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DATE OF REVIEW: 10/10/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthroscopy

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

M.D. Board Certified in Orthopedic surgery

REVIEW OUTCOME

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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

Table of Disputed Services
Denial letters 9/4/07, 8/15/07, Mgmt Services
MRI reports lumbar spine 7/10/07, left knee 7/11/07
Report 8/9/0, Dr.
Medical reports, 8/8/07, 8/15/07, Dr.
Report 7/10/07
ER record 5/15/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who twisted her left foot and fell, landing on the lower back, buttocks and thigh. She experienced pain in the lower back and was treated. She continued with pain in the left knee. She reports minimal symptoms, and denies any

locking or catching. She can bear full weight on the knee and has occasional swelling. An MRI of the knee shows diffuse degenerative changes, and a medial meniscus tear.

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

I agree with the benefit company's decision to deny the requested procedure. ODG guidelines do not support the request for knee arthroscopy. The patient does not have mechanical symptoms, such as locking or catching. Also, her pain is not concordant with the meniscal tear. Finally, she has severe and diffuse osteoarthritic changes. Peer reviewed literature has demonstrated poor results from outpatient arthroscopy in this patient population.

This opinion does not diverge from ODG guidelines.

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 JUDGMENT, 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)