



Notice of Independent Review Decision-WC

CLAIMS EVAL

CLAIMS EVAL REVIEWER REPORT - WC

Utilization Review and
Peer Review Services

DATE OF REVIEW: 3-9-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Initial work hardening program x 10 sessions

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Per The Employer's First report of Injury, the claimant sustained a work related injury on xx/xx/xx. On this date the claimant reported an injury due to xxxxx.

The claimant sought medical attention at xxxxx under the direction of Dr. on xxxxx. Conservative care was recommended.

On 7-25-11, the claimant was seen by DC who provided a diagnosis of cervical radiculitis, cervical strain/sprain, right shoulder sprain/strain and lumbar radiculitis. The evaluator recommended preauthorization for physical rehabilitation. The claimant was taken off work.

Chiropractic therapy on 7-27-11, 7-29-11, 8-1-11, 8-3-11, 8-5-11, 8-8-11, 8-10-11, 8-12-11, 8-16-11, 8-17-11, 8-19-11.

Follow up with Dr. on 8-18-11 notes the claimant continued with ongoing radicular complaints in the lower extremities as well as the burning painful sensations down the

right upper extremity. Therefore, he recommended an MRI of the cervical spine and lumbar spine. He also issued the claimant a TENS Unit.

8-19-11 Physical Performance Evaluation notes the claimant is functioning at a Sedentary PDL.

On 8-22-11 Dr. returned the claimant to work with restrictions.

11-5-11 MRI of the cervical spine shows straightening of cervical lordosis in keeping with muscle spasm. 1 mm central bulge at C4-C5. Minimal central posterior bulge at C5-C6.

11-5-11 MRI of the lumbar spine shows straightening of the lumbar lordosis suggestive of spasm. Disc space narrowing with 2.5 mm disc protrusion at T10-T11. Mild hypertrophy of the facets and ligamentum flavum causing mild spinal stenosis with slight foraminal encroachment at L4-L5. Right renal cyst.

On 11-10-11 MD., evaluated the claimant. In exam, he found no gross motor or sensory deficits. DTR were 1-2+ bilateral and symmetric. She has significant paraspinal tenderness to palpation on the L4-L5 segment. The claimant also had positive Kemp's test bilateral and negative SLR bilaterally. The evaluator recommended short course of oral analgesics or anti-inflammatories.

1-5-12 MD., the claimant is seen for followup. She states she did very well with Medrol Dosepak, Celebrex and Tramadol with a combination of therapy. She reported her back pain increased due to the Christmas holidays. Her neck pain has resolved. Assessment: Normal motor and sensory findings. The claimant is neurologically intact. DTR are 2+ bilaterally and symmetric. She has significant tenderness to palpation at the lumbar paraspinals. There is pain left greater than right in the L4-L5 distribution. Positive Kemp's test on the left greater than right noted. Assessment: cervical and lumbar strain/sprain. Plan: the claimant was continued on Tramadol and Celebrex. The claimant is to continue with physical therapy. If she is not better, she may be a candidate to look at her lumbar facets as a possible pain generator source.

1-5-12 Physical Performance Evaluation notes the claimant was performing at a Sedentary- Light PDL.

1-5-12 Initial interview notes the recommendation for a work hardening program in order to better facilitate her reconditioning and return to work.

1-20-12 DC., the claimant's treating doctor of record, referred the claimant to that facility for a work hardening program in conjunction with 4 hours of transitional duty upon approval. In reviewing her case, the claimant stated that she was working at her normal capacity at the time of the accident. According to the patient, she was xxxxxxxx, when she injured her neck, right shoulder, and low back, She stated that she started to experience immediate neck, right shoulder, and low back pain. She reported the incident to her supervisor. Her supervisor referred her to go to the following day, where

she was seen and examined by the attending physician, M.D. Dr. did not perform any diagnostic studies, and diagnosed her with a cervical and lumbar sprain/strain, and to initiate physical therapy at. The day she went to physical therapy to initiate the rehabilitative process at, the physical therapist did not show up, and was told to wait. She became frustrated with her experience at the facility and the fact that she did not undergo any diagnostic studies, so she sought medical treatment under the care of Dr.. Upon examination and assessment with Dr., the patient reported numbness and tingling sensations from the knees down to her feet in both legs. She also states pain radiating down from her neck and into her shoulders and arm. She was referred out for an MRI of the cervical and lumbar spine. The cervical spine MRI results revealed a 1 mm central bulge at C4-C5. There was also a central posterior bulge at C5-C6. Lastly, there was straightening of the cervical lordosis in keeping with muscle spasms. The lumbar MRI revealed disc space narrowing with a 2.5 mm disc herniation at T10-11. There was also hypertrophy of the facets and ligamentum flavum, causing mild spinal stenosis with slight foraminal encroachment at L4-5. Due to her radicular complaints, the patient was referred to a pain management specialist, Dr. in which she was prescribed with Tramadol and Celebrex to manage her pain. The claimant underwent an entrance Functional Capacity Evaluation on 01/05/2012, which revealed her ability to perform at a "Sedentary-Light" physical demand level. The evaluation confirmed that the claimant continues to demonstrate a functional performance deficit, as she has not reached the "Medium" physical demand level required to fulfill her duties as xxxxx for xxxx. According to her job description provided by her supervisor (provided for your review), she must be able to consistently lift objects that weigh 40 lbs. or more. These employees should be prepared to walk and move constantly, bend and twist their bodies and squat to reach stock areas. In addition, inventory stockers should be able to perform tasks involving firm grasping and should be able to reach above the shoulder and below the waste without trouble. The claimant is experiencing decreased cardiovascular conditioning and poor endurance levels. Upper and lower body strengthening is also essential for her to perform her job duties as an inventory stocker for xxxxxx. The claimant has shown significant improvement in her sessions of active physical rehabilitation for the cervical and lumbar spine, According to her treating physician, Dr. the claimant has reached a plateau with the physical rehabilitation of the cervical and lumbar spine and would benefit greatly from the work hardening program. Mrs. expressed moderate anxiety and frustration as to whether she will be able to perform her job at full duty as an inventory stocker, due to the fact that she is struggling at modified duty at this moment. She has been working at modified duty for approximately 5 months now. She exhibits moderate fear of re-injury (as noted by LPC), and she feels that she may not be able to perform the full duty job responsibilities of an Inventory stocker at full duty. The claimant is showing good effort and motivation to return back to work at full duty (as she is currently at modified duty), but cannot currently perform the full duties of an inventory stocker. Since the injury, the patient's feelings of anxiety and depression have been hindering her progression in physical therapy, and he fears the thought of having to undergo any surgeries and/or other invasive procedures to correct her issue. The claimant is now ready for a highly structured work hardening program performed in conjunction with 4 hours of transitional duty upon approval as per Dr. in order to increase her PDL level to "Medium" and return

to work at full duty and to be able to lift at least 40 lbs. The patient has confirmed that her position as is available to her as per his supervisor, although she must attain capability of being able to Lift objects that weigh 40 lbs. or more and be able to walk and move constantly, bend, twist, and squat to reach stock areas. The patient's past medical history consists of active physical therapy for the cervical and lumbar spine, prescription medication — Tramadol and Celebrex, and physical therapeutic modalities. Plan: Work hardening individualized protocol concentrating on improving muscular and connective tissue flexibility, muscular strength and endurance, body mechanics, cardiovascular conditioning, and functional performance by means of work simulation. Request: Individualized work hardening program, consisting of 10 sessions, addressing issues that are presently preventing the patient from achieving the target physical demand level, thus allowing her to return to gainful employment. A subsequent Functional Capacity Evaluation or Physical Performance Evaluation to monitor the claimant's progress will be performed on the last week of the program.

1-24-12 DO., performed a UR. She noted that the requested facility is not a CARF accredited. The address of the facility is the same as the treating provider under whom there has been no progress toward recovery. A phone call was placed on 1-24-12 and the reviewer spoke with Dr.. He was not able to explain why left ankle dorsiflexion was the strongest muscle tested. He did confirm that WH will be supervised by a provider that is part of the same group of providers that have provided care to date at the same address through he reports the facility and specific provider is different. In addition, MRI reports for studies approved as part of work up are not provided for review. It was not clear what objective structural damage or harm was sustained as a result of the injury. ODG criteria are not met for WH.

1-27-12 Computerized range of motion testing.

2-1-12 DC., preauthorization letter. He reported he received and reviewed the peer to peer decision regarding the request for 10 sessions of a highly structured work hardening program for the claimant. Dr. denial stated her confusion of why "comprehensive manual muscle testing reports that her greatest ability is left ankle dorsi-flexion?" She also stated that Dynamic testing with physiologic monitoring is not provided. The claimant injured her low back, while lifting a weight set in a box that weighed approximately 100 lbs, Typically, if a patient injures her low back, there is going to be a direct correlation and hinderance in the pelvic region with the low back, as the sacrum fits between the two hip bones connecting the spine to the pelvis. When performing the action of hip flexion and extension, the major muscles that directly intertwine with the lumbo-sacral region are the gluteus maximus, gluteus medius, and the tensor fasciae lata (TFL), which originate in the outer surface of the Ilium (pelvic bone), and insert into the head of the femur. With hip extension and knee flexion, the biceps femoris, semitendinosus, and semi-membranous muscles, which originate in the Ischial tuberosity (which is the Inferior aspect of the pelvic bone), and insert into the tibia. All of these muscles, in essence, are affected when there is injury or damage to the lumbar spine, as all of these muscles (including other core muscles), aid in the stabilization of the low back. The claimant underwent a subsequent CMT/ROM test on

01/27/2012, after he was verbally denied the work hardening program by Dr.. There was definite fear of re-injury when she underwent the physical performance evaluation (PPE), as she showed improved strength with hip flexion/extension and knee flexion and extension, when comparing the PPE results with the CMT/ROM testing that she underwent on 01/27/2012. It is evident that she continues to experience more strength with ankle dorsi flexion/inversion of both feet, as opposed to the larger muscle groups that intertwine with the core muscles that stabilize the low back, as the muscles that perform the action of dorsiflexion and inversion of the feet do not have any direct correlation with the lumbo-sacral region. On page 4 of the physical performance evaluation that she underwent on 01/05/2012, it clearly shows dynamic testing, when she performed the NIOSH lifts, which was observed by the evaluator, Dr.. The claimant continues to work at modified duty (and has been for the last 5 months), and it has been verified with her supervisor that she has a job at full duty to return to, once she has attained a "Medium" physical demand level of lifting 40 lbs. as stated in her job description that has been provided to us. This highly structured work hardening program should allow her to return to normal work duties after completion of the program. A denial of the program will ultimately slow the process to return her back to work at a safe level physical demand level. Texas Labor Code Sec. 408.021 Entitlement to Medical Benefits clearly states that an employee who sustains a compensable injury is entitled to a health care reasonably required by the nature of the injury as and when needed...The employee is specifically entitled to health care that (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or retain employment. Our records clearly indicate that further treatment is necessary to promote recovery supporting medical necessity. Individualized work hardening program, consisting of 10 sessions, addressing issues that are presently preventing the patient from achieving the target physical demand level, thus allowing her to return to gainful employment. A subsequent Functional Capacity Evaluation or Physical Performance Evaluation to monitor the patient's progress will be performed on the patient's last week in the program.

2-8-12 MD., performed a UR. He noted he spoke with Dr. on 2-8-12. The claimant has had a lifting injury x months ago and was referred for consideration of work hardening. She failed to demonstrate any significant progress with lesser levels of care including physical therapy and epidural steroid injection per Dr.. She is currently working light duty with difficulty but has a full duty job still available. No surgical consultation has been done, though Dr. did not feel she was a surgical candidate based on the minimal findings on MRI of the cervical spine and lumbar spine. He noted that the ODG requires the claimant to have a good chance of success to enter work hardening based upon the response to previous treatment. As the claimant clearly did not respond he does not meet this criteria. Recommend denial.

2-17-12 DC., he received and reviewed the peer to peer decision regarding the request for 10 sessions of a highly structured work hardening program for the claimant. Dr. M.D.'s denial stated ODG requires a patient to have a "good chance of success to enter work hardening based upon the response to previous treatment. As the patient clearly did not respond, she does not meet this criteria. Recommend denial." According to ODG

guidelines (under the heading of low back; work hardening) it clearly states that "there have been some suggestion that WH should be aimed at individuals who have been out of work for 2-3 months, or who have failed to transition back to full-duty after a more extended period of time, and that have evidence of more complex psychosocial problems in addition to physical and vocational barriers to successful return back to work." The claimant has been working at xxxx as an xxxxx position for over 6 months at modified/restricted duty. The functional capacity evaluation (FCE) that she underwent on 01/05/2012 clearly shows that she has shown progression and improvement in range of motion and strength in her upper and lower extremities, when compared to her FCE that she underwent back in 08/19/2011 (as she has progressed in her PDL from a Sedentary to a Sedentary-Light PDL). Although Mrs. has shown "response" in progression and improvement with her physical rehabilitation, patient continues to exhibiting moderate levels of guarding and fear of re-aggravation to her neck and low back, and has reached a plateau with the previous active therapy sessions. Additionally, Mrs. LPC. evaluated the claimant on her mental status, in which she continues to show moderate to severe levels of depression with a BDI of 21. According to Mrs., she states in her initial consultation that the claimant "reports having difficulty managing her pain and experiences a great deal of interference with activities of daily living due to her pain and difficulties adjusting to her injury. She reports feelings of depression, anxiety, irritability, restlessness, and sleep problems despite multiple levels of intervention. She is also experiencing a high level of stress regarding the treatment process of her injury and would prefer to return to work without experiencing her pain and other physical symptoms. According to ODG Guidelines, 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. Thus, a work hardening program would be ideal for the claimant due to her ongoing functional strength deficit as well as her psychological issues that she continues to experience, due to her ongoing work related injury. It has been stated that ODG WH criteria are outlined below. The patient (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or retain employment. His records clearly indicated that further treatment was necessary to promote recovery supporting medical necessity.

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

MEDICAL NECESSITY OF WORK HARDENING IS NOT ESTABLISHED. THERE IS NO INDICATIONS AS WHETHER THE PATIENT CAN BENEFIT FROM THE WORK HARDENING BASED ON THE PREVIOUS INADEQUATE RESPONSE AND DOCUMENTATION. THEREFORE, THE REQUEST FOR INITIAL WORK HARDENING PROGRAM X 10 SESSIONS IS NOT REASONABLE OR MEDICALLY NECESSARY.

ODG-TWC, last update 2-29-12 Occupational Disorders - Pain - 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.

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 be 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.

ODG Work Conditioning (WC) Physical Therapy Guidelines

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.

Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

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
- AHCP- 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)**