

# Vanguard MedReview, Inc.

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## Notice of Independent Review Decision

July 27, 2014

### IRO CASE #:

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

Occupational Therapy 3xwk x4wks Left Hand 97535 97140

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

This physician is Board Certified in Physical Medicine and Rehabilitation and has over 16 years of experience

### REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured while working on xx/xx/xx.

11/16/2013: Operative Report. **Preoperative Diagnosis:** Left Hand Crush  
**Procedure:** 1. Ray amputation, left small finger. 2. Exploration of wounds, left hand. 3. Incision, irrigation, debridement of skin, muscle and fascia, left hand. 4. Repair of extensor digitorum communis, EIP, EDC x 3. 5. Open reduction internal fixation of proximal phalanx fracture, left index, long and ring finger.

12/27/2013: Clinic Note. **History:** Mr. returns for follow-up status post crush injury to the left hand while working with a forklift requiring ray amputation to the left small finger as well as ORIF of P1 fractures to the ring, long, index finger and extensor tendon repairs on 11/19/13. He is here today for follow-up. The splint was removed, hand cleansed, pins are intact and clean. He has extremely stiff almost immobile hand at this point. The thumb is improving with home exercise program. There is no hematoma, seroma, infection, nor opened wounds but due

to this type of crush injury I am sure he has tendinous adhesions as well contractures of his lumbricals at this point as well as intraosseous. Nonetheless we will send him to rehabilitation for finger splints and begin a dedicated outpatient therapy program. His home exercise program was discussed. I will see him back in four weeks with x-rays and most likely remove pins at that time. He is in good spirits. All his questions were answered and he left pleased.

01/07/2014: Occupational Therapy Evaluation Outpatient Hands. **Initial Status:** Pt now presents for initial evaluation. He reports he is no longer able to work secondary to his injury. Pt. also reports that shortly after his injury, he moved in with his aunt and uncle that are able to provide him with assistance for ADL performance as needed. **Patient Goal:** To use L hand, to be capable of using it. **Findings:** Skin condition/scarring: All wounds closed, K wires visible proximal to PIP joint of L IF, MF, RF. L hand with thick layer of dry skin encasing digits and palm of hand. Scar on dorsum of L hand running ulnar to radial at mid metacarpal level, pink in vascularity, yielding giving way to pressure in pliability, normal in height. **Edema:** Left: Circumferential: IF 7.9, MF 8.5, RF 7.9, Thumb 7.0, DPC cm Right: Circumferential: IF 6.5, MF 6.2, RF 6.0, Thumb 6.4, DPC cm **Pain:** 7/10 at rest, 9/10 activity. At rest, greatest pain located at volar MCP level, with activity at pin site **Orthoses:** Pt to continue wearing functional hand orthotic fabricated as a walk-in on 12/27/13 between exercises and at night. Pt. will benefit from fabrication of functional hand orthotic with IPS free for day wear. **ROM and Strength:** See Upper Extremity Measurement Grid **Sensation:** Semmes-Weinstein Monofilament Test: Volar: wrist, palm, thumb and IF along middle and distal phalanx intact to 2.83. RF, MF and along proximal phalanx intact to 4.31 Dorsal: All intact to 2.83 except along scar intact to 4.31. Pt was educated regarding skin protection technique. **Prior Level of function:** Independent with all ADLs, IADLs, and mobility **Quick Dash:** General module: 97/100, work: N/A Arts/sports: N/A **Home Exercise Program:** Pt issued HEP consisting of AROM/PROM to IPs of L, IF, MF, RF, wrist, and thumb. **Assessment:** Pt presents for initial evaluation. Pt is now 7 weeks s/p zone 5 EDC repair x 3, EIP repair and K wire fixation of prox phalanx fx IF-RF. Per DASH score perceives his injury to be greatly disabling. Pt expressed feelings of frustration and helplessness over his injury and subsequent decrease in functional use of L hand. Pt was apprehensive regarding initiation of HEP for L hand, however pt was cooperative and participated well with encouragement. He presents with K-wires intact to IF-RF, that span through prox phalanx into metacarpal heads. Pt was educated today regarding K-wire precautions, pt not to perform PROM to MCPs at this time, however pt is to perform A/APROM as indicated above. Mr. presents with significantly decreased functional use of L hand with decreased AROM t/o L hand, increased pain, increased edema and decreased sensation. Pt will benefit from skilled Occupational Therapy in order to address the following problem list and goals: Increased pain/hypersensitivity: Severe Increased edema: moderate Decreased AROM: severe Decreased PROM: Severe Decreased fine motor coordination: to be assessed Decreased strength: to be assessed Scarring: adherent Wound: intact Decreased ADLs: lift/carry, grasping, light housework, dressing, feeding **Short term goals (4 weeks):** 1. Demonstrate independence with HEP as seen by progress toward goals 2. Increase AROM to L wrist flex/ext by 10 degrees or

greater for increased independence with ADL performance such as dressing, bathing, and grooming. 3. Pt will demonstrate no loss of PROM in L hand in order to prevent painful contracture/deformity 4. Increase AROM to L thumb MP and IP by 10 degrees or greater for increased functional grip of L hand. 5. Demonstrate TAM in all digits of 40 degrees or greater for increased functional grip of L hand. 6. Demonstrate 5 lbs or greater L hand key pinch for increased functional use of L hand. 7. Demonstrate 1 lb or greater in L hand grip strength for increased functional use of L hand. 8. Demonstrate 1 lb or greater in L hand tip and tripod pinch for increased functional use of L hand. **Long Term Goals (by discharge):** 1. Demonstrate Modified independence with all basic ADLs. 2. Increase AROM of L hand/wrist to WFL in order to return to work/ADL related tasks. 3. Increase L grip strength to WFL in order to return to work/ADL related tasks. **Prognosis:** Fair **Plan of Care:** Pt will be seen 4x/week for 3 weeks as per prescription. Treatment will address goals as above and consist of: Orthoses: Static: functional hand orthotic, other: PRN Modalities: FES, Hot pack Manual Techniques: Massage: scar/edema Other: Therapeutic exercise, PReS, AROM, PROM, Edema management, Scar management, Pain management, Desensitization, HEP

02/26/2014: Clinic Note. returns for follow-up status post traumatic injury to the left hand on 11/16/13 when his hand was crushed. He was taken to surgery and ray amputation of the left small finger followed by ORIF of P1 fractures to the index, long and ring fingers with extensor tendon repairs. I saw him on 12/27/13 and he was instructed to return to the office in one month with x-rays however he did not show at this appointment and is here today for follow-up. No x-rays have been obtained. The hand swelling is resolved. There is no pain. The pins are intact. He has an obvious nonfunctional hand at this point but there are no open wounds. I will see him back in one week with x-rays and remove k-wires and begin aggressive rehabilitation at that time. He understands that he may require future tenolysis, capsulotomy surgery and that hand function could be great in disability significant although he appears in good spirits.

03/07/2014: Radiology Report interpreted. **Impression:** Satisfactory alignment of the second through fourth finger proximal phalangeal fractures, subsequent to immobilization with K wires.

03/07/2014: Clinic Note. **History:** returns for follow-up status post crush injury to the left hand. I was concerned about the significance of his crush requiring revision amputation of his entire hand but fortunately he is healed. He returns today with x-rays. He continues to have fracture lines to the index, long and ring P1 fractures with intact k-wires which are anatomic. There is no pin infection. The pins are intact. I will see him back in one month for repeat x-rays and possible pin removal at that time.

04/02/2014: Radiology Report: XR Left Hand 3 views. **Impression:** Unchanged, satisfactory alignment of 2-4 proximal phalangeal fractures in K wire fixation. Minimal interim fracture remodeling with fracture lines remaining evident.

04/02/2014: Clinic Note. **History:** returns for follow-up status post crush injury to the left hand. Today the x-rays revealed continued bone healing but not a solid union. The fracture is still faintly visible and with fracture lines. The bones are anatomic. The pins are without infection and I believe that his delayed healing is a response to the 12 ton crush injury with near loss of the entire hand. He is in good spirits. He is to continue with home exercise program and I will see him back in one month with x-rays and possibly remove pins at that time.

04/30/2014: Radiology Report: XR Left Hand, 3 views. **Impression:** Minimal interim bony remodeling of 2-4 proximal phalangeal fractures, which remain in satisfactory alignment in K wire fixation.

04/30/2014: Clinic Note. **History:** Due to delayed bone healing his k-wires were removed on 4/30/14. At that time his left index, long and ring finger had flexion contractures of 30°. His MCP joint to involved fingers was 0 and approximately 20° and DIP joints were 0. He had limited active flexion and pain with passive flexion. There were no opened wounds nor infection. I will ask for occupational therapy three times a week for four weeks at a total of 12 visits. He has not received therapy as of yet and thus no improvement has been noted in fact to the contrary Mr. remains quite stiff and near functionless. Occupational therapy will improve his active as well as passive motion and hopefully prevent future surgeries. **Addendum:** Under sterile conditions following topical local the k-wires to three digits were removed with heavy needle drivers with Neosporin and Coban applied totaling six Kershner wires to the index, long and ring fingers. He tolerated the procedure well with no complications. He was discharged to begin therapy and home exercise program.

05/06/2014: Occupational Therapy Re-Evaluation Outpatient Hands. **Diagnosis:** Crush injury to L hand: proximal phalanx fracture to L IF, MF, RF, Ray amputation L SM, repair to EDC x3, repair EIP **Precautions:** Standard/universal, K-wires, per ext tendon repair protocol **Initial Status:** Pt presents today with significant IPJ flexion contractures to the L IF, MF and RFs **Summary of Findings:** Skin Condition/Scarring: All wounds closed with no evidence of drainage at this time. L hand with thick layer of dry skin encasing digits and palm of hand. Edema: Left Circumferential: Wrist 18.6 cm Right Circumferential: Wrist 18.2 cm. Pain: 7/10 at rest 9/10 at activity Orthoses: Patient fabricated L forearm based dynamic PIPJ extension splint to be worn TID following heat. Pt also provided with a LMB splint to be worn intermittently throughout the day. Patient to benefit from coban composite flexion wrap and potential a static MPJ flexion splint to maximize flexion ROM at the MPs. Sensation: Semmes-Weinstein Monofilament Test to L volar fingertips: 2.83 (normal sensation for L digits 1-4) Coordination: Nine hole peg test: Right=21 sec Left=37 sec Home Exercise Program: Pt issued custom L forearm based IPJ dynamic extension splint to increase extension at the PIP and DIPJs of the L index, middle and ring fingers Pt issued HEP consisting of AROM/PROM to IPs of L IF, MF, RF, wrist and thumb. **Assessment:** Pt presents with significantly decreased functional use of L hand with decreased AROM t/o L hand. Pt will benefit from skilled occupational therapy. Increased pain/hypersensitivity: Moderate, Severe Increased edema: minimal, moderate

Decreased AROM: severe Decreased PROM: Severe Decreased fine motor coordination: moderate Decreased strength: to be assessed Scarring: adherent Wound: intact Decreased ADLs: lift/carry, grasping, light housework, dressing, feeding. **Plan:** Pt will be seen 4x/week for 3 weeks as per prescription Treatment will address goals and will consist of: Orthoses: L custom dorsal forearm-based dynamic IPJ extension splint, Modalities: FES, Hot pack Manual Techniques: Joint Mobilization, Massage: scar/edema Other: Therapeutic exercise, PREs, AROM, PROM, Edema management, Scar management, Pain management, Desensitization, Neuro Re-education, HEP

06/10/2014: Occupational Therapy Re-Evaluation Outpatient Hands. **Initial Status:** Pt presents today with significant IPJ flexion contractures to the L IF, MF and RFs. **Patient Goal:** To be able to work with my L hand like a regular hand and to straighten my fingers. **Plan:** Pt will be seen 2x/week for 4 weeks as per prescription. Treatment will address goals.

06/10/2014: Occupational Therapy Treatment Flowsheet indicated the patient had completed 12 session of therapy on these dates: 01/19/14, 01/14/14, 01/29/14, 01/31/14, 05/06/14, 05/13/16, 05/15/14, 05/16/14, 05/20/14, 05/21/14, 05/30/14, 06/03/14.

06/16/2014: UR. Rational for Denial: The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The patient is a male who reported an injury on xx/xx/xx. The mechanism of injury was a crush. His diagnoses include crushing injury of hands. Current medications were not provided within the submitted medical records. His surgical history was noted to include a partial hand amputation on 11/16/2013, and K wire removal on 4/30/2014. Other therapies were noted to include occupational therapy. Within the occupational therapy note dated 5/06/2014, the patient reported that he had a functional hand orthotic fabricated and was presenting for initial evaluation. During the clinical visits, the patient reported that he had significant IPJ flexion contractures. The patient further stated his pain was rated 7/10 at rest and 9/10 with activity. Within the clinical note dated 6/10/2014, the patient stated his goal as "wanting to work with his left hand and to be able to straighten his fingers." During the clinical visit, the patient had a pain rating 5/10 at rest and 7/10 with activity. The ODG suggest physical medicine is indicated with the association of functional limitations and is likely to respond to skilled physical medicine treatments. In addition, the guidelines outline physical therapy for contractures with 12 visits over 8 weeks. While the injured worker did display functional deficits postoperatively with contractures after the removal of the K wires, the documentation lacked a quantifiable loss of range of movement, and the number of previously completed occupational therapy sessions. I discussed the case with who stated he would fax over additional documentation to support the request. However, at the time of submission, no additional clinical had been received. As such, further documentation needs to provide quantifiable and documented functional deficits and an increase of functional gain in-between sessions as documented. Thus the request is non-certified.

07/09/2014: UR. Rational for Denial: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Mediations were not provided. Surgical history included ray amputation left small finger, repair to EDC times 3, repair EIP. Diagnostic studies were not provided. Other therapies included physical therapy and an LMB splint. The patient is a male who reported an injury on xx/xx/xx. The physical therapy treatment log dated 5/6/2014 through 5/20/2014 indicated that the active ROM of the PIP joint of the index finger on 5/13/2014 was -60 degrees/80 degrees, the PIP joint of the middle finger was -75 degrees/95 degrees, the PIP joint on the ring finger was -20 degrees/90 degrees. As of 5/20/2014, the active ROM of the MP joint of the index finger was 0 degrees/25 degrees, PIP was -55 degrees/25 degrees, DIP was 0 degrees/25 degrees; the MP joint of the middle finger was 0 degrees/20 degrees, the PIP joint was -20 degrees/90 degrees, and the DIP joint was -20 degrees/90 degrees; the MP joint of the ring finger was 0 degrees/20 degrees, the PIP joint was -70 degrees/85 degrees, and the DIP joint was -20 degrees/35 degrees. Per the re-evaluation dated 6/10/2014, it was noted that the patient's K-wires were removed on 4/30/2014. It was noted the patient presented with significant IPJ flexion contractures to the left index finger, middle finger and ring finger. The patient reported his pain to be at 5/10 with rest and 7/10 with activity. The case manager notes indicated that 36 sessions of physical therapy has been certified to date post-operatively. On 6/19/2014, the request for additional occupational therapy 3 times a week times 4 weeks, left hand (97535 and 97140) was reviewed and denied due to lack of documentation of quantifiable loss of ROM, and the number of previously completed occupational therapy sessions. The ODG state that physical therapy guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical therapy. For a crushing injury of the hand/finger it is recommended the patient receive 9 visits of physical therapy over 8 weeks; for fracture of 1 or more of the phalanges of the hand (fingers) postsurgical treatment, complicated, is 16 visits over 10 weeks; and for amputation of finger, it is recommended the patient receive 18 visits over 6 weeks. In addition, the ODG preface states when treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. The records submitted for review indicated 36 sessions of postoperative physical therapy have been certified to date. Furthermore, the records submitted for review indicated that the patient had significant IPJ flexion contractures to the left index finger, middle finger, and ring finger. The records submitted for review failed to include documentation of significant objective functional improvement to support additional occupational therapy. Furthermore, the records submitted for review indicated the patient has exceeded the guideline recommendation of 18 visits of therapy over 6 weeks without exceptional factors noted. As such, the request for additional occupational therapy 3 times a week times 4 weeks left hand (97535 and 97140) is not supported. Therefore, the request is non-certified.

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

The initial adverse determinations are overturned. ODG hand chapter recommends up to 24 Post-surgical tendon repair visits over 16 weeks (the most

severe of the claimant's injuries - with ODG recommendations of 16 visits over 10 weeks for complicated post-op phalanx fractures and 18 visits over 6 weeks for non-replantation finger amputations). Submitted clinical information documents a total of 12 OT visits so far, with 4 in January, 2014 then 8 in May, 2014 - the gap due to delayed fracture healing and eventual K wire removal not until 4/30/14. The time line of rehab actually starts then. During those 8 visits there was modest gains in Range of Motion, with physician ROM estimates on 4/30/14 of MCP's 0 to 20 and DIP's contracted at 0; compared to OT measurements on 5/20/14 MCP's 0 to 20-25, PIP's 0 to 85-90 and DIP's 0 to 20/35/95. Modest, nonetheless, gains. Given that the request is in accordance to ODG recommended number and timeline for the submitted diagnoses, gains with ROM after 8 visits and residual deficits in ROM, strength and function, an additional 12 visits of OT is medically necessary. For these reasons, Occupational Therapy 3xwk x4wks Left Hand 97535 97140 is medically necessary at this time and should be approved.

PER ODG:

<p>Physical/ Occupational therapy</p>	<p>Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (<a href="#">Handoll-Cochrane, 2003</a>) (<a href="#">Handoll2-Cochrane, 2003</a>) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. (<a href="#">Handoll-Cochrane, 2002</a>) (<a href="#">Handoll-Cochrane, 2006</a>) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy (p&lt;0.05). (<a href="#">Rapoliene, 2006</a>)</p> <p><i>Active Treatment versus Passive Modalities:</i> See the <a href="#">Low Back Chapter</a> for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).</p> <p><b>ODG Physical/Occupational Therapy Guidelines –</b>  Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the <a href="#">ODG Preface</a>.</p> <p><b>Fracture of carpal bone (wrist) (ICD9 814):</b>  Medical treatment: 8 visits over 10 weeks  Post-surgical treatment: 16 visits over 10 weeks</p>
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**Fracture of metacarpal bone (hand) (ICD9 815):**

Medical treatment: 9 visits over 3 weeks

Post-surgical treatment: 16 visits over 10 weeks

**Fracture of one or more phalanges of hand (fingers) (ICD9 816):**

Minor, 8 visits over 5 weeks

Post-surgical treatment: Complicated, 16 visits over 10 weeks

**Fracture of radius/ulna (forearm) (ICD9 813):**

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 16 visits over 8 weeks

**Dislocation of wrist (ICD9 833):**

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks

**Dislocation of finger (ICD9 834):**

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

**Trigger finger (ICD9 727.03):**

Post-surgical treatment: 9 visits over 8 weeks

**Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):**

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

**Synovitis and tenosynovitis (ICD9 727.0):**

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

**Mallet finger (ICD9 736.1)**

16 visits over 8 weeks

**Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):**

Post-surgical treatment: 12 visits over 8 weeks

**Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):**

Post-surgical treatment: 18 visits over 6 weeks

**Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):**

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

**Sprains and strains of wrist and hand (ICD9 842):**

9 visits over 8 weeks

**Sprains and strains of elbow and forearm (ICD9 841):**

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

**Open wound of finger or hand (ICD9 883):**

9 visits over 8 weeks. See also [Early mobilization](#) (for tendon injuries).

Post-surgical treatment/tendon repair: 24 visits over 16 weeks

**Pain in joint (ICD9 719.4):**

9 visits over 8 weeks

**Arthropathy, unspecified (ICD9 716.9):**

Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks

**Amputation of thumb; finger (ICD9 885; 886):**

Medical treatment: 18 visits over 6 weeks

Post-replantation surgery: 36 visits over 12 weeks

**Amputation of hand (ICD9 887):**

Post-replantation surgery: 48 visits over 26 weeks

**Work conditioning (See also [Procedure Summary](#) entry):**

12 visits over 8 weeks

**Carpal tunnel syndrome (ICD9 354.0):**

Medical treatment: 1-3 visits over 3-5 weeks

Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks

Post-surgical treatment (open): 3-8 visits over 3-5 weeks

**Crushing injury of hand/finger (ICD9 927.2 & 927.3):**

9 visits over 8 weeks

**Contusion of upper limb (ICD9 923)**

	6 visits over 3 weeks <b>Crushing injury of upper limb (ICD9 927)</b> 9 visits over 8 weeks
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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)