Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

DATE OF REVIEW: 4/24/09

IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Total knee replacement left knee

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)

Description of review outcome for each healthcare service in dispute

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient suffered an injury of the left knee and was found to have degenerative changes in the medial meniscal pathology. She underwent arthroscopic evaluation after failing conservative management on xx-xx-xx. She continued to have persistent effusions and knee pain, and was treated conservatively with anti inflammatory medications, rest, Synvisc injections. She continued with debilitating symptoms and a total knee arthoplasty has been recommended. Reasons for denying the request include the fact that the patient had full range of motion in the knee, and there was a request for Stryker navigational equipment.

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

I disagree with the denial of the proposed operative procedure. The patient has recalcitrant pain that has failed adequate conservative measures, patient's with moderate osteoarthritis may still have good range of motion, and this should not be an exclusion criterion for total knee arthroplasty. The most recent request does not include a request for Stryker navigational equipment, therefore, based on the records provided for this review, the requested surgery is medically reasonable and necessary.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**