

SENT VIA EMAIL OR FAX ON
Mar/09/2009

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Duragesic Patch: 12mcg 1 patch q48 15/months-lumbar

Baclofen: 20mg 1 bid #60/month-lumbar

Lycia: 75mg 2qam, 1qnoon, 2qpm #150/month-lumbar

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 1/29/09 and 2/5/09

PT Therapy Report 2/1/08

Approval Letters 12/20/07 and 5/30/08

Letter 2/20/09

Records from the following:

Dr. 11/3/03 thru 1/7/09

Dr. 1/26/09

Dr. 11/17/03 thru 2/14/07

Dr. 5/28/02, 8/18/05

Dr. 9/25/02

Dr. 9/3/02

Dr. 3/31/03, 5/15/05

Dr. 10/16/03
Dr. 1/7/04 thru 10/30/06
Dr. 1/16/04, 3/2/04
Dr. 3/2/04
Dr. 3/2/04
Imaging 3/24/04
Hospital 3/27/04 thru 3/29/04
HC System 3/27/04
Medical 5/17/04 thru 11/28/06
9/21/04, 10/14/04
Dr. 11/12/04
MD 3/24/05
11/17/05 thru 2/17/06
Dr. 6/19/06
Rehab 8/10/06 thru 9/1/06
Dr. 3/7/07 thru 4/3/08

PATIENT CLINICAL HISTORY SUMMARY

This woman has post lamiectomy pain. The records provided did not elaborate on the original injury or surgery. The information gleaned from the records implies she had a L5/S1 implant in a 2000 MRI report. This suggests a prosthetic disc. She subsequently had fusions in 2000, 2002 and a hardware removal with fusion in 2004. It appears she has a back fusion from L2 to S1. An EMG in 2004 was cited as showed a chronic L4 radiculopathy and some changes at L4, L5 and S1 roots bilaterally. She has facet changes. She continues to have bilateral back and buttock pain with bilateral foot pain. The records cite in one note of neuropathy in her legs, presumably from the failed back syndrome/ radiculopathy rather than a separate neuropathy. There was no further comment on a neuropathy. She remains on Lyrica, which she has problems tolerating, Duragesic, which she literally cut back on, and Lioresal. The records cite a 3/31/08 review by Dr. This review itself was not provided. Dr. apparently justified the use of the 3 medications. The request today is for the ongoing use of the medications.

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

The first issue is the diagnosis. This lady has failed back syndrome post fusions. The Reviewer saw multiple notes of unrelated conditions that can also cause pain. Treatment requests were for medical management. The exact cause of the pain has been debated. There are reasons to attribute the pain to mechanical factors as well as neuropathic pain.

The first is for the Duragesic patch. This is Fentanyl. It is only approved by the FDA for the management of chronic pain. It is a long acting opioid. The use of opioids in the management of chronic pain is controversial, but also accepted. The ODG accepts this. Second, the ODG does recognize that failed back pain may be neuropathic in origin. The role of opiates has not been proven nor disproven. The ODG does not approve the use of the medication as the primary treatment for pain, especially musculoskeletal pain. In this case, however, the pain is chronic and has been present for years. There are criteria that include monitoring, contracts, assessments etc that were not described in the medical records provided, but presumably are being followed by a pain specialist. The Reviewer would therefore justify the use of Duragesic, however, the Reviewer has concerns. She apparently wants a low dose, but is using the medication on a qod basis. The patch is generally used every 72 hours, but some people get maximal benefit every 48 hours. The other issue are the notes in mid 2008 describing her as cutting the patch. This is dangerous. The patch has a reservoir that leaks. There were some deaths attributed to overdosing with Fentanyl with leaking patches. She should not be on Fentanyl if she is trimming the patches. The later notes from 2008 and 2009 appear to show this problem has resolved.

Opioids

This topic is covered under multiple headings. See more specific entries, as follows:
[Opioids, criteria for use](#); [Opioids for chronic pain](#); [Opioids for neuropathic pain](#);

[Opioids for osteoarthritis](#); [Opioids, cancer pain vs. nonmalignant pain](#); [Opioids, dealing with misuse & addiction](#); [Opioids, differentiation: dependence & addiction](#); [Opioids, dosing](#); [Opioids, indicators for addiction](#); [Opioids, long-term assessment](#); [Opioids, pain treatment agreement](#); [Opioids, psychological intervention](#); [Opioids, screening for risk of addiction](#) (tests); [Opioids, state medical boards guidelines](#); [Opioids, steps to avoid misuse/addiction](#); [Detoxification](#); [Substance abuse](#) (tolerance, dependence, addiction); [Weaning of medications](#); [Implantable drug-delivery systems](#) (IDDSs); [Methadone](#); [Rapid detox](#); [Testosterone replacement for hypogonadism](#) (related to opioids); [Opioid hyperalgesia](#) & [Opioids, specific drug list](#). Opioid drugs are also referred to opiate analgesics, narcotic analgesics, or schedule C (II -IV) controlled substances. Opioid analgesics are a class of drugs (e.g., morphine, codeine, and methadone) that have a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. **They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain.** These medications are generally classified according to potency and duration of dosage duration. ...

Overall Classification:

Pure-agonists: include natural and synthetic opioids such as...fentanyl (Duragesic®). This group of opioids does not have a ceiling effect for their analgesic efficacy nor do they antagonize (reverse) the effects of other pure opioids. ([Baumann, 2002](#)) Morphine is the most widely used type of opioid analgesic for the treatment of moderate to severe pain due to its availability, the range of doses offered, and its low cost.

Opioid Classifications: Short-acting/Long-acting opioids: ...

Long-acting opioids: also known as “controlled-release”, “extended-release”, “sustained-release” or “long-acting” opioids, are a highly potent form of opiate analgesic. The proposed advantage of long-acting opioids is that they stabilize medication levels, and provide around-the-clock analgesia...**Fentanyl (Duragesic Patch®), ...**

Opioids for chronic pain

Recommendations for general conditions:

Neuropathic pain: Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations ([antidepressants](#), [anticonvulsants](#)). There are no trials of long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. See [Opioids for neuropathic pain](#)....

Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, **analgesic** treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, **opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs.** A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (≤ 70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. ([Ballantyne, 2006](#)) ([Furlan, 2006](#)) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). ([Kalso, 2004](#)) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. ([Martell-Annals, 2007](#)) ...

There are several proposed guidelines for the use of opioids for chronic non-malignant pain, but these have not been evaluated in clinical practice, and selection of the patient that will best respond to this treatment modality remains difficult....

Outcomes measures: It is now suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. ([Nicholas, 2006](#)) ([Ballantyne, 2006](#)) A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. ([Eriksen, 2006](#))...

Overall treatment suggestions: Current guidelines suggest the following:

- A trial of opioids as a first step in treatment, and the steps involved are outlined in the [Criteria for Use of Opioids](#). The trial includes an initiation phase that involves selection of the opioid and initial dose. ([VA/DoD, 2003](#))
- There is then a titration phase that includes dose adjustment. At this phase it may be determined that opioids are not achieving the desired outcomes, and they should be discontinued.
- The final stage is the maintenance phase. If pain worsens during this phase the differential to evaluate includes disease progression, increased activity, and/or new or increased pre-existing psychosocial factors that influence pain. In addition, the patient may develop hyperalgesia, tolerance, dependence or actual addiction. ([Washington, 2002](#)) ([Colorado, 2002](#)) ([Ontario, 2000](#)) ([VA/DoD, 2003](#)) ([Maddox-AAPM/APS, 1997](#)) ([Wisconsin, 2004](#)) ([Warfield, 2004](#)) See [Substance abuse \(tolerance, dependence, addiction\)](#). See also [Implantable pumps for narcotics](#). See also Opioids in the [Low Back Chapter](#). See [Criteria for Use of Opioids](#).

Opioids, criteria for use

CRITERIA FOR USE OF OPIOIDS

Therapeutic Trial of Opioids

1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:

- (a) Are there reasonable alternatives to treatment, and have these been tried?
- (b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?
- (c) Has the patient received a screen for the risk of addiction? Is there likelihood of abuse or an adverse outcome? See [Substance abuse \(tolerance, dependence, addiction\)](#). See [Opioids, screening for risk of addiction](#). ([Webster, 2008](#)) ([Ballyantyne, 2007](#))
- (d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression, or a previous history of substance abuse). Patients

may misuse opioids prescribed for pain to obtain relief from depressed feelings, anxiety, insomnia, or discomforting memories. There are better treatments for this. ([Sullivan, 2006](#)) ([Sullivan, 2005](#)) ([Wilsey, 2008](#)) ([Savage, 2008](#))

(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

2) Steps to Take Before a Therapeutic Trial of Opioids:

(a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain.

(b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.

(c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals.

(d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.

(e) Pain related assessment should include history of pain treatment and effect of pain and function.

(f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.

(g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. ([Sullivan, 2006](#)) ([Sullivan, 2005](#)) ([Wilsey, 2008](#)) ([Savage, 2008](#)) ([Ballyantyne, 2007](#))

(h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

(i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See [Guidelines for Pain Treatment Agreement](#). This should include the consequences of non-adherence.

(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs.

3) Initiating Therapy

(a) Intermittent pain: Start with a short-acting opioid trying one medication at a time.

(b) Continuous pain: extended-release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required.

(c) Only change 1 drug at a time.

(d) Prophylactic treatment of constipation should be initiated.

(e) If partial analgesia is not obtained, opioids should be discontinued.

4) On-Going Management. Actions Should Include:

(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.

(b) The lowest possible dose should be prescribed to improve pain and function.

(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of [function](#), or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. *The 4 A's for Ongoing Monitoring*: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. ([Passik, 2000](#))

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. ([Webster, 2008](#))

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to nonopioid means of pain control.

(h) Consideration of a consultation with a [multidisciplinary pain clinic](#) if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. ([Sullivan, 2006](#)) ([Sullivan, 2005](#)) ([Wilsey, 2008](#)) ([Savage, 2008](#)) ([Ballyantyne, 2007](#))

5) Recommended Frequency of Visits While in the Trial Phase (first 6 months):

(a) Every 2 weeks for the first 2 to 4 months

(b) Then at approximate 1 ½ to 2-month intervals

Note: According to the California Medical Board Guidelines for Prescribing Controlled Substances for Pain, patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. ([California, 1994](#))

6) When to Discontinue Opioids: See [Opioid hyperalgesia](#). Also see [Weaning of Medications](#). Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned.

(a) If there is no overall improvement in function, unless there are extenuating circumstances

(b) Continuing pain with the evidence of intolerable adverse effects; lack of significant benefit (persistent pain and lack of improved function despite high doses of opiates- e.g. > 120 mg/day morphine equivalents)

(c) Decrease in functioning

(d) Resolution of pain

(e) If serious non-adherence is occurring

(f) The patient requests discontinuing

(g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances.

(h) Many physicians will allow one “slip” from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations.

(i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. ([Weaver, 2002](#))

(j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

7) When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain

([Washington, 2002](#)) ([Colorado, 2002](#)) ([Ontario, 2000](#)) ([VA/DoD, 2003](#)) ([Maddox-AAPM/APS, 1997](#)) ([Wisconsin, 2004](#)) ([Warfield, 2004](#))

Duragesic® (fentanyl transdermal system)

Not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. It is manufactured by ALZA Corporation and marketed by Janssen Pharmaceutica (both subsidiaries of Johnson & Johnson). The **FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Due to the significant side effects, not for use in routine musculoskeletal pain.** See [Fentanyl](#).

Fentanyl

Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids such as fentanyl. Due to significant side effects, **not for use in routine musculoskeletal pain.** For more information and references, see [Opioids](#). See also [Actiq®](#) (fentanyl lollipop); [Duragesic®](#) (fentanyl transdermal system); & [Fentora®](#) (fentanyl buccal tablet).

Baclofen, or Lioresal is the next issue. It is a muscle relaxer for spasticity, but the ODG even recognizes its use in chronic low back pain as a second line medication. It has been anecdotally been reported effective for neuropathic pain separate from its antispasticity benefit. The ODG recognizes this with the off label use for trigeminal neuralgia. Apparently it has been beneficial. It would be approve.

Baclofen

See [CRPS, sympathetic and epidural blocks](#). See also [Muscle relaxants](#).

Muscle relaxants (for pain)

Recommend non-sedating muscle relaxants with caution as a second-line

option for short-term treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. ([Chou, 2007](#)) ([Mens, 2005](#)) ([Van Tulder, 1998](#)) ([van Tulder, 2003](#)) ([van Tulder, 2006](#)) ([Schnitzer, 2004](#)) ([See, 2008](#)) See the [Low Back Chapter](#). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. ([Homik, 2004](#)) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. ([Chou, 2004](#)) According to a recent review in *American Family Physician*, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. ([See2, 2008](#))

Classifications: Muscle relaxants are a broad range of medications that are generally divided into antispasmodics, antispasticity drugs, and drugs with both actions. ([See, 2008](#)) ([van Tulder, 2006](#))

ANTISPASTICITY DRUGS: Used to decrease spasticity in conditions such as cerebral palsy, MS, and spinal cord injuries (upper motor neuron syndromes). Associated symptoms include exaggerated reflexes, autonomic hyperreflexia, dystonia, contractures, paresis, lack of dexterity and fatigability. ([Chou, 2004](#))

Baclofen (Lioresal®, generic available): The mechanism of action is blockade of the pre- and post-synaptic GABA_B receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non-FDA approved). ([ICSI, 2007](#))

Side Effects: Sedation, dizziness, weakness, hypotension, nausea, respiratory depression and constipation. This drug should not be discontinued abruptly (withdrawal includes the risk of hallucinations and seizures). Use with caution in patients with renal and liver impairment.

Dosing: Oral: 5 mg three times a day. Upward titration can be made every 3 days up to a maximum dose of 80 mg a day. ([See, 2008](#))...

Lyrica is considered a Class IV controlled substance. It is approved for specific neuropathic pain for diabetes, post herpetic neuralgia and for seizures. By extrapolation it is used for other neuropathic causes of pain. As noted above, the ODG recognizes a neuropathic component of failed back syndrome. There are comments in the record that this lady was not using her full dose. Dr. Coronado explained that the reason was difficulty in tolerating the medication and not due to lack of cooperation or participation. In fact, she wrote that the Lyrica helped the burning pain. Therefore, this medication is also justified.

Lyrica® (pregabalin)

Lyrica® is the brand name for pregabalin, and it is produced by Pfizer. See [Pregabalin](#) (Lyrica®).

Pregabalin (Lyrica®)

Pregabalin (Lyrica®) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is

considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. See [Anti-epilepsy drugs](#) (AEDs) for general guidelines, as well as specific [Pregabalin](#) listing for more information and references.

Therefore, the Reviewer is in agreement with Dr. Agana that these three medications are justified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)