



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**CLAIMS EVAL REVIEWER REPORT - WC**

**DATE OF REVIEW:**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

ASC transforaminal ESI with selective NRB L4-5 64483, 64450

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

American Board of Orthopaedic Surgery-Board Certified

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

On 7-12-06, MD., the claimant is a male that presents with low back pain and bilateral leg pain. The lumbar pain began after a xxxx injury after lifting a box of approximately 80 lbs causing immediate pulling pain. He was diagnosed with HNP and had L4-L5 discectomy surgery by Dr. on 12-6-01, which gave him good relief of leg symptoms but the low back pain remained the same and he never returned to work. The claimant had physical therapy and chiropractic care which did not help. The evaluator stressed the need for proper body mechanics. The evaluator recommended a lumbar MRI. He will probably require a lumbar fusion to improve the leg and back pain.

8-11-06 MRI of the lumbar spine with and without contrast showed status post left laminectomy at L4 without evidence of epidural fibrosis. Disc desiccation from L3-L4 through L5-S1. Multilevel spinal canal and neural foraminal stenosis.

10-3-06 Left L4-L5 transforaminal epidural steroid injection.

10-12-06 Bilateral L4-L5 and L5-S1 facet injection.

Follow up with Dr. on 10-27-06 notes the claimant had facet blocks without any change to his presentation. The evaluator requested a left sided transforaminal epidural steroid injection at the L4-L5 level.

11-15-06 Left L4-L5 transforaminal epidural steroid injection.

Follow up with Dr. on 2-14-07 notes the claimant had a left sided L5-S1 transforaminal epidural steroid injection on 1-30-07 and reported he is not having any relief in pain. The evaluator reported that now that he has tried conservative treatment through therapy, medications, facet block injections and an L4-L5 and L5-S1 transforaminal epidural steroid injection without any considerable amount of relief of symptoms, he recommended a lumbar discogram to try to identify if the symptoms are discogenic.

Follow up with Dr. on 3-19-08 notes the claimant reports pain with increased activity. The claimant had tenderness over the paraspinal muscles and the lumbosacral region. He has a positive SLR but negative Patrick's test. The evaluator requested bilateral facet block injection.

Follow up with Dr. on 10-8-09 notes the claimant received a denial for the requested lumbar discogram.

11-9-09, MD., the claimant reports his symptoms have progressively worsened without any particular traumatic event. Therefore, the evaluator recommended a lumbar MRI.

12-3-09 MRI of the lumbar spine shows left laminotomy L4 and L5 with epidural fibrosis in the lateral recess on the left at both levels. Hypertrophic changes at L5-S1 are producing moderate bilateral foraminal stenosis.

Follow up with Dr. on 3-26-10 notes the recommendation for a left L5-S1 transforaminal epidural steroid injection due to the claimant's symptoms.

Follow up with Dr. on 5-20-10 notes the claimant has received a second denial from the

requested epidural steroid injection. Therefore, at this point, he was submitting for an IRO.

3-26-10., the claimant continues to function as much as possible as well as exercising. The lower extremity radicular symptoms are the primary debilitating factor. On exam, the claimant has decreased sensation along the anterior, lateral and posterior thigh as well as some decreased sensation along the posterior and lateral aspect of the lower leg. Motor function is intact. There is a decrease on the diameter of the left calf. The right measures 41 cm and left measures 38 cm. the evaluator requested a left L5-S1 transforaminal epidural steroid injection.

5-20-10, MD., the claimant continues to struggle with lumbar pain. On exam, he has guarded range of motion, tenderness of the paraspinous muscles. Lower extremities with continued decreased sensation along the posterior and lateral aspect of the thigh and lower legs, on the left more so than on the right. The previously identified muscular atrophy continues unchanged from before. The claimant has been denied two epidural steroid injection, he will submit for an IRO.

6-24-10 Left L5-S1 transforaminal epidural steroid injection, left L5 selective nerve root injection.

7-8-10, MD., the claimant is back after undergone left sided L5-S1 transforaminal epidural steroid injection with an L5 selective nerve root block on 6-24-10. From this procedure, he reported he did not had any relief to any of the symptoms at this point. He continues to struggle with the lumbar pain as well as the bilateral posterior sharp pulling pain that can escalate 8/10. The evaluator reported the claimant had no relief with the transforaminal epidural steroid injection, a caudal epidural steroid injection would be indicated taking the consideration of the fibrosis noted from his previous laminectomy. The claimant wishes to proceed with the injection.

7-29-10, MD., the claimant was denied the previously requested caudal injection with the rationale that the prior transforaminal epidural steroid injection did not help the claimant. However, it is very clearly specified that more than likely the reason that this was not ineffective treatment for him was because of his epidural fibrosis. Therefore, it makes sense to proceed at this point with a caudal epidural steroid injection to be both diagnostic and therapeutic for his symptoms.

10-20-10, MD., the claimant tries to be as active as possible; however, he is back reporting that both his lumbar pain, left lateral pelvic and thigh pain has increased even more over the last couple of weeks with a base line of 8 on a scale of 10. He walks on a regular basis, but once he becomes either stationary or stands without motion for a period of greater than 10 minutes, it is very difficult for him to start walking again. Although he had proof of sending the necessary paperwork for an IRO, the representative states not having received anything and therefore he is not willing to discuss the possibility of a review. On exam, The patient stands from a seated position with some difficulty, but with his left leg outstretched. The lumbar spine has a guarded motion that exacerbates on extension and lateral tilt. There is tenderness of the left paraspinous muscles, left lumbosacral region, and left gluteus minimus. The lower extremities have hyperesthesias along the left lateral and posterior thigh with a quick fatigue of the left hip flexor. There is a positive left straight leg raise test with a negative bilateral Patrick's. The left Achilles reflex is absent. Plan: He has been denied

the right to have an epidural injection even to the point of the IRO by the unethical typical practice of the Insurance company denying that the paper actually was submitted in time, although there is a proof that it did get there. Insurance companies are well known not for ethical values, but for financial gain. Therefore, the patient needs to restart the entire process in the hopes that someone that actually decides to work and not just ignore the patient's symptoms and reviews his case. We would like to begin the process with requesting a caudal injection since the transforaminal epidural injection was not effective for him due to the previously diagnosed epidural scar. He is encouraged to maintain high levels of activity and try to avoid any type of direct heavy lifting. He discussed the medication regiment and possible side effects of the medications.

1-26-11, MD., the claimant is back reporting that since his last visit, although he continues to walk on a regular basis, the distance that he is able to tolerate has decreased to now no more than 30 minutes at one particular time. The lumbar pain continues to be a constant presence that can escalate to levels of 8 on a scale of 0 to 10. He has been having some left leg irritation and hyperesthesias on the lateral aspect of the thigh, but it does not extend beyond the knee level. On exam, The patient has some difficulty standing from a seated position as he keeps his left leg outstretched.

The lumbar spine has a guarded motion that exacerbates on flexion, extension, and lateral tilt. There is tenderness of the paraspinal muscles in the lumbosacral region, on the left greater than on the right. The lower extremities have hyperesthesias on the left lateral thigh and posterior and lateral lower. There is quick fatigue of the left hip flexor and a positive left straight leg raise test. There is an absent of left Achilles reflex. Discussion: He had spoken with the adjuster who stated that because the patient has not had any change to his presentation, the injection would not be reviewed. She went on to say that that they would suggest six sessions of physical therapy to see if this would help or change the symptoms. This is ironic that an adjuster considers the possibility of practicing medicine without a license and suggesting treatment for a patient that is not only unnecessary, but useless for this particular situation. The patient has consistent, persistent, and reproducible neurological changes to his left leg for which treatment is indicated. Yet, the adjuster believes that she can practice medicine over the phone without actually ever seeing the patient. Therefore, at this point, he will submit for reconsideration of the caudal injection for this patient to help his radicular symptoms.

4-26-11, MD., the claimant reports that he tries to be active and walk on a regular basis. However, with anything greater than 30 minutes of direct weightbearing and walking exercises, the left leg begins to develop a dull pain of 6 on a scale of 10 along the lateral aspect of the thigh and into the lower leg with fatigue and occasional giving way. He has to have multiple periods of rest in order to be able to return whenever he is walking for exercise. Medication helps with the sharper edge of the pain, but at no point is he ever completely comfortable. On exam, the patient stands in a very slow pattern in a semi-kyphotic position propelling him forward by the use of the armrest. The lumbar spine has a very guarded movement that exacerbates easily with flexion, lateral tilt, and rotation. There is tenderness of the paraspinal muscles on the left as well as the left lumbosacral region. The lower extremities have the hyperesthesias along the left lateral thigh with a decreased sensation along the left posterior and lateral lower leg. There is a positive left straight leg raise test and a quick fatigue of the left hip flexor, There is an absence of a left Achilles reflexes. Plan: The patient continues to fight with his adjuster regarding the need for an epidural injection. However, he has been having several

adjuster changes and none of which are willing to help him. They all claimed that he does not meet the standards for the epidural injections, yet he has met every one of them. He is encouraged to stay active, avoid heavy lifting. He has received a prescription of Tramadol, Relafen, and Soma. He discussed the potential side effects of long term medication usage. He discussed an exercise program.

7-25-11, MD., the claimant reports that his lumbar pain remains unchanged from before and he is unable to walk for a period of greater than 30 minutes for having to stop and rest. This pain can escalate to levels of 6 on a scale of 0 to 10. The left leg radicular pain also remains consistent with a dull pain pattern along the lateral aspect of the thigh and lateral and posterior lower leg. There is quick fatigue of the left leg with several incidents of giving way, but has not had any falls. The medication only helps curb the sharper edge of the pain. On exam, The patient stands very slowly from a seated position with his left leg outstretched and propelling himself forward. The lumbar spine has a very guarded movement that exacerbates on flexion, extension, and bilateral rotation. There is tenderness of the paraspinal muscle and left lumbosacral region. The lower extremities have hyperesthesias along the left lateral thigh with numbness along the left lateral and posterior lower leg. There is a positive left straight leg raise test and quick fatigue of the left hip flexor, There are no reflexes that could be assessed on the left Achilles or patellar region. Plan: The patient's symptoms continue and at times could be more aggressive than before. Therefore, at this time, he would like to proceed with a left-sided L4-5 transforaminal epidural injection with selective nerve root block to be both diagnostic and therapeutic for this patient's symptoms. The risks of the procedure were discussed. The patient is very cognizant they will need to stay on top of this and not allow any lapse time between denials of the insurance company which are more than likely. He is encouraged to stay active, avoid heavy lifting, and maintain proper body mechanics.

8-3-11, MD., performed a Utilization Review. In the medical report dated, the patient presents with lumbar pain with radicular pain along the left leg and thigh. On physical examination, the lumbar spine has a very guarded movement. There is tenderness of the paraspinal muscle and left lumbosacral region. The lower extremities have hyperesthesia along the left lateral thigh with numbness along the left lateral and posterior lower leg. There is a positive Left Straight Leg Raise test and quick fatigue of the left hip flexor. A request for ASC Transforaminal ESI with selective nerve root block L4-5 is made. Objective documentation that the patient has received and failed maximal and optimal conservative care (Physical therapy, medications, and activity modification) is not submitted for review. There are no procedural reports submitted for review with regard to the previous ESI that was performed. As such, the medical necessity of the request is not fully established at this time. Determination: Non-certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for ASC Transforaminal ESI with selective nerve root block L4-5 64483 64450 is non-certified.

8-12-11, MD., the claimant is an active individual, the constant and variable lumbar pain limits many of his functions. He states that he walks at least three times a week for two laps with equivalency of greater than two miles. By the time he finishes the first quarter of a lap, he does it with a constant lumbar pressure pain, He alternates his routine every other day because by the following day, his lumbar pain is worsened and he is unable to walk for long periods of time. The lower extremity radicular symptoms are also intermittent, but not as aggressive. Most of the symptoms are radiating to the left lateral

thigh and the anterior, lateral, and posterior lower leg on the left. After a conversation with the patient's adjuster she stated that originally she denied the prior epidural injection was because she did not have the documentation results of the prior injection that was done in February 2010. Furthermore, there was also no evidence of any type of conservative treatment, physical therapy, or home program including medications. On exam, The patient is sitting down in a slouched position with his legs outstretched to help his symptoms. He has a hard time standing from a sitting position and does it in a very slow guarded movement. The lumbar spine has a guarded motion that exacerbates easily on extension and flexion, although he is able to reach to his knees. The lower extremities have some hyperesthesias along the left lateral thigh with numbness along the left anterior and lateral lower leg. There is a positive left straight leg raise test and an absence of reflexes on the left Achilles. Assessment: Lumbar radiculopathy, lumbar internal disc derangement, lumbar foraminal stenosis. Plan: The patient continues to participate in an active conservative treatment approach that included not only the medications, but the regular walking and stretching that he does at least three times a week. The reason that the prior epidural injection was not listed is because this is a different nerve root that is being injected. He was looking to inject the left-sided L4-L5 while the injection that was given back in February was on the left-sided L5-S1 which did not help the symptoms. The patient is a proactive individual that has considerably changed his medications and no longer taking any narcotics. Nonetheless, the radicular symptoms and lumbar pain do limit his functions. Therefore, at this point, he answered all the requirements stated for by the adjuster in the hopes that by resubmitting for this epidural injection gets accepted in order to help provide improvement to the patient's symptoms and increase his quality of life.

8-23-11, MD., performed a Utilization Review. As per 8/12/11 note, the patient presents with lumbar pain with radicular pain along the left leg and thigh. On physical examination, the lumbar spine has a very guarded movement and difficulty to rise from a seated position. There is numbness along the left anterior and lateral lower leg. There is a positive SLR on the left and absent Achilles reflex. The MRI revealed mild foraminal stenosis at L4-5. The attending is appealing the request for transforaminal epidural with selective nerve root block at L4-5. However, there is no objective documentation that the patient has undergone and failed a course of physical therapy as part of conservative measures. The patient was noted to be doing exercises, but active rehabilitative efforts with evidence-based therapy sessions were not documented with PT reports. Likewise, maximized pharmacotherapy was not substantiated with pain and symptom logs with medication use. At this point in time, the medical necessity of this request is not fully established. Determination: This request is not certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for an appeal transforaminal epidural with selective nerve root block L4-5 6445 6440 is not certified.

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

Neurologically, an absence of the Achilles reflex is not cause by an L4/L5 neuroforaminal narrowing. Also the description of a positive straight leg raising is not defined or described. Low back pain or buttocks pain is not a positive SLR. As noted by current literature listed below, this injection is only of short term benefit and is not curative. I do not see objective evidence of a neurological change as related to the L4/L5 neuroforaminal narrowing. Therefore, the request for ASC transforaminal ESI

with selective NRB L4-5 64483, 64450 is not reasonable or medically necessary.

**ODG-TWC, last update 8-4-11 Occupational Disorders of the Low Back – Epidural steroid injection:** Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

Short-term symptoms: **The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program.** There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986) (ISIS, 1999) (DePalma, 2005) (Molloy, 2005) (Wilson-MacDonald, 2005) This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week. (Koc, 2009)

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)

Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part,

secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti, 2003) (CMS, 2004) (Delpont, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) (Buenaventura, 2009) Also see Epidural steroid injections, “series of three” and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 2009)

### **Criteria for the use of Epidural steroid injections:**

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there

was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.

(5) No more than two nerve root levels should be injected using transforaminal blocks.

(6) No more than one interlaminar level should be injected at one session.

(7) Therapeutic phase: If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**