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Notice of Independent Review Decision

DATE: July 16, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 Hours of Chronic Pain Management

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

This physician is a Board Certified Pain Management Physician with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

04/29/11: Operative Report by MD with Surgery Center
06/13/11: Initial Comprehensive Evaluation by DO with Medical Rehabilitation
08/31/11: Letter of Request for Rehab by DC with Health Center
03/22/12: History and Physical CPM by MD
03/22/12: Functional Capacity Evaluation by JDC with Center
03/28/12: Initial Behavioral Medicine Consultation by PsyD
05/15/12: History and Physical CPM by DO
05/16/12: Assessment/Evaluation for Chronic Pain Management Program by, LPC and, PhD with Injury 1
05/16/12: Chronic Pain Management Interdisciplinary Plan and Goals of Treatment by DO, LPC, and DC
05/22/12: Psychological Assessment Report by PsyD with Injury 1
05/25/12: Chronic Pain Management Program Preauthorization Request by with Injury 1
06/05/12: UR performed by PhD
06/14/12: Reconsideration Request by PsyD with Injury 1
06/22/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained a work-related injury to her bilateral upper extremities on xx/xx/xx. She is status post bilateral carpal tunnel releases.

04/29/11: Operative Report by MD. Postoperative Diagnosis: 1. Right carpal tunnel syndrome. 2. Right cubital tunnel syndrome. Procedure Performed: 1. Right endoscopic carpal tunnel release. 2. Right ulnar nerve decompression at the elbow.

06/13/11: The claimant was evaluated by DO who noted that she had developed pain in the right wrist area. She also described pain in the left wrist as well as bilateral elbow pain. On physical exam, soft tissue palpation of the right upper extremity indicated severe muscle tightness of the right wrist. There was moderate perceptible swelling noted of the right wrist. Soft tissue palpation indicated severe muscle tightness of the right elbow and moderate swelling at the right elbow. Soft tissue palpation indicated moderate hypertonicity of the left wrist, intense degree of tenderness, and moderate swelling at the left wrist. There was also moderate tenderness at the left elbow. Triceps reflex bilaterally was 2/5, biceps reflex bilaterally was 2/5, and brachioradialis reflex bilaterally was 2/5. Bracelet test was positive bilaterally. Phalen's sign was positive bilaterally. Mill's test was positive on the right. Tinel's sign at the elbow was present bilaterally. Elbow flexion test was positive bilaterally. Left elbow ROM flexion was 125 degrees, extension -3 degrees, pronation 83 degrees, and supination 82 degrees. Right elbow ROM flexion was 124 degrees, extension -4 degrees, pronation 83 degrees, and supination 77 degrees. Left wrist ROM flexion was 67 degrees, extension was 58 degrees, radial deviation was 9 degrees, ulnar deviation was 8 degrees. Right wrist ROM flexion was 63 degrees, extension was 55 degrees, radial deviation was 8 degrees, and ulnar deviation was 8 degrees. PLAN: The patient is in an acute care program. She will be referred out for physical therapy.

08/13/11: The claimant was evaluated by DC who noted that she was status post right cubital and carpal tunnel releases and that she had completed 12 sessions of rehab to date. She stated that she was better since surgery but was still having daily pain rated at 1-4/10 in the right elbow and right wrist. Her right elbow ROMs were improved but still decreased to 70-75% of normal. Her strengths of the right wrist were better but still decreased to 4/5 in flexion. Her right wrist ROMs were improved but still decreased to 80-85% of normal. Dr. requested 12 sessions of continued postop active rehab to the right elbow and wrist.

03/22/12: The claimant was evaluated by, MD who noted that she was sent for the chronic pain management program. Current medications included Neurontin and ibuprofen. On physical exam, she had full range of motion in the shoulders, elbows, and wrists bilaterally. PLAN: 1. Patient will be an excellent candidate for the chronic pain management program. 2. She will continue to see her treating physician. 3. I will reevaluate her in 4 weeks.

03/22/12: Functional Capacity Evaluation by, DO. RECOMMENDATIONS: 1. Any referrals the treating doctor feels necessary that will help the evaluatee's condition. 2. Recommend participation in a multidisciplinary Chronic Pain Management program to further address mental and psychological issues that are complicating evaluatee's progress in their treatment program and ultimately their return to gainful employment. 3. According to the objective findings from the testing including PILE lifting, static lifting, the clinical examination, and all other activities previously mentioned in this report; it is my opinion that this evaluatee does not meet the requirements, safety, and performance ability to do their job safely, effectively, and confidently (without restrictions). The

evaluee is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.

03/28/12: The claimant was evaluated by PsyD who stated that she continued to have pain. Current medications included Neurontin and ibuprofen. She self-rated her pain as 7/10 with medication, 8/10 without medication, and 8/10 daily average pain. She scored 52 on the BDI-II, indicating severe depression. Her score on the BAI was 46, reflecting severe anxiety. Her responses on the FABQ showed significant fear avoidance of work as well as significant fear avoidance of physical activity in general.

05/15/12: The claimant was evaluated by DO who stated that she had undergone cubital and carpal tunnel releases on both arms. Current medications included ibuprofen, Amitriptyline, and Neurontin. On physical exam, there was continued tenderness over both carpal tunnels, which was somewhat improved from previous. The cubital tunnel areas were nontender with negative Tinel's sign. PLAN AND RECOMMENDATIONS: I think this patient should progress a chronic pain program. I will maintain her on her Elavil to help her sleep and she is only taking an as needed basis at this point. The patient understands the purpose of program is to return her back to the work force which may affect secondary gains. I will refill her Elavil today.

05/16/12: The claimant was evaluated by LPC and PhD for participation in the Chronic Pain Management Program. TREATMENT RECOMMENDATION/PLAN: We concur with Dr. recommendation that the patient participate in a Chronic Pain Management Program as Ms. has exhausted conservative treatment including surgeries on both wrists, physical therapy, and individual psychotherapy, yet continues to struggle with pain and functional problems that pose difficulty to her performance of routine demands of living and occupational functioning. Thus, it is recommended that Ms. be approved for participation in the Chronic Pain Management Program in order to increase her physical and functional tolerances while decreasing her fear avoidance behaviors so as to facilitate a safe and successful return to work.

05/22/12: The claimant was evaluated by PsyD who noted that she indicated she had more than 30 physical therapy sessions without much change in her pain and that she participated in four individual psychotherapy sessions. Current medications included Amitriptyline, ibuprofen, Neurontin, and Elavil. She reported her average daily pain as 6/10. She reported difficulty with acts of daily living. She scored 16 on the BDI-II, indicating mild depression. She scored 8 on the BAI, reflecting mild anxiety. Her responses on the FABQ showed significant fear avoidance of work as well as non-significant fear avoidance of physical activity in general. MMPI-2 interpretation indicated that her depressed mood was accompanied by physical complaints and extreme fatigue. BHI-2: She did not endorse any of the validity items, which reduces the risk that this profile was produced by random responding. MULTIAxIAL DIAGNOSIS: Axis I: Pain disorder associated with both psychological factors and a medical condition, chronic. Major Depressive Disorder, single episode, moderate. Axis III: Injury to bilateral upper extremities. Axis IV: Primary support group, social environment, economic, and occupational. Axis V: GAF: Current 58; Estimated Pre-Injury: 82+. TREATMENT RECOMMENDATION/PLAN: We concur with Dr. Trinh's recommendation that the patient participate in a Chronic Pain Management Program as

Ms. has exhausted conservative treatment including surgeries on both wrists, physical therapy, and individual psychotherapy yet continues to struggle with pain and functional problems that pose difficulty to her performance of routine demands of living and occupational functioning.

05/25/12: Chronic Pain Management Program Preauthorization Request by with Injury 1 . SUMMARY: Please recall that prior treatment modalities have failed to stabilize Ms. psychosocial distress, increase her engagement in activities of daily living, or enhance her physical functioning such that she could safely return to work. Ms. is approximately two years status post injury. Her pain is chronic, persistent, and intractable at 4/8/10, depending on her level of activity. Conservative care has not been sufficient to extinguish her pain or increase her functional tolerances such that she could successfully return to her previous position. She describes limited functioning within daily, job, and familial activities. She has developed a chronic pain syndrome; the treatment of choice is participation in an interdisciplinary pain rehabilitation program. Ms. treating doctor has prescribed participation in an interdisciplinary chronic pain rehabilitation program as medically necessary. This intensive level of care is needed to reduce this patient's pain experience, develop self-regulation skills, and facilitate a timely return to the work force.

06/05/12: UR performed by PhD. The mental health evaluation of 5/22/12 finds impressions of pain disorder and major depressive disorder. However, this is inadequate as an evaluation for admission to a comprehensive pain rehabilitation program. The employed psychometric assessments (see also below) are inadequate to support the diagnosis or explicate the clinical problems, to assist in ruling out other conditions which may explain or contribute to the symptoms, and to help design and predict response to treatment and there is no "thorough behavioral psychological examination" to provide a reasonable "manifest explanation for the etiology and maintenance of patient's clinical problems" (i.e., pain complaint, behavior, and disability), to enable a "better understanding of the patient in their social environment," or to provide "a cogent explanation for the identified complaints and dysfunction." Several of the employed psychological tests (BAI, BDI, FABQ, BHI-2) do not have established peer reviewed, post-market reliability, empirical validity and normative data to render appropriate sensitivity and specificity for assessment and diagnosis of patients with this type of presentation. Therefore, this renders the interpretations questionable; they do not serve as a basis for informing differential diagnosis; and an inflated estimate of reported distress and dysfunction may be inferred. There is no MMPI-2 no profile interpretation; and the results are not integrated in the above evaluation. Appropriate interpretation of psychological tests involves "synthesizing all relevant data with test results, consideration of various "characteristics of the person," and adequate clinical/behavioral correlation. This is not evident here. There is no documentation or known finding that the patient's treating physician (Dr.) has currently ruled out all other appropriate care for the chronic pain problem, a pivotal indication for initiating a chronic pain management program. At this time, the patient does not manifest a level of dysfunction and disability consistent with the need for a comprehensive pain management program. Dr. now endorses that there is no dysfunction or disability other than performance of repetitive motion of her hands and wrists; and the patient has not received training in typing or consideration of retraining. There are no reliable data or controlled studies demonstrating favorable outcomes from multidisciplinary pain

rehabilitation for persons with chronic pain complaints secondary to repetitive strain or cumulative trauma injuries of the upper extremities, such as this presentation; and there is no clinical evidence that an exception to this is warranted based on a (absent) through behavioral and functional analysis of the patient's pain behavior and disability, ADL, occupational antecedents, and relevant operant factors. A multidisciplinary decision by the provider on appropriateness for this treatment cannot be made, and a reasonable treatment plan developed, without these assessments. I am not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended.

06/22/12: UR performed by MD. Rationale: Clinical data submitted indicates the list of diagnoses has gradually transitioned into bilateral carpal tunnel syndrome s/p release, ulnar neuropathy at the elbow treated with surgical decompression and radiculitis without documentation of a focal neurocompressive lesion or electrophysiologically identified active nerve root irritation (4/20 and 4/22/10, and repeated on 6/28/10). The worker has undergone at least two Designated Doctor Examinations and one Peer Record Review with the determination of attainment of maximum medical improvement being reversed by the second Designated Doctor, with opinions of outside evaluations in conflict regarding the medical necessity of participation in a work hardening program. The initial non-certification recommendation was based upon the opinion that a thorough psychometric assessment was not performed and the data presented did not represent a level of dysfunction that warranted enrollment in a comprehensive multidisciplinary program. During the peer-to-peer discussion, the issues related to the Mental Health Assessment and psychometric testing as addressed. An explanation was sought as to the nature and extent of the residual physical impairment that may be responsible for the lack of functional recovery at this stage in the process, including the request for documentation from the surgeon as to reasons for failure to progress as had been anticipated. The worker has received benefit of an extensive course of multi-faceted treatment including physical medicine services and individual counseling. There has been consideration of but no agreement as to the medical necessity for participation in a work hardening program in the past, and now the request has escalated into the current request for participation in an extended chronic pain management program. The worker is requiring minimal medication and the functional abilities, while at the light physical demand level, are sufficient for her to perform her work activities, with and without accommodation including ergonomic modifications. The program psychologist had agreed to forward clinical record as may be available from the operating surgeon. What is not evident is the reason the worker has not progressed over the past several months after having been given the opportunity to participate in usual and customary post-operative physical rehabilitation services. There is no documentation as to any reason the worker has not been released to work as she has met the physical requirements for her prior and similar occupations. The worker has been deemed to have attained maximum medical improvement with a zero percent permanent physical impairment rating and with physical abilities that meet or exceed the workplace requirement. There is no explanation for the residual symptoms on the basis of objective physical impairment. The medical necessity for continued multidisciplinary treatment cannot be established in accordance with clinical guidelines and on the basis of the clinical data presented at this time.

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

The previous adverse determinations are upheld. The claimant has attained the functional capacity evaluations at the light physical demand level, which are sufficient for her to perform her work related duties. According to the report of, Psy.D., dated 05/22/12, she has had over 30 physical therapy sessions. These are sufficient sessions to treat the examinee’s functional and physical symptoms.

Previously, on 03/22/12, M.D., evaluated the claimant with a history and physical examination and stated she had full range of motion of the shoulders, elbows, and wrists.

She has had two utilization reviews, the first by Ph.D., who reviewed the psychological data and questioned whether full evaluation of the claimant’s symptoms had been performed. On 06/22/12, a utilization review was performed by M.D. He questioned why the claimant was not released to return to work, as she was stated to be at maximum medical improvement with a zero percent whole person impairment rating.

There is no objective evidence of electrodiagnostic testing of electromyography and nerve conduction velocity to state why the claimant has continued disability, in spite of the 30+ sessions of physical therapy with individual counseling and multifocal treatments. The treatment performed, without objective evidence of continued nerve impairment, has exceeded the ODG guidelines for the claimant’s condition. Therefore, the request for 80 Hours of Chronic Pain Management is not medically necessary and is non certified.

ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in “Delayed recovery.” There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient’s pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below.</p> <p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the following circumstances:</p> <p>(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.</p> <p>(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.</p> <p>(3) An adequate and thorough multidisciplinary evaluation has been made. This should</p>
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include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours

	<p>requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).</p> <p>(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.</p> <p>(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.</p> <p>(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.</p>
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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 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)