Policy: **Medical Necessity Decision Assist Guideline for Musculoskeletal Conditions and Somatic / Neuropathic Pain Disorders**

Date of Implementation: **February 5, 2004**

Product: **Specialty**

Medical necessity evaluations, especially for musculoskeletal conditions and somatic / neuropathic pain disorders**,** require approaching the clinical data and scientific evidence from a global perspective, synthesizing the various elements into a congruent clinical picture. This American Specialty Health – Specialty (ASH) Clinical Practice Guideline (CPG) provides a comprehensive overview of ASH Medical Necessity Decision Assist Guidelines for the following:

- Verifying that services submitted for an initial trial of care meet the definition of Medical Necessity;
- Verifying that services submitted for continuing care meet the definition of Medical Necessity;
- Denial of coverage of services submitted for not meeting the definition of Medical Necessity; and
- Identifying cases suggesting the need for referral or coordination of care.

Please note: Client exceptions to ASH clinical practice guidelines can be found at http://www.ashcompanies.com/Providers/CQM/PayorExceptions.aspx.

Definitions of Key Terminology

Medical Necessity

ASH clinical quality evaluators evaluate medical necessity of services consistent with the definition of medical necessity adopted by ASH Quality Oversight Committee as reflected in ASH policy Medical Necessity Definition - UM 8.

Musculoskeletal Conditions

Illness, injury or disease involving the connective and/or contractile tissues of the body, including bone, joint, ligament, muscle, tendon and fascia.

Somatic / Neuropathic Pain Disorders

Injury, illness, or disease of the musculoskeletal system and pain-related disorders that produce somatic or neuropathic pain responses. Somatic pain is caused by the activation of pain receptors in the cutaneous tissues (skin), connective tissues, or deep tissues (muscle, tendons, ligaments). When it occurs in the musculoskeletal tissues, it is called deep somatic pain. Deep somatic pain is usually described as dull or aching and may be localized or

referred. Examples of deep somatic pain include trigger points and myofascial pain syndromes. Surface somatic pain is usually sharper and may have a burning or pricking quality. Common causes of surface somatic pain include post-surgical pain or pain related to a laceration. Neuropathic pain is a neurological disorder resulting from damage to nerves that carry information about pain. Neuropathic pain is reported to feel different from somatic or visceral pain and is often described as "shooting", "electric", "stabbing", or "burning". It may be felt traveling along a nerve path from the spine into the arms and hands or into the buttocks, legs, or feet. Examples of neuropathic pain conditions include radiculopathies, neuralgias, failed back syndrome, complex regional pain syndrome, arachnoiditis, and painful neuropathies (e.g., diabetes or alcohol related).

Elective/Convenience Services

Examples of elective/convenience services include: (a) preventive services; (b) wellness services; (c) services not necessary to return the patient to pre-illness/pre-injury functional status and level of activity; (d) services provided after the patient has reached Maximum Therapeutic Benefit. (Elective/convenience services may not be covered through ASH benefits) (See ASH policy Medical Necessity Definition - UM 8.)

Preventive Services

Preventive services are designed to reduce the incidence or prevalence of illness, impairment, and risk factors, and to promote optimal health, wellness, and function. These services are not designed or performed to treat or manage a specific health condition. (*Preventive services* may not be covered under specific clients or through ASH benefits.)

Chiropractic Maintenance Therapy Services

Chiropractic maintenance therapy services is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. As defined by Medicare, when further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. Other health care plan benefits may cover supportive care if the supportive care criteria defined in the Supportive Care definition below are met. (Chiropractic maintenance therapy services are not covered through ASH benefits).

Skilled Maintenance Therapy Services

Skilled maintenance therapy services are where individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified physical or occupational therapist or speech language pathologist are necessary to maintain the patient's current condition or to prevent or slow further deterioration. Such a maintenance program must demonstrate the need for a skilled professional to ensure the services are safe and effective to improve, maintain or slow deterioration of a patient's

condition. Maintenance care may involve periodic withdrawals of treatment, decreased frequency of care, and/or periodic follow up with the skilled professional to reassess the patient's condition and to update and/or modify the treatment plan.

Supportive Care Services

Supportive care is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic withdrawals of treatment. Supportive care follows appropriate application of passive and active care including rehabilitation and lifestyle modifications. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and lifestyle modifications, have been considered and attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when the risk of supportive care outweighs its benefits, e.g., physician dependence, somatization, illness behavior, or secondary gain. (Supportive care may not be covered through ASH benefits. Client exceptions to ASH clinical guidelines may be found at http://www.ashcompanies.com/Providers/CQM/PayorExceptions.aspx.)

Minimal Clinically Important Difference (MCID)

The MCID is the minimal amount of change in a score of a valid outcome assessment tool that should be considered to indicate an actual improvement in the patient's function or pain. This is a statistical number which has been validated and is reproducible with the scale. The MCID for the Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is 6. (Fairbank & Pynsent, 2000; Fritz & Irrgang, 2001) The MCID for the Neck Disability Index (NDI) is from 5-7 points, or 10-14 percent. (Vernon, 1991; Cleland, 2008) The original psychometrics of the Disabilities of the Arm and Shoulder (DASH) suggests an MCID of 15 points. (Solway, 2002) However, current literature suggests a MCID of approximately 10 points may be acceptable. (Dawson, 2008, Roy, 2009) The Lower Extremity Functional Scale (LEFS) has a 9 point MCID (Binkley, 1999) and studies suggest that the MCID for an 11 point (0-10) numeric pain scale is 2 points. (Childs, 2005, Cleland, 2008)

Maximum Therapeutic Benefit (MTB)

MTB is the patient's health status when the application of the present treatment regimen has achieved its full potential. Continuation of the same treatment approach will not significantly improve the patient's impairments and function during this episode of care.

If the patient's condition has reached MTB, and the patient continues to have significant complaints, impairments, and documented functional limitations, one should consider the following:

- Altering the treatment regimen. Such as, utilizing a different physiological approach to the treatment of the condition or withdrawal of predominately passive care (modalities, massage etc.) and increase the active care (therapeutic exercise) aspects

of treatment to attain greater functional gains;
- Reviewing self-management program including home exercise programs;
- Referring the patient for consultation by another health care practitioner for possible co-management or a different therapeutic approach; and/or
- Reviewing the clinical status of the case to determine if supportive care is necessary.

Acute
The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is less than six weeks in duration, typically characterized by the presence of one or more signs of inflammation or other adaptive response.

Sub-Acute
The stage of an injury, illness or disease, in which the presence of clinical signs and symptoms is greater than six weeks, but not greater than twelve weeks in duration.

Chronic
The stage of an injury, illness or disease, in which the presence of clinical signs and symptoms is greater than twelve weeks in duration.

Red Flag(s)
Signs and symptoms presented through history or examination/assessment that warrant more detailed and immediate medical assessment and/or intervention.

Yellow Flag(s)
Adverse prognostic indicators with a psychosocial predominance associated with chronic pain and disability. Yellow flags signal the potential need for more intensive and complex treatment and/or earlier specialist referral.

Co-Morbid Condition(s)
The presence of a concomitant condition, that has an unrelated pathology or disease process, but may inhibit, lengthen, or alter in some way the expected response to care.

Factors influencing Medical Necessity Determinations
***Clinical Service(s) Approval*:**
- Condition(s) is/are likely to respond favorably to services submitted for review;
- No evidence of contraindication to services submitted for review;
- Documentation supports practitioner's diagnosis and treatment plan;
- Maximum therapeutic benefit has **not** been reached; and
- Demonstration of progression toward active home/self care and discharge.

***Clinical Service(s) Adverse Determinations (Partial or Full)*:**
- Lack of documentation to support the diagnosis;

- Outdated exam findings (> 30 days);
- Complaints and symptoms are not clearly described;
- Treatment/therapy is inappropriate or unrelated to the condition/diagnosis;
- Discrepancy between complaints and/or description of severity and/or evaluation findings as documented by practitioner and member;
- Inaccurate reporting of clinical findings;
- Realistic, measurable, and evidence-based therapeutic goals have not been documented;
- There is prolonged reliance on passive care which is not supported by the clinical literature;
- Home care, self-care, and active-care instructions are not documented;
- Identification of absolute or relative contraindications to care (co-morbid conditions or red flags such as, history of stroke or transient ischemic attacks [TIAs], progressive spondylolisthesis, uncontrolled hypertension, inflammatory arthritis, joint hyper-mobility, bone tumors, osteopenia/osteoporosis, bleeding disorders or anticoagulant therapy);
- Signs, symptoms and/or other pertinent information presented through history and/or physical examination and/or response to care requiring urgent attention, further testing, and/or possible specialist referral;
- Signs, symptoms and/or other pertinent information presented through history and/or physical examination that requires a referral to another health care practitioner for co-management and practitioner refuses to refer;
- Initial trial of care has not demonstrated significant clinical improvement;
- Preventive services, chiropractic maintenance therapy service or elective/convenience services;
- Case requires referral to the referring or appropriate physician or other health care practitioner;
- Clinically significant therapeutic progress (MCID, improvement in pain, impairments and objective evaluation findings) is not evident through assessment of the records submitted, indicating Maximum Therapeutic Benefit has been reached;
- Patient has returned to pre-clinical status or has been unresponsive to care; and
- Evidence of treatment dependency and/or presence of Yellow Flags.

Clinical Review Factors Critical to Utilization Management Decision-Making for Musculoskeletal Conditions and Somatic / Neuropathic Pain Disorders

Assessment of Red Flags

The red flag approach is utilized broadly in patient care. At any time the patient is under care, the practitioner is responsible for seeking and recognizing signs and symptoms that require additional diagnostics, treatment/service, and/or referral. This crucial ongoing process is necessary to discover potential serious underlying conditions that may need urgent attention. Red flags can present themselves at several points during the patient encounter and can

appear in many different forms. If a red flag is identified during a medical necessity review, the reviewer should communicate with the provider of services as soon as possible by telephone and/or through standardized communication codes. Recommend referral of the member to the referring or other appropriate physician or other appropriate health care practitioner with the measure of urgency as warranted by the history and clinical findings.

Due to the rarity of actual red flag diagnoses in clinical practice, it is emphasized that the practitioner does not need to perform expensive or invasive diagnostic procedures (e.g., x-ray, imaging, laboratory studies) in the absence of suspicious clinical characteristics. As an example, there is no need to screen the patient for red flag conditions by taking x-rays of the lower back if the initial presentation emerges as simple mechanical low back pain absent of red flag characteristics. Important red flags and events as well as the points during the clinical encounter at which they are likely to appear include:

Past or Current History

- Personal or family history of cancer;
- Current or recent urinary tract, respiratory tract, or other infection;
- Anticoagulant therapy or blood clotting disorder;
- Metabolic bone disorder (osteopenia and osteoporosis);
- Unintended weight loss;
- Unexplained dizziness or hearing loss;
- Trauma with skin penetration; and
- Immunosuppression (AIDS/ARC).

Present Complaint

- Writhing or cramping pain;
- Precipitation by significant trauma;
- Pain worse at night or not relieved by any position;
- Suspicion of cerebrovascular compromise; and
- Symptoms indicative of progressive neurological disorder.

Physical Examination/Assessment

- Pulsing abdominal mass;
- Fever, chills, or sweats without other obvious source;
- New or recent neurologic deficit (special senses, sensory, language, and motor);
- Positive cerebrovascular screening tests (carotid / vertebrobasilar insufficiency);
- Uncontrolled hypertension;
- Signs of nutritional deficiency;
- Signs of allergic reaction;
- Abuse/neglect; and
- Psychological distress.

Pattern of Symptoms Not Consistent with Benign Disorder

- Chest tightness, difficulty breathing, chest pain;
- Headache of morbid proportion;
- Rapidly progressive neurological deficit;
- Significant, unexplained extremity weakness or clumsiness;
- Change in bladder or bowel function;
- Numbness or paresthesia; and
- New or recent bilateral radiculopathy.

Lack of Response to Appropriate Care

- History of consultation/care from a series of practitioners or a variety of health care approaches without resolving the patient's complaint;
- Unsatisfactory clinical progress, especially when compared to apparently similar cases or natural progression of the condition; and
- Signs and symptoms that do not fit the normal pattern and are not resolving.

Assessment of Yellow Flags

When yellow flags are present, clinicians need to be vigilant for deviations from the normal course of illness. Examples of yellow flags include depressive symptoms, injuries still in litigation, signs and symptoms not consistent with pain severity, and behaviors incongruent with underlying anatomic and physiologic principles.

If a yellow flag is identified during a medical necessity review, the reviewer should communicate with the provider of services as soon as possible by telephone and/or through standardized communication codes. Recommend referral of the member to referring or appropriate physician or other health care practitioner as appropriate.

Guide for Determining Condition Severity

The severity of the musculoskeletal condition and/or somatic / neuropathic pain disorder is considered when determining an appropriate therapeutic trial. The following table outlines the primary historical and examination factors that are considered by the clinical quality evaluator in determining condition severity.

Table A: Guide for determining condition severity based on various historical and examination factors as reported through information submitted for review

Severity → / Factors ↓	**Mild**	**Moderate**	**Severe**

Severity of Pain (1–10 scale)	1–4	5–7	8–10
Frequency of Pain	Occasional	Intermittent or frequent	Constant
Activities of Daily Living (ADLs)	Minimal or no effect on ADLs	May have some effect on ADLs	Considerable effect on ADLs
Self Rating of Effect on ADLs (1-10)	1–4	5–7	8–10
Exam Findings:	Consistent with mild severity:	Consistent with moderate severity:	Consistent with severe conditions:
1) Range of Motion	1) Mild or no loss	1) Mild to moderate loss	1) Considerable or excessive loss
2) Palpatory Tenderness	2) Mild to moderate	2) Moderate to marked	2) Marked or severe
3) Neurologic Findings	3) None	3) None	3) May be present
4) Orthopedic Testing	4) Variable	4) Variable	4) Positive findings with pain

Historical Factors and Initial Health Status

- Mechanism of onset and date of onset are appropriate for musculoskeletal conditions and/or somatic / neuropathic pain disorders etiology;
- Past history of musculoskeletal injuries and/or somatic / neuropathic pain disorders and response to care does not contraindicate services submitted for review;
- Past history of pertinent related and unrelated medical conditions does not contraindicate services submitted for review;
- Chief complaint(s) have musculoskeletal and/or somatic / neuropathic pain disorder component(s) likely to respond favorably to services submitted for review;
- Provocative and palliative factors indicate the presence of musculoskeletal conditions and/or somatic / neuropathic pain disorders etiology;
- Limitations to Activities of Daily Living (ADLs) are appropriate for the presence of musculoskeletal conditions and/or somatic/neuropathic pain disorders;
- Severity, frequency and quality of pain are appropriate for the presence of musculoskeletal condition(s) and/or somatic / neuropathic pain disorder(s);
- Past history of the same or similar condition indicates a favorable response to care; and
- Absence or presence of co-morbid condition(s) (e.g., history of stroke or TIAs, progressive spondylolisthesis, uncontrolled hypertension, inflammatory arthritis, joint hyper-mobility, bone tumors, osteopenia, bleeding disorders or anticoagulant therapy) that represent relative contraindications to care.

Examination Factors

- Examination procedures and level of complexity, intensity are appropriate for the chief complaint and historical findings;
- Objective palpatory, orthopedic, neurologic, and other physical examination findings are appropriately documented, including the nature, extent, severity, character, and significance of the finding in relation to the chief complaint and differential diagnosis;
- Examination findings provide evidence of musculoskeletal component(s) likely to respond favorably to services submitted for review;
- Examination findings provide a reasonable and reliable basis for the stated diagnosis; and
- Examination findings provide a reasonable and reliable basis for treatment planning, taking into account variables such as age, sex, physical conditioning, occupational and recreational activities, co-morbid conditions, etc.

Treatment Planning Factors

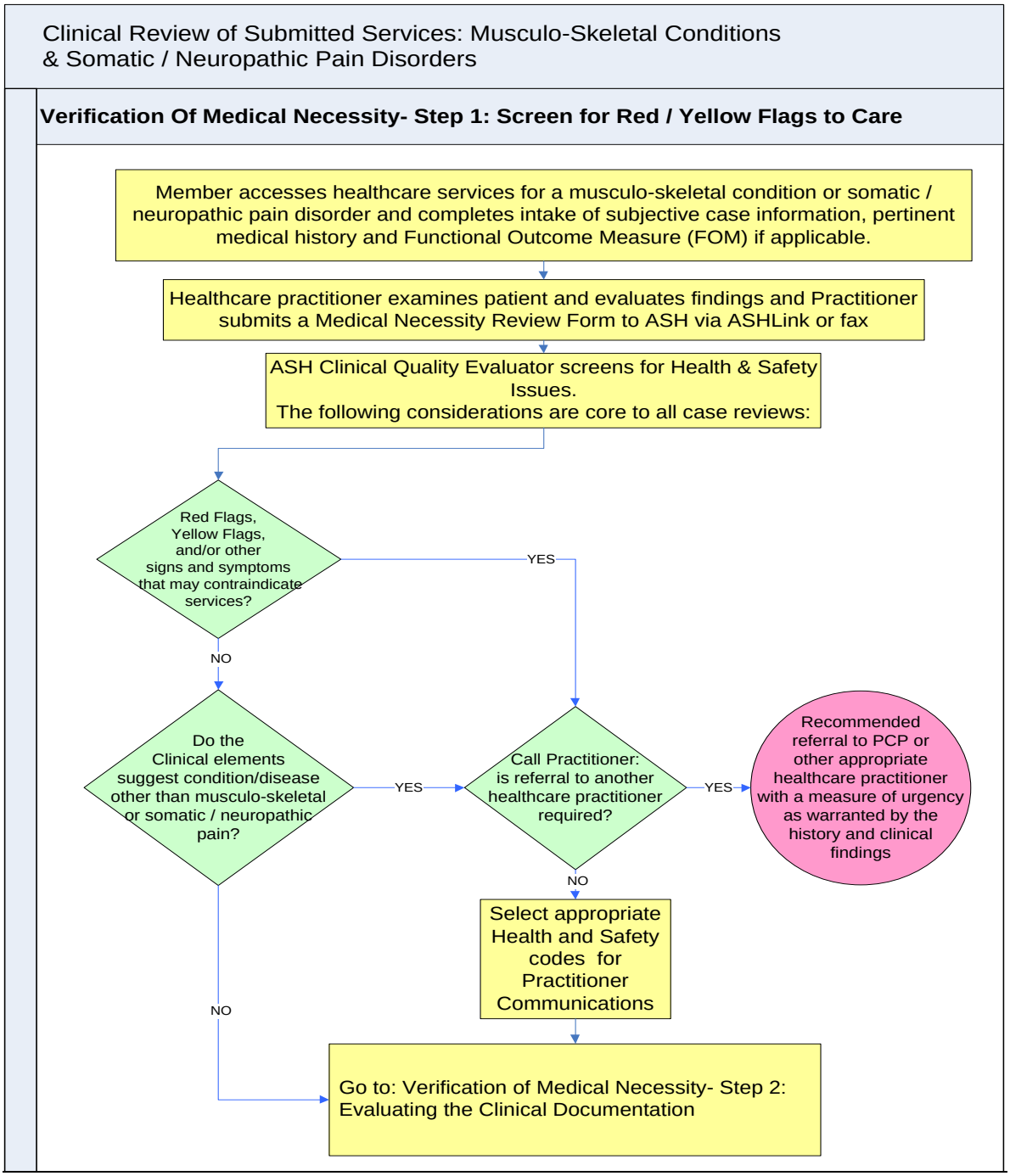
- Dosage (frequency and duration of service) is appropriately correlated with clinical findings and clinical evidence;
- Therapeutic goals are functionally oriented, realistic, measurable, evidence-based;

- Proposed date of release/discharge from treatment is clearly defined;
- Treatment/therapy type and relationship to condition and goals are appropriate;
- Functional Outcome Measures (FOM), when used, demonstrates minimal clinically important difference (MCID) from baseline results through periodic re-assessments during the course of care. This is important in order to determine the need for continued care, the appropriate frequency, estimated date of release from care, and if a change in the treatment plan or a referral to an appropriate health care practitioner is indicated. Not all outcome measures have MCID's determined and supported in the literature. Actual significance of these findings requires correlation with the overall clinical presentation, including updated subjective and objective examination findings;
- Home care, self-care, and active-care instructions are documented; and
- Durable Medical Equipment (DME), supplies, and supports are provided when medically necessary and appropriately correlated with clinical findings and clinical evidence.

Diagnostic Imaging or Special Study (e.g., CT, MRI, EMG, NCV, Other Laboratory Studies)

- Laboratory tests are performed only when medically necessary to improve diagnostic accuracy and treatment planning. Abnormal values are interpreted as they relate to the chief complaint or to unrelated co-morbid conditions that may or may not be contraindications to proposed treatment plan;
- X-ray procedures are performed only when medically necessary to improve diagnostic accuracy and treatment planning. *(Indicators from history and physical examination indicating the need for x-ray procedures are described in ASH policy X-Ray Guidelines – CPG 1)*;
- Advanced imaging studies, when medically necessary and/or available, are evaluated for structural integrity and to rule out osseous or related soft tissue pathology;
- EMG and NCV studies, when medically necessary and/or available, are evaluated for objective evidence of neural deficit;
- Imaging or special studies' findings are consistent with a musculoskeletal condition or somatic / neuropathic pain disorder; and
- Imaging or special studies' findings support a reasonable basis for the treatment submitted.

The following algorithms and informational tables provide the clinical elements considered by the clinical quality evaluator when reviewing clinical documentation submitted by a treating practitioner. A single symptom or clinical finding, in isolation, generally will not define the appropriate approval or denial of services. The entire clinical picture must be taken into account. Specific contraindications to proposed interventions may result in denial of submitted services.


Clinical Review of Submitted Services: Musculo-Skeletal Conditions & Somatic / Neuropathic Pain Disorders
Verification Of Medical Necessity- Step 1: Screen for Red / Yellow Flags to Care
Member accesses healthcare services for a musculo-skeletal condition or somatic / neuropathic pain disorder and completes intake of subjective case information, pertinent medical history and Functional Outcome Measure (FOM) if applicable.
Healthcare practitioner examines patient and evaluates findings and Practitioner submits a Medical Necessity Review Form to ASH via ASHLink or fax
ASH Clinical Quality Evaluator screens for Health & Safety Issues.
The following considerations are core to all case reviews:
Red Flags, Yellow Flags, and/or other signs and symptoms that may contraindicate services?
YES
NO
Do the Clinical elements suggest condition/disease other than musculo-skeletal or somatic / neuropathic pain?
YES
Call Practitioner: is referral to another healthcare practitioner required?
YES
Recommended referral to PCP or other appropriate healthcare practitioner with a measure of urgency as warranted by the history and clinical findings
NO
Select appropriate Health and Safety codes for Practitioner Communications
NO
Go to: Verification of Medical Necessity- Step 2: Evaluating the Clinical Documentation

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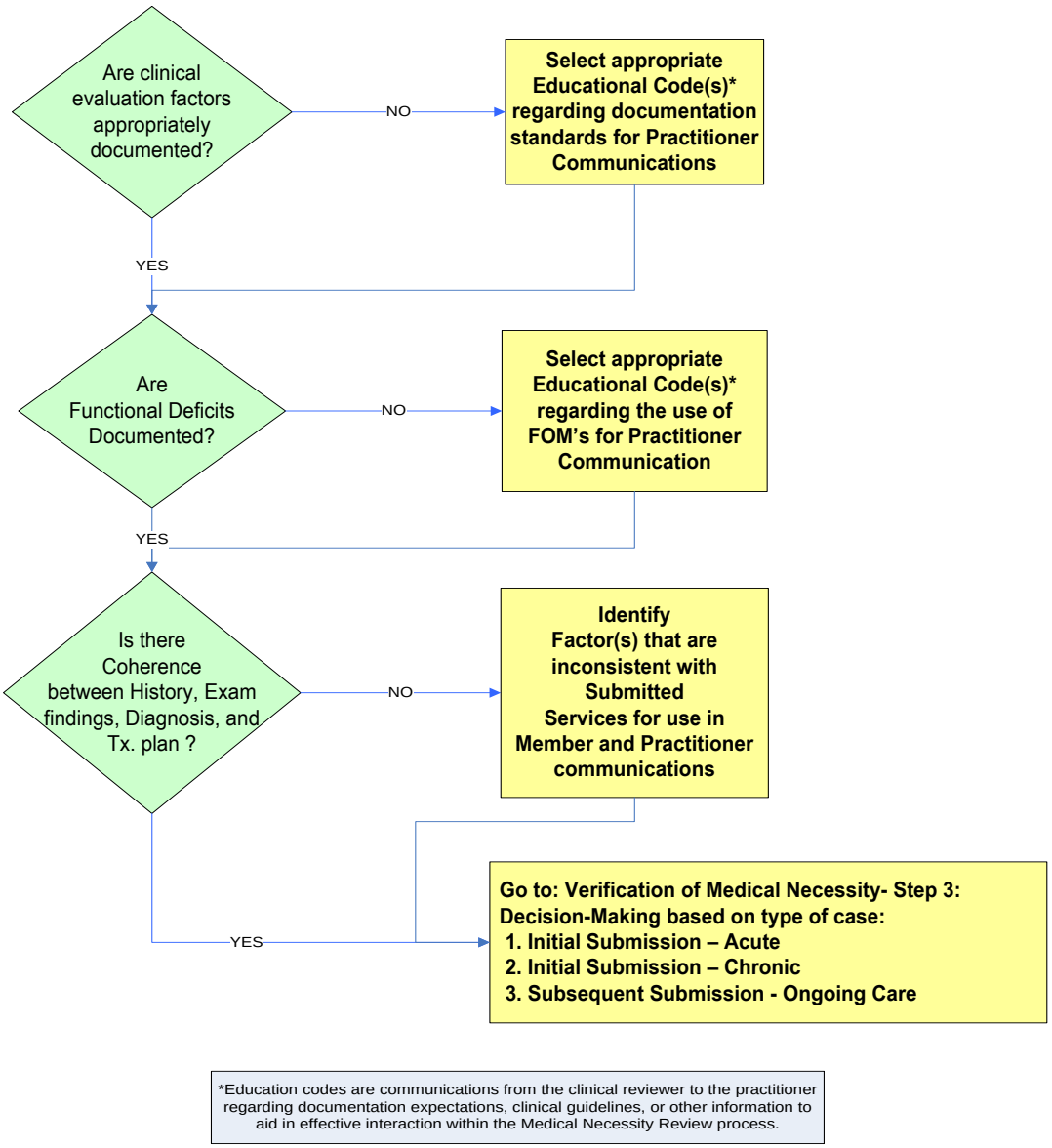
Clinical Review of Submitted Services: Musculo-Skeletal Conditions
& Somatic / Neuropathic Pain Disorders

Verification Of Medical Necessity- Step 2: Evaluating the Clinical Documentation



*Education codes are communications from the clinical reviewer to the practitioner regarding documentation expectations, clinical guidelines, or other information to aid in effective interaction within the Medical Necessity Review process.

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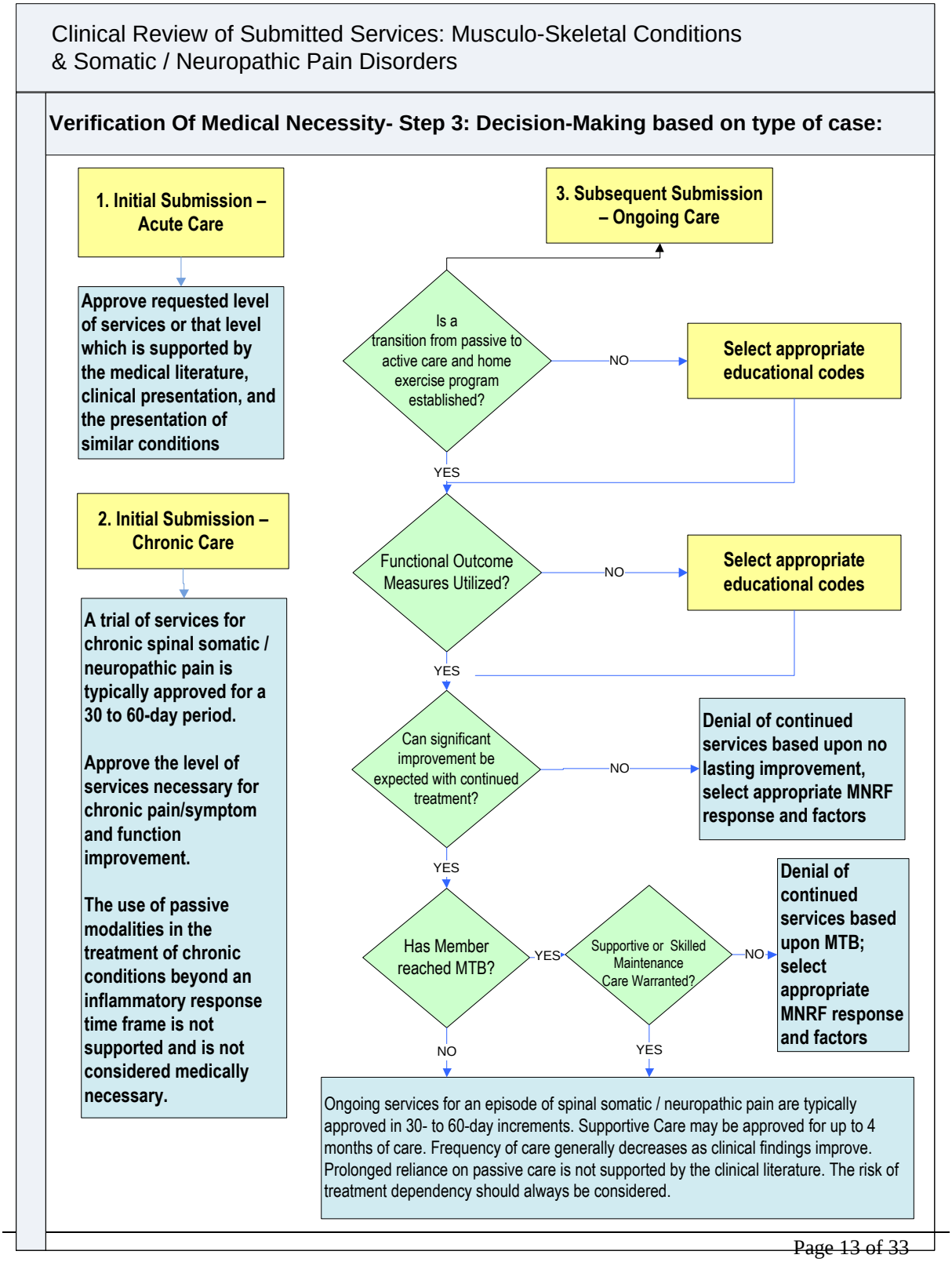
Clinical Review of Submitted Services: Musculo-Skeletal Conditions & Somatic / Neuropathic Pain Disorders
Verification Of Medical Necessity- Step 3: Decision-Making based on type of case:
1. Initial Submission – Acute Care
Approve requested level of services or that level which is supported by the medical literature, clinical presentation, and the presentation of similar conditions
2. Initial Submission – Chronic Care
A trial of services for chronic spinal somatic / neuropathic pain is typically approved for a 30 to 60-day period.
Approve the level of services necessary for chronic pain/symptom and function improvement.
The use of passive modalities in the treatment of chronic conditions beyond an inflammatory response time frame is not supported and is not considered medically necessary.
3. Subsequent Submission – Ongoing Care
Is a transition from passive to active care and home exercise program established?
NO
Select appropriate educational codes
YES
Functional Outcome Measures Utilized?
NO
Select appropriate educational codes
YES
Can significant improvement be expected with continued treatment?
NO
Denial of continued services based upon no lasting improvement, select appropriate MNRF response and factors
YES
Has Member reached MTB?
YES
Supportive or Skilled Maintenance Care Warranted?
NO
Denial of continued services based upon MTB; select appropriate MNRF response and factors
NO
YES
Ongoing services for an episode of spinal somatic / neuropathic pain are typically approved in 30- to 60-day increments. Supportive Care may be approved for up to 4 months of care. Frequency of care generally decreases as clinical findings improve. Prolonged reliance on passive care is not supported by the clinical literature. The risk of treatment dependency should always be considered.

Spinal Musculoskeletal Conditions and Somatic / Neuropathic Pain

(e.g., lumbar sprain/strain, cervical sprain/strain, thoracic sprain/strain, spinal subluxation, myalgia, arthralgia, discopathy, myofascitis, cervico-brachial radiculopathies, sciatica, somatic / neuropathic spinal pain)

APPROVE APPROPRIATE FREQUENCY AND DURATION OF SERVICES FOR INITIAL THERAPEUTIC TRIAL

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Acute or Sub-Acute Episode: • Rapid onset; insidious or traumatic; may be flare-up of previous condition • Mild, moderate, or severe pain • Functional deficit may be reported • Absence of signs and symptoms suggesting red flag conditions • Absence of yellow flags • May have restrictions in specific ADLs	The severity of the clinical findings that support a spinal somatic / neuropathic pain diagnosis and the initiation of a trial of services should be considered. (See Table A) There must be coherence between history, examination findings, diagnosis, and treatment plan. Absence of clinical findings that may contraindicate the initiation of a trial of services: • Infection, fracture, or organic pathology • Malingering signs	Approve the level of services necessary for acute pain/symptom relief and functional improvement as indicated by: • Condition severity • All submitted pertinent clinical evidence (diagnostic evidence and/or therapeutic functional outcome evidence determined to be valid and reliable during the clinical assessment and the treatment plan/program) Acute episodes of uncomplicated spinal somatic / neuropathic pain are typically approved for up to a 30-day trial of services. Clinical quality evaluators are trained to identify variations in clinical presentation that may influence the approval of a treatment plan.

Chronic: • Rapid onset; insidious or traumatic; may be flare-up of previous condition • Mild, moderate, or severe pain • Functional deficit may be reported • Absence of signs and symptoms suggesting red flag conditions • Absence of yellow flags • May have restrictions in specific ADLs • Non-pediatric (12 years of age and older) • Prior similar treatment has been successful • Ongoing or recurrent functional deficit	The severity of the clinical findings that support a spinal somatic / neuropathic pain diagnosis and the initiation of a trial of services should be considered. (See Table A) There must be coherence between history, examination findings, diagnosis, and treatment plan. Absence of clinical findings that may contraindicate the initiation of a trial of services: • Infection, fracture, or organic pathology • Malingering signs	Approve the level of services necessary for chronic pain/symptom relief and functional improvement as indicated by: • Condition severity • All submitted pertinent clinical evidence The use of passive modalities in the treatment of chronic conditions beyond an inflammatory response time frame is not supported and services directed by the use of such interventions is not considered medically necessary. A trial of services for chronic spinal somatic / neuropathic pain is typically approved up to a 60-day trial of services. If the trial of therapy shows no improvement within the first few weeks, it is unlikely that undergoing the same course of treatment will change those results. If the trial of therapy shows slow but continuing improvement, the treatment episode may be extended to enhance those results. For cases justifying the need for supportive or skilled maintenance care: • Approve the level of services that has previously shown to be effective in reducing or alleviating the member's pain/symptoms (up to 4

		months) • The risk of treatment dependency should always be considered. Clinical quality evaluators are trained to identify variations in clinical presentation that may influence the approval of a treatment plan.

APPROVE APPROPRIATE SERVICES UNDER CONTINUATION OF A TREATMENT PLAN FOR AN ONGOING EPISODE

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Improvement reported but not to pre-clinical status such as: • Pain improved significantly • Frequency of symptoms substantially decreased • Functional deficit absent or significantly improved as compared to baseline • Centralization of referred and/or radiating pain if symptoms were originally present Additionally: • Transitioning from passive to active care • Confirm appropriate coordination of other appropriate health care services, if necessary • Absence of signs and symptoms suggesting red flag conditions • Absence of yellow flags or	Clinical findings that support the continuation of services for an ongoing episode should include the following: • Improved orthopedic and/or neurological findings • Decreased tenderness • Muscle spasm has decreased • Increased range of motion (ROM) at area of complaint • Increased ability to perform ADLs • Coherence between the member's response to services and the new treatment proposal • Improvement in impairments and or function noted, but not to pre-clinical status Absence of clinical findings	Approve the level of services necessary for pain/symptom relief and functional improvement if: • The member has made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services • Additional significant improvement can be reasonably expected by continued treatment • The member has not reached maximum therapeutic benefit (MTB) • There is no indication that immediate services/evaluation is required by other health care professionals Uncomplicated diagnoses do not typically require services

treatment dependency • Member complying with treatment plan (e.g., willingness to make necessary lifestyle changes to help reduce frequency and intensity of symptoms) • No signs that the need for additional services is due to new complicating factors or misdiagnosis	that may contraindicate initiating a trial of services: • Infection, fracture, or organic pathology • Malingering signs	beyond the initial treatment plan. Ongoing services for an acute episode of spinal somatic / neuropathic pain are typically approved up to a 60-day trial of services. Frequency of services generally decreases as symptoms and clinical findings improve. Prolonged reliance on passive care is not supported by the clinical literature. The risk of treatment dependency should always be considered. Transition from passive to active treatment modalities is considered in the determination of medical necessity of ongoing services.

DENIAL OF NEW OR CONTINUING TREATMENT PLAN FOR THE PRESENT EPISODE

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Initial Treatment Plan: • No onset reported or available from prior submissions • Numeric Pain Rating Scale (NPRS) ≤1 • No functional deficit reported • Wellness exam, pre-employment exam, pre-participation sports physical, preventive services, chiropractic maintenance therapy services or elective/convenience services • Signs and symptoms suggesting red flag conditions	Essentially normal exam, including but not limited to: • +0 to +1 Tenderness • Absent or mild muscle spasm • Normal regional ROMs Additionally: • Poor coherence between history, examination findings, diagnosis, and treatment plan • Signs of active cerebrovascular involvement	Deny the services submitted by practitioner as indicated by: • Unremarkable member history • Minimal or no clinical findings • Care is preventive services, chiropractic maintenance therapy services or elective/convenience services • Treatment proposed for non- covered condition • Non-subluxation

	• Signs of vertebrobasilar involvement • Signs of neurological compromise • Malingering signs	condition treated by a chiropractor under Medicare contracts Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags for appropriate communication and referral / co-management recommendations
Ongoing Services: • Insufficient response to initial trial of services • Member has returned to pre-clinical status • Member has reached maximum therapeutic benefit (MTB) and supportive care or skilled maintenance therapy services is not indicated • Additional care are preventive services, chiropractic maintenance therapy services, or elective/convenience services • Signs and symptoms suggesting red flag conditions • Evidence of treatment dependency and/or presence of yellow flags	Same factors as with initial treatment plan in addition to: • Examination findings have returned to pre-clinical status • Improvement in impairments and or function noted, but not to pre-clinical status	Deny services submitted by practitioner as indicated by: • Member has returned to pre-clinical status • Member has reached maximum therapeutic benefit (MTB) and supportive or skilled maintenance care is not indicated • No probability that the condition will continue to improve significantly and/or resolve with additional treatment • Referral may be an option • Non-subluxation condition under Medicare contracts Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags

NEED FOR REFERRAL OR COORDINATION OF SERVICES FOR NEW OR CONTINUING MEMBER

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Acute or Chronic: • Symptoms worsening following treatment • Deteriorating condition • Reoccurring exacerbations despite continued treatment • No progress despite treatment • Unexplained diagnostic findings • Red flags identified • Peripheralization of referred or radiating pain or deterioration of neurological findings • Deterioration of functional capacity • Identification of co-morbid conditions (e.g., history of stroke or TIAs, progressive spondylolisthesis, uncontrolled hypertension, inflammatory arthritis, joint hyper-mobility, bone tumors, osteopenia, bleeding disorders or anticoagulant therapy) that represent relative contraindications to services • Constant, progressive non-mechanical pain • Systemically unwell (e.g., weight loss of greater than 4.5 kg over 6-month period)	• Rapidly deteriorating orthopedic and/or neurological findings • Clinical and historical findings indicating potential for vertebrobasilar compromise (cervical) • Cauda equina findings (lumbar) • Evidence or suspicion of spinal fracture • Clinical findings outside scope of treatment • Pain not provoked and/or relieved through physical examination procedures	• When a potential health and safety issue is identified, communicate with the provider of services as soon as possible by telephone and/or through standardized communication codes. Recommend referral of the member to referring or appropriate physician or other appropriate health care practitioner with the measure of urgency as warranted by the history and clinical findings. Report actions taken to the Health and Safety Investigation Team. (Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags) • Appropriately document all communication with attending practitioner. • Recommend referral to referring or appropriate physician or other appropriate health practitioner if member is pediatric age (12 years of age and under) and has other than a mild to moderate MS condition and when not already

		referred by the referring physician.

Headache

(e.g., cervicogenic headache, classic migraine, tension headache)

APPROVE APPROPRIATE FREQUENCY AND DURATION OF SERVICES FOR INITIAL THERAPEUTIC TRIAL

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Acute or Sub-Acute: • First or uncommon event for the member • Mild, moderate, or severe pain • Functional deficit may be reported • Absence of signs and symptoms suggesting red flag contraindications • Absence of yellow flags • Report of common headache "triggers" (e.g., stress, anxiety, fatigue, hunger, anger, poor posture, or overexertion) • Headache type known to be responsive to submitted therapy • Unavailability of treatment alternatives that are likely to provide a more favorable outcome	The severity of the clinical findings that support a headache diagnosis and the initiation of a trial of services should be considered. (See Table A) In addition, the following elements of examination should be considered specific to the headache diagnosis: • Neurologic exam (Central Nervous System [CNS] and peripheral) • Vascular examination, including but not exclusive to normal blood pressure • Trigger points and/or local hypertonic muscles There must be coherence between history, examination findings, diagnosis, and treatment plan. Absence of clinical findings that may contraindicate the initiation of a trial of services: • Infection, fracture, or organic pathology	Approve the level of services necessary for acute pain/symptom relief and functional improvement as indicated by: • Condition severity • All submitted pertinent clinical evidence (diagnostic evidence and/or therapeutic functional outcome evidence determined to be valid and reliable during the clinical assessment and the treatment plan/program); Acute episodes of uncomplicated headache are typically approved up to a 30-day trial of services. Clinical quality evaluators are trained to identify variations in clinical presentation that may influence the approval of a treatment plan.

	• Malingering signs	
Chronic • History and complaint are similar to previous episodes reported by member • Mild, moderate, or severe pain • Functional deficit may be reported • Previous treatment has been successful • Absence of signs and symptoms suggesting red flag contraindications • Absence of yellow flags • Unavailability of treatment alternatives that are likely to provide a more favorable outcome	Clinical findings that support the initiation of a trial of services for a headache diagnosis should include the following: • Neurologic exam (CNS and peripheral) • Vascular examination, including but not exclusive to normal blood pressure • Trigger points and/or local hypertonic muscles • Coherence between history, examination findings, diagnosis, and treatment plan Absence of clinical findings that may contraindicate the initiation of a trial of services: • Infection, fracture, or organic pathology • Malingering signs	Approve the level of services necessary for pain/symptom relief and functional improvement as indicated by: • Condition severity; • All submitted pertinent clinical evidence A trial of services for chronic headache is typically approved for up to a 60-day trial of services. If the trial of therapy shows no improvement within the first few weeks, it is unlikely that undergoing the same course of treatment will change those results. If the trial of therapy shows slow but continuing improvement, the treatment episode may be extended to enhance those results. For cases justifying the need for supportive or skilled maintenance services: • Approve the level of services that has previously shown to be effective in reducing or alleviating the member's pain/symptoms (up to 4 months) • The risk of treatment dependency should

		always be considered

APPROVE APPROPRIATE SERVICES FOR CONTINUATION OF A TREATMENT PLAN FOR THE PRESENT EPISODE

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Improvement reported from present treatment plan but not to pre-clinical status such as: • Pain substantially decreased • Frequency and/or duration of headache substantially decreased • Functional deficit absent or significantly improved as compared to baseline Additionally: • Confirm appropriate coordination of other appropriate health care services, if necessary • Absence of signs and symptoms suggesting red flag contraindications • Absence of yellow flags or treatment dependency • Transition from passive to active care • Member complying with treatment plan (e.g., willingness to make necessary lifestyle changes to help reduce frequency and intensity of headache episodes) • No signs that the need for additional services is due to new complicating factors	• Neurologic exam • Vascular exam • Improvement in MS examination findings (palpation, posture, tenderness, range of motion) • Improvement of previous clinical findings (defined in terms of frequency or duration or intensity) • No evidence of worsening objective examination findings • Improvement in impairments and or function noted, but not to pre-clinical status Absence of clinical findings that may contraindicate initiating a trial of services: • Infection, fracture, or organic pathology • Malingering signs	Approve the level of services necessary for pain/symptom relief and functional improvement if: • The member has made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services • Additional significant improvement can be reasonably expected by continued treatment • The member has not reached maximum therapeutic benefit (MTB) • There is no indication that immediate services/evaluation is required by other health care professionals Uncomplicated diagnoses do not typically require services beyond the initial treatment plan. Frequency of services generally decreases as symptoms and clinical findings improve. Prolonged reliance on passive care is not supported by the clinical literature. Ongoing services for a chronic or recurring episode of

or misdiagnosis		headaches are typically approved up to a 60-day trial of services. The risk of treatment dependency should always be considered. Transition from passive to active treatment modalities is considered in the determination of medical necessity of ongoing care.

DENIAL OF NEW OR CONTINUING TREATMENT PLAN FOR THE PRESENT EPISODE

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Initial Treatment Plan: • No onset reported or available from prior submissions • Numeric Pain Rating Scale (NPRS) ≤1 • No functional deficit reported • Wellness exam, pre-employment exam, pre-participation sports physical, preventive services, chiropractic maintenance therapy or elective/convenience services • Worsening in symptoms • Red flags present • Evidence of treatment dependency and/or presence of yellow flags	Essentially normal exam including but not limited to: • +0 to +1 Tenderness • Absent or mild muscle spasm Additionally: • Poor coherence between history, examination findings, diagnosis, and treatment plan • Signs of active cerebrovascular involvement • Signs of vertebrobasilar involvement • Signs of neurological compromise • Malingering signs	Deny the services submitted by practitioner as indicated by: • Unremarkable member history • Minimal or no clinical findings • Services are preventive services, chiropractic maintenance therapy or elective/convenience services • Referral may be an option In the presence of red or yellow flags, contact the practitioner to coordinate the member's care and ensure they have been seen by their referring or appropriate physician, specialist, or other appropriate health care practitioner. (Refer to the sections Assessment of Red Flags and Assessment

		of Yellow Flags)
Ongoing Services: • Insufficient response to initial trial of services • Member has returned to pre-clinical status • Member has reached maximum therapeutic benefit (MTB) and supportive care or skilled maintenance therapy services is not indicated • Additional services is preventive services, chiropractic maintenance therapy or elective/convenience services • Red flags present • Evidence of treatment dependency and/or presence of yellow flags	Same factors as within initial treatment plan in addition to: • Examination findings have returned to pre-clinical status • Minimal to no improvement in physical findings • Worsening symptoms and objective findings and/or the onset of vascular and/or neurological findings • No improvement in impairments and or function noted	Deny the level of services submitted by practitioner as indicated by: • Member has returned to pre-clinical status • Member has reached maximum therapeutic benefit (MTB) and supportive or skilled maintenance care services are not indicated • No probability that the condition will continue to improve and/or resolve with additional treatment • Referral may be an option Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags

NEED FOR REFERRAL OR CO-MANAGEMENT OF NEW OR CONTINUING MEMBER

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Acute or Chronic: • Deteriorating condition • Worsening symptoms following treatment • Reoccurring exacerbations despite continued treatment • Unexplained diagnostic findings	• Central nervous system deficit or evidence of a space-occupying lesion • Clinical and historical findings indicating potential for vertebrobasilar compromise • Signs of active cerebrovascular	• When a potential health and safety issue is identified, communicate with the provider of services as soon as possible by telephone and/or through standardized communication codes. Recommend referral of

• Awakened in the night with severe headache • Headache accompanied by fever • No progress despite treatment • Presence of red flags • Unremitting or progressive headache pain, visual disturbance other than migraine aura • Identification of co-morbid conditions (e.g., history of stroke or TIAs, moderate to severe hypertension, inflammatory arthritis, joint hyper-mobility, benign bone tumors, osteopenia, bleeding disorders or anticoagulant therapy) that represent relative contraindications to submitted services • Systemically unwell (weight loss greater than 4.5 kg over 6-month period)	involvement • Clinical findings outside scope of treatment • Pain not provoked and/or relieved through physical examination procedures	the member to referring or appropriate physician or other appropriate health care practitioner with the measure of urgency as warranted by the history and clinical findings. Report actions taken to the Health and Safety Investigation Team. (Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags) • Appropriately document all communication with attending practitioner. • Recommend referral to referring or appropriate physician or other appropriate health practitioner if member is pediatric age (12 years of age and under) and has other than a mild to moderate MS condition and when not already referred by the referring physician.

Extremity Pain/ Dysfunction Conditions

(e.g., carpal tunnel syndrome; lateral epicondylitis; wrist tendonitis; joint dysfunction of the upper or lower extremities; rotator cuff syndromes; patellofemoral syndromes; plantar fasciitis; sprain/strain of the extremity; arthritic conditions, , reflex sympathetic dystrophies)

APPROVE APPROPRIATE FREQUENCY AND DURATION OF SERVICES FOR INITIAL THERAPEUTIC TRIAL

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Acute or Sub-Acute Episode: • Rapid onset; insidious or traumatic; may be flare-up of previous condition • Mild, moderate, or severe pain • Functional deficit should be reported via a FOM that corresponds with condition requiring treatment. • Absence of signs or symptoms suggesting red flag conditions • Absence of yellow flags • May have restrictions in specific ADLs	The severity of the clinical findings that support an extremity pain/dysfunction condition diagnosis and the initiation of a trial of services should be considered. (See Table A) Coherence between history, examination findings, diagnosis, and treatment plan Absence of clinical findings that may contraindicate the initiation of a trial of services: • Infection, fracture, or organic pathology • Malingering signs	Approve the level of services necessary for acute pain/symptom relief and functional improvement as indicated by: • Condition severity • All submitted pertinent clinical evidence Acute episodes of uncomplicated extremity pain/dysfunction conditions are typically approved for a frequency and duration of services necessary to resolve the condition and or progress that patient to a self-management program. Conditions which present with underlying complications and the response to services is questionable are approved for services on a trial basis up to 30 days.
Chronic: • History and complaint are similar to previous episodes reported by member • Mild, moderate, or severe pain • Functional deficit should be reported via	The severity of the clinical findings that support an extremity pain/dysfunction condition (diagnosis) and the initiation of a trial of services should be considered. (See Table A) Coherence between history, examination findings, diagnosis,	Approve the level of services necessary for pain/symptom relief and functional improvement as indicated by: • Condition severity • All submitted pertinent clinical evidence

a FOM that corresponds with condition requiring treatment • Absence of symptoms to suspect red flag conditions • Absence of yellow flags • May have restrictions in specific ADLs • Non-pediatric (12 years of age and under) • Prior similar treatment has been successful • Ongoing or recurrent functional deficit	and treatment plan Absence of clinical findings that may contraindicate the initiation of a trial of services: • Infection, fracture, or organic pathology • Malingering signs	A trial of services for chronic extremity pain/dysfunction condition is typically approved up to a 60-day trial of services. If the trial of therapy shows no improvement within the first few weeks, it is unlikely that undergoing the same course of treatment will change those results. If the trial of therapy shows slow but continuing improvement, the treatment episode may be extended to enhance those results. For cases justifying the need for supportive or skilled maintenance care: • Approve the level of services that has previously shown to be effective in reducing or alleviating the member's pain/symptoms (up to 4 months) • The risk of treatment dependency should always be considered

APPROVE APPROPRIATE SERVICES UNDER CONTINUATION OF A TREATMENT PLAN FOR AN ONGOING EPISODE

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Improvement reported but not to pre-clinical status such as: • Pain improved significantly • Frequency of symptoms	Clinical findings that support the continuation of services for an ongoing episode should include the following: • Improved orthopedic	Approve the level of services necessary for acute pain/symptom relief and functional improvement if: • The member has made

substantially decreased • Functional deficit absent or significantly improved as compared to baseline Additionally: • Transitioning from passive to active care • Self-management program is established, documented and updated periodically. • Confirm appropriate coordination of other appropriate health care services, if necessary • Absence of symptoms to suspect red flag conditions • Absence of yellow flags or treatment dependency	and/or neurological findings • Decreased tenderness • Decreased muscle spasm • Increased ROM at area of complaint • Increased ability to perform ADLs • Coherence between the member's response to services and the new treatment proposal • Improvement in impairments and or function noted, but not to pre-clinical status Absence of clinical findings that may contraindicate initiating a trial of services: • Infection, fracture, or organic pathology • Malingering signs	reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services • Additional significant improvement can be reasonably expected by continued treatment • The member has not reached maximum therapeutic benefit (MTB) • There is no indication that immediate services/evaluation is required by other health care professionals Uncomplicated diagnoses do not typically require services beyond the initial treatment plan. Ongoing services for an acute episode of extremity pain/dysfunction condition are typically approved up to a 60-day trial of services. Frequency of services generally decreases as symptoms and clinical findings improve. Prolonged reliance on passive care is not supported by the clinical literature. The risk of treatment dependency should always be considered. Transition from passive to active treatment modalities is considered in the determination of medical necessity of ongoing services.

DENIAL OF NEW OR CONTINUING TREATMENT PLAN FOR THE PRESENT EPISODE

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Initial Treatment Plan: • No onset reported or available from prior submissions • Numeric Pain Rating Scale (NPRS) ≤1 • No functional deficit reported • Wellness exam, pre-employment exam, pre-participation sports physical, preventive services, chiropractic maintenance therapy or elective/convenience services • Signs and symptoms present to suspect red flag conditions • Evidence of treatment dependency and/or presence of yellow flags	Essentially normal exam including but not limited to: • +0 to +1 Tenderness • Absent or mild muscle spasm • Normal regional ROMs Additionally: • Poor coherence between history, examination findings, diagnosis, and treatment plan • Signs of active cerebrovascular involvement • Signs of vertebrobasilar involvement • Signs of neurological compromise	Deny the level of services submitted by practitioner as indicated by: • Unremarkable member history • Minimal or no clinical findings • Services are preventive services, chiropractic maintenance therapy or elective/convenience services • Treatment proposed for non- covered condition Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags
Ongoing Services: • Insufficient response to initial trial of services • Member has returned to pre-clinical status • Member has reached maximum therapeutic benefit (MTB) and supportive or skilled maintenance care is not indicted • Additional services are preventive services, chiropractic maintenance therapy or elective/convenience services • Red flags identified	Same factors as within initial treatment plan in addition to: • Examination findings have returned to pre-clinical status • Minimal to no improvement in physical findings • Improvement in impairments and or function noted, but not to pre-clinical status	Deny the level of services submitted by practitioner as indicated by: • Member has returned to pre-clinical status • Member has reached maximum therapeutic benefit (MTB) and supportive or skilled maintenance care services are not indicated • No probability that the condition will continue to improve significantly and/or resolve with additional treatment • Referral may be an option

• Evidence of treatment dependency and/or presence of yellow flags		Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags

NEED FOR REFERRAL OR COORDINATION OF SERVICES FOR NEW OR CONTINUING MEMBER

Patient History/Complaint	Clinical Findings	Action by Clinical Quality Evaluator
Acute or Chronic: • Deteriorating condition • No progress despite treatment • Reoccurring exacerbations despite continued treatment • Red flags identified • Deterioration of functional capacity • Identification of co-morbid conditions (e.g., inflammatory arthritis, joint hyper-mobility, benign bone tumors, osteopenia, bleeding disorders or anticoagulant therapy) that represent relative contraindications to submitted services • Constant, progressive non-mechanical pain • Systemically unwell (e.g., weight loss of greater than 4.5 kg over 6-month period)	• Rapidly deteriorating orthopedic and/or neurological findings • Clinical findings outside scope of treatment • Signs present to suspect red flag conditions (e.g., infection, fracture, metastatic disease, gross or progressive neurological deficit, compartment syndromes, deep vein thrombosis, full tendon rupture, complicated fracture, avascular necrosis)	• When a potential health and safety issue is identified, communicate with the provider of services as soon as possible by telephone and/or through standardized communication codes. Recommend referral of the member to referring or appropriate physician or other appropriate health care practitioner with the measure of urgency as warranted by the history and clinical findings. Report actions taken to the Health and Safety Investigation Team. (Refer to the sections Assessment of Red Flags and Assessment of Yellow Flags) • Appropriately document all communication with attending practitioner. • Recommend referral to

		referring or appropriate physician or other appropriate health practitioner if member is pediatric age (12 years of age and under) and has other than a mild to moderate MS condition and when not already referred by the referring physician.

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