



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

## Notice of Independent Review Decision-WC

**DATE OF REVIEW: 5-2-12**

**IRO CASE #:**

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

Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnosis.

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

American Board of Anesthesiology and Pain Medicine

### **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**

- 6-22-10 Neuroelectrodiagnostic consultation performed by MD.
- 6-22-10 EMG/NCS of bilateral lower extremities performed by Dr.
- 6-22-10 EMG/NCS of bilateral upper extremities performed by Dr.
- 9-15-10 MRI of the lumbar spine.
- 4-1-11 MRI of the cervical spine.
- 7-27-11 Surgery performed by MD.
- 2-10-12 DO., office visit.
- 2-24-12 DO., office visit.
- 3-7-12 UR performed by MD.
- 3-13-12 DO., office visit.
- 3-20-12 UR performed by DO.
- 4-5-12 DO., office visit.

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

6-22-10 Neuroelectrodiagnostic consultation performed by MD., notes the recommendation for EMG/NCS.

6-22-10 EMG/NCS of bilateral lower extremities performed by Dr. showed active right S1 radiculopathy (ongoing, active S1 nerve root denervation process).

6-22-10 EMG/NCS of bilateral upper extremities performed by Dr. showed right CTS. Suggestive but not conclusive of right C6-C7 nerve root irritative process. The claimant was not able to relax so he was not able to determine whether ongoing denervation changes of cervical paraspinal muscles was present or not.

9-15-10 MRI of the lumbar spine shows a 3 mm posterior central disc protrusion ----- upon the thecal sac. Full thickness radial tear in the posterior ----- disc at L5-S1. Mild degenerative facet joint hypertrophy----- (incomplete copy).

4-1-11 MRI of the cervical spine shows non specific straightening of the usual cervical lordosis. There is mild disc dehydration at C5-C6 and C6-C7 and to a lesser extent from C2-C3 through C4-C5. There is no marrow replacement. There is somewhat of a diffuse reduction in the AP dimension of the spinal canal which could be a congenital finding. There is a combination of posterior osseous ridging and disc bulging at both the C5-C6 and C6-C7 levels which sub totally effaces the ventral and dorsal subarachnoid spaces. There is at least mild central spinal stenosis at both levels. There is also uncinete hypertrophy bilaterally at both levels with subsequent foraminal stenosis. These finding are most evident at C6-C7 on the left and bilaterally at C5-C6. There is at least mild central spinal stenosis at C6-C7 and to a lesser extent C5-C6. There is no significant disc bulge or protrusion at the remaining cervical levels. There is no obvious central or foraminal stenosis. There is no discrete signal abnormality evident within the cord.

7-27-11 Surgery performed by MD: Anterior cervical discectomy, foraminotomy, radical disc excision and implantation interbody fusion device with bone matrix saturated with aspirated stem cells. Aspiration of bone marrow from the adjacent vertebral body through a separate aspiration hole in the cortex using an 18-gauge needle.

2-10-12 DO., the claimant is a pleasant male who presents to Anesthesia Pain Management with the chief complaint of chronic, persistent neck, right shoulder, arm, and hand pain associated with swelling, temperature changes, color changes, moist skin, as well as low back pain following a work injury in xx/xx.

History of present illness: The patient gives a good work history in the warehouse for over nine years. He injured himself while working over a heavy pallet. He developed persistent neck pain radiating to his shoulder, arm, and hand, as well as back pain which almost a year later required neck surgery. Unfortunately, his pain has continued. In fact, he feels his pain got worse after surgery associated with stiffness, swelling, moist hand, and cramps. He is unable to wear his rings on his right hand due to swelling. He admits to mood irritability and poor sleep. He feels his pain is constant and 9/10. A pain related stress inventory filled out today was remarkable for 14 of 20 true responses suggestive of moderate to severe reactive depression and anxiety associated with this pain complaint. He was referred for consideration of treatment for

apparent CRPS formerly known as reflex sympathetic dystrophy. The patient additionally has persistent back pain consistent with a herniated disk at L5-S1 levels as the MRI on 9/15/11 showed a central disk protrusion at that level. The patient states that anterior discectomy infusion that he received at C6-C7 has offered him little benefit regarding his shoulder, arm, and hand pain which persists. He states his hand is moist all the time. It is often stiff and crampy. The pain radiates from his neck into his arm and hand but, circumferentially, he states it is often swollen and he feels it is "spreading". He states he had temperature changes and decreased sensitivity prior to surgery. He states he protects his arm when he walks and most routine daily activities. On exam, he walked with a slow physiologic gait. Toe and heel walk were normal and equal bilaterally. Inspection about the right upper extremity revealed circumferential swelling from the distal digits to his mid forearm area. His hand was moist to touch. He had no gross dystrophic changes but he did hold his arm in a protective manner. He had 2+ allodynia and 2+ hyperesthesia circumferentially up into the right neck and shoulder beginning in the distal right upper extremity. He had decreased neck range of motion with multiple areas of trigger point tenderness and paravertebral spasm in the cervical and upper thoracic regions. Passive range of motion throughout: the right upper extremity caused pain consistent with allodynia as well as to light touch. He had decreased range of motion about the wrist, elbow and shoulder secondary to pain and contraction. His left arm was warm. There were no sudomotor or vasomotor changes in his left upper extremity or in his lower extremities. He did have decreased lumbosacral flexion with moderate lumbar interspinous tenderness, moderate right sciatic notch tenderness with a moderate positive straight leg raising sign on the right. He had a positive Lasegue's sign at 70 degrees. Toes were downgoing. Pinprick sensation was preserved. Diagnosis: Post cervical laminectomy pain syndrome following work-related injury with secondary CRPS stage II. Secondary myofascial pain syndrome of the cervical and upper thoracic regions secondary to injury number one. Chronic back pain syndrome associated with lumbar disk protrusion and lumbar radiculopathy secondary to work-related injury. Moderate reactive depression and anxiety in a chronic pain state. Discussion: The patient's prognosis is fair-good. Aggressive active range of motion exercise in conjunction with titration of neuropathic and antidepressant support should help with his ongoing pain complaint. Due to the ongoing dystonic spasm, hyperesthesia, and allodynia, sympathetic blockade via a central cervical epidural catheter will be offered at once. He discussed active range of motion exercise during the sympathetic blockade. Based on response to this care, further injection therapy will be made. Spinal cord stimulation will be reserved for recalcitrant pain. This unfortunate gentleman has clear signs and symptoms based in IASP criteria for CRPS. As a result, we are going to begin him on aggressive treatment including: Trazadone 100 mg at night in conjunction with Zanaflex a centrally acting alpha adrenergic. Neuropathic pain medicine Neurontin should provide daytime analgesia in conjunction with his Hydrocodone 3 times per day. We went over our drug contract. He did sign this and is aware of this. Additionally, he is willing to go forth, with randomized urinalysis to monitor compliance. His urinalysis today was consistent with the agents reported to him. There was no evidence of illicit drug use. Titration of this drug will be done immediately. Follow-up care in two weeks' time for further medication management will be offered.

Once medication management has been stabilized, central sympathetic blockade will be offered.

2-24-12 DO., the claimant is already feeling brighter. His sleep is improved following institution of Trazadone in conjunction with Zanaflex at night. He did go over active range of motion and exercise therapy about his shoulder, arm, and hand. He is still having swelling, and hyperesthesia throughout his right arm and hand consistent with secondary CRPS. He has been approved by another physician and therefore, he was recommending the same treatment which is cervical epidural blockade for this gentleman's ongoing posterior cervical neck pain syndrome associated with his work-related injuries and failed neck surgery. He has hyperesthesia and allodynia and clear symptoms consistent with radiculopathy. He has decreased pinprick sensation in the C5-C6 distribution on the right. His MRI is consistent with previous protrusion, as he ultimately underwent surgical intervention which unfortunately has not helped him with his right arm and hand symptoms which he protects quite evidently today. As a result, central cervical epidural blockade utilizing local anesthetic and corticosteroid solution of his pain score 7-8/10 today will be recommended. This in conjunction with active range of motion exercise and our current oral drug regimen should go a long way in helping him with his recovery. He scheduled him for this. He did discuss the intended benefits, side effects, and complications and informed consent was obtained. Therapeutic is no illicit drug use. He is taking medicine from this office under a drug contract.

3-7-12 UR performed by MD: Cervical Epidural Steroid Injection, Cervical Spine, IV Sedation, #62318, #77003- levels not specified Explanation of Findings: Based on the clinical information provided, the request for cervical epidural steroid injection with IV sedation is not recommended as medically necessary. There is no comprehensive assessment of the treatment completed to date or the patient's response. The patient is status post cervical fusion at C6-7 on 7/27/11; however, it is unclear what postoperative treatment the patient has completed to date. There are no postoperative imaging studies/electrodiagnostic results provided to support a diagnosis of radiculopathy as required by the Official Disability Guidelines. The request is nonspecific and does not indicate which level/s is/are to be injected. The records indicate that the patient underwent previous epidural steroid injection; however, the date and level of this injection is not documented, and the patient's objective, functional response to the procedure is not provided. The Official Disability Guidelines support repeat epidural steroid injection with evidence of at least 50% pain relief for 6-8 weeks.

3-13-12 DO., the claimant is eagerly waiting to go ahead with treatment for his right shoulder, arm, and hand pain associated with post cervical laminectomy pain syndrome. He has failed conservative rehabilitative and medical treatment options. His evaluation clearly designates the condition, past treatments, diagnosis, and the prognosis including outlined ODG accepted guidelines for treatment. Unfortunately, he recently was denied after his office specifically made the request for cervical epidural treatment for not only his radiculopathy but his secondary CRPS diagnosed based on IASP criteria. Mr. Kennedy is more functional and more active. He has done well under purpose care. He is thankful for the progress as he feels this has been the best office

that has helped him thus far. This has included a combination of neuropathic and antidepressant support. For some reason he has been denied reasonable and necessary but yet he states in another office he was approved for the same treatment. He will look into this in detail and find out why this gentleman is being denied reasonable and necessary treatment. Apparently, the peer person who wrote this request factually is incorrect, factually states there is no comprehensive assessment when this office specifically sent assessments on February 24 and February 10 outlining the treatment plan. Additionally, he states that that the request is nonspecific. That is factually not true. First of all, cervical epidural catheters are placed in the upper thoracic region. Injectate, however, is placed throughout the cervical spine extending from C5-C6 to C6-C7 as outlined on his notation. Anyone familiar with this procedure would clearly know that. Additionally, he uses an epidurogram to outline the generator and if there is any scar or adhesions, to manipulate the catheter in order to instill the local anesthetic at the desired route. This is not a single translaminar or transforaminal injection whereby the injectate level which is nonspecific to its question is being entertained. That being said, we will resubmit this procedure once again. He will also look into why this procedure is not being approved by one physician but being approved by another physician. Mr. Kennedy is irate. He counseled him. He provided him with reassurance. His office spent quite a bit of time today explaining to him the procedures and he will go forth with this recommendation.

3-20-12 UR performed by DO: Cervical Epidural Steroid Injection, Cervical Spine, IV Sedation, 1162318, 477003- levels not specified, on appeal Explanation of Findings: The patient has post fusion RSD of his right arm and an ESI is reasonable to do a sympathetic block for this. The patient is medically stable and does not need to have sedation by another anesthesiologist. Dr. is an anesthesiologist and can sedate the patient while doing the injection but refuses to do so. The entire request, as submitted, is not medically necessary. The prior authorization for an ESI with Dr. did not require MAC since Dr. is also an anesthesiologist and sedates patients himself. MAC is Dr. personal preference and is not required. The requested cervical epidural steroid injection to the cervical spine and IV Sedation (CPTs #62318 and #77003 - levels not specified) is not medically necessary as requested. References Used in Support of Decision: ODG: Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy.

4-5-12 DO., the claimant is very upset and he did not blame him. Apparently, the doctor has denied reasonable and necessary treatment consistent with ODG guidelines for failed neck pain syndrome with persistent radiculopathy and secondary CRPS based, on my request for IV sedation. Well the reason for IV sedation is quite obvious. Despite me being a board certified, anesthesiologist, this gentleman is being treated for reactive depression, anxiety, insomnia, and has fear of needles. He does not want to be treated "as a guinea pig". He wants the standard of care which in the local, national, and world communities for the treatment of chronic pain syndrome on a person with antidepressant support and insomnia includes IV sedation. He is quite anxious but yet he wants to undergo this treatment which will be efficacious in helping resolve his pain

complaints. He as a result is now due to this denial having to raise his Norco to q.i.d. dosing just to get his pain down to 6-7/10. Today he is in dire straits. He is quite visible pain and agony and he wants to go on with this treatment as soon as possible. He will go ahead and did the IRO. His urinalysis is consistent with the agents given to him. There has been no evidence of illicit drug use or aberrant activity. This gentleman has marked increased neck range of motion. He has decreased pinprick sensation as outlined before. He has a mild positive Spurling's test in his neck. His right hand is cold to touch and he has mild hyperesthesia extending up into his arm and shoulder area. Central cervical epidural blockade should go a long way on helping him hasten this recovery period. Unfortunately, whoever reviewed this case referred to Dr., who I am quite familiar with. Dr. does not have the training, education, experience, and did not treat this gentleman well as he had hoped, the patient, and that is why he is his office. Mr. has gained great respect for the treatment outcomes that he has seen in our office with other patients. He is thankful that he has come to his care and he instituted effective tricyclic and antidepressant support to help him with his affect, mood, and sleep. Mr. is anxious, however, and therefore wants the appropriate sedation that we are recommending for a cervical procedure in which case a cervical epidural block will be performed utilizing a catheter approach to let local anesthetic throughout the cervical and upper thoracic columns. He did not want the patient moving during this procedure. He wanted the patient calm, collected and to have a good outcome as other patients have received and as a result we are going to again maintain that this is a standard treatment regimen that has been highly efficacious in the past and is certainly reasonable under ODG guidelines.

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

**THE PHYSICIAN IS USING THE PROCEDURE TO TREAT THE CERVICAL RADICULOPATHY AND THE COMPLEX REGIONAL PAIN SYNDROME.**

**A SINGLE CATHETER INJECTION WITH EPIDUROGRAM FOR THE TREATMENT OF THE COMPLEX REGIONAL PAIN SYNDROME AND CERVICAL RADICULOPATHY SYMPTOMS IS REASONABLE. THE CATHETER WOULD BE ENTERED AT THE UPPER THORACIC LEVEL AND THREADED TO THE CORRECT LOCATION. THIS WOULD FOLLOW THE ODG GUIDELINES AND IS AN ACCEPTED PROCEDURE FOR THE PATIENT'S CONDITION. THEREFORE, THE REQUEST FOR INJECTION, INCLUDING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSIS IS REASONABLE AND MEDICALLY NECESSARY.**

**ODG-TWC, last update 1-30-12 Occupational Disorders of the Neck and Upper Back – Cervical epidural steroid injection:** Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings

of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-Cochrane, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriplegia with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral 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, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) See the Low Back Chapter for more information and references.

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

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

- (1) Radiculopathy must be documented by physical examination and 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) for guidance
- (4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

(8) Repeat injections should be based on continued objective documented pain and function response.

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

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or 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.

Criteria for the use of Epidural steroid injections, diagnostic:

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;

(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;

(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;

**Criteria for sympathetic and epidural blocks:** Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. See Sympathetically maintained pain (SMP). Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006) Predictors of poor response: Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006) Alternatives to regional sympathetic blocks: may be necessary when there is evidence of coagulopathy, systemic infection, and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. Mixed conduction blocks (central neural blocks): suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2)

Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above. Clonidine has also been effective epidurally. (Stanton-Hicks, 2006) Baclofen has been demonstrated to be effective intrathecally to reduce dystonia. (van Hilten, 2000) IV regional sympathetic blocks: controversial due to varying success. Guanethadine was used, but is no longer available in the US. Bretylium and reserpine require daily blocks, and have potential side effects of transient syncope with apnea, orthostatic hypotension, pain with administration, nausea and vomiting. Bretylium provided more than 30% pain relief for a mean of 20 days compared to placebo. (Hord, 1992) Due to modest benefits and the invasiveness of the therapies, epidural clonidine injection and intravenous regional sympathetic block with bretylium should be offered only after careful counseling, and they should be followed by intensive physical therapy. Intravenous regional sympathetic block (Bier's block) with guanethidine and lidocaine resulted in excellent pain relief and full restoration of both function and range of movement of the affected extremity in patients suffering from CRPS-I of the hand. (Paraskevas, 2005) Local or systemic parecoxib combined with lidocaine/clonidine IV regional analgesia is an effective treatment for CRPS-I in a dominant upper limb. (Frade, 2005) See also Sympathetically maintained pain (SMP); & Regional sympathetic blocks.

**Recommendations (based on consensus guidelines) for use of sympathetic blocks:** (1) In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended. (2) In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual. (3) In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction and increased tolerance of activity and touch (decreased allodynia) in physical therapy/occupational therapy. (4) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. (5) In acute exacerbations, 1 to 3 blocks may be required for treatment. (5) A formal test of the block should be documented (preferably using skin temperature). (6) Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain. (Burton, 2006) (Stanton-Hicks, 2004) (Stanton-Hicks, 2006) (International Research Foundation for RSD/CRPS, 2003) (Colorado, 2006)(Washington, 2002) (Rho, 2002)

**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)**