

AccuReview

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[Date notice sent to all parties]: January 21, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning Program 30 hours 97545 97546

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 with over 14 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured after moving X on XX/XX/XX. Current diagnosis include lumbar facet/disc pain, lumbar radiculopathy, lumbar herniated nucleus pulposus, and lumbar strain.

XX/XX/XX: Medication List. Start Temusulosin HCL 0.4mg, Start Medrol Pak 4mg, Start Lidoderm 5%, Start Methocarbamol 750mg, Start Nocro 10/325. Also taking: Flexeril 10mg, Norco 5/325. Referral to imaging x-ray left hip and MRI L-spine w/o contrast.

XX/XX/XX: Work Note Prescription. Claimant seen for severe back pain and sciatica, needs to stay off work for 2 weeks.

XX/XX/XX: Lumbar MRI. Impression: 1. Left posterolateral disc herniations producing neural foraminal encroachment are noted at the levels of L4-5 and L5-S1. There is a minimal herniation to the right at the L4-5 level.

XX/XX/XX: Xray Hip Left Comp >2V. Impression: Negative examination of the left hip.

XX/XX/XX: Transcription: LBP, currently not working. His pain is still severe. He is taking hydrocodone, tamsulosin, Lidoderm patches and methocarbamol. Pain reported 5-8/10 when he is not taking meds. He reported bending, sitting for long periods of long time worsens the pain. Pain is sharp and moves down his legs. HE also reports urinating a times is difficult and reported occasional accidents. PE: Musculoskeletal: Lumbar: Claimant is in moderate distress secondary to pain. Lumbar ROM is decreased to at approximately 90 degrees with pain. Palpation is positive for pain

at L1 through the sciatic area paraspinous are bilaterally. SLR is positive on left in the seated position and SLR is positive on right in the seated position. Assessment: Lumbar radiculopathy 724.4, Lumbar strain 847.2, Herniated Disk. Plan: ultram 50mg PO BID PRN pain, ibuprofen 600mg PO TID PRN pain, advised to stop taking narcotics and try ultram, Toradol 60mg IM, claimant to do no activity until rechecked.

XX/XX/XX: Progress Note. F/U back injury, referred to neurosurgeon, does better with medication, stiff in morning, pain 7/10, not working. PE: Musculoskeletal: Lumbar: claimant is in mild distress secondary to pain, lumbar ROM is decreased in all planes, palpation is positive for pain b/l in L spine, SLR is positive bilaterally in the seated position. Assessment: Lumbar radiculopathy 724.4, Lumbar strain 847.2, Herniated disk. Plan: he has a musculoskeletal injury for which a structured PT program is medically necessary due to limited ROM and clinically relevant pain. This condition limits his ability due to perform the essential functions of the job. Management will include modalities, massage, stretching/strengthening, in conjunction with therapeutic exercises. The plan is to focus on functional outcomes and return to regular work. The program is anticipated to require 4-10 visits or less, depending on recovery and functional outcomes. He may require additional visits, but only if objective improvements can be demonstrated. Continue meds, no activity, recheck in 1 week.

XX/XX/XX: Transcription. Assessment: Bulging lumbar disc 722.10, Acute left lumbar radiculopathy 724.4. Plan: changed from ultram 50mg to tramadol 50mg. CC: claimant presented with shoulder back injury, L thumb, pain 5-7/10, on no activity pt on pt therapy. Claimant saw the neurosurgeon on XX/XX/XX with complaints of back pain, back stiffness, decreased spine ROM and decreased flexion. He is currently experiencing symptoms. The pain is located in the mid back bilaterally and on the left side more than the right. The pain radiates to thighs. The pain is constant and described as sharp and shooting in nature and moderate in severity. Symptoms are improving. Exacerbating factors: bending, climbing stairs, sitting and sitting for prolonged amounts of time. Relieving factors: nonsteroidal anti-inflammatory drugs, non-opioid analgesics, opioid analgesics and PT. PE: Tenderness: lumbar spine, left paraspinous and right paraspinous. ROM: flexion was restricted and was painful. SLR positive.

XX/XX/XX: Approved Requested Services PT 3xWk x 2Wks Lumbar Spine

XX/XX/XX: Office Visit. CC: LBP. Claimant complained of back pain that radiates down in the left leg associated with numbness and tingling in his left thigh. Medications: hydrocodone, ibuprofen, and tramadol. PE: anatalgic gait. Lumbar ROM: limited extension with pain. Facet loading: positive left and right. SLR left 45 degrees. Motor Left 4/5 @ hip flexion, knee flexion. DX: 724.4 thoracic or lumbosacral neuritis or radiculitis, unspecified, 721.3 lumbosacral spondylosis without myelopathy, 722.10 lumbar displacement of intervertebral disc without myelopathy. Assessment/Plan: claimant with evident and likely lumbar facet arthropathy vs. lumbar radiculopathy. Request EMG B LE, Consider LFBs if EMG comes back negative for radiculopathy, RTC one month for EMG review and further decision making.

XX/XX/XX: Case Summary Report Non-Certification EMG/NCV RT/LT Lower Extremity.

XX/XX/XX: Designated Doctor Examination. The claimant has had 12 session of PT and more has been recommended. He stated that PT has helped him. Based on the fact that he has had functional improvement from the first 12 sessions of PT, it is reasonable to expect improvement for more PT. ODG recommends repeating treatment that has proven to be effective for a patient. If PT is not available then a work conditioning program would be appropriate as work conditioning is recommended by ODG and is defined by ODG as an additional series of intensive PT visits required beyond a normal course of PT, primarily for exercise training/supervision. The claimant is not at MMI as treatment that will within reasonable medical probability cause further material recovery from or lasting improvement to his injury is still available to him. These treatments include but are not limited to the following: PT, work conditioning. No impairment rating is assigned, as he is not at MMI.

XX/XX/XX: Office Visit. CC: LBP. Claimant continues to complain of low back pain with intermittent radiation down the LLE to the thigh. EMG/BLEs was denied by WC. Recommended LESI. Claimant is positive PRE and MRI findings. PE: unchanged. DX: 724.4 thoracic or lumbosacral neuritis or radiculitis, unspecified, 721.3 lumbosacral spondylosis without myelopathy, 722.10 lumbar displacement of intervertebral disc without myelopathy. Assessment/Plan:

claimant with evident and likely lumbar facet arthropathy and lumbar radiculopathy. 1. Claimant has severe left L4-5 and S1 radiculopathy with myotomal, sensory loss. He has failed PT x 12 session, NSAIDs and muscle relaxers. He has also seen neurosurgeon for who recommended pain management-recommend left LESI L4-5 and S1 with TIVA du eto needle anxiety. 2. Consider LFBs pain is more axila. 3. Meds: ibuprofen 800mg PO BID, Zanaflex 4mg, Lyrica 50mg.

XX/XX/XX: Office Visit. CC: LBP that radiates to left lower extremity. Able to stand for less than 30 minutes, able to sit for less than 30 minutes, able to walk for less than 30 minutes; pain 4-6/10 and 7-9/10 at worst. Claimant is not working. Objective: lumbar examination: toe walking poor, heel walking poor on the left, deep tendon reflexes diminished in the lower extremities, SLR positive on the left and right. Assessment: lumbar strain 847.2, lumbar herniated nucleus pulpos 722.10 and lumbar radiculopathy 724.4. Plan: MRI lumbar spine.

XX/XX/XX: Transcription. CC: LBP. Claimant reported he is about 65% better with pain 5/10, currently taking ibuprofen and tramadol, still not working. He stated back pain is located in the sacroiliac regions and on the left side more than the right. The pain is intermittent, sharp in nature. Claimant has been referred to PT and has functional improvement, tolerating well and therapy notes are available for review. PE: Musculoskeletal: Lumbosacral Spine: Tenderness: left sciatic notch, flexion was painful, right lateral flexion was painful. Assessment: Acute left lumbar radiculopathy 724.4, Bulging lumbar disc 722.10. Plan: PT referral physical therapy consult. Ordered PT frequency 3 x week, duration 4 weeks, evaluate and treat.

XX/XX/XX: Approved Request Left L4-L5-S1 ESI w/ Total IV sedation.

XX/XX/XX: Lumbar MRI. Impression: 1. Moderate disc herniation noted at the L1-2, L4-5 and L5-S1 levels there is at the lower 2 levels are mainly to the left side of midline and there is mild encroachment on the neural foramen at L4-5 and on the lateral recess at L5-S1. The findings at the L4-5 and L5-S1 level are unchanged from a previous examination of May 2014 but the other disc herniation at the level of L1-2 is apparently new.

XX/XX/XX: Neurological Evaluation. Impression: Sural sensory latency was unobtainable otherwise NCS was normal. No evidence of denervation. Essentially normal study no definite evidence of lumbar radiculopathy.

XX/XX/XX: Approved Request Lumbar Facet Block L5/S1 Bilaterally Medial Branch of the Doral Ramus x1.

XX/XX/XX: Transcription. CC: claimant presented for F/U for acute left lumbar radiculopathy, bulging lumbar disc, out of tramadol and IBU, pain 5/10, not working at this time. PE: Musculoskeletal: Lumbosacral Spine: Tenderness: lumbar spine (paraspinal, spinal, L2, L3, L4, and L5). Flexion was painful, extension was painful, SLR positive. Assessment: bulging lumbar disc 722.10, acute left lumbar radiculopathy 724.4. Plan: Renew tramadol and ibuprofen, RTC one month.

XX/XX/XX: Physician Work activity Status Report. Modified Activity: Restricted Activity: return to work on XX/XX/XX with the following restrictions: no lifting over 20lbs, no pushing and/or pulling over 20lbs of force. Anticipated XX/XX/XX.

XX/XX/XX: Functional Capacity Evaluation. Summary: The claimant is currently functioning at a Sedentary PDL. According to the job description for Supervisor the Dictionary of Occupational Titles, he must be able to lift and carry up to 20 pounds on an occasional basis safely. This is considered a Light PDL. Based on this evaluation, it is felt the claimant cannot perform at the level required by his employer at this time by demonstrating the ability to left 15 lbs on an occasional basis and 8 lbs on a frequent basis in a safe manner. Additionally, he demonstrated difficulties in the ability to perform the following non-material handling activities that are required to perform his perfunctory job duties. Standing, walking, bending/stooping, squatting and reaching. The claimant has decreased flexibility and muscle strength. Furthermore, he demonstrated poor body mechanics which might aggravate his pain is uncorrected.

XX/XX/XX: Progress Notes. The claimant has been attending cognitive pain management sessions and has been consistent with his attendance and missed when he had surgery on his foot. He has completed 9 of 10 authorized sessions. Please consider this a request for 10 additional sessions, thus awarding this claimant the opportunity to build

a realistic program, which will enable him to make a successful transition to a higher level of functioning. These 10 sessions being requested will also continue to focus on decreasing his anxiety, depression and pain symptoms even further and help him return to work by exploring available back-to-workforce opportunities in the community. Additional time will be used to help the claimant adjust to changes associated with his injury and comes to terms with the fact that no one escapes disappointment, failure, and loss in the course of a lifetime. Furthermore, additional time will be used to address issues of loss to allow the claimant to improve self-esteem and more effectively manage his feelings of frustrations in regards to his physical limitations. In summary, the claimant is continuing to progress toward his goals and ability to improve in the daily activities of his life. He participated in the written assignments and is willing to share his thoughts with the group members. Additional sessions would help him form a routine and schedule. He is learning adequate coping mechanisms to deal with the multifaceted deficits that are occurring as a response to his injury. The claimant demonstrated the need for additional intensive treatment and continued support in order to return to a higher level of function and return to the workforce. He would benefit with continued group sessions to better manage and use his coping skills. Additional sessions are absolutely necessary to the motivation and education he is receiving, which are helping him to redefine his life and return him to optimal functioning. I am requesting 10 additional sessions of the Chronic Pain Management Program at this time.

XX/XX/XX: Office Visit: LBP, able to stand less than 15 minutes, able to sit less than 15 minutes, able to walk less than 15 minutes, pain 4-6/10, worst 7-9/10. Assessment: lumbar strain 847.2. Plan: Neurontin 100mg.

XX/XX/XX: Office Visit. CC: LBP, able to stand less than 30 minutes, able to sit less than 30 minutes, able to walk less than 30 minutes, pain 4-6/10, worst 7-9/10. No significant changes since last visit. Assessment: lumbar facet/disc pain 722.93, lumbar radiculopathy 724.4, lumbar herniated nucleus pulposus 722.10, lumbar strain 847.2. Plan: Neurontin 100mg.

XX/XX/XX: Functional Capacity Evaluation. Material Handling Abilities: frequent bilateral lifting 15 pounds. Summary/Impression: The claimant performed tasks with maximum effort; he walked with left analgic gait and was required to take breaks between tasks. Limiting Factors Noted During Testing: During this evaluation, the claimant was unable to achieve 100% of the physical demands of his job/occupation. The limiting factor(s) noted during these objective functional tests included: Evaluator Stopped, Increased Pain, Mechanical Changes and Mechanical Deficits. Assessment Purpose/Reason for Referral: The purpose of this Job Specific Functional Capacity Evaluation is to determine claimant's functional abilities as they relate to the essential physical demands of his job. Based on the pre-testing reported pain levels, the claimant's pain reported could be considered reliable and pain may contribute to functional limits during functional testing.

XX/XX/XX: UR. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is Non-Certified. ODG recommends Work Conditioning for patients who require an additional series of intensive PT beyond a normal course of PT. This patient completed a chronic pain program in XX/XXXX. Psychosocial barriers to recovery preclude participation in a Work Conditioning program. Additionally, re-enrollment into the same or similar programs like work conditioning after the completion of chronic pain management is not guideline supported.

XX/XX/XX: Office Visit. CC: LBP. Work conditioning denied. PE: pain in the lumbar facets bilaterally at the L5/S1 and at the L4/5. Facet pain on spine rotation/extension/flexion and palpation. Assessment: Lumbar strain 847.2. Plan: Appeal work conditioning.

XX/XX/XX: UR. Reason for denial: Based on the clinical information submitted for review and using the evidence-based, peer-reviewed guidelines referenced above, this request for work conditioning program 30 hours 97545 97546 is not medically necessary. I spoke with XX who confirmed that the patient went through a chronic pain program. Documentation does not substantiate effectiveness of first chronic pain program, and the most recent notes show minimal changes in activities. It was noted the patient was only able to stand for less than 30 minutes and sit for less than 30 minutes. He was able to walk for less than 30 minutes. The main reason for a work conditioning program is was for the patient to return to some form of vocation and the program is to try and get the patient in a place where he can do this. Per the ODG, upon completion of a rehabilitation program, neither re-enrollment nor repetition of

the same or similar rehabilitation program is medically warranted for the same condition or injury. The patient has already participated in a program at this time. Further, the documentation does substantiate depression based on the XX/XX/XX medical report. Per ODG psychosocial barriers to recovery contraindicate participation in a work conditioning program. Therefore, given the above, this request is not certified.

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

Denial of 30 hours of work conditioning is UPHELD/AGREED WITH since ODG does not recommend "re-enrollment in nor repetition of the same or similar rehabilitation program," and clinically, the claimant has already completed a Chronic Pain Management Program, the most aggressive/end stage level of rehabilitation which addresses psychosocial barriers to recovery in efforts to return to function. There is documentation of MINIMAL improvement in activity despite this program. Work Conditioning at this point represents a REGRESSION in rehabilitation; it does not address psychosocial barriers to recovery such as vocation (the requesting provider's rationale for the request per the second UR peer discussion) and is therefore, NOT appropriate or medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for Work Conditioning Program 30 hours 97545 97546 is denied.

Per ODG:

<p>Work conditioning, work hardening</p>	<p>Criteria for admission to a Work Hardening (WH) Program:</p> <p>(1) <i>Prescription:</i> The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(2) <i>Screening Documentation:</i> Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient’s program should reflect this assessment.</p> <p>(3) <i>Job demands:</i> A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient’s ability to perform these required tasks (as limited by the work injury and associated deficits).</p> <p>(4) <i>Functional capacity evaluations (FCEs):</i> A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal</p>
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effort should be addressed prior to treatment in these programs.

(5) *Previous PT*: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

(6) *Rule out surgery*: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).

(7) *Healing*: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.

(8) *Other contraindications*: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.

(9) *RTW plan*: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.

(10) *Drug problems*: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.

(11) *Program documentation*: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should be documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.

(12) *Further mental health evaluation*: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.

(13) *Supervision*: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.

(14) *Trial*: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening

procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.

(15) *Concurrently working*: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.

(16) *Conferences*: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.

(17) *Voc rehab*: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.

(18) *Post-injury cap*: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see [Chronic pain programs](#)). Exceptions to the 2-year post-injury cap may be made for patients with injuries that have required long-term medical care; i.e., extensive burns, diagnoses requiring multiple surgical procedures, or recent (within 6 months) completion of the last surgery, for patients who do not have the psychological barriers to return to work that would qualify them for a CPM program. ([L&I, 2013](#))

(19) *Program timelines*: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.

(20) *Discharge documentation*: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) *Repetition*: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also [Physical therapy](#) for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.

Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

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)