

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 10, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed outpatient Lumbar L4-5, L5-S1 transforaminal epidural steroid injection

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Occupational Medicine and Aerospace Medicine and is engaged in the full time practice.

REVIEW OUTCOME

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

- Upheld (Agree)
- XX Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4	64484		Prosp	1			Xx/xx/xx	xxxxx	Overtured
724.4	62284		Prosp	1			Xx/xx/xx	xxxxx	Overtured
724.4	99144		Prosp	1			Xx/xx/xx	xxxxx	Overtured
724.4	64483		Prosp	1			Xx/xx/xx	xxxxx	Overtured
724.4	72275		Prosp	1			Xx/xx/xx	xxxxx	Overtured

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-20 pages

Respondent records- a total of 99 pages of records received to include but not limited to: 8.9.13, 8.15.13, 8.26.13; letter 7.16.13; Request for an IRO forms; Pre-Authorizations 5.4.12, 5.15.12, 2.17.12, 7.11.13, 8.9.13; letter 8.7.13; report 9.10.10; report, 12.20.10; MRI Lumbar Spine 12.21.10, 3.25.12; 2.8.11; DWC form 69; Impairment Evaluation 3.10.11; TDI letter 8.1.12; DDE report 8.17.12; Peer Review, 7.9.13; record, 7.9.13

Requestor records- a total of 0 pages of records received to include but not limited to:
First Request for records sent via fax 8.22.13; Second Request for records sent via fax 8.30.13

PATIENT CLINICAL HISTORY [SUMMARY]:

This case is complicated by the lack of first hand documentation. Almost all the documentation included for my review is from various reviewers with questionable allegiances. Only one note is included from the pain management specialist requesting the TF-ESI. However, the results of the EMG/NCV (right leg only and outdated) studies as well as two of the MRIs are included. With reviewing the various documents, one finds discrepancies: the claimant's age is wrong; what happened to the claimant is confused (falling into a hole, fall injury, to lifting concrete, to lifting an 85 lb concrete sack into a hole); the claimant's sex is noted as female ("her") in one case; numbness in right foot said to be present before xxxx (no other reviewer mentioned this); assumption that claimant's examination must be difficult because of obesity; and diminished bladder control, and others. These discrepancies indicate a lack of attention to detail that may or may not have influenced the various reviewers' determinations. Also, a disability evaluation indicated the claimant suffered a new, second, low back injury on xx/xx/xx: no subsequent further mention is made of this observation. Because of the confusion in the available documentation, a thorough summary of what is available for review is presented in order to reach a reasonable conclusion in this case.

DOCUMENTS AVAILABLE FOR REVIEW:

1: Prospective Review (M2) Response, August 26, 2013, Disputed issue was denial of preauthorization of approval for outpatient lumbar transforaminal epidural steroid injection (TF-ESI) at right L4-5 and L5—S1; initial request was denied because Official Disability Guidelines (ODGs) indicated ESI should be done only with signs of radiculopathy by physical examination, imaging studies, and/or electrodiagnostic testing: these requirements were not confirmed in the documentation. It is commented claimant is using oral medications, but no documentation of a home exercise program/physical therapy was documented. maintained position proposed treatment with ESI was not medically reasonable and necessary for the compensable injury. Mr. was apparently injured while lifting. The carrier has disputed some medical treatment modalities. Past medical history (PMH) was significant only for smoking (1 ppd) and hypertension. Mr. was overweight (72 inches, 250 pounds). Examination revealed decreased toe flexion and extension in both lower extremities, limited lumbar range of motion, bilateral positive straight leg raise testing, as well as tenderness at lumbar facet joints. Past medical treatment for this injury included: diagnostic studies, physical therapy, **multiple lumbar ESIs to right lumbar area (significant benefit reported)**, radiofrequency thermoregulation to right L4-5, L5-S1 facets ((02/08/11); Dx: lumbago, lumbosacral neuritis. The reviewer indicated claimant was past primary level of care re: "her" injury (claimant is a male). The reviewer concluded that the claimant did not reach the ODG requirements of signs of radiculopathy on physical exam, confirmed by imaging studies and/or electrodiagnostic studies. Consequently, the request for ESI was denied.

2: Fund URA recommendation, July 16, 2013, Reviewer indicated the claimant was injured; he was diagnosed with lumbago. The reviewer indicated claimant had low back pain, with radicular pain extending to feet on right; symptoms alleviated by rest on floor with pillow under back, position change, stretching with inversion table, and medications. Physical exam revealed decreased toe flexion and extension of both lower extremities, limited painful lumbar ROM; bilateral positive straight leg raising; tenderness at lumbar facet joints. MRI results were given. The reviewer indicated lumbar ESIs should be only performed with signs of radiculopathy, corroborated by imaging studies and/or electrodiagnostic studies: these were not found in this claimant's case. The claimant was on oral medications, and no indication of a HEP, other than stretching, was available; there was no indication of the efficacy of a physical therapy program. Consequently, the request for lumbar ESIs was denied.

3: 28 TAC 134.600 for pre-authorization-TML, July 11, 2013, Request denied. Clinical summary: claimant injured when fell, and was diagnosed with lumbago. Claimant evaluated on July 9, 2013. Complaints: low back pain with radicular pain extending to feet on right; symptoms better with rest on floor with pillow under back, position change, stretching with inversion table,

and medications. Exam: decreased bilateral toe flexion and extension, limited painful lumbar ROM, tender lumbar facet joints. Determination was that ODGs require signs of radiculopathy, corroborated by imaging and or electrodiagnostic studies. It was noted claimant using oral medication, but HEP, other than stretching, not documented. No evidence of efficacy of a physical therapy program.

4: Summary of requests/approvals/denials, undated: lumbar MRIs approved on 3/23/2009, 12/15/2010, 3/25/2012; physical therapy, x 6 approved on /22/2009; lumbar ESIs x 2 approved on 8/28/2009, 10/09/2009, denied on 02/10/2012, 02/24/2012. 05/09/2012, 07/16/2013; bilateral, or unilateral facet injections or RFTCs approved on 12/11/2009, 01/25/2010, 10/05/2010, 01/14/2011, denied on 11/24/2009, 03/10/2010, 04/02/2010, 04/19/2010, 06/11/2010, 07/30/2010, 08/12/2010, 01/11/2011, 02/10/2012.

5: Fund URA recommendation, August 15, 2013, Reviewer indicated the appeal for the L4-5, L5-S1 TF-ESI should be denied. Summary of clinical history indicated a fall jury in xxxx, a prior approval for two ESIs in xxxx, and later about 4 approvals for facet/medial branch nerve blocks/radiofrequency thermocoagulation (RFTC) procedures; no herniated nucleus pulposus or nerve root encroachment on MRI. Rationale: no evidence of documented radiculopathy changes; nonremarkable MRI (2012); no new significant neurological/discopathy changes.

6: 28 TAC 134.600 for preauthorization, August 9, 2013, Reconsideration/appeal for transforaminal L4-L5, L5-S1 ESI ; note, not working; fall injury in xxxx; approval for 2 ESIs in xxxx, and about 4 approvals for facet medial branch RFTC; no evidence of documented radiculopathy changes/no HNPs nor nerve root encroachments.

7: Letter August 7, 2013: Request be allowed to proceed with TF-ESI; procedure is medically indicated and medically necessary; more conservative measures such as physical therapy and medications have not been effective; imperative that claimant have interventional pain management procedures; TF-ESI is treatment of choice.

8. 28 TAC 134.600 for pre-authorization- May 4, 2012, Lumbar TF-ESI of right L4-5, L5-Si denied; procedure previously denied; claimant (?) not working. Claimant injured in xx/xxxx; request is for 2 level TF-ESI; MRI and EDX study in 2010 did not confirm radiculopathic pathology; also, claimant's findings are on left side, and not on right; exam revealed tenderness to palpation of lumbar spine over spinous and paraspinous regions; pain with flexion and extension and lateral motion; pain radiated down right greater than left lower extremity; numbness in right lower extremity,--claimant had this numbness before xxxx; straight leg raising to 20 degrees with pain dorsiflexion worse, caused pain to radiate to right greater than left lower extremity. Hx: previous ESI did help numbness and decreased overall pain, and improved functional capacity; February 2012 notes indicate positive SLR on right more than left at 20 degrees,--probably non-physiologic; claimant weighs 270 lbs and probably very difficult to examine. Remote imaging inconsistent with clinical suspicion of radicular pain, and nonphysiologic findings indicate ESIs neither necessary nor consistent with ODG.

9.: 28 TAC 134.600 for preauthorization, May 15, 2012, reconsideration for TF ESI L4-, L5-S1 denied; claimant (?) not working. This request is for reconsideration of denial. Findings of previous reviewer (May 4, 2012) quoted. This reviewer agrees with previous findings, as well as EDX did not document pathology that would cause predominately right-sided symptoms, as well as exam of May 2, 2012 does not document radiculopathy findings. ODG indicates radiculopathy must be documented, objective findings on exam need to be present; imaging studies/electrodiagnostic testing must corroborate radiculopathy.

10: EMG/NCV testing of right leg only, December 20, 2010: Hx: pleasant male with work-related injury on xx/xxxx: fell loading his back; has had low back pain since; now complains of right leg numbness, tingling, pain and weakness for past 3 months; exam: full ROM; strength, sensation, reflexes, balance, and gait normal. Findings: normal study: no evidence of peripheral

neuropathy entrapment neuropathy, radiculopathy or other lower motor neuron disease of right leg.

11: MRI of lumbar spine with and without contrast for back pain, December 21, 2010, L5-S1: disc desiccation; endplate degenerative changes; left paracentral disc protrusion measuring 3 mm resulting in mild abutment of descending left S1 nerve root; L1-L2: minimal endplate degenerative changes.

12: MRI of lumbar spine without contrast for back pain, right leg weakness, and diminished bladder control, March 25, 2012, thickened fat signal intensity filum terminale of cauda equina; no tethering of cord; minimal disc bulging at L4-5 and L5-S1 extending into left neuronal foramen without impaction on neural elements,

13: Operative report—right RFTC of facets at L4-5, L5-S1, February 8, 2011, for low back pain, right greater than left.

14: Impairment evaluation, March 10, 2011, Claimant has undergone numerous conservative care options other than surgery, pain persists. Hx: Claimant indicates has intermittent low back pain with baseline intensity of 3/10, increasing with activity; pain radiated over lateral aspect of calf corresponding to L5 dermatome. Exam: obese male (72 inches, 264 lbs, BMI 35.8), muscle guarding in lumbar spine, without spasm or edema; palpatory tenderness in lower lumbar spine over both SI joints; lumbar ROM limited in flexion and right lateral flexion; rest of exam normal. WP-IR: 5%. According to Section 408.021 of the Texas Labor Code, an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury,--employee specifically entitled to health care that 1-cures or relieves effects resulting from compensable injury; 2-promotes recovery, or 3-enhances the ability of employee to return to, or retain, employment.

15: Disability evaluation, August 17, 2012, Claimant is male who was injured while working; primary doctor is and pain specialist injured on xx/xx/xx. MRIs were unremarkable; EMG was normal; examinee recovered from lumbar injury and returned to full duty without restrictions on February 23, 2011. On March 15, 2011, claimant developed LBP after bending over in a vault lifting a water meter; he has had back pain since then. felt the xx/xx/xxxx, injury was a new injury. Claimant was taken off work on March 17, 2011, after second injury. The third MRI (March 25, 2012) revealed a new finding of a mild bulging disc at L4-5, as well as L5-S1, without neural foraminal impingement: these findings were on the left. Exam: gait slow and antalgic; could not toe walk on right foot; tenderness at palpation of left paraspinal muscles; lumbar ROM: extension, flexion, right and left lateral bending restricted; muscle strength of right extensors at ankle was 4/5; muscle strength of great toe extensors and flexors was 4/5 on right; circumference of right calf 46.0 cm, left calf-46.5 cm. Dx: lumbar strain. Evaluation: the L4-5 level is not compensable with relation to xx/xx/xxxx injury, and the L5-S1 disc protrusion is subsequent to March 15, 2011 injury,--and is not related to initial injury of xx/xx/xxxx. Claimant had a bonafide injury on xx/xx/xxxx, which resolved, as patient RTW full duty on February 23, 2011; a second injury was sustained on xx/xx/xxxx, which is not related to the xx/xx/xxxx, injury; claimant continues to be symptomatic from this injury, which appears to be a significant lumbar sprain with radicular symptoms, with no definite radiculopathy.

16: PEER review, July 9, 2013, Hx: Mechanism of injury for March 6, 2009, injury--claimant's low back pain developed during the evening after work shift ended. Exam: 72 inches, 220 lbs, moderate distress; muscle spasm at palpation of lower lumbar region. Dx: back pain/strain. Claimant wanted a release to RTW, since pain was improving. The pain did get somewhat worse over time. There was good lumbar ROM, and a work hardening/conditioning program was outlined. There was significant improvement in his pain, although the pain again later exacerbated. The claimant was then sent for physical therapy. The physical therapy assessment indicated myalgia and lumbago. The claimant was taken off work; the claimant improved over time. An impairment evaluation on June 29, 2009, indicated MMI had been reached with a 0% WP IR. The symptoms seemed to increase and decrease on a regular basis, and the impairment evaluator later rescinded his determination of MMI. A functional capacity

evaluation was done on August 13, 2009, , which included a psychological assessment (elements of depression, anxiety, irritability, interpersonal problems, minimal substance abuse, and pain symptoms). A pain management assessment on August 24, 2009, indicated LBP, with radiculopathy at L5-S1. An ESI was recommended, and completed, on September 15, 2009. After an initial increase in pain, there was a 100% pain reduction after one week (October 6, 2009). The pain returned, but still there was a 50% overall pain reduction. The claimant was returned to work, with restrictions. A second ESI was performed on November 3, 2009, and facet joint injections were suggested. The pain became worse, and the claimant was taken off work on November 25, 2009. Bilateral facet injections were done (L4-5, L5-S1), on December 29, 2009. There was a significant improvement in pain, and median branch blocks were suggested, as were radiofrequency transection of nerves, since none of the conservative measures seemed to help. The claimant was hypertensive and obese (250 lbs). The pain was located over the facet joints, with minimal radiation to the lower extremities. The pain remained unchanged. The radiofrequency lesioning was performed on September 19, 2010; the pain was unchanged. By November 17, 2010, the pain management specialist felt a return to work without restrictions was warranted, with a support belt. A work hardening program was prescribed. By December 9, 2010, the claimant now had symptoms in the lower extremity—numbness on the right with associated weakness, that started suddenly,—the pain was rated at 8/10. EMG/NCV testing was normal. A MRI revealed disc desiccation at L5-S1, with a 3 mm disc protrusion abutting the descending left S1 nerve root. Exam revealed a positive straight leg-raising test at 30 degrees. Dx was low back pain with minimal lower extremity radiculopathy. The back pain increased, and the diagnosis was now chronic persistent low back pain. Additional radiofrequency thermocoagulation was done on February 8, 2011, with good results, and a return to full duty done. By March 28, 2011, the claimant presented with continued complaints of LBP and minimal lower extremity radiculopathy, and indicated the new job irritated his back. On February 6, 2012, the pain specialist reported the claimant experienced a “pop” in his back, and the pain returned with an intensity of 5/10. A TF-ESI was felt to be necessary. The claimant went to the ED, on March 25, 2012, complaining of back pain of moderately severe intensity. A MRI revealed broad-based bulging at L4-5 and L5-S1. By May 12, 2012, the pain specialist indicated her conservative modalities were exhausted. A Designated Doctor evaluation indicated a second injury had occurred unrelated to the original event. The reviewer felt the diagnosis for the original injury (xx/xxxx) was resolved soft tissue myofascial strain of paravertebral musculature of the lumbar region of the spine, and no further treatment was necessary for the compensable injury.

17: Initial evaluation---pain management, July 9, 2013, Complaint: radicular pain extending down into feet and right side, worse with low back pain. Low back pain was experienced daily, aching, constant, sharp on right radiating to left; symptoms ongoing; pain moderately limits activity; exacerbated by bending, lifting, any activity; better with lying on floor with pillow under back, position change, medication, and daily stretching with inversion table. Pain intensity varies from 4-5/10 to 9/10. Smokes 1 ppd for 20 years; currently working 40 hours, alcohol negative. Exam: 230 lbs, 72 inches, BMI-31.19; right side worse than left; claimant continues to work; new finding is instability of ankle secondary to weakness, secondary to back pathology; ROM of right foot: decreased toe extension and flexion; ROM left foot: decreased flexion and extension; ROM lumbar spine: decreased extension, flexion, lateral bending, rotation; positive straight leg raise right and left; tender palpation of facet joints and lumbar spine, right worse than left. Assessment: lumbago; lumbosacral neuritis. Recommend: TF-ESI at L4-5, L5-S1; continue with physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S

**POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES,
THEN INDICATE BELOW WITH EXPLANATION.**

RATIONALE-AN ANALYSIS AND EXPLANATION FOR THE RECOMMENDATION:

ODGs:

The above noted reviewers who denied a new course of ESIs for this claimant did not give a full and faithful review of what the ODGs state re: ESIs in their comments. According to the ODGs, ESIs are recommended as a option for the short-term treatment of radicular pain (pain in dermatomal distribution with corroborative findings of radiculopathy, in conjunction with active rehab efforts, including HEP [home exercise program]). Radiculopathy symptoms are GENERALLY due to herniated nucleus pulposus or spinal stenosis . ESIs may lead to improvement of radicular pain between 2 and 6 weeks after the injection, but do not affect impairment of function or the need for surgery, and do not provide long-term benefits beyond 3 months. Chronic pain (symptoms lasting more than 6 months) has been found to decrease success rates,--up to 3 times beyond 24 months). The ideal time to start or treatment, or to determine it is too late to start therapy, has not been determined. Indications for repeating ESIs in patients with chronic pain at a level previously injected (greater than 24 months) include a symptom free interval or indication of a new clinical presentation at the level. There seems to be a preference or the transforaminal (TF) approach over the caudal injections—most helpful in large HNP's, foraminal stenosis, and lateral disc herniations. Factors that decrease success are: patients who are unemployed because of pain, smokers, history of previous back surgery, pain that is not decreased by medication, evidence of substance abuse, disability, and litigation. ESIs may be helpful with radicular symptoms not responsive to 2-6 weeks of conservative therapy. Injections are recommended if they can facilitate a return to functionality via activity and exercise. Also, in Appendix D of the ODGs (Documenting Exceptions to the Guidelines), it states: "These publications are guidelines, not inflexible proscriptions and they should not be used as a sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions..., but they cannot take into account the uniqueness of each patient's clinical circumstances."

ANALYSIS:

Re: this claimant (Mr.), the following is agreed upon: The claimant had a previous series of TF-ESIs that were reported as successful. The patient had a symptom-free interval, and then had a new clinical presentation at that level. The claimant's physician indicated he was undergoing physical therapy, but that it had been less than effective. All agree that the claimant is using medications that help, but do not alleviate the discomfort, and that he is using a HEP (although the reviewers do not recognize it as such) consisting of stretching/inversion table at home. He is a smoker (1ppd/20 years), but is apparently trying to quit (using Chantrix). The comment is repeatedly made the claimant is "obese" (a BMI of 31 is not obese, it is "overweight"): the ODGs do not reference one's BMI as having any effect on the use or non-use of ESIs. It is questionable whether the claimant is working: his physician indicates he is working, several of the reviewers' statements indicate he is not working. There is no indication the claimant is involved in any litigation. There is no history of previous back surgery, substance abuse, or disability.

Now, we address the presence or non-presence of radiculopathy.

-The reviewers seem to feel that, since the EMG/NCV does not indicate nerve injury, there cannot be a radiculopathy. This is not correct. If the EMG/NCV is positive, it is suggestive of a radiculopathy; if the study is negative, it does not rule out a radiculopathy (*AMA Guides to the Evaluation of Permanent Impairment*, 5th edition). To be a reasonable adjunct to the evaluation of an impairment, EMG/NCVs need to be repeated every 6 months, as nerve injuries do not immediately reveal themselves. The EMG/NCV was done in 2010, before the claimant's exacerbation of symptoms, and prior to his first RTW in March 2011. To be useful, any EMG/NCV used for this evaluation must have been completed no more than 6 months ago.

-The reviewers repeatedly indicate that, since the MRI did not indicate a herniated disc, there could be no radiculopathy. This is not correct. A review of the MRI literature indicates, as is the EMG/NCV, MRIs are useful, but not fully diagnostic. Those with radicular symptoms may have a completely normal MRI, and those without symptoms may have a "diagnostic" MRI. When

the clinical findings agree with the MRI findings, it is beneficial. Again, the *AMA Guides to the Evaluation of Permanent Impairment*, 5th edition, clearly states MRIs should not be done unless surgery is being contemplated. Diagnosis, for the most part, is clinical. Even so, the claimant's last MRI (these should also be repeated every 6 months to monitor the progression of pathology) indicates broad-based bulging discs at L4-5, and L5-S1, extending to the left. This pathology is in the area of concern, even though it appears to be on the "wrong side". It is not unusual for symptoms to be on the contra-lateral side and bulging discs can cause symptoms that equal HNPs, simply because of the displacement of tissue. However, in the case of this claimant, he has symptoms on the right and left sides, only the right side seems more severe at this time.

-Clinical findings: ; The claimant experiences low back pain daily, aching, constant, sharp on right radiating to left; symptoms ongoing; pain moderately limits activity; exacerbated by bending, lifting, any activity; better with lying on floor with pillow under back, position change, medication, and daily stretching with inversion table. The claimant's gait is slow and antalgic, he could not toe walk on the right (instability of ankle secondary to weakness); he has numbness in the right lower extremity, has pain referred to the L5 dermatome on the right lower extremity; he has positive straight leg raise test on the right and left, muscle strength of right extensors at ankle was 4/5; muscle strength of great toe extensors and flexors was 4/5; ROM of right foot: decreased toe extension and flexion; ROM left foot: decreased flexion and extension; ROM lumbar spine: decreased extension, flexion, lateral bending, rotation; positive straight leg raise right and left; tender palpation of facet joints and lumbar spine, right worse than left. Of particular importance is the finding of the circumference of right calf 46.0 cm, left calf-46.5 cm. Normally, if the claimant is right-handed (we have no information to this fact, but most individuals are right-handed), the right calf should be larger than the left. We do not know what the circumferences were before the injury, but it appears the right calf's circumference is decreasing significantly. This is usually a slow process. In that the exam findings now indicate the left side is also being affected, this could be a significant finding of an "occult" radiculopathy,-right more so than the left.

CONCLUSION:

Due to the preponderance of evidence in support of the TF-ESI at the right L4-5 and L5-S1 levels, at Surgery Center, as requested for this claimant, after a complete documentation/evaluation of the pertinent ODGs, and the almost complete satisfaction of ALL requirements for same, **THE DENIAL IS OVERTURNED.**

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES