

# CASEREVIEW

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## Notice of Independent Review Decision

[Date notice sent to all parties]: February 17, 2013

### IRO CASE #:

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

Three (3) days Inpatient (IP) hospital length of stay (LOS) for left-sided sacroiliac joint (SIJ) fusion.

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

This physician is Board Certified in Orthopedic Surgery with over 13 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:

10/23/02: Nerve Conduction Study report  
11/08/02: Clinical note  
11/08/02: Clinical note  
11/20/02: Recorded Claims Statement  
01/14/03: Clinical note  
01/28/03: Clinical note  
01/31/03: Clinical note  
02/07/03: Initial Patient Consult  
02/21/03: Follow-up Note  
04/03/03: Consultation Report  
04/24/03: Lumbar Myelogram and CT Scan Lumbar Spine post Myelogram  
05/08/03: Follow-up Note  
06/10/03: Operative Note

06/26/03: Follow-up Note  
09/18/03: Follow-up Note  
10/16/03: Follow-up Note  
11/03/03: Follow-up Note  
12/05/03: Follow-Up Note  
01/05/04: Follow-up Note  
01/26/04: Follow-up Note  
03/12/04: Follow-Up Note  
04/16/04: Follow-Up Note  
05/12/04: EMG/NCS of the lower extremities  
05/21/04: Follow-Up Note  
06/04/04: CT Scan Lumbar Spine interpreted  
06/21/04: Follow-up Note  
07/02/04: Follow-Up Note  
07/29/04: Required Medical Evaluation  
08/13/04: Follow-Up Note  
08/26/04: Follow-up Note  
09/13/04: Follow-up Note  
10/28/04: Initial Evaluation  
12/22/04: MMI Determination and Impairment a Designated Doctor  
01/25/05: Letter of Clarification  
04/18/05: Orthopedic Report  
05/29/05: Peer Review  
06/06/05: Orthopedic Report  
07/28/05: CT Lumbar Spine  
10/04/05: IRO Decision Notification Letter  
11/14/05: Orthopedic Report  
02/17/06: Orthopedic Report  
03/17/06: Orthopedic Report  
04/16/06: Orthopedic Report  
05/22/06: Orthopedic Report  
06/23/06: Orthopedic Report  
09/29/06: Orthopedic Report  
12/18/06: IRO Decision Notification Letter  
01/12/07: Letter to Chief Clerk of Proceedings  
01/12/07: Orthopedic Report  
04/13/07: Orthopedic Report  
06/15/07: A Letter of Medical Necessity for Medication  
07/25/07: IRO Notice of Independent Review Decision  
08/23/07: Orthopedic Report  
08/24/07: Physical Performance Evaluation and Return to Work Evaluation  
12/06/07: Orthopedic Report  
01/09/08: Letter of Medical Necessity for Lumbar Epidural Steroid Injection  
02/05/08: IRO Notice of Independent Review Decision  
03/14/08: Orthopedic Report  
06/16/08: Orthopedic Report  
10/02/08: Orthopedic Report  
01/05/09: Orthopedic Report

04/06/09: Orthopedic Report  
08/04/09: Orthopedic Report  
09/18/09: Letter of Medical Necessity for Medication  
10/07/09: Peer Review  
11/02/09: Orthopedic Report  
11/16/09: Letter of Medical Necessity for Medication  
02/02/10: Orthopedic Report  
04/15/10: Orthopedic Report  
07/16/10: Orthopedic Report  
10/12/10: Orthopedic Report  
01/06/11: Operative Report  
01/20/11: Orthopedic Report  
04/21/11: Orthopedic Report  
06/09/11: Orthopedic Report  
07/21/11: Orthopedic Report  
08/23/11: IRO Notice of Independent Review Decision  
09/20/11: Orthopedic Report  
10/24/11: Decision and Order by TDI  
12/09/11: Operative Report  
01/12/12: Orthopedic Report  
05/11/12: Orthopedic Report  
06/01/12: Orthopedic Report  
09/07/12: Orthopedic Report  
09/12/12: Operative Report  
09/18/12: Orthopedic Report  
11/01/12: Orthopedic Report  
12/06/12: Orthopedic Report  
01/02/13: UR performed  
01/07/13: Orthopedic Report  
01/22/13: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured on xx/xx/xx. The claimant described that she went to step up, there was a little ledge, and when she went to step up on the ledge, she stepped back down and stepped on a slick spot. Her foot went out from under her and she twisted her left ankle and landed on her left hip. She also stated that at the time her hip hadn't hurt, just her ankle and that it didn't bother her until she moved in the middle part of September. The claimant was treated with physical therapy beginning in November 2002 and also with muscle relaxants. She then underwent two epidural steroid injections pre-operatively with no improvement. She began treatment who went on to perform a posterolateral fusion and decompression from L4 to S1 on June 10, 2003. Following the fusion, the claimant underwent an additional three epidural steroid injections with no improvement. In April of 2005, her treatment was transferred who recommended hardware removal and revision of her fusion. He treated her with hardware injections while the surgery was denied with success. On February 1, 2006, performed hardware removal. In June of 2006, due to significant disc collapse seen on X-rays at the L5-S1 level, persistent pain postoperatively and episodes of

her left leg giving way, recommended an interbody fusion. While awaiting approval she was treated with medications. At that time she also had complaints of pain around the thoracolumbar junction. A thoracic epidural steroid injection was recommended but denied. In 2009 she participated in Chronic Pain Program and was utilizing an electric muscle stimulator to help decrease her pain. In October of 2010, the claimant had increase pain in the bilateral sacroiliac joints and received a bilateral SI joint injection on January 6, 2011 for which she received 80% pain relief. Her pain did not return until June 2011 for which a second bilateral SI joint was recommended, but was denied. A contested case hearing was held on October 24, 2011, overturning the denial. She underwent a second bilateral SI joint injection on December 9, 2011 with 80% relief. In May of 2012 her pain returned to an unbearable level and fusion of the right sacroiliac was recommended as well as it was mention that she would also need to undergo a left sacroiliac fusion. On September 12, 2012, performed a right sacroiliac fusion.

On October 23, 2002, a NCS showed bilateral right peroneal and right sural dysfunction, early hyperesthetic condition, and right peroneal and left sural dysfunction.

On February 21, 2003, the claimant was re-evaluated who noted on physical exam she continued to have significant pain in the lumbar midline and the paravertebral area, which was bilateral. She also presented pain upon palpation of the left sacroiliac joints, which was less than on previous visits, although her pain at the right sacroiliac joint had increased. She also presented with palpable moderate muscle spasms in the bilateral paravertebral areas. Her range of motion continued to be limited to flexion and extension secondary to pain. Straight leg raise was positive for lower back pain. Patrick Fabere's test continued to be positive predominantly on the left. Diagnosis: 1. Lumbar facet joint dysfunction. 2. Lumbar discongenic pain at L4-L5 and L5-S1. 3. Lumbar neuritis. 4. Thoracic discongenic pain at T11-T12. Plan: Proceed with 2<sup>nd</sup> LESI and physical therapy.

On April 24, 2003, Impression: Spondylosis predominantly at L5-S1 with normal alignment seen with five non-rib-bearing lumbar appearing vertebral bodies noted. Lumbar Myelogram, Impression: 1. Small to moderate ventral epidural defect at L4-5 with underfilling peripherally of the left more so than right L5 nerve root sleeve. 2. Posterior bony ridging L5-S1 resulting in small indentation of the ventral aspect of the thecal sac at this level with underfilling asymmetrically involving the right S1 nerve root sleeve. 3. Minimal ventral epidural defect L3-4. CT Scan Lumbar Spine post Myelogram, Impression: 1. At L4-5 diffuse bulging of the annulus of 3-4 mm lateralizing to the left accompanied by ligamentum flaum hypertrophy and facet arthropathy with borderline central stenosis with contact and underfilling of the left greater than right L5 nerve root sleeve and deformity noted ventrally with a moderate degree at least of left greater than right lateral recess narrowing felt to account for underfilling, myelographically the left greater than the right L5 nerve root sleeve seen. 2. Spondylosis at L5-S1 with significant right foraminal encroachment due to right foraminal bony ridging arising inferiorly from the L5 vertebral body and accompanied by facet arthropathy with a moderate

degree of right foraminal encroachment at least with a small to moderate degree of left foraminal encroachment with contact of both L5 nerve root sleeves in their neural foramina by bony ridging and deformity, more significantly demonstrated on the right side with significant superior displacement noted on the right.

On June 10, 2003, a note indicated that the claimant was taken to the operating room on June 10, 2003 and underwent a decompression at L4/5 and L5/S1. Then a posterolateral two level fusion was carried out. Segmental instrumentation was used and they harvested bone from the right iliac crest.

On November 3, 2003, the claimant was re-evaluated who indicated a CT scan on October 13, 2003 showed the implants in good position and there was no evidence of failure, loosening or any nerve root compression.

On December 5, 2003, the claimant was re-evaluated who reported she had complaints of increasing pain rated 10/10 with radiating pain into the left lower extremity and constant numbness of the left lower extremity. Plan: Transforaminal lumbar epidural steroid injection with assistance of spinal catheter, which would allow him to proceed with directed therapy towards the affected nerve roots on the left L5-S1.

On May 12, 2004, EMG/NCS of the lower extremities, Impression: 1. Lumbar radiculopathy involving the L5 and S1 nerve roots bilaterally, which was indicated by significant acute denervation potential activity and reduced motor unit recruitment patterns recorded in L5 and S1 unnervated paraspinals and distal musculature with in the lower extremities bilaterally. Bilateral L5 radiculopathy was further indicated by reduced peroneal motor amplitude values recorded at the right EDB, absent peroneal CMAP's recorded at the left EDB, and absent peroneal f-wave potentials recorded at the left EDB. 2. No electrophysiological evidence of distal mononeuropathy was recorded in these electrodiagnostic studies of the lower extremities.

On June 4, 2004, CT Scan Lumbar Spine, Impression: 1. Postsurgical change of posterior fusion via transpedicular screws from L4 to S1 without fracture or loosening of screws seen with fairly good alignment noted. Lack of incorporation of osseous fusion masses, however, seen from L4-5 down to S1. 2. Posterior decompressive procedure L4-5 with postlaminotomy bulging of the annulus/ventral epidural fibrosis without focality highly suggestive of recurrent protrusion. No central stenosis is seen with small degree of lateral recess narrowing. 3. Spondylosis, L5-S1 with significant disk space narrowing and posterior bony ridging extending bioforaminally, right more so than left. This protrudes into the right neural foramina by 6 mm appearing to contact and inferiorly deform the right L5 nerve root sleeve in its neural foramina. It also extends left foraminally without significant deformity clearly seen of the left L5 nerve root sleeve. No significant central stenosis is seen at L5-S1.

On October 28, 2004, the claimant was seen for persistent aching pain in the lumbar area with radiation to the left leg accompanied by numbness sensation in

the L5 territory on the left side. On physical exam there was pain in the midline of the lumbar area that increased in intensity with flexion and rotation of the lumbar spine with radiation to the left leg. Straight Leg Raise was positive on the left side at approximately 30 degrees. There were possible sensory deficits to touch and pin prick in the territory of L5. Plan: prescribed Norco 10 mg and Flexeril 10 mg. He encouraged continued therapy.

On April 18, 2005, the claimant transferred her treatment. On physical examination he found she walked with an antalgic gait. Her patella and Achilles reflexes were 2+ and symmetrical. Straight Leg Raise was positive on the left and negative on the right. Quadriceps strength and ankle inversion was 4/5 on the left and normal on the right. Extensor hallucis longus strength was 0 on the left and 5 on the right. Foot eversion strength was 1/5 on the left and normal on the right. Toe flexor strength was 1/5 on the left and normal on the right. The patient had diminished sensation along the left L5 distribution. also reported that a Thoracic MRI was performed on 06/14/04 that showed a sizeable disc herniation at T10-T11. Impression: 1. Psuedoarthrosis. 2. Lower Extremity Radiculopathy. 3. Foraminal Stenosis L5-S1. 4. HNP T10-T11. Plan: Start with an anterior lumbar discectomy with interbody fusion followed by revision posterior decompression with revision of her posterolateral instrumentation and fusion masses. Once recovered, proceed with a thoracotomy and T10-T11 discectomy and interbody fusion.

On July 28, 2005, CT scan of the Lumbar Spine, Impression: 1. Pedicle screws at L4 in good position bilaterally with what appear to be successful posterior fusions. 2. Pedicle screws in good position at L5 bilaterally with what appear to be successful posterior fusions. 3. I do not see significant osseous narrowing of the intervertebral foramina at any level.

On March 17, 2006, the claimant was re-evaluated who reported she was feeling 70% better and was not having any radicular complaints. She still had some residual pain in her back around her left SI joint and buttock and at the thoracolumbar region.

On May 22, 2006, the claimant was re-evaluated who reported she was still complaining of a significant amount of pain in her left SI joint. On examination she was tender to palpation in the paraspinous musculature of the lumbosacral region as well as over the left SI joint. She had positive Gaeslin's and Faber testing. Plan: Additional PT and possible left SI joint block.

On November 2, 2009, the claimant was re-evaluated for constant pain in her lower back area rated 7/10 with weakness in the bilateral lower extremities. She had been prescribed a cane on her last visit, but it did not help with her walking. She was requesting a walker due to instability with a walking cane. On physical exam she had tenderness in her lower lumbar region and decreased ROM in all directions limited by pain. Straight leg raise elicited back pain only. Her motor strength and sensation were weakened throughout her lower extremities and her reflexes were not elicitable. Diagnosis: 1. Herniated nucleus pulposus of L4-L5

and L5-S1, status post fusion. 2. Chronic pain. Plan: Continue electric muscle stimulator and medications. She was also prescribed a walker with a seat.

On October 12, 2010, the claimant was re-evaluated reported the claimant had lost 50 pounds and had been participating in at-home physical therapy. She was using a cane for ambulation. She continued to have low back pain rated a 7/10 with some discomfort with side-to-side movement, soreness, and stiffness. She stated most of her pain was located in her bilateral SI joint area. On exam she had tenderness in her lower lumbar region, more so in her bilateral SI joint area. She had positive FABER, positive Fortin finger, and positive flamingo test bilaterally. Diagnosis: 1. Bilateral sacroiliac joint strain, secondary to lumbar fusion at the L5-S1 level. 2. Status post lumbar fusion, L4-S1. Plan: We believe the patient is seeing adjacent segment degeneration following spinal fusion. The sacroiliac joint forms the lowest segment of the spinal process. The SI joint plays an important role in distributing force and influenced by the movement of the lumbosacral spine; therefore, we believe there is a cause and effect relationship between the fusion and SI joint degeneration and, in that case, we believe the patient would benefit from an SI joint injection bilaterally.

On January 6, 2011, Operative Report. Postoperative Diagnosis: Right Sacroiliac Joint Strain. Left Sacroiliac Joint Strain. Procedures: 1. Right Sacroiliac joint injection. 2. Left Sacroiliac joint injection. 3. Fluoroscopic interpretation of SI arthrogram with needle localization.

On January 20, 2011, the claimant was re-evaluated who reported the bilateral sacroiliac joint injections gave her approximately 70% relief and helped with function in her low back. Plan: Begin a post injection physical therapy program.

On April 21, 2011, the claimant was re-evaluated who reported the bilateral sacroiliac joint injections gave her approximately 80% relief and helped with function in her low back and lower extremities. On physical examination of her bilateral SI joint areas, she had mildly positive tenderness, mildly positive FABER, mildly positive Fortin finger test, and a positive flamingo sign.

On June 9, 2011, the claimant was re-evaluated who recommended a second bilateral SI joint injection.

On December 9, 2011, Operative Report. Postoperative Diagnosis: Right Sacroiliac Joint Strain. Left Sacroiliac Joint Strain. Procedures: 1. Right Sacroiliac joint injection. 2. Left Sacroiliac joint injection. 3. Fluoroscopic interpretation of SI arthrogram with needle localization.

On January 12, 2012, the claimant was re-evaluated who reported the bilateral sacroiliac joint injections gave her approximately 80% relief and helped increase her mobility. Prior to the injection she was using a wheelchair and was only able to stand for approximately 30 minutes at a time. Following the injection she had been using the wheelchair a lot less. On examination she had mild tenderness,

mildly positive FABER, mildly positive Fortin finger test and positive flamingo sign. Plan: The patient may be a candidate for an SI joint fusion in the future.

On May 11, 2012, the claimant was re-evaluated who reported her pain is now unbearable. She had difficulty with various motions and movements and had to use her wheelchair for her persistent buttock pain on walking. The claimant did receive relief with the bilateral sacroiliac joint injections but was interested in a more definitive treatment plan. On examination of the right SI joint she had severe tenderness upon palpation. She was leaning on the left side of her buttocks due to pain on the right side. She had difficulty getting out of her chair and onto the examination notable. She had a positive FABER test and positive compression test. She had a positive thigh thrust and positive distraction. Plan: Right SI joint fusion.

On September 7, 2012, the claimant was re-evaluated for a postoperative visit. It was mentioned that the claimant would probably need bilateral sacroiliac fusions as she did have successful relief of her symptoms after sacroiliac injections. They would start with the right side.

On September 12, 2012, Operative Report. Postoperative Diagnosis: Right sacroiliac pain. Procedures: 1. Sacroiliac fusion, right. 2. Fluoroscopic assist for confirmation of proper instrumentation placement.

On November 1, 2012, the claimant was re-evaluated who reported that claimant no longer had pain in her right sacroiliac joint area. She had occasional soreness and stiffness, but had noticed a complete difference following her SI joint fusion. She did have complaints of severe pain into her left SI joint area. She had a corticosteroid injection performed in the past which gave her temporary relief. On examination she had mild tenderness upon palpation around her SI joint area. She was able to cross her legs without difficulty. On evaluation of her left SI joint area there was severe tenderness upon palpation with positive FABER test, positive Fortin finger, and positive Flamingo test. She continued to use her walker as she had not been able to fully bear weight. X-rays were obtained of the right SI joint that revealed three SI bone fusion implants present in good position and good alignment. Plan: Continue her physical therapy program. Since she is doing well with her right SI joint fusion, she would be a candidate for a left SI joint fusion.

On December 6, 2012, the claimant was re-evaluated who reported she had been doing the best walking since she had been hurt. On exam she had a negative Fortin finger, FABER and posterior shear on the right, but Flamingo, FABER and posterior shear were positive on the left. Plan: A left-sided sacroiliac fusion.

On January 2, 2013, performed a UR. Rationale for Denial: The injured worker does not meet the guidelines. We have records from April to the present. A MRI note 04/24/03 of the lumbar does not mention the SI joints and is ten (10) years old. No recent x-rays are available. The injured worker is only less than four (4) months post right sided surgery. It seems only reasonable to have 6 months or

more of healing before embarking on the left side. This is especially true since SI joint surgery is so questionable. Therefore, the medical necessity of the requested procedure was not established.

On January 7, 2013, appealed the first denial letter regarding the recommendation of a left sided sacroiliac fusion. opined that in this claimant's case, she has had significant relief and has virtually no pain on the right side following the sacroiliac joint fusion and therefore, believed the claimant's healing time has been sufficient. also opines that the diagnosis is not confirmed by x-rays, but by pain relief with intraarticular sacroiliac joint injections under fluoroscopic guidance. believes that claimant meets all indications for SI joint fusion including failure of nonoperative treatments, chronic pain lasting for years, and diagnosis by injection.

On January 22, 2013, performed a UR. Rationale for Denial: The statement that the claimant meets all the indications for the fusion is not accurate. Depending on signs that we know, they are not specific or reliable with insufficient evidence available of any need for a fusion of a joint with a debatable bulging. The claimant may have some arthritis in the area of the sacroiliac joint. There are no indications that the fusion is indicated nor do the ODG recommend sacroiliac fusions since there is no way clinically to be able to assess any motion at the joint and no indication that there is instability to require fusion. This request for a sacroiliac fusion on the left side should be denied. The reported improvement of a fusion on the right side sacroiliac done on September 12, 2012 is likely secondary to the postop rehabilitation and the maneuvers over the joints and not necessarily to the fusion.

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

The previous adverse determinations are upheld. Fusion of the left sacroiliac (SI) joint is not recommended at the present time for Melissa Pouncey. The Official Disability Guidelines (ODG) supports SI joint fusion in the setting of chronic or severe sacroiliac joint pain. The diagnosis of SI pain associated with degenerative changes should be confirmed radiographically and by a positive response to an intra-articular injection.

needs to be fully recovered from the right sacroiliac fusion of 9/12/12 before the left side can be determined to be a source of pain. If the claimant is still symptomatic in the left SI joint six months after her right SI fusion, she should undergo an intra-articular left SI joint injection. If substantial pain relief is obtained following the left SI joint injection, then the left SI joint can be determined to be a source of pain that may require fusion. A positive response from bilateral injections does not prove that the left SI joint is the source of pain. In addition, radiographic evidence of degenerative changes in the left SI joint should be documented in the record before considering surgery. The ODG would support a left SI joint fusion only under these criteria. Therefore, the request for Three (3) days Inpatient (IP) hospital length of stay (LOS) for left-sided sacroiliac joint (SIJ) fusion is not found to be medically necessary at this time.

PER ODG:

Sacroiliac joint fusion	<p>Not recommended except as a last resort for chronic or severe sacroiliac joint pain (see indications below). The surgery has been reported to result in benefit in selected cases, but no high quality studies have been conducted on sacroiliac joint fusion. The largest of the related studies was conducted with 20 carefully selected patients. The trial concluded that sacroiliac joint fusion might be a safe, well tolerated, and successful procedure, leading to significant improvement in functional outcome and a high fusion rate. More high quality studies need to be conducted. (<a href="#">Buchowski, 2005</a>) (<a href="#">Sherman, 2004</a>) (<a href="#">Giannikas, 2003</a>) (<a href="#">Guner, 1998</a>) See also <a href="#">Percutaneous sacroiliac joint fusion</a>.</p> <p><b>Indications for SI Joint Fusion:</b></p> <ul style="list-style-type: none"><li>- Failure of nonoperative treatment</li><li>- Chronic pain lasting for years</li><li>- Diagnosis confirmed by pain relief with intraarticular sacroiliac joint injections under fluoroscopic guidance - positive response to the injection was noted, and patients had recurrence of symptoms after the initial positive</li><li>- Preoperative and postoperative general health and function assessed</li><li>- Medical records and plain radiographs have been reviewed retrospectively to determine the clinical and radiographic outcome</li></ul>
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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 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)**