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Notice of Independent Review Decision

DATE OF REVIEW: 8/25/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroplasty, knee, condyle and plateau, medial or lateral compartment

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

Upheld (Agree)

X 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

Adverse Determination Letters – 7/11/08, 7/18/08
FCE reports 9/7/07, 2/13/08
Report MRI left knee with contrast , lumbar spine w/o contrast 11/29/06
CMT/ROM report 3/25/08
Operative reports 1/24/07, 10/30/07
Letters 4/2/07, 1/22/08 Dr.
Reports 206-2008, Dr.

Reports 8/11/08, 11/9/07, 9/6/06, 7/25/07, 6/8/07, 5/11/07, 4/9/07,
3/5/0712/20/06, 10/30/06 Dr.
DDE 9/14/07, Dr.
ER record

ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who suffered a knee injury resulting in multiple attempts at arthroscopic management . Significant osteoarthritic and chondral damage was noted on the medial compartment with joint space narrowing. The patient had no lateral symptoms and some chondromalacia of the patellofemoral joint. The patient failed conservative treatment, including multiple arthroscopic and steroid and joint fluid treatments.

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

I disagree with the benefit company's decision to deny the requested surgery. He denials were based on the patient's young age and the patient having patellofemoral disease as contraindications to surgery. The records indicate that the vast majority of the patient's symptoms are medial, and the patella femoral changes are not significant enough to act as a contraindication. The patient's age is not a contraindication, but rather a risk. The requested surgery is medically necessary and meets ODG guidelines as well as standards for orthopedic care.

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)