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DATE OF REVIEW: 01/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO Retrospective Review

Work Hardening 97545 and 97546 for dates of service 8/4/09-8/07/09, 08/10/09-08/14/09, 08/17/09 -08/21/09, 08/24/09 - 08/28/09, 08/31/09 and 09/03/09-09/04/09

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

This case was reviewed by a Texas licensed DC, specializing in Chiropractic. The physician advisor has the following additional qualifications, if applicable:

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO Retrospective Review Work Hardening 97545 and 97546 for dates of service 8/4/09-8/07/09, 08/10/09-08/14/09, 08/17/09 -08/21/09, 08/24/09 - 08/28/09, 08/31/09 and 09/03/09-09/04/09	97545, 97546	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Invoice		1		
2	IRO Request		56		
3	Designated Doctor Report	DO	5	09/30/2009	09/30/2009
4	Diagnostic Test	XXXXX, PA	4	10/07/2008	10/07/2008
5	Diagnostic Test	XXXXX, LLC	2	12/15/2008	12/15/2008
6	Fax Confirmation	XXXXXX	1	12/21/2009	12/21/2009
7	Fax Confirmation		2	12/09/2009	02/11/2009
8	Fax Confirmation	Texas Department of Insurance	1	12/09/2009	12/09/2009

9	FCE Report	Rehab	16	08/17/2009	08/17/2009
10	Invoice	XXXXXX	30	08/04/2009	09/04/2009
11	Op Report	XXXXXX, MD	2	04/16/2009	04/16/2009
12	Office Visit Report	MD	13	02/16/2009	06/08/2009
13	Office Visit Report	MD	2	05/06/2009	05/06/2009
14	Peer Review Report	XXXXXX	5	09/29/2009	09/29/2009
15	PT Notes	DC	2	03/02/2009	03/02/2009
16	RME	DC	1	06/01/2009	06/01/2009
17	RX History	MD	1	07/24/2009	07/24/2009
18	Office Visit Report	Rehab	108	08/03/2009	12/14/2009
19	IRO Record Receipt		7	12/09/2009	12/09/2009
20	IRO Request		5	12/07/2009	12/07/2009
21	Claim File		3	12/09/2009	12/09/2009

PATIENT CLINICAL HISTORY (SUMMARY):

Clinical History Summarized:

This employee is a female employee, who was injured on xx/xx/xx when she fell at work. An Employer's First Report on Injury has not been provided for review.

On 10/7/08, approximately 3 weeks post injury date, the employee was seen at XXXXX, PA by MD. Chief complaint was bilateral knee pain, worse at night. X-rays of the right and left knee and lumbar spine were performed on 10/7/08 and read by M.D. on 10/8/08. Impressions included the following:

- Left knee: negative for fracture or dislocation/neoplasia; there appears to be a fabella, although remotely I cannot totally exclude an intra-articular loose body
- Right knee: degenerative osteoarthritic changes involving the right knee with narrowing of the medial compartment; at least two calcific intra-articular loose bodies are identified with differential to include old trauma or remotely synovial osteochondromatosis
- Lumbar spine: negative for fractures, stenosis, subluxation or gross neural foraminal narrowing/neoplasia; the sacroiliac joints are open/unremarkable; negative for gross scoliosis of the lumbar spine

There appears to be a diagnosis listed of contusion bilateral knee.

On 12/15/08, the employee underwent a weight bearing upright MRI of the right knee, performed at the Upright MRI LLC. This study, read by Dr. revealed the following impression: horizontal tear of the body and posterior horn of the medial meniscus; horizontal tear at the outer margin of the posterior horn of the lateral meniscus; osteochondral injury at the posterior inferior surface of the medial femoral condyles; focal chondral injury at the articular cartilage of the lateral femoral condyles; probable complete rupture of the ACL; moderate to marked chondromalacia patella; mild to moderate tibiofemoral and patellofemoral osteoarthritis; mild to moderate joint effusion; and ganglion within the posterior intercondylar tunnel.

On 2/16/09, the employee was evaluated by, M.D. on referral by Dr. Complaint is right knee pain. MRI was reviewed a diagnosis is "as MRI". Recommendations included right knee injection, PT and if no relief, arthroscopy. Dr. issued a Rx for PT to right knee 3 x 4 weeks; a DWC 73 noting the employee was off work; and a request for right knee injection. Dr. also noted that the employee was a well developed, well nourished female in no distress; and this notation continues to appear on all follow up visits, as well.

On 2/18/09, the employee underwent a right knee injection performed by Dr. with a follow up visit scheduled for 1 month.

On 3/16/09, the employee had a follow up visit with Dr. at which time it was noted that the injections were of no benefit and the employee was still doing physical therapy. Dr. recommended right knee debridement with resection torn menisci and inspection of osteochondral injury right knee and possible debridement. The employee was continued to be off work through 4/16/09.

On 4/16/09, the employee underwent right knee surgery, performed by Dr. at the XXXXXXX, LLP. According to the operative report, the surgery consisted of right knee arthroscopy, arthroscopic resection of subtotal right medial meniscus, chondroplasty of medial femoral condyle and chondroplasty of lateral femoral condyle. It was noted that the lateral meniscus and lateral tibial plateau was normal.

On 4/27/09, the employee had a post op visit with Dr. at which time the employee was given a refill on Vicodin Extra Strength, a RX for PT and instructed to follow up in 1 month.

On 5/6/09, the employee was evaluated by M.D. at the XXXXXX PA on referral by Dr. Examination was entirely normal except for a slightly swollen and tender over the lateral aspect right knee. Impression included torn ligament of the right knee and s/p right knee surgery. Future therapeutic options were

discussed to include medications, therapy to the right knee and follow up in one month. Dr. also noted review of systems, psychological, that the employee "was not depressed and is alert".

On 6/4/09, the employee completed physical therapy session # 12 at the XXXXXX PA under the direction of DC. It was noted that the employee had completed her treatment plan with fair results and the knee was still painful and swollen. However, it was also documented that the employee's ROM was improved to almost 120 degrees of flexion.

On 6/8/09, the employee had a follow up visit with Dr. at which time it was noted that she was still complaining of right knee pain; there was no change in physical exam; that the employee has reached MMI, she may return to work on 6/9/09 and she should be evaluated for IR. It appears that Dr. referred the employee to Dr. to perform the IR. Records include a 1 page DWC 69 Report of Medical Evaluation dated 6/00/2009 which states that an exam was performed on 06/00/2009; that the employee had reached clinical MMI as of 06/00/2009; and that the IR was ? %.

According to the undated Statement of Medical Necessity, signed by Dr., D.P.M., the employee's treating doctor, M.D., released the employee back to work with restrictions on June 11, 2009 and Ms. went to her employer on the same day. However, her manager sent her away stating that they do not have any positions that fulfill the restrictions. She was told to return when she can perform her job without limitations. Dr. also states that not knowing what to do she returned to Dr. who then referred her for a Work hardening Program to rehab her to be able to RTW.

According to a Billing Retrospective Review report dated 9/29/09, an FCE was performed on 6/19/09 which revealed that the employee was functioning at a light physical demand level and that her job requirement level was medium; and that it was recommended that the employee participate in a WH program. This FCE report has not been provided for review to this evaluator.

On 7/24/09, Dr. issued a prescription stating "refer for Work Hardening" and noted that the only medication the employee was taking was Indocin SR 1 po twice daily # 20.

According to the submitted records, to include the explanation of benefits reports, the employee participated in a WH program beginning on 8/4/09 thru 9/4/09 for a total of 20 sessions at the XXXXX under the direction of, D.P.M., Director of WH program. Records indicate the employee did not complete a Psychological Issue and Symptoms Checklist until 8/5/09; and on 8/5/09, Ph.D., indicated that code 90801 was performed. This code is for a psychiatric diagnostic interview examination. Dr. noted that her score on the BDI-II was 18 (mild to moderate) and her score on the BAI was 21 (moderate); and the plan noted the employee was a good candidate for the WH program. It is noted that the BDI and BAI reports are not provided in the submitted records. Records indicate that a Vocational Initial Interview was not performed until 8/10/09 by, MA, CRC, CVE

On 8/17/09, an FCE was performed which concluded that the employee was functioning at a sedentary PDL; that based on this evaluation and a self-reported job description she needs to be at a medium PDL; and that based on her presentation and clinical history her condition is worsening. It was also noted that dynamic lifting protocol was stopped by the employee due to psychophysical factors. Finally, on page 1 of the FCE report it is noted that under work status, the following is stated: "currently working part time".

On 8/18/09, a re-evaluation report was issued by Dr. to Dr. which stated the following:

"Ms. has completed 10 sessions of work hardening and a re-evaluation was performed. Her attendance is excellent and motivation is high. However, due to her learning disability and high pain, her progress is slow. She has made greater progress in non-material handling activities than with her lifting schedule due to high pain focus and anxiety. She has improved her endurance, as she is now able to ride a stationary bike for 25 minutes from 5 minutes, sitting for 45 minutes from 10 minutes, standing for 25 minutes from 5 minutes and walking for 20 minutes from 5 minutes. She is able to perform more with fewer breaks. She has improved her lifting from 10 lbs at 5 repetitions to 10 lbs at 10 repetitions. She is able to do all this although still experiencing high pain levels. The psychologist has assessed her and relayed that she continues to have pain issues but that it can be addressed within the work hardening program.

It is our opinion that Ms. has made slow progress but can make further improvement with additional sessions of work hardening."

On 9/29/09, a Billing Retrospective Review was performed by, D.O. with XXXXX This physician, who is Board Certified in PM & R, noted, in part, that the employee began a WH program on 8/4/09 and completed 16 sessions; and that he had made 3 attempts on 3 different days to hold a peer to peer discussion with Dr. Also noted was the following:

"According to a team conference date of 08/12/09, the patient was still functioning at a sedentary to light physical demand level with the job requirement physical demand level of medium per report. A repeat Functional Capacity Evaluation was obtained on 08/17/09, which revealed that the patient was functioning at a sedentary physical demand level and that she required the medium physical demand level per report. There was also no indication as to why 16 sessions of the work hardening program were required."

Dr. concluded, in part, the following:

"None of the work hardening program treatment was medically reasonable or necessary from 08/04/09 onward. There was no documented psychological evaluation detailing the medical necessity for the work hardening program

including no indication of any specific psychological dysfunction or psychological issues occurring that would justify a multidisciplinary rehabilitation program such as work hardening. There was also no clear detail provided as to why the patient could not achieve her functional goals with a work conditioning program. There was also no indication from the work hardening progress notes that were available for review that the patient made any specific significant overall functional gains as she was still functioning at a sedentary to light physical demand level both before the work hardening program started and after the program has been done based on the most recent Functional Capacity Evaluation that was obtained on 08/17/09. There was also no indication that the patient had any specific job to return back to, duties, but no indication that the patient's employer had the specific job that she could go back to, or whether some type of job retraining would be required or not.

There was also no indication that the patient was making significant gains in the work hardening program as well, which also indicated that it was not necessary to continue the work hardening program for the total of 16 sessions that were done."

On 9/30/09, the employee was evaluated by, D.O., a TDI-DWC appointed Designated Doctor, who determined the employee had reached clinical MMI as of 9/30/09 and assigned an 8% IR. Dr. states that this rating is based on the ROM model for loss of range of motion on flexion (92 degrees, 4%) and extension (-5, 4%); however, these values are inconsistent with what was previously documented in the records. In addition, Dr. states the employee underwent partial medial and lateral meniscectomies which is not consistent with the operative report dated 4/16/09. Dr. issued a DWC 73 indicating the employee may RTW w/o restrictions as of 9/30/09. Finally, Dr. also notes a Beck Depression Score of 51 and a Beck Anxiety Inventory of 41 which places her in severe levels of depression and anxiety.

On 12/14/09, Dr. submitted a letter addressed "Dear IRO reviewer" in which she states the following:

"On September 14, 2008 while descending a wet stairwell at the hotel after hurricane IKE, Ms. slipped and fell twisting and landing on her right knee. She was employed as a laundry room laborer with a Hotel. MRI study confirmed medial and lateral meniscus tears with underlying chondromalacia patella. Ms. underwent right knee surgery and was referred for Work Hardening by her treating physician, M.D. Her initial FCE placed her at a sedentary -light ability level. Psychological screening revealed she was severely depressed and anxious secondary to her condition and ability to RTW. Pre-enrollment discussion with the interdisciplinary team of our CARF accredited program concluded that she would be an appropriate candidate for Work Hardening as outlined in ODG. The psychological assessments and mental health evaluation were all submitted to the carrier along with the Work hardening notes, Team conference reports and group psychotherapy notes.

Ms. began the program with high motivation of returning to work. After completion of 10 sessions of Work Hardening, the progress was discussed among the team. A letter (see attached) to the referring physician, Dr. was sent indicating the progress made and psychologist recommendations. Ms. high non-lean body mass, poor body posture, underlying degenerative joint disease, learning disability and abnormal psychological disposition all contributed to the slow progress. Her depression and anxiety was worsening because of the slow progress. However, she remained very motivated to return to work as she had already lost her apartment and her car because her employer would not accept her back with limitations. It is based on discussions with Ms. regarding her slow progress and with the understood goal of helping her to return to work as a laundry room laborer, the evident need for additional sessions of Work Hardening after the initial 10 sessions, as recommended by ODG, was decided.

As ODG allows for 10 initial trial sessions prior to re-assessment and since as a CARF accredited facility we were not required to pre-authorize the initial 20 sessions, we believe that a partial allowance is implied by ODG.

In line with ODG "A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required", additional sessions were planned to further her progress. The patient was extremely motivated to complete the program and wanted to avoid a knee fusion. However, upon approaching the end of the additional session her symptoms were worsening so we discontinued the program and she was returned to her treating physician for further recommendations."

Disputed Services:

Work hardening services, codes 97545 and 97546, for dates of service 8/4/09-8/7/09, 8/10/09-8/14/09, 8/17/09-8/21/09, 8/24/09-8/28/09, 8/31/09 and 9/3/09-9/4/09

Analysis and Explanation of the DECISION INCLUDE clinical basis, Findings and Conclusions Used to Support the Decision:

I disagree with the requestor. Work hardening services, codes 97545 and 97546, for dates of service 8/4/09-8/7/09, 8/10/09-8/14/09, 8/17/09-8/21/09, 8/24/09-8/28/09, 8/31/09 and 9/3/09-9/4/09 were not reasonable, indicated, medically necessary or in keeping with ODG recommendations.

Rationale/Basis for Decision:

Based upon review of the records, in my opinion, the documentation does not support that a multi-disciplinary return to work program, WH, was reasonable, indicated and medically necessary as related to the injury of 9/14/08. The documentation clearly indicates that the employee did not have any psycho-behavioral issues documented in the records prior to a self-reported assessment on or about 8/5/09, which was 1 day following the commencement of the WH Program. In addition, there was no documentation that the employee had required or undergone any lower levels of care for psycho-behavioral issues prior to beginning the WH program. The employee's work required PDL appears to have been established based on self-reporting by the employee and a written job description from the employer was not obtained. This is not in compliance with ODG, Fitness for Duty Chapter: "When considering whether a worker is fit for duty, an appreciation for the workplace in general and the specific task(s) is crucial. The physician needs a detailed job description from the employer. Ideally, this information should be corroborated by the worker". There is

also noted discrepancies in the submitted records in regards to the employee's actual physical limitations in regards to ROM assessments; the employee's actual functional limitations; the extent of the employee's level of alleged depression and anxiety; and the actual benefit derived from any of the WH sessions. Based upon the records provided, it does not appear that the employee was an appropriate candidate for WH or that the employee meet with the criteria established by ODG for WH: ODG Chapter Knee & Leg re: Work Hardening Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. ([Schonstein-Cochrane, 2003](#)) There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. ([Karjalainen, 2003](#)) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. ([CARF, 2006](#)) ([Washington, 2006](#)) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable [functional improvement](#) should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. ([Schonstein-Cochrane, 2008](#)) For more information and references, see the [Low Back Chapter](#). The Low Back WH & WC Criteria are copied below.

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

Criteria for admission to a Work Hardening (WH) Program:

- (1) *Prescription:* The program has been recommended by a physician or nurse case manager, and a prescription has been provided.
- (2) *Screening Documentation:* Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.
- (3) *Job demands:* A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).
- (4) *Functional capacity evaluations (FCEs):* A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.
- (5) *Previous PT:* There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.
- (6) *Rule out surgery:* The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).
- (7) *Healing:* Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
- (8) *Other contraindications:* There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.
- (9) *RTW plan:* A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.
- (10) *Drug problems:* There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.
- (11) *Program documentation:* The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.

- (12) *Further mental health evaluation*: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.
- (13) *Supervision*: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.
- (14) *Trial*: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.
- (15) *Concurrently working*: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.
- (16) *Conferences*: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.
- (17) *Voc rehab*: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.
- (18) *Post-injury cap*: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see [Chronic pain programs](#)).
- (19) *Program timelines*: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.
- (20) *Discharge documentation*: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.
- (21) *Repetition*: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**