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Notice of Independent Review Decision

DATE: February 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Arthrodesis, Anterior Interbody Technique, Including Minimal Discectomy to Prepare Interspace (Other than for decompression); Cervical Below C2

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Orthopaedic Surgeons with 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:
07/12/12: Patient Demographic Page
07/20/12, 07/24/12, 07/26/12, 07/31/12, 08/01/12, 08/26/12, 08/14/12, 08/17/12, 08/21/12, 10/19/12: Weekly Therapy Progress Note
08/07/12: MRI Cervical Spine without Contrast report interpreted
08/27/12: Pain Management Consultation
09/15/12: Anesthesia Record
09/25/12: Operative Report
10/11/12: Authorization for Physical Therapy
10/15/12: Followup Visit
10/22/12: Precertification Request
10/23/12: Referral Form
10/26/12: History and Physical
11/02/12: Radiology Prior Authorization Request Form
11/07/12: UR
11/09/12: Electrodiagnostic Results
11/14/12: Chart Review

11/15/12: Preauthorization Request
11/16/12: Initial Prospective Review
11/27/12: X-Ray Cervical Spine Complete report
11/27/12: Myelogram C-Spine report interpreted
11/27/12: CT C-Spine with Contrast (Post Myelogram) report
11/30/12: History and Physical
12/05/12: Office Visit
12/31/12: Pre-Surgical Psychological Evaluation
01/04/13: Preauthorization Request
01/09/13: UR
01/09/13: Reconsideration Request
01/10/13: Notice of Reconsideration Request Received
01/14/13: UR

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who sustained an injury to his neck while at work on xx/xx/xx.

08/07/12: MRI Cervical Spine without Contrast report. IMPRESSION: C2-C3 Broad 1 mm osteophyte disc bulge complex. C3-C4 1 mm right posterolateral osteophyte disc bulge complex. C4-C5 1-2 mm right posterolateral osteophyte disc protrusion complex with mild bilateral neural foraminal narrowing, right greater than left. C5-C6 1 mm right posterolateral osteophyte disc protrusion complex with mild right neural foraminal narrowing. C6-C7 1 mm right-sided disc protrusion. C7-T1 normal.

08/27/12: The claimant was evaluated for neck and right wrist pain with tingling and numbness down the right arm into the wrist and first three fingers. He stated that his arm felt weak. He had been treated with physical therapy, wrist bracing, and medications. On physical exam, he had limited cervical spine range of motion. He had positive Spurling's on the right, negative on the left. He has tender to palpation in the lower portion of his neck on the rights die and over the trapezial area. He had no pain with facet loading, no step-off, or paraspinal atrophy. He had 2+ ulnar and radial pulses. Neurological exam was intact from C5 to T1 for light touch except for the right outer arm to the first three fingers. Motor strength was intact except for biceps and BR on the right being 4/5. Reflexes were symmetric. Hoffman's sign was negative. RECOMMENDATIONS: His wrist pain seems to be from the C4-C5 or C5-C6 level with irritation of the nerve roots given his clinical examination and symptoms, mechanism of injury, and diagnostic studies. He would like to proceed forward with injection therapy as he has exhausted other conservative measures.

09/25/12: Operative Report. POSTOPERATIVE DIAGNOSIS: Right wrist sprain. PROCEDURE PERFORMED: Fluoroscopically guided right C5 and C6 epidural steroid injection.

10/15/12: The claimant was reevaluated. It was noted that the injection performed on 09/25/12 did not help and he had tingling and numbness in the hand

and feet for a few days after the injection. He continued to have pain rated at 7-8/10 in the neck with tingling and numbness down the right arm and into the wrist and first three fingers. On physical exam, his gait was normal. He had limited cervical spine range of motion. Positive Spurling's on the right. ordered a bilateral upper extremity EMG/NCV.

10/26/12: The claimant was evaluated for neck pain. He rated his pain as 5/10. He complained of right arm/hand numbness and tingling. It was noted that he pain was made worse by lifting, standing, and sitting. He stated that steroid injection only helped 3%. On physical exam, his gait was normal. He had midline tenderness in the lower cervical region. He had decreased ROM in the cervical spine. Motor testing of the right upper extremity was 5 at the deltoid, 4 at the biceps, 4 at the brachioradialis, 5 at the triceps, 5 at the finger flexors, and 5 at the hand intrinsics. Sensation was decreased in a C5 distribution. Reflexes were 2+ at the biceps and brachioradialis. Hoffman's sign was negative. There were no Lhermitte's symptoms. Review of his cervical MRI dated 08/07/12 demonstrated right HNP at C4-C5. PLAN: His MRI shows a small HNP, but his symptoms correlate well with this area. Will do CTM with flexion/extension x-rays and EMG/NCS.

11/09/12: Electrodiagnostic Results. IMPRESSION: Abnormal because of the prolonged sensory latency with stimulation of both radial nerves, indicating trauma or entrapment of both radial nerves at the wrist. The slowing in both ulnar nerves as they cross over the medial epicondyles indicates trauma or entrapment of both ulnar nerves at the elbow. The slowing in both median nerves between the elbow and the wrist indicates trauma or entrapment of both median nerves in the forearm. With multiple traumatic or entrapment neuropathies, the possibility of diabetes should be considered. EMG: The significant abnormalities include fibrillations in the C5, C6, and C7 paraspinous muscles bilaterally. These abnormalities indicate a radiculopathy at C5, C6, and C7 bilaterally. The possibility of spinal stenosis with multiple nerve root impingement should be considered.

11/27/12: X-Ray Cervical Spine Complete report. IMPRESSION: No osseous injury or destruction is seen in the cervical spine. No spondylolisthesis is seen in the cervical spine in the neutral, flexion, and extension positions. Osseous stenoses are seen in the bilateral foramina from C3-C4 through C6-C7 on the oblique views.

11/27/12: Myelogram C-Spine report. IMPRESSION: Fluoscopically guided cervical myelogram was performed. Slight ventral dural impressions are seen at the C2-C3, C3-C4, C5-C6, and C6-C7 levels. Indentations are seen on the C4 through C7 nerve root sleeves bilaterally.

11/27/12: CT C-Spine with Contrast (Post Myelogram) report. IMPRESSION: No central stenosis is seen in the cervical spine. Uncinate joint spurring causes mild bilateral foraminal stenosis at C3-C4 through C6-C7. 1 mm bulges at C2-C3, C5-C6, and C6-C7 slightly flatten the thecal sac without causing central stenosis. A 2

mm right paracentral protrusion at C3-C4 indents the thecal sac without causing central stenosis.

11/30/12: The claimant was reevaluated. On physical exam, his gait was normal. He was tender in the lower cervical region. He had decreased cervical spine ROM. Motor testing was 5 at the deltoid, finger flexors, and hand intrinsics on the right and 4 at the biceps, brachioradialis, and triceps. Sensation was decreased at C5, C6, and C7. Hoffman's sign was negative. Positive for Lhermitte's on the right. PLAN: He has a positive EMG, and the CT myelogram correlates with his symptoms. I am recommending C3-C6 ACDF. C4-C5 does not show any stenosis. However, to fuse C3-C4 and C5-C7 would cause premature degeneration of C4-C5, so I am including this in the fusion as well.

12/05/12: The claimant was evaluated for continued neck pain and right upper extremity pain. On examination, he had decreased cervical spine range of motion. He had pain in the cervical region. He had decreased strength at the right biceps being 4/5. He had decreased sensation in the right upper extremity versus the left upper extremity. He was given prescriptions for Tramadol, Mobic, and Elavil and was to followup prn and was referred for a followup.

12/31/12: Pre-Surgical Psychological Evaluation. TREATMENT RECOMMENDATIONS: In conclusion, does not appear to present with any psychosocial stressors (i.e., active psychosis; major, uncontrolled severe depression and anxiety; active suicidal ideation; serious alcohol and drug addiction; or severe cognitive deficits) that would exclude him from undergoing this procedure at this time; hence, he is an appropriate candidate for the proposed spinal surgery.

10/09/13: UR performed. SUMMARY OF TREATMENT PLAN: In my judgment, the clinical information provided does not establish the medical necessity of this request. At this point, there is no documentation of any physical findings that correlate with all three levels being requested. Also, based on the recent CT scan, there is no pathology noted at the C4-C5 level. Regarding the 3-day hospital length of stay, according to the ODG for anterior fusion, actual data, median stay is 1 day. The request for 3 days exceeds the guidelines. However, as the surgery is not recommended, the 3-day inpatient stay is also not indicated. Therefore, based on evidence-based guidelines and medical evidence provided, this request has been determined to not be supported for medical necessity.

01/14/13: UR performed. SUMMARY OF TREATMENT PLAN: In my judgment, the clinical information provided does not establish the medical necessity of this request. The patient did show radial, median, and ulnar nerve bilateral neuropathy. The EMG showed right neuropathy, multiple peripheral neuropathy as well as the fact that there was only fibrillation potential seen on EMG. The patient is recommended for surgery based on MRI and CT myelogram results; however, the MRI and CT myelogram results failed to demonstrate significant stenosis at C3-C7 levels. Therefore, the surgery does not appear to be medically necessary per the evidence-based guidelines and imaging results. The

significance of the EMG findings is unclear based on the multiple peripheral neuropathy. Therefore, based on the evidence-based guidelines and medical evidence provided, this request has been determined to not be supported for medical necessity. As the surgery is not indicated, an inpatient stay is also not recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. I would agree. Based on the available records, it is my opinion that there is no significant evidence of stenosis at any level. There appears to be only one level involved on physical exam. The EMG report of both radial, ulnar, and median nerves involved would raise a red fleg on its accuracy. Therefore, the request for Arthrodesis, Anterior Interbody Technique, Including Minimal Discectomy to Prepare Interspace (Other than for decompression); Cervical Below C2 dates of service 01/04/13 to 01/07/12 is not medically necessary and is non-certified.

ODG:

Fusion, anterior cervical	Recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. (See Discectomy/laminectomy/laminoplasty.) Evidence is also conflicting as to whether autograft or allograft is preferable and/or what specific benefits are provided with fixation devices. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy. (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983) Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability. (Bambakidis, 2005) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. (Savolainen, 1998) (Dowd, 1999) (Colorado, 2001) (Fouyas-Cochrane, 2002) (Goffin, 2003) Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. (Wieser, 2007) This evidence was substantiated in a recent Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking, as outlined below: *(1) Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute:* Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. (Jacobs-*Cochrane*, 2004) (Abd-Alrahman, 1999) (Dowd, 1999) (Martins, 1976) (van den Bent, 1996) (Savolainen, 1998) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. (Ragab, 2006) (Eck, 2002) (Matsunaga, 1999) (Katsuura, 2001) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. (Yamamoto, 1991) (Abd-Alrahman, 1999) *(2) Fusion with autograft versus allograft:* The Cochrane review found limited

	evidence that the use of autograft provided better pain reduction than animal allograft. It also found that there was no difference between biocompatible osteoconductive polymer or autograft (limited evidence). (Jacobs-*Cochrane*, 2004) (McConnell, 2003) A problem with autograft is morbidity as related to the donor site including infection, prolonged drainage, hematomas, persistent pain and sensory loss. (Younger, 1989) (Sawin, 1998) (Sasso, 2005) Autograft is thought to increase fusion rates with less graft collapse. (Deutsch, 2007). See Decompression, myelopathy. *(3) Fusion with autograft with plate fixation versus allograft with plate fixation, Single level:* A recent retrospective review of patients who received allograft with plate fixation versus autograft with plate fixation at a single level found fusion rates in 100% versus 90.3% respectively. This was not statistically significant. Satisfactory outcomes were noted in all non-union patients. (Samartzis, 2005) *(4) Fusion with different types of autograft:* The Cochrane review did not find evidence that a vertebral body graft was superior to an iliac crest graft. (McGuire, 1994) *(5) Fusion with autograft versus fusion with autograft and additional instrumentation:* *Plate Fixation*: In single-level surgery there is limited evidence that there is any difference between the use of plates and fusion with autograft in terms of union rates. For two-level surgery, there was moderate evidence that there was more improvement in arm pain for patients treated with a plate than for those without a plate. Fusion rate is improved with plating in multi-level surgery. (Wright, 2007) See Plate fixation, cervical spine surgery. *Cage*: Donor site pain may be decreased with the use of a cage rather than a plate, but donor site pain was not presented in a standardized manner. At two years pseudoarthrosis rate has been found to be lower in the fusion group (15%) versus the cage group (44%). A six-year follow-up of the same study group revealed no significant difference in outcome variables between the two treatment groups (both groups had pain relief). In the subgroup of patients with the cage who attained fusion, the overall outcome was better than with fusion alone. Patients treated with cage instrumentation have less segmental kyphosis and better-preserved disc height. This only appears to affect outcome in a positive way in cage patients that achieve fusion (versus cage patients with pseudoarthrosis). (Poelsson, 2007) (Varuch, 2002) (Hacker 2000) See also Adjacent segment disease/degeneration (fusion). *(6) Fusion with allograft alone versus with allograft and additional instrumentation:* *Plate Fixation:* Retrospective studies indicate high levels of pseudoarthrosis rates (as high as 20% for one-level and 50% for two-level procedures) using allograft alone. In a recent comparative retrospective study examining fusion rate with plating, successful fusion was achieved in 96% of single-level cases and 91% of two-level procedures. This could be compared to a previous retrospective study by the same authors of non-plated cases that achieved successful fusion in 90% of single-level procedures and 72% of two-level procedures. (Kaiser, 2002) (Martin, 1999) See Plate fixation, cervical spine surgery. *Complications:* *Collapse of the grafted bone and loss of cervical lordosis:* collapse of grafted bone has been found to be less likely in plated groups for patients with multiple-level fusion. Plating has been found to maintain cervical lordosis in both multi-level and one-level procedures. (Troyanovich, 2002) (Herrmann, 2004) (Katsuura, 1996) The significance on outcome of kyphosis or loss of cervical lordosis in terms of prediction of clinical outcome remains under investigation. (Peolsson, 2004) (Haden, 2005) (Poelsson, 2007) (Hwang, 2007) See also Laryngoscopy (screening for recurrent laryngeal nerve injury prior to revision ACDF). *Pseudoarthrosis:* This is recognized as an etiology of continued cervical pain and unsatisfactory outcome. Treatment options include a revision anterior approach vs. a posterior approach. Regardless of approach, there is a high rate of continued moderate to severe pain even after solid fusion is achieved. (Kuhns, 2005)

	(Mummaneni, 2004) (Coric, 1997) *Anterior versus posterior fusion:* In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007) *Predictors of outcome of ACDF:* Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar pain, short duration of symptoms, younger age, no use of analgesics, gainful employment, higher preoperative NDI and normal ratings on biopsychosoical tests such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health, litigation and workers' compensation. (Anderson, 2009) (Peolsson, 2006) (Peolsson, 2003) Patients who smoke have compromised fusion outcomes. (Peolsson, 2008) See Plate fixation, cervical spine surgery. See also Adjacent segment disease/degeneration (fusion) & Iliac crest donor-site pain treatment. *Use of Bone-morphogenetic protein (BMP):* FDA informed healthcare professionals of reports of life-threatening complications associated with recombinant human Bone Morphogenetic Protein (rhBMP) when used in the cervical spine for spinal fusion. The safety and effectiveness of rhBMP in the cervical spine have not been demonstrated, and these products are not approved for this use. These complications were associated with swelling of neck and throat tissue, which resulted in compression of the airway and/or neurological structures in the neck. (FDA MedWatch, 2008) Bone-morphogenetic protein was used in approximately 25% of all spinal fusions nationally in 2006, with use associated with more frequent complications for anterior cervical fusions. No differences were seen for lumbar, thoracic, or posterior cervical procedures, but the use of BMP in anterior cervical fusion procedures was associated with a higher rate of complication occurrence (7.09% with BMP vs 4.68% without BMP) with the primary increases seen in wound-related complications (1.22% with vs 0.65% without) and dysphagia or hoarseness (4.35% with vs 2.45% without). (Cahill-*JAMA*, 2009) For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

Discectomy-laminectomy-laminoplasty	Recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. (See Fusion, anterior cervical.) Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. In addition, although surgery for spondylosis and radiculopathy may offer some short term benefit, non-operative treatment with PT can provide similar improvement in pain and function at 12-16 months for patients without progressive neurologic deficits or instability. (Persson, 1997) The American Academy of Orthopaedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniations with predominate arm pain and for caudal lesions in large, short-necked individuals. (Albert, 1999) The overall goals of cervical surgery should be decompression, restoration of alignment, and stability. (Jacobs-*Cochrane*, 2004) (Dowd, 1999) (Colorado, 2001) In terms of posterior procedures, there does not appear to be sufficient evidence to support the use of laminoplasty versus laminectomy based on outcomes or post-operative morbidity. Research has indicated that as many as 60% of patients who received laminoplasty had posterior neck and shoulder girdle pain post-operatively (versus 25% in the laminectomy group). (Hosono, 1996) (Heller, 2001) Some authors continue to prefer laminoplasty

	to anterior spinal decompression and fusion (for myelopathy due to disc herniation) as they feel the risk of chronic neck pain is less troublesome than the risk of bone graft complications and/or adjacent spondylosis that can be found with the fusion procedure. (Sakaura, 2005) It is not clear from the evidence that long-term outcomes are improved with the surgical treatment of cervical radiculopathy compared with nonoperative measures. However, relatively rapid and substantial relief of pain and impairment in the short term (6-12 weeks after surgery) after surgical treatment appears to have been reliably achieved. (Haldeman, 2008) *Late deterioration:* Has been found with both anterior and posterior approaches. (Rao, 2006) With the anterior approach, recurrent symptoms have been found secondary to deterioration of the adjacent segment, inadequate decompression at the time of the initial surgery, pseudoarthrosis, graft or implant failure, and/or continued growth of osteophytes. With the posterior approach, recurrent symptoms have been found secondary to development of kyphosis, instability, spread of ossification of the posterior longitudinal ligament, and development of stenosis at new levels. In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007) *Pre-operative evaluation:* *MRI:* This is a very sensitive test for radicular disorders but has a lower negative predictive value. Disc bulges have been found in one study in 52% of subjects and protrusions in 27% without back pain. At age 60 years, 93% of subjects in one study had disc degeneration/bulges on MRI. (Boden, 1990) *EMG:* Optional for cervical surgery. See Electromyography. **ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):** Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement): A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test. B. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. *Note:* Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG. C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic. D. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures. E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care. For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

Hospital length of stay (LOS)	**ODG hospital length of stay (LOS) guidelines:** **Cervical Fusion, Anterior** (*81.02 -- Other cervical fusion, anterior technique*) Actual data -- median 1 day; mean 2.2 days (±0.1); discharges 161,761; charges (mean) $50,653 Best practice target (no complications) -- *1 days*

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)**