX: Office Visit. CC: neck, left shoulder pain and LBP. Symptoms are persistent and ADL is still limited. The claimant currently depends on analgesics for pain relief with pain 9/10 on VAS. Current medications: Metformin HCL, ibuprofen, Norco, and Zanaflex. PE: neurological exam: Weakness of left arm, 4/5 strength, palpable tenderness noted at the mid-line of the C/L spine and at left shoulder with decreased ROM left shoulder and left shoulder abduction <60 degrees with severe pain. Assessment: Pain in joint, ankle and foot 719.47, rotator cuff sprain and strain 840.4. Claimant presented with persistent neck pain, LBP, and left shoulder pain with injuries suspected. Therefore, will recommend MRI of Left Shoulder without contrast, Norco and Zanaflex, UDS for med compliance and continue PT for next 4-6 weeks, RTC in 2 weeks.

XX/XX/XX: Initial Interview. DSM-IV: Axis I 307.89 pain disorder with Both Psychological Factors and a General Medical Condition, ACUTE; Axis II V71.09 Deferred; Axis III 847.0, 847.2; Axis IV: Pain, job concerns, financial struggles, multiple social losses, and problems with family; Axis V: GAF=60. Treatment Recommendations: It is recommended to continue with medical lines of treatment and assist the claimant with her recovery. Claimant should participate in a work hardening program in order to better facilitate her reconditioning and return to work. She should be re-evaluated for chronic pain, depression, anxiety, and psychosocial functioning if she continues to have difficulty or she develops new symptoms of emotional difficulty.

XX/XX/XX: FCE. Summary/Discussion: The results of FCE on this date revealed that she is unable to safely and dependably return to the usual and customary duties of a special education teacher and reported pain at 4/10 in neck described as constant throbbing, aching pain with reported frequent numbness and tingling in the left upper extremity. Manual muscle tests of the upper extremities were done to monitor nerves in the neck. The claimant demonstrated restricted ROM of the cervical spine and a strength deficit in the left shoulder, elbow and wrist when compared bilaterally. The claimant reported low back pain described as frequent achy pain and increased with sudden movements of the lumbar spine, and with prolonged sitting, standing and walking. After the NIOSH Static Lift Tests, the claimant reported increased neck pain and the Dynamic Lift Tests were suspended due to neck pain, fatigue, and the claimant reaching his/her maximum lift ability. Overall, the claimant demonstrated the ability to safely and

dependably perform at a sedentary PDL, which fails to meet the minimum job requirements.

XX/XX/XX: Office Visit. CC: neck pain, left shoulder pain and LBP. Symptoms are persistent though being managed conservatively; ADL limited and continues to be dependent on analgesics for pain. Current medications: Metformin HCL, ibuprofen, Norco, and Zanaflex. PE: musculoskeletal exam: wearing a left shoulder sling, paravertebral muscle tenderness is present throughout C/L spine and left shoulder, decreased ROM of the left shoulder with pain and left shoulder abduction and flexion <30 degrees with severe pain. Assessment: Pain in joint, shoulder region 719.47. Claimant presented with persistent neck pain, LBP, and left shoulder pain, however symptoms are manageable conservatively. Therefore, will plan to continue with additional conservative therapy and re-evaluate in 4 weeks.

XX/XX/XX: Office Visit. CC: neck pain, left shoulder pain and LBP. Symptoms are persistent though being managed conservatively; ADL limited and continues to be dependent on analgesics for pain. Current medications: Metformin HCL, ibuprofen, Norco, and Zanaflex. PE: musculoskeletal exam: paravertebral muscle tenderness is present throughout C/L spine and left shoulder, decreased ROM of the left shoulder with pain and limited ROM on lumbar spine. Assessment: Pain in joint, shoulder region 719.47. Claimant presented with persistent neck pain, LBP, and left shoulder pain, however symptoms are manageable conservatively. Therefore, will plan to continue with additional conservative therapy and re-evaluate in 4 weeks.

XX/XX/XX: PPE. Summary/Discussion: The results of PPE on this date revealed that she is unable to safely and dependably return to the usual and customary duties of a special education teacher and reported pain at 3/10 in neck described as constant throbbing, burning, and shooting pain with reported radiating down to left shoulder and frequent numbness and tingling in the left upper extremity. Manual muscle tests of the upper extremities were done to monitor nerves in the neck. The claimant demonstrated restricted ROM of the cervical spine and a strength deficit in the left shoulder, elbow and wrist when compared bilaterally. The claimant reported low back pain described as frequent achy pain and increased with sudden movements of the lumbar spine, and with prolonged sitting, standing and walking. After the NIOSH Static Lift Tests, the claimant reported neck pain as burning, shooting, and aching pain and the Dynamic Lift Tests were suspended due to neck pain, fatigue, and the claimant reaching his/her maximum lift ability. Overall, the claimant demonstrated the ability to safely and dependably perform at a light PDL, which fails to meet the minimum job requirements.

XX/XX/XX: Progress Summary. Impressions: The interviewer feels that there is a strong indication that the claimant is experiencing pain that is creating interference in her life. It appears as though she is having long-term adjustment problems of depression and anxiety which are secondary to her work-related injury. The following diagnosis is based on the information reported by the claimant and the clinician's observation: DSM-IV: Axis I 307.89 pain disorder with Both Psychological Factors and a General Medical Condition; Axis II V71.09 Deferred; Axis III 847.0, 847.2; Axis IV: Chronic Pain, job concerns, financial struggles, multiple social losses, and problems with family; Axis V: GAF=60. Treatment Recommendations: It is recommended to continue with medical lines of treatment and assist the claimant with her recovery. Claimant should participate in a work hardening program in order to better facilitate her reconditioning and return to work. She should be re-evaluated for chronic pain, depression, anxiety, and psychosocial functioning if she continues to have difficulty or she develops new symptoms of emotional difficulty.

XX/XX/XX: Office Visit. CC: neck pain, left shoulder pain and LBP. Symptoms are persistent though being managed conservatively, pain 5/10; ADL limited and continues to be dependent on analgesics for pain. Current medications: Metformin HCL, ibuprofen, Norco, and Zanaflex. PE: musculoskeletal exam: paravertebral muscle tenderness is present throughout C/L spine and left shoulder, decreased ROM of the left shoulder with pain and limited ROM on lumbar spine, weakness in left arm. Assessment: Sprain of ligaments of thoracic spine, initial encounter S23.3, Sprain of ligaments of lumbar spine, initial encounter S33.5, Pain in joint, shoulder region 719.47. Claimant presented with persistent neck pain, LBP, and left shoulder pain, PE reveal no change, therefore, will plan to continue with additional conservative therapy and re-evaluate in 4 weeks.

XX/XX/XX: MRI cervical spine without contrast. Impression: 1. Central 3 mm disc protrusion/herniation at C3-4 creating effacement of the cord without significant nerve root compromise. 2. Broad-based annular bulges at C5-6 and C6-7. 3. Straightening of the usual cervical lordosis suggestive of muscle spasm.

XX/XX/XX: MRI lumbar spine without contrast. Impression: 1. Disc space narrowing with central 3-4 mm disc protrusions/herniation at L4-5 and L5-S1 with annular fissures and facet hypertrophy creating effacement of the thecal sac with some mild bilateral L5 and S1 nerve root encroachment, respectively. 2. Straightening of the usual lumbar lordosis suggestive of muscle spasm.

XX/XX/XX: FCE. Summary/Discussion: The results of FCE on this date revealed that she is unable to safely and dependably return to the usual and customary duties of a special education teacher and reported pain at 6-7/10 in neck and low back described as constant throbbing, burning, and shooting pain with reported radiating pain, numbness and tingling in the left arm. Manual muscle tests of the upper extremities were done to monitor nerves in the neck. The claimant demonstrated restricted ROM of the cervical and lumbar spine and a strength deficit in the left shoulder, left grip, and left ankle when compared bilaterally. After the NIOSH Static Lift Tests, the claimant reported increased neck and low back pain; described back pain as aching and neck pain as shooting pain and the Dynamic Lift Tests were suspended due to increased neck and low back pain, muscular fatigue, and the claimant reaching his/her maximum lift ability. Overall, the claimant demonstrated the ability to safely and dependably perform at a Medium PDL, which fails to meet the minimum job requirements.

XX/XX/XX: Office Visit. CC: neck pain, still persistent pain radiates from her neck to her left shoulder; 7/10. The pain increase with repetitive motions and she continued to participate in an active supervised rehabilitation program which she received minimal improvement of neck pain. Current medications: Metformin HCL, ibuprofen, Norco, Zanaflex, and Antibiotic. PE: Musculoskeletal and neurological examination: Paravertebral muscle tenderness is present throughout the cervical spine. Cervical ROM is limited due to pain. Decreased sensation at C4 dermatome. Weakness of left shoulder abduction and left wrist extension 4/5. Positive Spurling Test @ bilateral C4. Assessment: Other cervical dis displacement, mid-cervical region M50.22, Radiculopathy, cervical region M54.12. Plan: Cervical ESI #1 @ C6-7, RX: zanaflex and norco, continue chiro/PT for the next 4-6 weeks, RTC 2 weeks.

XX/XX/XX: Requested Program: Chronic Pain Management Program. Initial Recommendation: After completion of approved individual and group psychotherapy sessions, I am recommending that this claimant participate in our Multidisciplinary CPMP to aid the claimant in dealing with depression, anxiety, and pain symptoms associated to both psychological factors and a general medical condition, and chronic pain. Claimant has completed approved sessions of psychotherapy and PT exercises; unfortunately, claimant was noted making minimal progress, due on large part to poor coping skills, anxiety, depression, and pain complaints. Claimant has been compliant with our clinic's treatment guidelines and has demonstrated minimal progress. Please consider this as a request for 10 sessions of MCPMT, thus awarding this claimant the opportunity to participate in a program that will enable her to make a successful transition to a higher level of functioning and return to work. Summary: The pain resulting from her injury has severely impacted normal functioning physically and interpersonally. Claimant reported frustration and anger related to the pain and pain behavior, in addition to decrease the ability to manage pain. Pain has reported high stress resulting in all major life areas. The claimant will benefit from a course of pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning. Claimant should be treated daily in pain management program with both behavioral and physical modalities as well as medication monitoring. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consists of, but is not limited to daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting, and returning to a higher level of functioning as possible. Evaluation Summary: The claimant received functional evaluation which revealed significant physical limitations and is a good candidate for CPMP. DX: sprain of joints and ligaments of other part neck, initial encounter; sprain of ligaments of lumbar spine, initial encounter; adjustment disorder with mixed anxiety and depressed mood. Findings: Her listed diagnosis, chronic pain, and adjustment difficulties are causally related to her work related injury; Significant functional limitations and de-conditioning status that require medical, rehabilitative, psychological, social, and vocational changes; Psychosocial problems connected with chronic pain, job concerns, social losses, problems with family, and financial struggles which appeared secondary to her work related injury; Motivation and mental capacity to make added progress; BDI-II 19, BAI 16, FABQ P=24/24, W=42/42. Medications: Tramadol. All treatments will focus on teaching/training her to live more effectively with her pain and to move her out of a condition of disability.

XX/XX/XX: UR. Reason for denial: A review of the case notes that the claimant recently completed 160 hours of a work hardening program which XX acknowledged. He reported that she made progress in the program but is not at her required PDL and has ongoing issues of depression and anxiety. She has a return to work. Given that this claimant recently completed a work hardening program and psychotherapy, the necessity for a chronic pain management program is not established, per evidence-based guidelines.

XX/XX/XX: Request for Reconsideration. The participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program is otherwise indicated per ODG. In addition, the claimant, as a XX is required to perform and work at a HEAVY PDL. Recent PPE on XX objectively showed that she demonstrated the ability to safely and dependably perform at a MEDIUM, which fails to meet the minimum job requirement for her work position as a XX. In addition, the claimant continues to display psychosocial issues, rely on prescription medication for pain relief, and exhibit functional deficits which all meet the requirements for a multidisciplinary pain management program.

XX/XX/XX: UR. Reason for denial: The request was previously noncertified, noting the claimant's prior BDI and BAI scores improved with individual psychotherapy; the claimant was functioning at a medium PDL; and had completed 160 hours of work hardening and would likely not produce any additional progress with CPMP at this time. The request remains noncertified. Additional documentation included the reconsideration letter from the requesting provider dated XX/XX/XX. There is documented improvement with prior work hardening and there is lack of substantial documentation of deficits that would warrant the medical necessity for repetition of additional chronic programs. Reenrollment in the same or similar rehabilitation programs are not routinely recommended by the guidelines. There is documentation of improvement with treatment rendered to date, with lack of substantial documentation indicating a chronic pain management program would result in any additional recovery at this time. I discussed the case with XX. He was unable to provided additional clinical information to warrant the request. The reconsideration request for 80 hours of CPMP is not certified.

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

Previous request was noncertified based on the claimant's prior BDI and BAI scores improved with individual psychotherapy; the claimant was functioning at a medium PDL; and had completed 160 hours of work hardening and would likely not produce any additional progress with Chronic Pain Management Program at this time. Additional documentation included the reconsideration letter from the requesting provider dated XX/XX/XX. There is documented improvement with prior work hardening but there lacks substantial documentation of deficits that would justify medical necessity for repetition of additional chronic programs. Per guideline, reenrollment in the same or similar rehabilitation programs is not recommended. There is documentation of improvement with treatment rendered to date, with lack of substantial documentation indicating a chronic pain management program would result in any additional recovery at this time. Therefore, after review of the medical records and documentation provided, the request for 80 Hours/Units of Chronic Pain Management Program to include CPT Code 97799 is denied.

Per ODG:

Chronic pain programs (functional restoration programs)	**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 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)**