

AccuReview

An Independent Review Organization

569 TM West Parkway

West, TX 76691

Phone (254) 640-1738

Fax (888) 492-8305

Notice of Independent Review Decision

[Date notice sent to all parties]: August 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Appeal Posterior Cervical Decompression via Laminotomies, Foraminotomy and Instrumented Arthrodesis at C4-C5 with 1 day Inpatient Stay

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

The physician is a board certified neurological Surgeon with over 16 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:

11-02-06: MR C-Spine

06-08-09: MRI C-Spine w/o Contrast

08-04-09: Operative Report

01-26-10: Consultants Medical Report

03-23-10: Consultants Medical Report

07-12-10: Operative Report at Hospital

08-25-10: XR Cerv Spine 2-3 Views

09-13-10: Consultants Medical Report

12-06-10: TIC XR Cerv Spine Min 4vws

04-07-11: Patient Evaluation at Evaluation Center

05-12-11: Operative Report at Pain Management

08-10-11: MRI Cervical Spine w/o Contrast

08-18-11: Cardiac Education and Discharge Instruction Program

09-06-11: Office Note
08-21-12: Office Note
09-25-12: Office Visit
10-08-12: MRI Cervical Spine w/o Contrast
10-08-12: TIC XR Cerv Spine min 4vws
10-22-12: Review of c-Spine X-ray & MRI on CD
12-18-12: Office Visit
03-18-13: Office Visit
04-17-13: Procedure Note
04-30-13: Office Visit
05-23-13: UR performed
06-05-13: (MEC) XMYELOCERV – Myelogram Cervical
06-05-13: (TMH) CMYELOC-CT Post Myelogram Cervical
06-18-13: Office Note
06-19-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He was walking through wrappers when the east wrappers struck him in the right shoulder and threw him into a cage.

11-02-06: MR C-Spine/Clark. Impression: 1. Fairly large disc herniation at C3-4 with contrast of the right paraspinal spinal cord. 2. Prominent C4-5 disc bulge with bilateral neural foraminal narrowing.

06-08-09: MRI C-Spine w/o Contrast. Impression: 1. Mild multilevel cervical spondylosis. 2. Multilevel neural foraminal narrowing as above.

08-04-09: Operative Report. Preoperative Diagnosis: Cervical stenosis, spinal cord compression, and herniated disk at C3-C4 and C4-C5. Postoperative Diagnosis: Cervical stenosis, spinal cord compression, and herniated disk at C3-C4 and C4-C5. Procedures: 1. Anterior cervical decompression discectomy with osteophyte resection and decompression of the spinal canal at C3-C4 using intraoperative microscope, CPT code 63075. 2. Anterior cervical decompression discectomy with osteophyte resection and decompression of the spinal cord with intraoperative microscope at C4-C5, CPT code 63076. 3. Arthrodesis, anterior interbody technique at C3-C4, CPT code 22554. 4. Arthrodesis, anterior interbody technique at C4-C5, CPT code 22585. 5. Anterior cervical instrumentation (Medtronic) C3, C4, C5, CPT code 22845. 6. Biomechanical intravertebral spacer application to the interspace at C3-C4, CPT code 22851. 7. Application of biomechanical intervertebral spacer, a separate one, to the inner space at C4-C5, CPT code 22851.

01-26-10: Medical Report. Claimant presented with neck pain radiating through his shoulders, ongoing. Noted in the previous x-ray he did have 1 mm subluxation of the C5, 6 level. The concern is that even though he had surgery of the C3, 4 and C4, 5 level the subjacent levels are somewhat unstable and giving him pain which is localized to the lower cervical spine posteriorly. The claimant is not able

to perform the activities of daily living without a lot of pain medications, and even with the pain medications when the weather changes it becomes intolerable. Decision made with the claimant to request for anterior cervical decompressive discectomy and arthrodesis at the C5, 6 and C6, 7 level with need to remove instrumentation. The stenosis is coming from anterior to the spinal cord rather than posterior.

03-23-10: Medical Report. Claimant continues to have neck pain radiating from the posterior part of his neck and into his right shoulder and infrascapular region, especially when he turns and is involved in increased activities such as lifting. He has spurling sign as well as radicular pain down his C6 distribution. The MRI shows there is instrumentation artifact at C4, 5. However, on the report it does not mention anything about the C5, C6 level. Based on the x-ray one could already infer that there is a problem with osteophytes and stenosis at the C5, 6 level. The actual images of the MRI show for C5, C6 level which is the level adjacent to the previous surgery of C3 to C5 is the worst in terms of osteophytes and stenosis. Indicating this could be a level of increased subjacent stenosis despite the report not mentioning anything about the C5, 6 level on the MRI report but it was mentioned on the x-ray. Recommend fusion surgery at the C5/6 level with instrumentation at this level.

07-12-10: Operative Report. Preoperative Diagnosis: 1. C5-C6 herniated disc. 2. Previous surgery at C3-C4 and C4-C5 with previous instrumentation. Postoperative Diagnosis: C5-C6 herniated disc. 2. Previous surgery at C3-C4 and C4-C5 with previous instrumentation. Procedures: 1. Anterior cervical decompressive discectomy at C5-C6 with resection of osteophytes and decompression of the spinal canal; CPT code 63075. 2. Arthrodesis, anterior interbody technique at C5-6; CPT code 22554. 3. Reinsertion of spinal fixation instrumentation device (removal of the C3, 4, and 5 instrumentation and reinsertion into the C5-C6 level using Medtronic; CPT code 22849. 4. Application and insertion of a biomechanical intervertebral spacer into the interspace at C5-C6, CPT code 22851.

08-25-10: XR Cerv Spine 2-3 Views. Impression: Degenerative disc disease. Cervical muscle spasms. Stable fusions.

09-13-10: Consultants Medical Report. The claimant is noted to have significant stiffness of the neck posteriorly, which is quite common after anterior cervical decompressive discectomy. There is no mal-alignment. Follow up at six months with x-ray. Advised to begin stretching, muscle relaxants for the stiffness that he has posteriorly.

12-06-10: TIC XR Cerv Spine Min 4vws. Impression: 1. Anterior fusion from C3 through C6. 2. No instability on flexion or extension views.

04-07-11: Patient Evaluation. Claimant complained of dull burning neck pain 5/10 with pain medication, aggravated with weather changes to sharp shooting stabbing pain. PE: Revealed claimant was wearing a rigid cervical collar, with

fairly good anterior flexion, but moderately limited hyperextension of the cervical spine. Rotation was mildly limited bilaterally, with motions limited by complaints of pain in the posterior cervical area. There were complaints of tenderness to palpation over the trapezius muscles bilaterally. Impression: 1. Postoperative status three level anterior cervical discectomy and fusion with residual neck pain. No abnormal neurological findings. Recommendations: the claimant has residual cervical pain related to his three-level anterior discectomy, and fusion. He shows evidence of satisfactory appearance of the surgical sites on plain x-rays of his cervical spine. He is at MMI and does have impairments related to this three-level fusion. The claimant has a 25% whole person impairment rating related to her cervical fusion with permanent impairment. He can return to a wide variety of light work activities, but probably cannot exceed this level of work based on today's examination and evaluation.

05-12-11: Operative Report. Diagnosis: 338.4 Chronic pain syndrome, 722.81 Postlaminectomy syndrome of cervical region, 722.0 Cervical disc displacement/herniation, 723.1 Cervical spine pain, 847.0 Neck sprain, 311 Depressive disorder, not elsewhere classified. Preoperative Diagnosis: 722.81 Postlaminectomy syndrome of cervical region, 338.4 Chronic Pain Syndrome. Procedure: Spinal cord stimulator trial.

08-10-11: MRI Cervical Spine w/o Contrast. Conclusion: Slight limitation due to motion, previous anterior discectomy and fusion C5-C6. C4-C5 lateral disc bulging and lateral marginal osteophytes causing mild to moderate left and mild right sided neural foraminal stenosis.

09-06-11: Office Note. Claimant is having pain in both shoulders down the left arm, left side worse than right. He states that the left shoulder and arm pain worsened to the point where he sought medical attention and was worked up to rule out cardiac issues this was determined not to be the cause and thus prompted a new MRI of the cervical spine to be done. He is considering placement of electronic nerve stimulator for potential continued relief. He has been undergoing chronic pain management. The claimant does have adjacent level disc disease at C4/5, which correlates with his cervical radicular symptoms. Claimant would like to continue conservative treatment and is requesting physical therapy with option of last resort to consider decompression of the C4/5 level which does correlate with his symptoms.

08-21-12: Office Note. Claimant presented with worsening left shoulder and arm pain that is now moving to the right shoulder as well with numbness in the fingers on both hands. Review of Systems: Musculoskeletal: complained of arm pain, neck pain and shoulder pain. Neurologic: complained of numbness, paresthesias and radicular pain. Physical/Neurological Examination: Musculoskeletal: muscle strength: decreased strength (of the handgrips left worse than right, paraspinal muscle spasms, spasticity (intermittent "jerking" of arms) and appears to be without any rigidity. Neurologic: sensation overall: paresthesias and sensation is decreased (numbness between fingers right and left fingers). Impression/Plan: Recommend a new MRI due to worsening left shoulder, and arm pain that is

moving to the right side, concerned with pseudoarthrosis at C4-5 and/or adjacent level disease.

09-25-12: Office Visit. Claimant presented with neck and left arm pain and stated with medications is able to perform normal daily activities with current pain 4/10, best in 30 days: 3/10, and worse per last 30 days: 6/10. Current Medications: Lyrica 75mg PO TID, Norco 10/325mg 2 tabs PO Q6HRS, Klonopin 2mg 2 tabs PO QHS, Prestiq 50mg PO QD, ASA 81mg PO QD, Lisinopril 5mg PO QD, Crestor 10mg PO QD. Diagnosis: 722.81 Postlaminectomy syndrome of cervical region, 723.4 Cervical radiculitis/Root compression, 722.0 Cervical disc displacement/herniation, 723.1 Cervical spine pain, 847.0 Neck sprain, 311 Depressive disorder, not elsewhere classified. Plan Notes: 99213 Office visit today, UDS performed for medication compliance. Recommendations: 1. Follow up MRI results, 2. Continue medications, 3. Medication compliance in 3 months, 4. Follow up in 6 months.

10-08-12: MRI Cervical Spine w/o Contrast. Impression: 1. Anterior fusion from C3 through C6, alignment is anatomic. 2. Mild cervical spondylosis at the C4-5 level, mild spinal canal narrowing. There is also moderate bilateral neural foraminal narrowing at C4-5. 3. Mild neural foraminal narrowing on the right at C5-6. 4. MRI of the cervical spine is otherwise negative.

10-08-12: TIC XR Cerv Spine min 4yrs. Impression: 1. Evidence of prior anterior cervical surgery from C3-4 through C5-6, as discussed above. There is at least mild uncovertebral hypertrophy suggested bilaterally at C3-4 through C5-6. 2. No appreciable acute bony abnormality demonstrated in the cervical spine.

10-22-12: Review of c-Spine X-ray & MRI on CD. C4-5: Pseudoarthrosis with bilateral foraminal stenosis facet hypertrophy. Recommend C4-5 posterior decompression via laminectomies foraminotomies and instrumented arthrodesis (posterolateral).

03-18-13: Office Visit. Claimant presented with neck and left upper extremity pain 8/10, best per last 30 days: 3/10 and worst per last 30 days: 8/10. Reflex and Sensory: neurological examination was normal except for the following: Sensory: decreased sensation to pinprick in the C6 dermatome of the bilateral hands. Diagnosis: 722.81 Postlaminectomy syndrome of cervical region, 723.4 Cervical radiculitis/Root compression, 722.0 Cervical disc displacement/herniation, 723.1 Cervical spine pain, 847.0 Neck sprain, 311 Depressive disorder, not elsewhere classified. Plan Notes: UDS performed for medication compliance. Recommendations: 1. Claimant has had a previous right sided SCS treatment with good results, therefore believed a left SCS trial should be tried. 2. Continue current medications. 3. Schedule a three month follow up. 4. Prior SCS trial perform TF-ESI left C3-4. 5. Physical therapy after TF-ESI. 6. Start Lodine 500mg PO BID.

04-17-13: Procedure Note. Procedure: #1 TF-ESI, Left C3-4. Preoperative Diagnosis: HNP, Cervical radiculitis. Postoperative Diagnosis: HNP, Cervical radiculitis.

04-30-13: Office Visit. Claimant reported 100% improvement for one week, and then his improvement decreased to 40-50% improvement, which continues through today. Current pain 7/10, best per last 30 days: 3/10, worst per last 30 days: 8/10. Regional PE: Obvious muscle wasting of the Left Biceps Muscle. Diagnosis: 722.81 Postlaminectomy syndrome of cervical region, 723.4 Cervical radiculitis/Root compression, 722.0 Cervical disc displacement/herniation, 723.1 Cervical spine pain, 847.0 Neck sprain, 311 Depressive disorder, not elsewhere classified. Plan Notes: 99213 Office visit today, UDS performed for medication compliance. Recommendations: 1. Reported atrophy of left biceps, 2. Recommend surgery for his condition, 3. Decadron 4mg PO QID x 2 days, 4. Continue weaning Norco 1 tab PO Q6HR x 7 days, then 1 tab PO8HR x 7 days, then 1 tab PO Q12HR x 7 days, then QD for 7 days, 5. Refer to Applegate for rehab.

05-23-13: UR performed. Reason for denial: Spoke with who stated no recent nerve studies have been completed and there is no recent CT myelogram that may show the need for a fusion. This is a decade-long injury that has undergone multiple cervical fusion surgeries. There have been multiple pain management interventions to include ESI and spinal cord stimulators. The most recent enhanced imaging study as reported by the radiologist did not indicate a pseudoarthrosis. A handwritten note offered by the requesting provider declares there is a pseudoarthrosis. Without specific objectification by a radiologist, there is no clinical indication to proceed with an additional cervical fusion procedure. There is no objectification of instability, infection, or need for additional stabilization that has not already been addressed. Based on the data presented, this procedure is not medically necessary.

06-05-13: (MEC) XMYELOCERV – Myelogram Cervical. Findings: The study is limited due to the instability of the patient maintain proper position during the procedure. There is no high-grade cervical canal stenosis.

06-05-13: (TMH) CMYELOC-CT Post Myelogram Cervical. Impression: Postsurgical changes in the cervical spine as described. No definite evidence of significant cervical canal stenosis or high-grade foraminal narrowing.

06-18-13: Office Note. Physical/Neurological Examination: muscle atrophy of biceps muscle associated with weakness and neck pain. Review of Radiology Reports/Films: After review of the MRI on 10/8/12, especially series 2 image 4-10 which shows foraminal stenosis at C4/5, in combination with s-rays 10/8/12, showing pseudoarthrosis and osteophyte formation at C4/5. Most recent CT myelogram again shows stenosis and incomplete fusion despite anterior interbody graft with osteophyte formation at C4/5. Impression/Plan: Recommend posterior laminotomies and foraminotomies with postero-lateral arthrodesis for treatment of his pseudoarthrosis at C4/5 level. The anterior approach again would require

removal of interbody space which has some boney ingrowth, albeit incompletely, thus causing psuedoarthrodosis as well as osteophyte formation. It is believed this is impinging upon the exiting nerve root, resulting in radiculopathy and muscle atrophy of his biceps muscle associated with neck pain.

06-19-13: UR performed. Reason for denial: The previous determination noted a cervical fusion was completed on July 12, 2010 at C3-C4, C4-C5 and C5-C6. This was reported to be an anterior cervical fusion. There was no evidence of instability on flexion or extension films. Additionally, it was reported that a spinal cord stimulator had been implanted. The October 18, 2012 MRI noted a foraminal narrowing at C5-C6 however no other pathology was noted. It was also noted that the previous reviewer has spoken to the requesting provider who indicated that no recent nerve studies have been completed and there is no recent CT myelogram demonstrating the need for a repeat fusion. There is no determination from the radiologist that would support the need for a new surgery. The physical examination dated June 7, 2013 noted muscle atrophy of the biceps with weakness and neck pain. It is now reported that the most recent CT myelogram shows stenosis and incomplete fusion despite anterior interbody graft with osteophyte formation. A CT myelogram was completed on June 5, 2013. The radiology reports interbody fusion with plate and screws between C5 and C6. There are disc grafts noted at C3-C4, C4-C5 and C5-C6. The surgical hardware and disc grafts are reported to be unremarkable and appear to be incorporated in the bone. Specifically noted was that there is no canal stenosis at C4-C6, C5-C6 and there is minimal translation at C6-C7. The April 17, 2013 pain management note indicates a diagnosis of herniated nucleus pulpous and cervical radiculitis. This led to the spinal cord stimulator trial. The difficulty here is that the radiologist has one reading of the imaging studies and the requesting provider has a different reading of the same studies. The actual films are not presented (nor should they) for review. The standards for a fusion procedure as noted in the ODG note that a posterior fusion is still under study and should be insufficient anterior stabilization. As noted by the radiologist this standard (insufficient anterior stabilization) has not been met. Therefore, based on the clinical data presented for review and noting the standards for a posterior cervical fusion, the request is not certified.

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

The previous adverse decisions are agreed upon and upheld. The claimant has neck and shoulder/left arm pain with biceps atrophy after prior history of C3/4, C4/5 and C5/6 anterior cervical discectomy and fusion in 2010. It is not clear if his biceps atrophy is a new change or a chronic C6 radiculopathy. His radiographic findings are in dispute as the Radiologist doesn't see marked foraminal stenosis at C4/5 or pseudoarthrosis but the Surgeon disagrees. In cases such as this the ODG, allows the use of EMG which would be helpful in this case to see the source of the biceps atrophy. The claimant's exam notes reveal neck pain, shoulder and arm pain with unspecified amount of weakness in biceps/hands and C6 numbness from August 2012 to June 2013. The chronic nature of the patient's complaints and lack of relief from prior extensive surgeries make any further cervical fusion surgery not advisable at this time. The role of instrumentation, if he

were to have laminotomy and foraminotomy at C4/5, is unclear given the lack of motion at C4/5 on prior xrays. This patient also would benefit from a psychological evaluation to confirm adequate treatment of depression. His MRI findings are inconsistent to clearly settle any C4/5 foraminal stenosis questions. His response to the Spinal Cord Stimulator raises the only alternative to a bilateral C4/5 laminotomy/foraminotomy without any fusion if nerve studies show new C5 radiculopathy. Therefore, after review of the medical records and documents provided, the request for Posterior Cervical Decompression via Laminotomies, Foraminotomy and Instrumented Arthrodesis at C4-C5 with 1 day Inpatient Stay is denied.

Per ODG:

Fusion, posterior cervical	<p>Under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. (Callahan, 1977) (Liu, 2001) (Sagan, 2005) Although the addition of instrumentation is thought to add to fusion rate in posterior procedures, a study using strict criteria (including abnormal motion between segments, hardware failure, and radiolucency around the screws) reported a 38% rate of non-union in patients who received laminectomy with fusion compared to a 0% rate in a group receiving laminoplasty. (Heller, 2001) In a study based on 932,009 hospital discharges associated with cervical spine surgery for degenerative disease, complications and mortality were more common after posterior fusions or surgical procedures associated with a primary diagnosis of cervical spondylosis with myelopathy. The overall percent of cases with complications was 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007) Patients undergoing occipitocervical fusion or C1–2 (high cervical region) fusion is an absolute contraindication for returning to any type of activity with a risk of re-injury (such as contact sports), because the C-1 arch is relatively fragile and stability depends on the status of the periodontoid ligaments. (Burnett, 2006) For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).</p>
Decompression	<p>Definition: Decompression is a surgical procedure that is performed to alleviate pain or neurological dysfunction caused by neural impingement. Neurological impingement can result in radiculopathy, specific spinal nerve dysfunction or, when impinging on the cord, myelopathy. In the past decompression was generally performed as a laminectomy through a posterior approach. An anterior approach is now commonly recommended. See Discectomy/laminectomy/laminoplasty; & Decompression, myelopathy. The posterior approach includes the following procedures: (1) Laminectomy or laminotomy; and (2) Laminoplasty, which is a posterior approach that allows for retention of a covering of posterior lamina bone and ligamentum flavum over the spinal cord. It is thought to minimize instability, limit constriction of the dura from extradural scarring, and obviate the need for fusion. See also Fusion, anterior cervical; & Fusion, posterior cervical. (Rao, 2006)</p> <p>When decompression is used as a general term, see also Traction.</p>
Discectomy-laminectomy-laminoplasty	<p><u>ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):</u> Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement): A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive</p>

	<p>Spurling test.</p> <p>B. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. <i>Note:</i> Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG.</p> <p>C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.</p> <p>D. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.</p> <p>E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.</p> <p>For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).</p>
--	---

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)**