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***Notice of Independent Review Decision
Amendment X***

IRO REVIEWER REPORT

Date: X; Amendment X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X.

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

REVIEW OUTCOME:

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

- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)
- 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:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X stated that while X. X landed on X left side and hip. The diagnosis was displaced, X.

X underwent a Designated Doctor Evaluation (DDE) by X, DC on X. X reported X was X. The X. X drained X. X slipped backwards from the X. X put X hands out to break X fall and landed on X left side and bounced. X rolled to X back, lay there for a bit, then got on all fours and attempted to get up with the assistance of a coworker, but X was unable to get up. An X was called, and X was transported to X. X was examined and X. Surgery was recommended. X spent the X. X was admitted for X. At the time, X had complaints of pain in X left hip, left shoulder, left knee, lumbar spine, and cervical spine. On examination, X ambulated with a X-point cane with mildly abnormal gait patterns with an antalgic posture in flexion. X indicated the X was obtained from a friend, and per X, Dr. X and Dr. X agreed this was medically necessary. X friend also gave X. Left shoulder range of motion revealed flexion X degrees, extension X degrees, abduction X degrees, adduction X degrees, internal rotation X degrees, and external rotation X degrees. Examination of the left shoulder revealed X. Pain was reported with X. X was noted upon palpation of the X. X were noted in the X was noted in or around the left shoulder joint. Speeds, painful arc, apprehension, and empty can were all X. Tattoos were noted on the bilateral upper extremities. Left hip range of motion revealed flexion X degrees, extension X degrees, abduction X degrees, adduction X degrees, internal rotation X degrees, and external rotation X degrees. Examination of the left hip revealed X. X was noted with flexion and abduction of the hip. X reported X. No other areas of X were noted to the left hip bony or soft tissue structures. No X

was noted in or around the left hip joint. X for a left hip drop, Obers caused pain in the X. X were noted at the left proximal and distal left hip. Left knee range of motion revealed flexion X degrees; extension X degrees. Examination of the left knee revealed X. X was noted upon palpation around the left knee joint and surrounding soft tissue structures. No X was noted in or around the left knee joint. X did not demonstrate any instability or laxity in the left knee. Homan's orthopedic test was X. A X was noted at the left knee from the X. It was well healed with X. Tattoos were noted on the bilateral lower extremities. Lumbar spine range of motion revealed flexion X degrees, extension X degrees, right lateral flexion X degrees, left lateral flexion X degrees. Examination of the lumbar spine revealed X. X reported the lumbar spine pain was X. X reported the pain in the X. X was noted upon palpation of the X. The X were also tender to palpation. While lying prone on the table, X was unable to lie flat and the left hip was X. X was visibly uncomfortable lying on the table. Mild spasms and guarding were noted in the X. X was noted in or around the lumbar spine. Seated and supine left straight leg raises caused X. Left hip and groin pain was noted at X degrees with seated SLR and at X degrees with supine SLR with associated centrally located non-radiating lower back pain. Seated and supine SLR on the right caused diffuse lower back pain at X degrees, no radicular pain was reported. Kemp's was X on the right and left for facet joint pain with the left being greater than the right. X was X. X were X. Cervical range of motion revealed flexion X degrees, extension XX degrees, right lateral flexion X degrees, left lateral flexion X degrees, right rotation X degrees, and left rotation X degrees. Examination of the cervical spine revealed X. X was noted X. X reduced X neck pain. Grip strength on the right was X pounds, X pounds, X pounds; on the left, it was X pounds, X pounds, X pounds. X reported pain in the left shoulder with holding the dynamometer X was noted in the left knee joint. On neurological examination, X was alert and oriented X was noted at the left lateral knee from the prior total knee replacement per X. The

remainder of right and left upper and lower extremity sensation was intact to light touch. Upper and lower extremity muscle strength was grossly X in the left hip and shoulder with pain and X in the right. Upper and lower extremity DTR's were X and symmetrical. Upper and lower extremity X was intact. Heel / toe raising, balance testing and squatting were not performed due to safety concerns. The diagnosis was displaced, closed intertrochanteric fracture of the left femur. Dr. X provided the following opinions: Based on the mechanism of injury, the extent of injury extended to a X. "I was not asked to comment on the hip fracture on the X but this injury is clearly part of the injury and needs to be included. The left intertrochanteric hip fracture and need for surgical intervention is related as the MOI of a 170 pound male X. The cervical and lumbar spine MRIs dated X showed X. The multiple disc herniations in the cervical and lumbar spine appear to be arthritic in nature. Per the ODG, as in the cervical and thoracic spines, lumbar disc degeneration is a natural consequence of aging. Intervertebral disc degeneration, especially in the lumbar spine, usually begins in people in their second decade of life. Because there is some controversy over the role of disc degeneration in back pain, the term "nonspecific low back pain" is preferred instead of degenerative disc disease" (DDD). Approximately X. Pain may be exacerbated by flexion of the lumbar spine during heavy exertion, repetitive bending, twisting, or heavy lifting. However, minor trauma does not cause serious chronic low back pain and disability, or new MRI findings. The rate at which individuals develop degenerative age-associated changes on imaging is largely genetically determined, and exposures to activities including occupation and recreational pursuits have little effect on the rate of disc aging. X exam findings do not support X. X has no subjective complaints of X. Per the MD Guides radicular pain is a type of pain that arises in a nerve root near its origin at the spinal cord and radiates into a specific neurological distribution in an associated limb. The group of muscles that the nerve X. Common causes of X. The cervical spine and lumbar spine appear to have

sustained a X. The MOI supports a X. The left shoulder MRI dated X did not reveal X. The left shoulder MRI noted X had X. X indicated when X. X onto the left side and hitting X shoulder on X. Per the MD Guides, the X would appear to be a natural disease of life and not related to this injury. The bursitis is in all medical probability due to overuse and not related to the X. There is no evidence of aggravation (new structural change) of pre-existing (degenerative) conditions. There are no findings on the MRI (based on reasonable medical probability) to suggest the development of a post-traumatic process after the injury. The MOI supports a left shoulder sprain/strain due to the stretching or tearing of the tissue involved, either ligaments (sprains) or muscles (strains). The left knee MRI dated X was limited due to the X. This scan was noted to be X. X-rays of X left knee on X from X noted there was X. There was no X identified. The X was noted and appeared intact and well aligned with X. This x-ray on X indicates there is X The MRI X indicated there was X. X was then seen on X by Dr. X who performed x-rays of the left knee noting there was X. Due to the conflicting data on imaging studies in regard to the loosening of hardware in the left knee, I ordered a left knee x-ray. The x-ray was performed on X at X and read by X, MD. Dr. X noted there were X. There was X. X saw X. It is also noted X original total X. X has significant underlying degenerative changes noted on the imaging studies. In order to constitute a compensable aggravation of a mechanism of pre-existing condition, there must be more than the manifestation of symptoms; the injury must have caused some enhancement, acceleration or worsening of the underlying condition, not a temporary flare up of symptoms. In short, there must be some new damage or harm to the physical structure of the body. This injury does not meet the threshold for compensable aggravation as there are no acute findings on imaging studies or any indication there is any enhancement, acceleration or worsening, of the underlying condition. Furthermore, the fact that a condition becomes symptomatic at the workplace does not necessarily mean the condition is compensable. The

mechanism of injury supports the following: Sprain of ligaments of lumbar spine; strain of muscle, fascia and tendon of lower back; Sprain of ligaments of cervical spine; Strain of muscle, fascia and tendon at neck level; Sprain of left shoulder joint; Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm. The mechanism of injury does not support the following, as in all medical probability these are degenerative in nature and not part of this injury: Lumbar disc herniation; Radiculopathy, lumbar region; Cervical disc herniation; radiculopathy cervical region; Instability of internal left knee prosthesis. For the above referenced reason; the relevant clinical exam findings, the relevant medical history, the symptom timeline and the mechanism of injury as described above it is my medical opinion based upon my education training and experience and within reasonable medical probability that the fall into the pool caused sprain of ligaments of lumbar spine; strain of muscle, fascia, and tendon of lower back; sprain of ligaments of cervical spine; strain of muscle, fascia and tendon at neck level; sprain of left shoulder joint; strain of unspecified muscle, fascia and tendon at shoulder and upper arm level; left arm.” Per a DDE dated X, Dr. X opined as follows: “After reviewing the medical records, the mechanism of injury, the clinical examination, and the ODG, it is determined that X has not yet reached MMI. X was injured on X when X X. X was admitted to the hospital from X until X when X was released to X. X sought care from Dr. X and X. X completed X on X and then began X. At the time of my office visit X had completed X. Per the-ODG the following X is recommended. X. X has shown improvement with X thus it would appear reasonable to allow X to complete the additional ODG recommended X. In regard to the left knee, cervical spine, lumbar spine and left shoulder sprain / strains, X should be able to complete the recommended ODG treatment. It is noted, evidence based medicine reflects that strain/sprain and contusions are usually self-limiting and heal even without treatment within the first X weeks post injury. "Sprain/strain injuries are noted to resolve in the vast majority of cases

(X of the time) within X" SPINE, X, "Scientific Monograph of Qubec Taskforce", W.O. Spitzar, et al. X for the left knee, cervical spine, lumbar spine and shoulder was delayed as X was healing from the left hip fracture with surgery thus X has fallen outside of the ODG timeframe for the completion of therapy, however I anticipate once X completes the X visits of X as outlined above, X will be at MMI for the left knee, cervical, lumbar and left shoulder. I anticipate X will reach MMI on or about X for the compensable Injuries as outlined above." "Due to the fact, X is not at MMI, an impairment rating will not be assigned." Per a Report of Functional Capacity Evaluation dated X, by X, DC, X job required demand was medium physical demand level (PDL). At the time, X was performing at a sub-sedentary to sedentary PDL per NIOSH standards. X was capable of performing at a Sub-Sedentary to Sedentary physical demand level involving the injured area(s) and was experiencing a severe functional deficit as it related to meeting the standing (currently occasional versus constant job requirement), walking (currently occasional versus constant job requirement), bending (currently occasional versus frequent job requirement), reaching overhead (currently never versus frequent job requirement), reaching out (currently occasional versus frequent job requirement), climbing (currently infrequent versus frequent job requirement), squatting (currently infrequent versus frequent job requirement), kneeling (currently infrequent versus frequent job requirement), crawling (currently infrequent versus frequent job requirement), floor lifting (currently X pounds versus X pounds job requirement), floor to shoulder lifting (currently X pounds versus X pounds job requirement), floor to overhead lifting (currently 0 pounds versus X pounds job requirement), two hand carrying (currently X pounds versus X pounds job requirement), pushing (currently X pounds versus X pounds force required job requirement) and pulling (currently X pounds versus X pounds force required job requirement) job criteria as defined by the Dictionary of Occupational Titles and / or X Job Description Interview. On X, X underwent a mental health evaluation by

X, MS LPC. It was noted that X exhibited symptoms of stress and anxiety during the course of the clinical interview. X affect was apprehensive, and X voice and demeanor reflected a high level of frustration and depression. X scored a X on the X, indicating mild depression symptoms making it very difficult to take care of things at home, get along with others, or complete daily life tasks. X, indicating mild anxiety symptoms making it very difficult to take care of things at home, get along with others, or complete daily life tasks. X was a patient with mild symptoms that made it very difficult to take care of things at home, get along with others, or complete daily life tasks and should address coping strategies and stress management as part of the X. On the Fear Avoidance Belief Questionnaire, X scored a maximum score X on the physical activity portion of the assessment and a maximum score X on the work portion of the assessment. X scored X on the Oswestry Lower Back Pain Disability Questionnaire, indicating severe disability, with back pain impinging on all aspects of X life and positive intervention was required. On the Oswestry Neck Pain Disability Questionnaire, X scored X, indicating moderate disability. X experienced more pain and difficulty with sitting, lifting, and standing. Travel and social life were more difficult, and X may be disabled from work. Personal care, sexual activity, and sleeping were not grossly affected, and X could usually be managed by conservative means. On the pain impairment rating scale, X rated X pain as X at worst, X at its least, and X on average. It was noted that at the time, X was recommended for the X. X motivation was high; however, X was having difficulty adjusting to X ongoing health situation. The following goals had been set: 1. Decrease X Beck Depression level down X points moving him into minimal depression. 2. Decrease X Beck Anxiety level down X points moving him into minimal anxiety level. 3. Decrease X pain level X points in each level - worst, least, and average. Counseling sessions would include X. It was strongly recommended that X attended X. Per the DDE dated X, Dr. X opined that X had not yet reached MMI. "In regard to the left hip, left knee, cervical spine, lumbar spine and the left shoulder

sprain/strains, X has completed all of recommended ODG treatment however X underwent an FCE on X and it was determined X was functioning at a sub-sedentary to sedentary PDL per NIOSH standards and X job required a medium PDL. The examiner noted X was not a candidate for surgery and X injury had reached a plateau in care and there were no further treatments. X had not yet been returned to work; however X position was still available and full duty work was required. An X was recommended, approved, and X was scheduled to begin the X. In regard to X, the ODG X is conditionally recommended as an option to help assist in returning an injured worker back to work when an employer cannot accommodate modified duty. X should be intensive with variable treatment regimens ranging from X to X hours, X to X visits per week. The entirety of treatment should not exceed X day visits over X weeks not to exceed X hours. Reassessment after X to X weeks should determine whether completion of the current program is appropriate or whether other alternative should be considered. At the time of discharge there should be clear documentation of the current clinical and functional status, return to work and follow up services recommendations. The patient's attendance and progress should also be documented, including any reason for termination and successful completion of program or failure. There should also be documentation if the patient was unable to participate due to underlying medical conditions. Upon completion of any rehab program, neither reenrollment repetition of the same or similar rehab program is medically warranted for the same condition or injury. I anticipate X will reach MMI on or about X after the completion of the X as there is reasonable expectation of further material recovery with participation in the X." "Due to the fact, X is not at MMI, an impairment rating will not be assigned." Per an FCE dated X, Dr. X documented that X job required PDL was medium. X was currently performing at sedentary to light PDL. Per an FCE dated X, Dr. X documented X job required PDL was medium. X was currently performing at sedentary to light PDL. Examination noted X.

Inspection revealed X. Postural evaluation revealed X. On palpatory examination, Cervical spine and paraspinal musculature revealed X. Lumbar spine and paraspinal musculature revealed X. Left shoulder and musculature revealed X. Left hip revealed X. Deep tendon reflexes revealed X patellar on the right, hamstring absent bilaterally, and Achilles X on the left. Light touch revealed X. Motor revealed a grade X strength involving cervical extension, left lateral flexion; lumbar flexion, extension; upper extremity left shoulder abduction; lower extremities left hip abduction, flexion, and adduction. On orthopedic examination, maximum cervical compression was positive on the left for nerve root compression and bilaterally for facet loading pain. Shoulder Depression was X. Cervical Distraction was positive for relief of pain indicating nerve root compression. Jackson's Compression was X. Slump Test was X. Kemp's Test was X. SLR was X. SLR was X. Double Leg Raise was X. Empty can test (supraspinatus) was X. Painful Arc was X. Shoulder Adduction Test (Dugas) was X. Ober's Test was X. FADIR Test elicited pain in the groin. Scour Test: elicited pain, however, no popping nor clicking nor grinding was noted. Active range of motion (AROM) of the lumbar spine showed flexion X, extension X, right lateral flexion X, and left lateral flexion X. Cervical spine AROM showed flexion X, extension X, right lateral flexion X, left lateral flexion X, right rotation X, left rotation X. Left shoulder AROM showed flexion X, extension X, abduction X, adduction X, internal rotation X, external rotation X. Left hip AROM showed flexion X, extension X, abduction X, adduction X, internal rotation X, and external rotation X. Mental Health Reassessment dated X, by X, MS, LPC revealed that on the Patient Health Questionnaire-X, X scored X indicating moderate depressive symptoms making it very difficult to take care of things at home, get along with others, or complete daily life tasks. This score increased from the previous assessment for the X, that score was X, indicated mild depressive symptoms making it somewhat difficult to take care of things at home, get along with others, or complete daily life tasks. On the Generalized Anxiety Disorder-X, X scored X indicating

moderate anxiety symptoms, making it somewhat difficult to take care of things at home, get along with others, or complete daily life tasks. This score increased from the previous assessment for the X, that score was 7 indicating mild anxiety making it somewhat difficult to take care of things at home, get along with others, or complete daily life tasks. X scored a median score X on the physical activity portion of the FABQ assessment and a high score X on the work portion. On the Pain Impairment Rating Scale X rated X pain as X at its worse, X at its least, and X on average. At the time, X was recommended for the Behavioral Chronic Pain Management Program. X motivation was high; however, X was having difficulty adjusting to X health present situation.

MRI of the left knee dated X, revealed a severely limited study secondary to magnetic susceptibility artifact from prior knee arthroplasty; and suboptimal evaluation for meniscal or ligamentous injury. There was mild suprapatellar joint effusion and anterior knee soft tissue swelling. MRI of the left shoulder dated X, identified labral diffuse circumferential fraying; moderate supraspinatus tendinosis with mild muscle atrophy; severe glenohumeral joint osteoarthritis, and large glenohumeral joint effusion; and mild subacromial-subdeltoid bursitis. MRI of the lumbar spine dated X revealed at X. At X, there was X. At X, there was X. At X. At X, there was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, per X order, was denied by X, DC. Rationale: "The Official Disability Guidelines indicate that outpatient pain rehabilitation programs may be considered medically necessary when the patient has a chronic pain syndrome, with evidence of loss of function, previous methods have been unsuccessful, an adequate and thorough multidisciplinary evaluation has been made, a treatment plan should be

presented with specifics for treatment, the patient is motivated to change. However, the guidelines also indicate that neither re-enrollment in repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. Per functional capacity evaluation, the claimant's job demands a medium physical demand level, while they were currently performing at a sedentary to light physical demand level. They had completed X. Their motivation was high; however, they were having difficulty adjusting to their present health situation. The claimant's current complaints include pain in the left hip and groin, low back, neck, and left shoulder. The provider is requesting for a X. However, as the claimant already X. As such, the request for X, per X order, is recommended for non-certification. Peer to peer was not successful."

In an appeal letter dated X, Dr. X wrote, "Regarding the non-certification, the peer reviewer's report documents the X. In those requirements, (13) states "...but prior participation in a X." Additionally, X meets at least X of the X criteria for X. Therefore, the X is medically necessary and satisfies the ODG criteria for participation in the CPM program and as such, we request an appeal and reconsideration for the X."

Per a reconsideration review adverse determination letter dated X, the appeal request for X, per X order, was denied. Rationale: "Regarding X, the Official Disability Guidelines (ODG) states it is recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in delayed recovery. Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances: An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following, such as a physical

examination that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections, should be completed prior to considering a patient as a candidate for a program. Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program or diagnoses that would better be addressed using other treatment should be performed. An evaluation of social and vocational issues that require assessment. If the goal of treatment is to prevent or avoid controversial or optional surgery, a trial of X visits (X) may be implemented to assess whether surgery may X avoided. Once the evaluation is completed, a treatment plan should be presented with specifics for the treatment of identified problems and outcomes that will be followed. There should be documentation that the patient has motivation to change, and is willing to change their medication regimen. There should also be some documentation that the patient is aware that successful treatment may change compensation and / or other secondary gains. Treatment is not suggested for longer than X weeks without evidence of compliance and significant demonstrated efficacy, as documented by subjective and objective gains. Total treatment duration should generally not exceed X weeks (X full-days or X hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. If the treatment duration more than X weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. At the conclusion and subsequently, neither re-enrollment in the repetition of the same or similar rehabilitation program (e.g., X) is medically warranted for the same condition or injury. The request is not supported. The claimant had X. Additionally, based on the functional capacity evaluation dated X, the claimant was discouraged due to the lack of progressions, which indicates low motivation to change.

Furthermore, per the guidelines, the total treatment duration should not exceed more than X weeks to warrant the request. The claimant has a plateau of slightly above sedentary ability but below light physical demand level (PDL) ability despite X hours of multidisciplinary program. The confirmed plateau with no medical indication for continued use rehabilitation programs in this context. Therefore, the appeal request for X, per X order is non-certified."

In a letter IRO dated X, X, DC wrote, ""A request for X was non certified by the review doctor due to the following: peer review doctor due to the following: "The provider is requesting for a X. However, as the claimant already X. As such, the request for X.is recommended for non-certification." An appeal was the submitted and the original non-certification was upheld due to the following: "The request is not supported. The claimant had X. Additionally, based on the functional capacity evaluation dated X, the claimant was discouraged due to the lack of progressions, which indicates low motivation to change. Furthermore, per the guidelines, the total treatment duration should not exceed more than X weeks to warrant the request. The claimant has a plateau of slightly above sedentary ability but below light physical demand level (PDL) ability despite X of multidisciplinary program. The confirmed plateau with no medical indication for continued use rehabilitation programs in this context. Therefore, the appeal request for X, per the X order is non-certified." Regarding the non-certifications, both peer reviewers' report documents the X. In those requirements, (13) states "...but prior participation in a X." Additionally, because the claimant was discouraged after a lack of significant progress during the second X, and after demonstrating progress during the X. Contrary to the appeal peer reviewer's opinion, the X mental health evaluation states, "X motivation is high; however, X is having difficulty adjusting to X present health situation." Further, the claimant ended the X. Finally, the claimant meets at least X of the X criteria for multidisciplinary pain management

programs as defined by the ODG and other methods of treating chronic pain have been unsuccessful and there are no other options for X that are anticipated to result in clinical participation in the X.”

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient has continued pain and functional deficits for which enrolled in X. They have X. However, given continuing issues, while at the same time showing pattern of progression attributed to said program, request for further hours is warranted. X, per X order is medically necessary and certified

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

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient has continued pain and functional deficits for which enrolled in X. They have X. However, given continuing issues, while at the same time showing pattern of progression attributed to said program, request for further hours is warranted. X, per X order is medically necessary and certified

Overtured

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**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**