

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

July 21, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 day of Inpatient Hospital Stay between 05/09/2014 and 07/08/2014; Right L4/5 and L5/S1 Laminectomy between 05/09/2014 and 07/08/2014

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

This physician is a Board Certified Orthopedic Surgeon 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. While working, he had immediate pain in his lower back that got worse as the day went on. At first his pain was mainly across his lower back with some sharp pain in his back and right leg. The sharp pain has decreased now and he mainly has a constant ache.

xxxx: Office Visit. **HPI:** The patient presents today with back pain. Past treatment has included opioid analgesics (Vicodin) and physical therapy. Symptoms include back pain. Pain scores include a minimum pain level of 5/10 and a maximum pain level of 9/10. The pain is located in the low back. The pain radiates to right buttock, right thigh and right calf. The patient describes the pain as sharp and constant. The patient describes symptoms as worsening. Symptoms are

exacerbated by sitting, standing and walking. Symptoms are relieved by rest. He is still working. No past history of low back problems. The pain is always right side low back into the buttock and thigh. He has had some PT. The pain medication usage is limited. The pain can go to the ankle. **Physical Exam:** Full pain free rom bilateral LE; No LE edema; symmetric quad and Achilles reflexes; not atrophy; intact bilateral lower extremity pulses. **Assessment/Plan:** He has right EHL weakness on examination. I suspect HNP. I recommend an MRI lumbar spine w/o contrast. Continue with work for now with restrictions if necessary. His x-rays are normal. I will refill his pain medication. Started Elodolac 400MG, 1 (one) Tablet two times daily #60, 30 days starting 1/28/13, no refill. Started Norco 7.5-325MG, 1-2 tablet every 4-6 hours as needed, #40, 1/28/13.

01/31/2013: MRI Lumbar Spine without Contrast. **Impression:** 1. At the L4/L5 level, there is posterior disc bulging extending 2mm posteriorly producing effacement of the thecal sac. 2. At the L5/S1 level, there is disc desiccation, posterior disc bulging extending 2mm posteriorly, and a superimposed broad-based right paracentral/foraminal disc protrusion (herniation) with an annular tear extending 5mm posteriorly producing mild central canal stenosis, moderate to severe stenosis of the right lateral recess, mild stenosis of the left lateral recess, and mild right neural foramen stenosis.

02/04/2013: Office Visit. **HPI:** Patient presents today for a recheck and to discuss MRI results. **Assessment/Plan:** The patients MRI reveals a significant right L5/S1 _____ with small protrusion impinging the S1 nerve. Other discs normal. He has right side low back and intermittent right lower extremity pain. I suspect his pain is related to the L5/S1 segment. He is taking etodolac and underwent some PT. He is working. We discussed and ESI and he agrees.

02/21/2013: Office Visit. **HPI:** He is here today to discuss his injection denial. The reviewing physician states "The physical examination findings do not correlate with the MRI findings. The patient has no physical examination findings suggestive of nerve root irritation/compression" **Physical Exam:** full pain free rom bilateral LE; No LE edema; symmetric quad reflexes; absent right Achilles reflex and 2+ left; no atrophy; intact bilateral lower extremity pulses; positive right nerve root stretch test. **Assessment/Plan:** HNP, lumbar (722.10) Today's impression: right L5/S1. Plan: Inject spine L/S ESI; routine, Continue Norco 10-325MG, 1-2 Tablet every 4-6 hours as needed, #90m 2/21/13, no refill. Today's Assessment: The patient continues to have the right side low back pain with pain radiating down the right lower extremity. The pain has worsened since his last visit considerably. He has an absent right Achilles reflex today along with a positive nerve root stretch test consistent with his MRI which reveals a right L5/S1 HNP compressing the right S1 nerve root with resultant right S1 radiculopathy. Therefore, I once again recommend the caudal ESI which was denied. He is taking 6 Norco 10/325 per day which he understands is a rather large amount so I am going to consult for pain medication management. I am going to also prescribe a topical compound cream to apply 2-3 times per day.

03/07/2013: Operative Report. **Postoperative Diagnosis:** Lumbar herniated nucleus pulposus/stenosis. **Procedure Performed:** 1. Needle localization of caudal epidural space utilizing fluoroscopy. 2. Caudal epidural steroid injection.

03/19/2013: Office Visit. **HPI:** Patient presents for a recheck of back pain. The pain is minimum 5/10 and maximum 10/10. The pain is located in the low back. The pain radiates to right buttock, right thigh and right calf. The patient describes the pain as sharp, dull and aching. The pain is constant. Note for "Back pain": he is here today to follow-up after his caudal ESI. Since the injection his pain has gotten more intense. He is unable to sleep while on his back now. The first 3 days after the injection were the most severe, now his pain is the same as it was before the injection, just more intense. **Assessment/Plan:** HNP, lumbar (722.10)
Today's impression: Right L5/S1. He has persistent right lower extremity pain and numbness. I discussed with the patient that surgery could be considered for any radicular hip or lower extremity pain but that it most likely would not eliminate his low back pain. He will be seeing in about 10 days who will hopefully manage his medication. After discussion with the patient I am concerned that surgery is not going to be effective and recommend no further injection or surgery.

04/04/2013: Confidential Diagnostic Interview. He continues to experience pain in his low back which radiates to his right buttock and down his right leg to his calf. He experiences numbness and tingling in his right leg to his toes as well. He returned to light duty work after his injury but was laid off in March of 2013 as there were no more light duty positions available. He is extremely fearful of pain escalation and has become increasingly sedentary and deconditioned and guards his spine and lower right extremity. He indicates that he wants to return to work but fears reinjury. He was recently evaluated by a designated doctor and found not to be at MMI. **Mental Status:** Current psychological symptoms include anhedonia, difficulty sleeping (approximately 4-6 hours of broken sleep per night) a loss of sex drive, a loss of energy, a loss of enjoyment and frustration related to his injury and inability to do normal activities of daily living. also stated that he frequently "feels like crying" but can't shed tears. His pain also triggers significant fear of pain escalation which manifest as tension headaches, light headedness, shortness of breath, muscle bracing and guarding of his spine and lower extremities. scored a 12 on the BDI-II and a 15 on the BAI demonstrating mild depression and anxiety. His clinical presentation and testing suggested significantly more psychological difficulty than his BDI-II and BAI indicated. **Impression:** With appropriate medical and psychological intervention, is likely to make additional recovery, learn to work around his injury and return to gainful employment. Without these supports, the patient is likely to remain anxious, pain focused and sedentary, will persist in guarding of his spine and right lower extremity, continue to avoid weight bearing activities which increase his pain and he will remain more disabled than necessary. While he does not present as narcotic seeking, is at risk of Opioid dependency in the absence of the recommended behavioral intervention. **Diagnosis:** ICD-9 847.2, ICD-9 316 Psychological Factors associated with diseases classified elsewhere. Psychological factors in physical conditions, ICD-9 338.4 Chronic Pain Syndrome. Chronic pain associated with significant psychosocial dysfunction. DSM-IV-TR

Diagnosis: Axis I: 307.89 Pain Disorder associated with both psychological factors and a general medical condition, chronic. 309.28 Adjustment disorder with mixed anxiety and depressed mood, Axis II: V71.09 None present, Axis III: Chronic pain condition associated with lumbar spine injury. Axis IV: Problems related to pain and occupational, recreational and social decline in functioning. Axis V: Serious Symptoms-GAF-50. **Recommendations:** Mr. requires treatment to help him reduce his fear of pain escalation and to improve his functioning. While the best option for a recovery as indicated in the current literature would be to place him in a multidisciplinary chronic pain program, additional testing (EMG) and PT are pending. All lower level care will have to be ruled out or completed prior to consideration of a pain program.

04/09/2013: Office Visit. **HPI:** Patient presents today to discuss his MRI again. He has a numbness to the left and right of his spine, higher than the pain that was discussed previously. He is wondering if the MRI showed anything else going on that could be the cause of his additional numbness. **Assessment/Plan:** HNP, lumbar (722.10)m today's Impression: right L5/S1 Current Plans: The patient has thoracic numbness and paresthesias. I cannot explain that symptom. I reviewed his MRI and he has a right L5.S1 HNP compressing his right S1 nerve. Some mild right L4/5 LRS. The low back pain is bilateral but greater right. I once again do not recommend surgical treatment.

07/16/2013: Confidential Diagnostic Interview. **Impressions:** presented as a depressed, anxious, frustrated individual who is having a difficult time coping with his pain condition and physical limitations. The patient appears to be psychologically distraught due to his injury, his inability to work in his prior labor intensive job at this time and his fear that he will not be able to return to work or many of his prior masculine oriented activities. Mr. is realistically concerned that unless he is able to resume his prior labor intensive job at this time and his fear that he will not be able to return to work or many of his prior masculine oriented activities. is realistically concerned that unless he is able to resume his prior level of functioning, his outlook for continued employment at this current income level will be difficult to achieve. The patient's psychological concerns have been caused by his industrial accident, chronic pain, reduced physical functioning and delayed recover. His current fear of reinjury (Kinesiophobia) is likely to cause physiological reactivity and is creating a barrier to his recovery. has developed a chronic pain syndrome directly resulting from his work related injury. This condition occurs when the patient immobilizes the body and joints due to fear of pain escalation with activity. The diagnostic criterion for pain disorder includes the following: A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention. B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. D. The symptom or deficit is not intentionally produced or feigned. E. The pain is not better accounted for by a Mood, anxiety, or psychotic disorder and does not meet criteria for dyspareunia. **Recommendations:** Mr. requires treatment to help him reduce his fear of pain escalation and to improve his functioning. While the best

option for a recovery as indicated in the current literature would be to place him in a multidisciplinary chronic pain/functional restoration program, all lower level care will have to be ruled out or completed prior to consideration of a pain program. He is currently participating in PT.

07/17/2013: EMG Report. **Interpretation:** There is neurophysiological evidence of mild lumbosacral radiculopathy at L5 on the right. The denervation/ reinnervation changes on needle EMG are chronic and mild. There is no neurophysiologic evidence of peripheral neuropathy/myopathy. No evidence of peroneal neuropathy/posterior tibial neuropathy/ sciatic neuropathy/ lumbosacral plexopathy on the side.

07/23/2013: Initial Evaluation. **Objective:** Gait: is ambulating with a straight cane on the (R) with a (R) antalgic gait. He maintains slight trunk flexion during ambulation. He reports using the cane on the (R) for concern that if his (R) LE buckles and the cane is on the opposite side he will be unable to support himself. Posture: 2" forward head/neck, bilateral rounded shoulders, decreased weight bearing (R)LE, (R) side bent trunk position and 10 degrees flexed trunk. In sitting, positions himself on one ischium: he reports when sitting squarely in a chair, he experiences increased numbness in the (R) LE. Lumbar ROM: Marked limitation in lumbar motion in all planes-Flexion 0-10°, (L)5° with sharp pain. Lower Extremity ROM: It was difficult to fully assess lumbar ROM as was unable to lie on his back for >3 min. Hip extension lacks 20° to neutral. Strength: (R) lower extremity strength test reveals 4/5 strength throughout except for (R) hip abduction (3-/5), and quadriceps/hamstrings 4/5. Myotomal weakness is noted in the (R) EHL. has difficulty with toe walking (R). Palpation: Increased temperature is noted with palpation in the lumbo-sacral region. There is marked mm tightness along the (R) thoraco-lumbar and B/L L-S paraspinals. Joint Assessment: was unable to lie prone for lumbar joint assessment. **Assessment:** presents with B/L lumbar, (R) thoraco-lumbar pain and (R) LE radiculopathy. PT evaluation identifies mm. guarding, decreased flexibility/ROM, decreased strength, compromised posture and altered gait mechanics. He is a good candidate for aquatic therapy intervention to achieve the following short term goals: 1. Decrease pain to 4/10 at rest; decrease pain 8-9/10 with activity 2. Patient will be instructed in HEP and with appropriate physical coping strategies 3. Increase lumbar ROM by 10 degrees 4. Increase LE strength by ½ grade in deficit planes 5. Pt will be able to participate in ≥ 50 min aquatic therapy session **Plan:** Aquatic PT 2-3x/week x 4 weeks.

12/18/2013: Report of Medical Evaluation. **Physical Examination:** There is flattening of the normal lumbar lordosis. AROM is decreased in flexion, extension, right rotation and right side bending. He can flex with his knees locked so that the finger tips touch the distal thigh. The paraspinal muscles are in spasm and tender to palpation. There is tenderness to palpation over the SI joints, right > left. The examinee is unable to squat. He does not tolerate positioning/testing for the remainder of the orthopedic exam. There are positive Wadell's Signs in the following categories: Tenderness, Simulation, Regional Disturbance and

Overreaction. He cannot heel walk, toe walk, and walk heel to toe. Patellar and Achilles DTR's are 2+/4+ and symmetrical. There are no sensory deficits in a dermatomal pattern in the bilateral LE's. Muscle strength is 5+/5+ across all joints in all planes of motion in the bilateral LE's except the hips. Per the examinee, he is unable to give a good effort due to exacerbation of pain. EHL strength is 5+/5+.

05/09/2014: Office Visit. **HPI:** Symptoms include back pain, lower extremity numbness, lower extremity tingling and lower extremity weakness. Pain scores include a minimum pain level of 5/10 and a maximum pain level of 9/10. The pain is located in the low back and radiates to right buttock, right thigh and right calf. The patient describes the pain as aching and throbbing. The pain is constant. The patient describes symptoms as worsening. Symptoms are exacerbated by lifting, sitting, standing, and walking. Associated symptoms include difficulty walking. When the numbness started, he began using a cane. **Assessment & Plan:** Lumbar Laminectomy; Routine (right L4/5 L5/S1) X-ray exam of lumbar spine Complete; Routine. Today's Assessment: The patient has a history of low back pain bilateral right greater and continued to right LE pain numbness and paresthesias. He has a history of right S1 nerve compression from HNP/HIZ along with some mild right L4/5 stenosis. I discussed with the patient that I suspect the right LE complaints are from right S1 and possibly somewhat L5 compression. He is taking oxycodone and gabapentin along with Celebrex. He wants to get off the medication. I recommend a right L4/5 L5/S1 lami disc. He has failed conservative measures including ESI. He went to court and had a decision in his favor to have the HNP covered based upon his history. X-rays today and will follow up with MRI films/CD for further review of the actual images again.

05/14/2014: UR. Rational for Denial: The recent medical record dated 5/9/14 indicates that the patient complains of low back pain with lower extremity numbness, tingling and weakness. Current medications include oxycodone, Celebrex, Lisinopril-hydrochlorothiazide, prednisone and gabapentin. While the patient complains of low back pain and lower extremity symptoms, there is no recent comprehensive clinical evaluation from the treating physician suggesting the presence of lumbar radiculopathy to warrant the requested surgery. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the requested surgery and inpatient stay has not been established.

05/21/2014: UR. Rational for Denial: Although it was noted that the patient had right lower extremity complaints, a recent comprehensive clinical evaluation from the treating physician was still not provided for review. The most recent thorough physical examination was obtained on 12/18/13, during the agreed medical evaluation. Physical examination on that date revealed intact sensation deficits in the bilateral lower extremities, full muscle strength and reflexes throughout, and an unquantified decrease in lumbar ROM. It was also noted that the patient exhibited Waddell's signs in the areas of tenderness, simulation, regional disturbance, and over-reaction. Objective exam evidence of radiculopathy at the L4/5 and L5/S1 levels cannot be ascertained or correlated with the MRI findings. I discussed the case with PA, who had no additional clinical information to provide.

In agreement with the previous determination, the medical necessity of the request has not been established. As such, the appeal request for 1 right L4/L5 and L5/S1 Laminectomy and 1 day of inpatient hospital stay is non-certified.

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

The previous adverse determinations are upheld. The patient is not indicated for a right L4/5 and L5/S1 laminectomy. The Official Disability Guidelines (ODG) supports laminectomy for lumbar stenosis. Prior to surgery, the patient should have physical findings consistent with radiculopathy corresponding to compression of a specific nerve root. The radiculopathy can be associated with a pattern of weakness or dermatomal pain associated with the nerve root. The imaging studies should be consistent with the physical examination. The patient must complete a course of conservative care prior to surgery. The patient currently has persistent pain in the right lower extremity. The MRI study from January 2013 indicated that the patient had a L5-S1 disc bulge, associated with moderate to severe stenosis in the right lateral recess. A posterior disc bulge was also noted at L4-5. The patient's symptoms worsened after an epidural injection in March 2013. The December 2013 office note indicated that the patient had no sensory deficits or weakness. He also had four positive Waddell's signs. In May 2014, recommended decompression at L4-5 and L5-S1.

Based on the records reviewed, there is no evidence of radiculopathy. The patient has no documented weakness or sensory deficit. There is no documented dermatome associated with the right lower extremity pain. Based on the original lumbar MRI study, it is unclear why decompression is required at L4-5. Lastly, this patient is a poor surgical candidate based on the positive Waddell's signs. For these reasons, 1 day of Inpatient Hospital Stay between 05/09/2014 and 07/08/2014; Right L4/5 and L5/S1 Laminectomy between 05/09/2014 and 07/08/2014 is not medically necessary at this time and should be denied.

PER ODG:

Laminectomy/ laminotomy

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. ([Weinstein, 2008](#)) ([Katz, 2008](#)) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. ([Hansson, 2008](#)) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for

spinal stenosis. ([Pearson, 2010](#)) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. ([Weinstein, 2010](#)) Comparative effectiveness evidence from SPORT shows good value for standard posterior laminectomy after an imaging-confirmed diagnosis of spinal stenosis [as recommended in ODG], compared with nonoperative care over 4 years. ([Tosteson, 2011](#)) Decompressive surgery (laminectomy) is more effective for lumbar spinal stenosis than land based exercise, but given the risks of surgery, a self-management program with exercise prior to consideration of surgery is also supported. ([Jarrett, 2012](#)) This study indicates that in patients with a primary diagnosis of lumbar spinal stenosis (LSS), the rate of fusions and the use of implants has increased, and the decompression rate has decreased. Trends in the surgical management of stenosis have become increasingly important to study because more invasive procedures, including the addition of fusion and the use of implants, have been associated with greater use of resources and increased complications. ([Bae, 2013](#)) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also [Discectomy/laminectomy](#) for surgical indications, with the exception of confirming the presence of radiculopathy. For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 - 3. Unilateral buttock/posterior thigh/calf pain

([EMGs](#) are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. [MR](#) imaging
- 2. [CT](#) scanning
- 3. [Myelography](#)
- 4. [CT myelography](#) & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. [Activity modification](#) (not bed rest) after [patient education](#) (≥ 2 months)
- B. Drug therapy, requiring at least ONE of the following:
 - 1. [NSAID](#) drug therapy
 - 2. Other analgesic therapy
 - 3. [Muscle relaxants](#)

4. [Epidural Steroid Injection](#) (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority):
1. [Physical therapy](#) (teach home exercise/stretching)
 2. [Manual therapy](#) (chiropractor or massage therapist)
 3. [Psychological screening](#) that could affect surgical outcome
 4. [Back school](#) (Fisher, 2004)

For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

ODG hospital length of stay (LOS) guidelines:

Discectomy (*icd 80.51 - Excision of intervertebral disc*)

Actual data -- median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges (mean) \$26,219

Best practice target (no complications) -- *Outpatient*

Laminectomy (*icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root*)

Actual data -- median 2 days; mean 3.5 days (± 0.1); discharges 100,600; charges (mean) \$34,978

Best practice target (no complications) -- *1 day*

Note: About 6% of discharges paid by workers' compensation.

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)**