

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** October 31, 2012

**IRO CASE #:**

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

29805 Left Shoulder Diagnostic Arthroscopy

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

This physician is Board Certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

11/10/10: Consultation by MD  
11/11/10: MRI C-Spine report interpreted by MD  
11/17/10: Followup Visit by MD  
12/07/10: Operative Report by MD  
12/22/10: Followup Visit by MD  
02/03/11: MRI C-Spine report interpreted by MD  
02/03/11: MRI L-Spine report interpreted by MD  
02/07/11: Followup Visit by MD  
03/16/11: Consultation by MD  
03/18/11: Employers First Report of Injury or Illness by  
03/18/11: Associate Statement  
03/18/11: Associate Incident Log  
03/18/11: Bona Fide Job Offer  
03/18/11: Worker's Compensation Request for Medical Care

03/18/11: Texas Workers' Compensation Work Status Report  
03/18/11: X-ray Left Wrist, C-Spine, L-Spine reports interpreted by MD  
03/18/11: Visit Summary  
03/25/11: Bona Fide Job Offer  
03/21/11: Visit Summary  
03/21/11: Texas Workers' Compensation Work Status Report  
03/28/11: Texas Workers' Compensation Work Status Report  
03/28/11: Visit Summary  
03/28/11: Office Visit  
03/30/11: Followup Visit  
04/04/11: Visit Summary  
04/04/11: Texas Workers' Compensation Work Status Report  
04/04/11: Office Visit  
04/06/11: Followup Visit  
04/20/11: Cervical Myelogram report  
04/20/11: Post-myelogram CT of the Cervical Spine report  
05/11/11: Followup Visit  
05/11/11: Texas Workers' Compensation Work Status Report  
05/13/11: Office Visit  
05/16/11: Physical Assessment Evaluation and Treatment Plan  
05/19/11: Physical Performance Evaluation  
05/19/11: Texas Workers' Compensation Work Status Report  
05/31/11: Followup Visit  
05/31/11: Texas Workers' Compensation Work Status Report  
06/03/11, 06/07/11, 06/13/11, 06/18/11, 06/22/11, 06/23/11: Daily Progress Notes  
06/14/11: Followup Visit  
06/14/11: Texas Workers' Compensation Work Status Report  
06/16/11: EMG NCS report  
06/23/11: EMG NCS report  
06/27/11, 07/11/11: Followup Visits  
06/27/11: Texas Workers' Compensation Work Status Report  
06/30/11: Physical Assessment Evaluation and Treatment Plan  
07/11/11: Workers' Compensation Injury Consultation  
07/27/11: Physical Performance Evaluation  
08/02/11: Evaluation  
08/02/11: Initial Consultation  
08/02/11: Retrospective Review  
08/16/11: Evaluation and Texas Workers' Compensation Work Status Report  
08/16/11: Followup Visit  
08/22/11: Triage Screening for Sepsis, Emergency Department Order Sheet, Triage Note, Nurse's Notes, Emergency Physician Record, and Discharge Summary  
08/22/11: UR  
08/25/11: Retrospective Appeal Review  
08/29/11: Followup Visit  
09/02/11: Evaluation and Texas Workers' Compensation Work Status Report  
09/13/11: Peer Review

09/15/11: Retrospective Review  
09/23/11: Notice of Disputed Issue(s) and Refusal to Pay Benefits from AR  
Claims Management, Inc  
09/26/11, 10/24/11: Followup Visit  
09/29/11: Retrospective Appeal Review  
10/03/11, 10/24/11, 11/21/11: Evaluation and Texas Workers' Compensation  
Work Status Report  
11/21/11: Consultation  
12/02/11: Initial Physical Therapy Evaluation  
12/06/11: UR performed  
12/19/11: Followup Visit  
12/19/11: Evaluation  
01/10/12: UR performed  
01/20/12, 02/17/12, 03/19/12, 06/25/12, 07/19/12, 08/06/12, 08/11/12, 08/23/12:  
Evaluation and Texas Workers' Compensation Work Status Report  
01/20/12, 02/17/12, 03/19/12, 06/25/12, 07/30/12: Followup Visit  
05/10/12: Designated Doctor Exam  
07/03/12: UR performed  
07/06/12: MRI Left Shoulder  
07/12/12: UR performed  
07/19/12: Procedure Report  
08/23/12: Progress Notes and Texas Workers' Compensation Work Status  
09/06/12: Preauthorization Request  
09/07/12: Followup Visit  
09/12/12: UR performed  
09/12/12: Reconsideration Request  
09/13/12: Progress Notes  
09/19/12: UR performed  
09/27/12: Chart Review/Clarification  
09/27/12: Progress Notes and Texas Workers' Compensation Work Status  
Report  
09/28/12: Evaluation and Texas Workers' Compensation Work Status Report  
10/08/12: Preauthorization Request  
10/09/12: Withdraw Recommendation  
Independent Review Organization Summary from Arkansas Claims Management,  
Inc

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who injured her neck, left shoulder, and low back at work when she fell to the ground onto her left side. She is status post previous ACDF at C4-C5 and C5-C6 prior to her injury. She has completed six sessions of physical therapy. She is status post intra-articular cortisone injection and bursa injection.

11/11/10: MRI C-Spine report interpreted. IMPRESSION: There is a congenital segmentation anomaly at the C2-C3 level resulting in a hypoplastic C2-C3 disc space. There is also a congenital segmentation anomaly at T1-T2 with partial

fusion between the T1 and T2 vertebrae. There is moderate multilevel cervical spondylosis and disc bulging as detailed above. At the C4-C5 and C5-C6 levels, posterior osseous ridging and disc bulging is causing mild-moderate flattening of the ventral cord surface. This is slightly asymmetric to the right at C4-C5. There is a moderate degree of central canal stenosis at both levels. There is also bilateral foraminal stenosis at both levels. This is most severe on the right at the C4-C5 level where there is severe right foraminal stenosis. The cervical spinal cord is normal in signal.

12/07/10: Operative Report. POSTOPERATIVE DIAGNOSIS: Klippel-Feil syndrome. C4-C6 cervical disc herniation. OPERATION: C4-C5, C5-C6 total discectomy and anterior interbody fusion using allograft bone. Bilateral C5 and C6 nerve root decompressions. C4-C7 anterior arthrodesis using titanium plate and screws. Intraoperative neuromonitoring.

02/03/11: MRI C-Spine report interpreted. IMPRESSION: Prior C4-C6 ACDF without gross hardware complication. Congenital block vertebrae are seen at the C2-C3 and T1-T2 levels. There is a thin syrinx in the upper thoracic spinal cord measuring about 1.6 mm maximum diameter within the scan range. It extends inferiorly off the scan range. Thoracic spine MRI recommended for further characterization. Mild central stenosis C4-C5 and C5-C6. Mild-moderate foraminal stenosis is seen on the right at C3-C4, on the left at C5-C6, and on the right at C4-C5.

03/16/11: The claimant was evaluated for complaints of bilateral shoulder pain. X-ray interpretation of bilateral shoulders demonstrated moderate osteoarthritic change bilaterally in the AC joints. No significant GH arthritis. Type 2 acromion bilaterally with lateral downslope. No decrease in acromiohumeral space. On physical exam, she was mildly tender over the left AC joint as well as in the trapezius muscle area. Hawkin's impingement test was positive, O'Brien's positive, Neer impingement test positive, Speed's test positive, and Yergason's test positive. CURRENT PLANS: MRI bilateral shoulders. She has a lot of general musculoskeletal complaints but it does seem that she has issues that localize to the shoulder. This can certainly be aggravated by her neck issues, but again she seems to have localized pain to the shoulder. I would like to get an MRI of her shoulders to evaluate for RTC tears. If she doesn't have tears, then we might consider doing injections.

03/18/11: The claimant was injured when she fell. She reported injuring her neck, head, left hand, and left shoulder. She complained of pain to the neck, shoulder, back, and wrist.

03/18/11: X-ray C-Spine report FINDINGS: Congenital fusion of C2-C3 vertebral bodies including posterior elements. Previous C4-C5 and C5-C6 interspaces grafting and flexion with anterior plate and screws device has occurred. Evidently, anterior displacement or migration of these interspaces grafts of 3-4 mm has occurred. This finding is not associated with other evidence suggesting the

metallic plate and screws device loosening and this appearance may be asymptomatic or adequate. Further investigation might be achieved with flexion and extension lateral cervical plain film radiography and thin-section CT with reconstructed imaging however. Documented is a mild-moderate degree of diffuse bony structures demineralization suggestion osteoporosis.

04/20/11: Cervical Myelogram report. IMPRESSION: Successful intrathecal contrast injection for purposes of cervical CT myelography. The patient tolerated the procedure expressing no untoward side effects or immediate complications. At the conclusion of the procedure, contrast was confirmed in the region of the cervical intrathecal space.

04/20/11: Post-myelogram CT of the Cervical Spine report . IMPRESSION: Congenital anomaly of fusion of C2 to C3. Right neural foraminal stenosis at C3-C4 due to a combination of uncovertebral joint hypertrophy and spondylosis which results in narrowing of the right C3-C4 spinal recess and proximal neural foramen. Right spinal recess and neural foraminal stenosis due to a combination of spondylosis and disc protrusion towards the right at C4-C5. To some extent, the right epidural space deformity at C4-C5 may be postoperative. Moderate bilateral proximal spinal recess narrowing at C5-C6 due to residual effects of spondylosis. The patient has had an anterior interbody fusion at C4-C5 and C5-C6 as described above. The patient left in good condition with post-myelography instructions.

05/11/11: The claimant was reevaluated. On physical exam, she had left shoulder pain and left posterior cervical pain. TREATMENT: Patient reports a fall at work on March 18<sup>th</sup>. Now with new left arm/shoulder pain. I would like Dr. to see her for left shoulder injections and trigger point injections. Patient would also be weaned off her narcotics and soma that she has been on for 5 years. I would like to see her back in clinic in six months.

05/13/11: The claimant was evaluated by MD. She complained of stiffness, soreness pain in her neck. She had shooting pain in the neck that was constant and radiated down the shoulder with movement. She had shooting pain in the left arm and left shoulder that was constant. Current medications included hydrocodone and Soma. On examination, she had moderate tenderness to the left anterior shoulder. Hawkins's/Neer's tests were positive. Muscle strength testing was 4/5 in the left deltoid and internal rotators. 5/5 elsewhere left upper extremity. DTRs were 2+ at the biceps and triceps. DIAGNOSIS: Cervical sprain, lumbar disc injury, left shoulder internal derangement non compensable. She was given a prescription for hydrocodone, Zanaflex, and Cymbalta.

06/23/11: EMG NCS . DIAGNOSTIC IMPRESSIONS: Prolonged latency of both sensory nerves at the wrists is related to bilateral median sensory and motor entrapment neuropathy at the wrists.

09/13/11: Peer Review. OPINION: There is no evidence of a structural injury to the cervical spine, left shoulder, right shoulder, or lower back related to the injury event at issue. There is insufficient evidence to suggest that the occupational event of March 18 aggravated any pre-existing conditions. As previously mentioned, her symptoms prior to and immediately after the injury event are identical in workup and treatment had already begun prior to the injury event. In my opinion, she sustained, at most, a soft tissue injury superimposed upon her pre-existing conditions which would be expected to resolve within 4-6 weeks of the injury event. In my opinion, she has achieved complete recovery from that soft tissue component. Ongoing treatment is related to her pre-existing cervical, lumbar and bilateral shoulder pathologies.

01/20/12: The claimant was reevaluated. It was noted that she "clearly injured her shoulder in the fall which occasioned the work-related injury. She has severe pain internal to the left shoulder. She has palpable crepitus on range of motion studies and marked weakness in the upper arm, especially abduction against resistance when compared to the right arm/shoulder. We have renewed her pain medication at previously prescribed levels and we will submit another request for MRI of the left shoulder so we can get a firm diagnosis on the extent of her injury."

03/19/12: the claimant was reevaluated. It was noted that she was showing loss of muscle in the left forearm, which at the mid forearm and mid biceps area were both 3-4 mm smaller in circumference than the right arm. Dr. noted that the "appropriate next step for this patient would be cervical epidural steroid injections to try and relieve the radicular complaints as well as an MRI of the left shoulder to try and identify the degree and extent of the internal derangement present there which is clearly indicated by the presence of crepitus. Given the persistent refusal of the Worker's Comp carrier to authorize any further diagnostics on the left shoulder, an alternative approach would be to treat her left shoulder pain and internal derangement with intra-articular corticosteroid injection, although it would be preferable to have the MRI prior."

05/10/12: Designated Doctor Examination. Based on all other records as well as the physical examination of the patient, it is my opinion that she sustained on 03/18/11 a cervical sprain and strain, a left hand strain, thoracic sprain and strain, lumbar sprain and strain, and internal derangement of the left shoulder. I note that she had shoulder pain prior to the date of injury, but careful examination of the records from the surgeon indicates that her problem was in the right shoulder predominantly and she was also having some radicular type pain from the cervical spine, which affected indirectly the cervicothoracic junction in both shoulders through there was a primarily problem with the right shoulder and Dr. recommended orthopedic evaluation and a workup in that regard. That was independent of the current injury. On the other hand, the mechanism of her current injury is compatible with a new internal derangement of the left shoulder probably with a rotator cuff injury plus an impingement syndrome superimposed on preexisting degenerative pathology, that is because she fell to the left side and struck her left shoulder directly. This is not a simple strain to the left shoulder

clinically. Otherwise, I agree with the currently accepted compensable injuries. All of this is complicated by the fact that she had chronic pain that preceded the date of injury. A part of the chronic pain was at least related to congenital, anatomic, and structural defects, which were operated on shortly before the injury, so she was reasonably fresh from having a cervical fusion surgery in December of 2010. She also developed a chronic pain syndrome and probably has opiate addiction that complicated everything else.

06/26/12: The claimant was reevaluated. She continued to have pain in the shoulder and decreased range of motion. The crepitus continued to be appreciated. She had symptoms suggestive of a cervical radiculopathy, though her EMG/NCV reported no radiculopathy. She was to be scheduled for an intra-articular cortical steroid injection in the left shoulder.

07/06/12: MRI Left Shoulder report. IMPRESSION: Mild-moderate acromioclavicular joint arthritis. Mild rotator cuff tendinosis. Probable very mild subacromial/subdeltoid bursitis. No visible rotator cuff tear, fracture, or subluxation.

07/19/12: Procedure Report. POSTOPERATIVE DIAGNOSIS: Internal derangement left shoulder. OPERATIVE PROCEDURE: Intra-articular cortisone injection left shoulder.

07/19/12: The claimant was evaluated. Her pain was reported to be 7/10. It was noted that she had a 4 mm bone spur in the acromion noted on MRI and would need orthopedic evaluation.

07/30/12: The claimant was reevaluated who noted that she was seen for evaluation of results of intra-articular cortisone injection in the left shoulder as well as bilateral suboccipital nerve blocks. Her headaches had abated and though she still had some discomfort, this was dramatically better than she had been experiencing some time. The left shoulder injection, however, resulted in no improvement in her left shoulder symptoms. She had mild-moderate acromioclavicular joint arthritis, mild rotator cuff tendinosis, and subacromial/subdeltoid bursitis according to Dr. note. He noted that there had been some notation of an inferior spur formation of the AC joint, which contacted but did not efface the rotator cuff myotendinous junction and this "may be the cause of ongoing inflammatory problems in her shoulder, and until and unless this bone spur is dealt with, she is unlikely to get any significant improvement." She was authorized to take hydrocodone 1 q. 5h. due to increasing pain.

08/23/12: The claimant was evaluated by MD who noted that she had PT and cortisone injection without relief and complained of pain, especially with overhead motion. On examination, left shoulder AROM 0- 100 degrees, PROM 0-120 degrees. She was tender over the subacromion and proximal humerus. She had 3/5 rotator cuff strength and positive impingement. MRI showed no tear, impingement of the left shoulder derangement status post work injury. It was

noted that she had tried and failed conservative treatment. The plan was to perform diagnostic arthroscopy.

09/07/12: The claimant was reevaluated by DO who noted that while waiting for shoulder surgery, he would continue managing her pain medications. He prescribed her Norco 10/325 mg "in an adequate number of pills to take 1 five times per day for a month." She was to continue her Soma at previously prescribed levels.

09/12/12: UR performed. RATIONALE: MRI documents mild-moderate AC arthrosis, mild RC tendinosis, and probable very mild subacromial/deltoid bursitis. No cuff tear. Dr. could not identify who did the reported injection and does not see a procedure note. He will check into this and get the note faxed to Novare if he finds one. I need to know what injection was done and what the response/exam was for the time of the anesthetic especially given mild to minimal findings on the MRI. Procedure note dated 07/19/12 documents intra-articular injection of joint capsule. There is no post-injection exam during time of anesthetic. There is no documentation of response to injection for time of anesthetic. The 07/30/12 followup note documents no improvement of shoulder pain with intra-articular injection. It is not clear what improvement was expected from an intra-articular injection given clinical and MRI. There is no clinical or imaging evidence of glenohumeral osteoarthritis or adhesive capsulitis. Doing and intra-articular as opposed to AC joint or subacromial injection without adequate documentation is not a reason to proceed with a diagnostic arthroscopy. On 09/11/12, I spoke with Dr. We discussed that the procedure does not provide specific useful information. Dr. needs to review the notes and re-examine the patient. I expressed my intent to deny based on the information provided. He expressed understanding.

09/13/12: The claimant was reevaluated by MD for complaint of continued pain, especially with overhead motion. On examination, left shoulder AROM 0-100 degrees, PROM 0-120 degrees. Tender subacromial, tender proximal humerus. 3/5 rotator cuff strength. MRI showed no tear. She was diagnosed with left shoulder derangement. PLAN: Injection with 10 cc of Lido/Cortisone. Arthroscopy if no better.

09/19/12: Ur. RATIONALE: 2011 medical notes document ongoing spinal pain, which is evaluated by electrodiagnostic studies, CT myelogram and the like. Dr. performed a Peer Review on 09/23/11. It is a very accurate and complete summary of medical events today. He concluded no shoulder injury resulted from the 03/18/11 event. Nevertheless, continued care was provided. X-rays were unremarkable. An MRI of the left shoulder performed on 07/06/12 revealed tendinosis/bursitis and chronic changes in the AC joint. Dr. on 05/10/12, evaluated the claimant as a Designated Doctor. He noted the patient fell onto her left shoulder. He concluded extent of injury involving cervical/lumbar spine sprains, a left hand sprain, and internal derangement of the left shoulder. His physical examination is cogent for noting both sides with very restricted shoulder

active range of motion. Passive range of motions were not recorded. He documents a positive Neer/Hawkins test. The submitted request is for diagnostic arthroscopy of the left shoulder. It should be noted, according to Dr. 07/30/12 notations, an intra-articular steroid injection provided no relief. At the same sitting, C2 block provided significant relief of a temporary nature. On 08/23/12, Dr. submits for a left shoulder diagnostic arthroscopy. He documented very poor range of motion active and passive. DC returned my phone call and noted there has been no subacromial injection. We both agreed this would be indicated prior to surgery. Reviewing the notes once again, I could not find an order, attempt, or procedure suggesting she trialed a subacromial injection.

09/27/12: The claimant was reevaluated for followup two weeks post cortisone injection. She stated that the cortisone did not help. She complained of pain, especially with overhead motion. On examination, left shoulder AROM 0-90 degrees, PROM 0-100 degrees, tender subacromial, tender proximal humerus, 3/5 rotator cuff strength. IMPRESSION: Left shoulder derangement s/p work injury. Patient has tried and failed conservative treatment consisting of PT and cortisone injection. She has had over three months of continuous care. Recommend diagnostic scope.

09/27/12: Chart Review/Clarification I saw this patient on 09/27/12 for a followup visit to determine the effectiveness of a subacromial injection for the left shoulder. Her complaints on this day were ongoing pain especially with overhead motion. The patient had the injection performed on 09/13/12 without any relief. Her examination findings were as follows: AROM limited to 100 degrees, PROM limited to 120 degrees, tender subacromial region, tender proximal humerus, rotator cuff strength 3/5 on muscle strength scale. It is my recommendation that this patient have a diagnostic scope as the patient has completed all conservative care to include physical therapy and a subacromial injection without relief. The imaging for this case is ambiguous at best and based upon examination of this patient, she does meet criteria for a diagnostic scope.

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

The previous adverse decisions are upheld. There is no evidence on her MRI of an injury that would be surgically correctable. The only thing on her MRI were degenerative changes of the acromioclavicular joint and tendinosis, both of which were read as mild to moderate. It is not likely that either of these problems were caused by the fall, and it is unlikely that they would be surgically correctable. Therefore the request for 29805 Left Shoulder Diagnostic Arthroscopy is not medically necessary and is non certified.

ODG:

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| Diagnostic arthroscopy | Recommended as indicated below. <b>Criteria</b> for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive |
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|  | <p>and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (<a href="#">Washington, 2002</a>) (<a href="#">de Jager, 2004</a>) (<a href="#">Kaplan, 2004</a>)</p> <p>For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p> |
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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)**