

# CASEREVIEW

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## Notice of Independent Review Decision

DATE OF REVIEW: November 17, 2011

### IRO CASE #:

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

Inpatient right total knee replacement (TKR) with five (5) day length of stay (LOS)

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 years of experience.

### REVIEW OUTCOME:

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

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

Provide a description of the review outcome that clearly states whether or not 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 onxx/xx/xx when he fell while walking down stairs at work injuring both knees. He underwent left knee arthroscopies in xxxx and xxxx and a right knee arthroscopy in xxxx. Over the course of several years he received multiple steroid and Hyalgan injections into both knees. Of note, he has a history of hypertension and has had three open heart surgeries and coronary artery

bypass surgeries.

On August 26, 1997, the claimant was evaluated by MD for bilateral knee pain, left greater than right. X-rays for Dr. office showed degenerative joint disease of both knees with medial joint space narrowing and patellofemoral joint space narrowing, osteophytes and arthrosis. There was also a calcification off the posteromedial femur on the left side, which may have represented a loose body or may have been an extra-articular calcification, or a calcification embedded in the capsule. Diagnosis: 1. Bilateral degenerative joint disease, both knees. 2. Rule out torn medial meniscus, left knee. Plan: MRI of the left knee.

On September 2, 1997, MRI of the left knee revealed: 1. Signal within the posterior horn of the medial meniscus which may represent a tear contacting the external synovial surface or (possibly) the superior articular surface. 2. FOCI of abnormal signal within the subchondral cancellous bone of the femoral condyles as described above. This may represent small osteochondral traumatic defects versus degenerative changes.

On September 9, 1997, Operative report by MD. Procedures performed: Left knee arthroscopy, partial medial meniscectomy, chondroplasty mediofemoral condyle.

On October 1, 1997, the claimant had a follow-up evaluation with MD who noted his left knee was much improved, but he still ambulated with a mild antalgic limp and was complaining that his right knee was continuing to bother him and had similar symptoms that he had with his left knee. Dr. recommended a right knee arthroscopy.

On October 21, 1997, Operative report by MD. Postoperative diagnosis: Degenerative joint disease, right knee with chondromalacia, medial femoral condyle and chondromalacia of medial tibial plateau as well as torn medial meniscus, right knee. Procedures performed: Right knee arthroscopy, partial medial meniscectomy, chondroplasty, medial femoral condyle.

On November 4, 1997, the claimant had a follow-up evaluation with, MD who noted he was two week status post right knee arthroscopy and still had some pain and complaints of redness and drainage of his wounds. Keflex was prescribed. On physical examination he had no erythema or drainage of his wound. There was no sign of infection. He had no effusion and he had full extension of his knee and flexion to 120 degrees. Dr. recommended physical therapy and a work hardening program.

On December 3, 1997, the claimant had a follow-up evaluation with MD who noted his right knee was much improved, but his left knee was worse. His left knee was injected and he was recommended more work hardening.

On January 21, 1998, the claimant had a follow-up evaluation with MD who discussed with him that he had significant arthritis of his knees and there were different options for him which included: 1. Repeat arthroscopy of his left knee. 2. Total knee replacement. 3. For the claimant to change his type of employment to a job that did not require the heavy lifting on a repetitive fashion. 4. Synvisc and/or Hyalgan intra-articular injection of the knee for arthritis. At this visit, Dr. performed a cortisone injection into the right knee and prescribed a three week course of Lodine-XL 800mg.

On February 10, 1998, the claimant had a follow-up evaluation with MD where it was decided to proceed with a repeat diagnostic arthroscopy of his left knee.

On February 17, 1998, Operative report by MD. Procedures performed: Left knee arthroscopy, partial meniscectomy, chondroplasty mediofemoral condyle, partial synovectomy and excision of plica.

On March 18, 2008, the claimant had a follow-up evaluation with MD who on examination found moderate effusion of his right knee. Under sterile conditions the right knee was aspirated and 40 cc of serous fluid was obtained. He was then injected with 3 cc Celestone and 3 cc of .25% Marcaine with epinephrine. More physical therapy was recommended.

On January 16, 2002, the claimant had a follow-up evaluation with MD who on physical examination found that he ambulates with an antalgic limp. He had crepitance with range of motion of both knees. Tenderness along the medial and lateral joint lines both knees. Pain with patellar grind test both knees. Mild effusions both knees. He lacked about 20 degrees of extension in both knees and 30 degrees of flexion in both knees. Motor strength was 4/5 quadriceps and hamstrings both knees. AP standing and lateral x-rays of both knees revealed that there was severe tricompartmental arthritis both knees with varus deformities both knees. Dr. performed cortisone injections in both knees and prescribed him Celebrex 200 mg.

On November 3, 2004, the claimant had a follow-up evaluation with MD where on physical examination both knees revealed tenderness medial joint line, pain with deep knee bend, no effusion, erythema or warmth. Dr. performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was prescribed Ultram for pain.

On March 16, 2005, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was prescribed Ultram for pain.

On July 20, 2005, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was prescribed Ultram for pain.

On November 16, 2005, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine.

On March 8, 2006, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine.

On August 2, 2006, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was prescribed Ultram ER 200mg for pain.

On September 6, 2006, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. Two views standing x-rays of both knees revealed traumatic arthropathy of both knees with joint space narrowing and osteophyte formation. He was prescribed Ultram for pain.

On December 20, 2006, the claimant had a follow-up evaluation with, MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was prescribed Ultram for pain.

On February 7, 2007, the claimant had a follow-up evaluation with MD who noted his bilateral pain persisted and that Ultram was not helping that much anymore. The claimant also reported the Cortisone injections do not help for as long anymore. Dr. recommended Hyalgan injections for both knees. The claimant requested a Corticoid steroid injection, but Dr. explained he would not perform more than 3 to 4 in a year.

On February 28, 2007, the claimant had a follow-up evaluation with, MD who performed Hyalgan injections of both knees.

On February 28, 2007, the claimant had a follow-up evaluation with, MD who noted he had improvement after his first set of Hyalgan injections. Dr. performed Hyalgan injections of both knees.

On March 14 2007, the claimant had a follow-up evaluation with MD who performed his last set of Hyalgan injections of both knees.

On November 28, 2007, the claimant had a follow-up evaluation with MD who noted he had undergone extensive nonoperative treatment including corticosteroid injections and Hyalgan injections, but severe pain persisted. He had also been taking Tramadol for the pain, but it was not working for him. The claimant desired to proceed with total knee replacement surgery. Dr. consulted him on the risk of TKR and recommended he see his cardiologist, Dr. to see if he was medically optimized for surgery.

On January 30, 2008, the claimant had a follow-up evaluation with MD who noted he had to have lumbar spine surgery and was recovering from that. Both knees were injected with 4mg of Dexamethasone and 3 cc .25% Marcaine.

On May 14, 2008, the claimant had a follow-up evaluation with MD who performed an injection of the left knee with 4mg of Dexamethasone and 3cc of .25% Marcaine. His Ultram was refilled.

On August 6, 2008, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine.

On October 15, 2008, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was also placed in hinged knee sleeve braces for support of his traumatic arthropathy and knee pain.

On February 11, 2009, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was prescribed Ultram for pain.

On June 3, 2009, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine.

On March 3, 2010, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. He was continued on Ultram.

On August 4, 2010, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine.

On January 12, 2011, the claimant had a follow-up evaluation with MD who performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine.

On April 20, 2011, the claimant had a follow-up evaluation with MD who noted that since he last saw him, the claimant had had gastric lap band surgery. He originally weighed 297 and his height is 5'6". He had gotten his weight down to 245. On physical examination both knees revealed crepitus range of motion. He ambulated with an antalgic limp. There was no sign of DVT. Tenderness medial and lateral joint line on both knees. Pain with patellar grind test both knees. Dr. performed injections of both knees with 4mg of Dexamethasone and 3cc of .25% Marcaine. The claimant desired to proceed with total knee replacement surgery and Dr. informed him that it would be better if he could lose more weight. Furthermore he would have to be deemed medically optimized by his cardiologist, Dr. prior to having a TKR.

On May 17, 2011, the claimant was evaluated by MD. In a letter dated August 5, 2011, Dr. stated that from a cardiac standpoint, he was approved for surgery.

On August 17, 2011, the claimant had a follow-up evaluation with MD who noted that the work comp insurance adjustor denied any further cortisone injections and Hyalgan injections. His bilateral knee pain persisted. The claimant admitted he had gained some weight back. He was currently at 260 pounds at 5'6", which gave him a body mass index of ~42. On physical examination, it was noted he was morbidly obese male in no apparent distress. There was tenderness medial and lateral joint line of both knees. Pain with patellar grind test both knees. Crepitus with range of motion both knees. He lacked 10 degrees knee extension and has flexion only to about 90 to 100 degrees. He could not deep knee bend due to pain. They discussed several treatment options and the high risk of the TKR. The claimant stated he could no longer take the pain, he can't walk, can't exercise, he desired the TKR.

On September 8, 2011, DO performed a UR on the claimant. Rationale for Denial: The claimant's BMI is excessive and there is no documentation of nighttime joint pain, which does not meet the ODG criteria. Since planned surgery is not authorized, the hospitalization is therefore non-authorized.

On October 6, 2011, DO performed a UR on the claimant. Rationale for Denial: The claimant's weight is now 260 pounds and he is 5'6" with a BMI of approximately 42. The claimant does have a prior history of coronary artery disease, hypertension, hypercholesterolemia, asthma and PVD. The claimant was reported to be high risk for failure of a TKR and a high risk for death, heart attack, stroke and blood clots that could be fatal as well as wound healing problems, infection in the knee, postoperative difficulty with breathing with pulmonary complications secondary to his weight. Therefore, at this time, I uphold the recommendation for non-authorization of the TKR due to the claimant's significantly excessive BMI.

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

The previous decisions have been upheld. Unfortunately, the claimant does require a TKR; however, he does not meet the ODG Criteria #3, Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 35, where increased BMI poses elevated risks for pos-op complications. As of the latest clinical examination, the claimant was 5'6" and weight 260 pounds giving him an approximate BMI of 42. This failure of weight loss despite a lap band procedure plus his history of coronary artery disease and hypertension makes him a high risk for failure of a TKR and post-operative complications. Therefore, the requested surgery is denied, which then would make the length of hospital stay denied as well.

**ODG:**

Recommended as indicated below. Total hip and total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return patients to function. The most common

diagnosis is osteoarthritis. Overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related quality-of-life dimensions, with the occasional exception of the social dimension. Age was not found to be an obstacle to effective surgery, and men seemed to benefit more from the intervention than did women. ([Ethgen, 2004](#)) Total knee arthroplasty was found to be associated with substantial functional improvement. ([Kane, 2005](#)) Navigated knee replacement provides few advantages over conventional surgery on the basis of radiographic end points. ([Bathis, 2006](#)) ([Bauwens, 2007](#)) The majority of patients who undergo total joint replacement are able to maintain a moderate level of physical activity, and some maintain very high activity levels. ([Bauman, 2007](#)) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. ([Lowe, 2007](#)) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. ([Larsen, 2008](#)) In this RCT, perioperative celecoxib (Celebrex) significantly improved postoperative resting pain scores at 48 and 72 hrs, opioid consumption, and active ROM in the first three days after total knee arthroplasty, without increasing the risks of bleeding. The study group received a single 400 mg dose of celecoxib, one hour before surgery, and 200 mg of celecoxib every 12 hours for five days. ([Huang, 2008](#)) Total knee arthroplasty (TKA) not only improves knee mobility in older patients with severe osteoarthritis of the knee, it actually improves the overall level of physical functioning. Levels of physical impairment were assessed with three tools: the Nagi Disability Scale, the Instrumental Activities of Daily Living Scale (IADL) and the Activities of Daily Living (ADL) Scale. Tasks on the Nagi Disability Scale involve the highest level of physical functioning, the IADL an intermediate level, and the ADL Scale involves the most basic levels. Statistically significant average treatment effects for TKA were observed for one or more tasks for each measure of physical functioning. The improvements after TKA were "sizeable" on all three scales, while the no-treatment group showed declining levels of physical functioning. ([George, 2008](#)) This study showed that total knee replacement is second the most successful orthopaedic procedure for relieving chronic pain, after total hip. 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. Hip replacement reduced pain to levels normal for age, reduced physical functioning to within 75% normal levels, and restored quality of life to virtually normal levels. Total knee replacement was the next most successful procedure, and it all but eliminated pain, improved physical functioning to 60% normal, and restored quality of life to within 65% of normal. ([Hansson, 2008](#)) A 6-week program of progressive strength training targeting the quadriceps femoris muscle group substantially improves strength and function following total knee arthroplasty for treatment of osteoarthritis, compared to patients who received standard of care therapy; however, addition of neuromuscular electrical stimulation (NMES) to the strength training exercise did not improve outcomes. ([Petterson, 2009](#)) Knee replacement surgery is expensive but worth the cost, especially if performed by experienced surgeons, according to a recent study. Some \$11 billion is spent on 500,000 total knee replacements each year in the United States, and the number is projected to multiply seven times by 2030 because of the aging, overweight population. Over 90% knee replacements are successful, knee pain goes away and patients become more mobile. In the study, knee replacement surgery and subsequent costs added up to \$57,900 per patient, which was \$20,800 more than was spent on those who did not get the surgery. Those who got artificial knees lived more than a year longer in good health than those who did not, and the researchers calculated the added cost per year of good-quality life at \$18,300. ([Losina,](#)

[2009](#)) In a 7-year prospective study, patients with severe osteoarthritis who had total knee replacement had significant improvements in health-related quality of life, but health outcomes were negatively influenced by obesity and postdischarge complications, and women typically did not get as much benefit from surgery as do men. Overall, 76.8% were satisfied or very satisfied with their total knee replacement, and 79.5% said they would have the surgery again in similar circumstances. ([Núñez, 2009](#)) More than 95% of patients report that they are satisfied with the outcome of their total knee replacement 1 year after surgery. Factors that increased risk for dissatisfaction were younger age, being female, valgus alignment of the knee, and posttraumatic arthritis. ([Ayers, 2010](#)) Patients undergoing total knee arthroplasty (TKA) should receive ongoing COX-2 Inhibitor therapy for 6 weeks after their procedure, according to this unpublished RCT. ([Schroer, 2011](#))

*Unicompartmental knee replacement:* Recommended as an option. Unicompartmental knee replacement is effective among patients with knee OA restricted to a single compartment. ([Zhang, 2008](#)) In this RCT, the early results demonstrated that the unicompartmental knee replacement (UKR) group had less complications and more rapid rehabilitation than the total knee replacement (TKR) group. At five years there were an equal number of failures in the two groups but the UKR group had more excellent results and a greater range of movement. The 15 years survivorship rate based on revision or failure for any reason was 89.8% for UKR and 78.7% for TKR. The better early results with UKR are maintained at 15 years with no greater failure rate. ([Newman, 2009](#)) Long-term studies are needed to appropriately define the role of less invasive unicompartmental surgical approaches. ([Borus, 2008](#)) Unicondylar knee arthroplasty (UKA) and total knee arthroplasty (TKA) are both recommended for the treatment of medial compartment osteoarthritis in the varus knee. Citing the arduous rehabilitation and bone loss associated with traditional knee arthroplasty, some opt for UKA, especially in young, high-demand patients. ([McAllister, 2008](#)) With appropriate patient selection, UKAs are a successful option for patients with osteoarthritis. ([Dalury, 2009](#))

*Bicompartmental knee replacement:* Not recommended. See separate entry for [Bicompartmental knee replacement](#).

*Obesity:* After total knee arthroplasty (TKA) for osteoarthritis of the knee, obese patients fare nearly as well as their normal-weight peers. A British research team reports that higher BMI (up to 35) should not be a contraindication to TKA, provided that the patient is sufficiently fit to undergo the short-term rigors of surgery. TKA also halts the decline and maintains physical function in even the oldest age groups (> 75 years). ([Cushnaghan, 2008](#)) In this study, the rate of failure of total knee implants, at least up to 5 years after surgery, and the time to failure, were not influenced by patients' BMI, except for subjects affected by morbid obesity, but this group had a small sample size. Based on this evidence, however, it does not appear justified to give low priority to obese subjects for total knee arthroplasty, which would, as a result of restored ability to move, lead to weight loss. ([Bordini, 2009](#)) Obese patients presented for and underwent joint replacement surgery at a younger age as compared to nonobese patients. ([Gandhi, 2010](#)) Adverse events (eg, perioperative complications, post-op wound infections) occurred in 14.2% of the non-obese, 22.6% of the obese and 35.1% of the morbidly obese patients after total knee replacement. ([Dowsey, 2010](#)) A 2-year review of knee and hip replacement surgeries found that complication rates in obese patients were low, supporting doing the procedures even in the heaviest patients, but the review did show that hospital stays were longer in those who were obese than in those who were not. ([Parks, 2010](#)) Obese patients may have clinically significant weight loss after total joint arthroplasty, since their osteoarthritis had limited their mobility and ability to exercise. When weight was corrected for natural gain, the overall study population had a trend toward weight loss, and 19.9% of the study population had clinically significant weight loss. ([Stets, 2010](#))

*Minimally invasive total knee arthroplasty:* No significant benefit was seen in using a minimally invasive surgical technique over a standard traditional technique for total knee

arthroplasty, but the study did not focus on quality-of-life outcomes (eg, length of hospital stay, reliance on pain medications, and the need for inpatient rehabilitation after discharge), in which the minimally invasive approach is purported to show an advantage. ([Wülker, 2010](#))

***Bilateral knee replacement:*** The safety of simultaneous bilateral total knee replacement remains controversial. Compared with staged bilateral or unilateral total knee replacement, simultaneous bilateral total knee replacement carries a higher risk of serious cardiac complications, pulmonary complications, and mortality. ([Restrepo, 2007](#)) Recommend that congestive heart failure and pulmonary hypertension be contraindications for bilateral total knee arthroplasty (BTKA), but not age *per se*. BTKA is seen as offering advantages over staged unilateral knee replacement surgery, including reduced time in the hospital, decreased costs, and a faster return to active life. The procedure also has been shown, however, to carry an increased risk for morbidity and mortality compared with unilateral knee replacement, with overall incidence of major in-hospital complications and mortality of 9.5%. Patients with the highest risk for adverse outcomes were those with congestive heart failure (odds ratio [OR], 5.5) compared with those without comorbidities, and those with pulmonary hypertension (OR, 4.1). Other risk factors included older age, with patients who were 65 to 74 years old or older than 75 years having about twice the likelihood of complications compared with patients 45 to 65 years old. Men also showed a 50% greater risk for complications than women. Older age, however, should not necessarily rule out patients who can otherwise benefit from bilateral knee replacement, and age by itself will be a risk factor in any kind of surgery. Factors that can increase the risk with congestive heart failure include bone particles and marrow entering the bloodstream to embolize in the pulmonary vasculature and other organs. ([Memsoudis, 2011](#))

**ODG Indications for Surgery -- Knee arthroplasty:**

**Criteria** for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

**1. Conservative Care:** Medications. AND (Visco supplementation injections OR Steroid injection). PLUS

**2. Subjective Clinical Findings:** Limited range of motion. AND Nighttime joint pain. AND No pain relief with conservative care. PLUS

**3. Objective Clinical Findings:** Over 50 years of age AND Body Mass Index of less than 35, where increased BMI poses elevated risks for post-op complications. PLUS

**4. Imaging Clinical Findings:** Osteoarthritis on: Standing x-ray. OR Arthroscopy.

([Washington, 2003](#)) ([Sheng, 2004](#)) ([Saleh, 2002](#)) ([Callahan, 1995](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS). See also [Skilled nursing facility LOS](#) (SNF)

**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)**