**Sixty (60) Medical Management Tips:** (Provided by expert panel at the 21st National Workers Compensation and Disability Conference & Expo, November 7-9, 2012).

1. Choose providers that are good at patient care but not enablers.
2. If knee MRI is negative do not approve any exploratory surgery without a second opinion. Except for medial Plica fat pad on MVA or front knee injury.
3. Write substantive letters to the Physician advocating and clarifying your position.
4. Degenerative Disc Disease (DDD) does not exist, only age related changes (not a disease).
5. Early Imaging (MRI, CT) for non- specific low back pain is not indicated.
6. Not all pain physicians are Rehab Specialist.
7. Know Injured Worker medical records well. Identify and exclude preexisting conditions.
8. MRI can be in error. There are many more false positive than false negative.
9. Injured worker exaggerate and have selective memories, but that does not equate to lying or malingering.
10. Manage patient expectations at first visit to control outcomes.
11. Opiods, Benzo, Muscle Relaxants should not be prescribed together. All should be used for short term.
12. Any pain treatment should result in a definable and measurable improvement of function.
13. Avoid repeat treatments if not successful (Example: Epidural Injection for non -radicular pain) Are you better, worse or the same!
14. If you have a panel of treating doctors include a radiologist to reduce over reading.
15. Avoid becoming disdainful or disrespectful to the injured worker or his/her attorney.
16. Guidelines are not primarily UR (utilization review) tools. They are to be used to improve quality of medical practice.
17. The initial treatment physician words are more influential than we realize. (Example: “you are never going to work again”).
18. A pain diagnosis should be validated by concordant objective findings.
19. Avoid new or experimental treatment unless supported by reliable clinical data.
20. Have your initial exams include Waddell testing to screen for symptom magnification.
21. Consider obtaining a multidisciplinary evaluation with Physician, Physical Therapy and Psychology.
22. The American Chronic Pain Association should be your recommended website for patients with chronic pain.
23. Sometimes there is nothing else you can do for the patient and they should be released from care.

24. Calculating the Morphine Equivalent Dose (MED) is a way to standardize and compare different opioids.
25. Avoid medical care that treats all patients with same treatment. “If the only tool you have is a hammer, everything looks like a nail”.
26. A diagnostic ultrasound may avoid MRI’s and save money.
27. Be suspicious of office based dispensing of medications and in office testing and procedures.
28. Refer patients and providers to “choose wisely” website.
29. Radiculopathy has specific clinical findings.
30. Case managers can assess Injured Worker desire for change.
31. Prefer less invasive treatment first.
32. An acute Anterior Cruciate Ligament tear is always accompanied by blood in the knee. If there is no effusion, that tear may be old. Don’t assume is Work Comp.
33. Require continue medication weaning efforts from treating physicians.
34. Drug testing while Injured Worker is on chronic opioids is required part of their treatment.
35. Work restrictions should be based on risk of re-injury not complaints of pain. No reason to restrict just because of pain.
36. Evaluate whether the treating physician is too focused on the biomedical (mostly doing injections and medications).
37. Narcotics use is rarely acceptable beyond two weeks after acute injury or surgery.
38. Arthritis is not aggravated by soft tissue trauma. There is no data that soft tissue trauma accelerate arthritis. Do not pay for knee replacement.
39. If there is no change over time defined as less use of meds, better pain control, increase function and return to work consider early IME.
40. The only true outcome measure is function.
41. Failure of conservative treatment for low back pain is not an indication for surgery. Just because the individual fail conservative treatment does not mean that surgery is needed.
42. Hydrocodone taken with Soma is often referred to as the “Vegas Cocktail”.
43. Substitution therapy (Suboxone ) is useful to address addiction but a poor choice for chronic pain.
44. Avoid treatment complications from anti-inflammatories by using gastro-protective medications to prevent ulcers.
45. Use a medical director or physician consultant for problematic cases.
46. Cumulative Trauma Disorder is not a diagnosis. Should never be accepted as a diagnosis.
47. Compensating for an injured knee does not accelerate degenerative changes in the opposite knee.

48. Treatment follow up should include a physical exam that measures physical function.
49. Make medical care provider accountable for outcome and follow up of injured worker.
50. Jobs that involve repetitive squatting and kneeling have been linked to the development of arthritis. A direct blow never tears a meniscus.
51. Invite physicians to “meet the doctor” day luncheon with claims staff.
52. Key boarding is almost never the cause of CTS. However, mouse use for over 4 hours may be.
53. Annular tears on MRI are not an acute finding or indicative of trauma.
54. Cognitive behavioral therapy can provide psychological support without psychological diagnosis.
55. Keep injured worker accountable by clearly stating expectations.
56. Chondral injuries to the knee are rare. They are more likely degenerated and not related.
57. Don’t “hide the ball” with regards to information, records or surveillance films.
58. Patients should not have most musculoskeletal surgery without agreeing to participate in a full postoperative course of Rehabilitation. Also lose weight and stop smoking.
59. Axial low back pain alone is not an indication for fusion. The outcomes are not good.
60. Reminding a treating physician that the injured worker is not improved may help him wean some medications.