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IRO Certificate #4599

DATE OF REVIEW: 6/23/09

IRO CASE #:

Description of the Service or Services In Dispute
Right knee arthroscopy and partial medial meniscectomy

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

Physician 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 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

determination letters, 5/22/09, request 4/29/09
Clinical notes, 4/27/09, Dr.
PT records undated, Health & Rehab
RME 5/1/09, Evaluation Center
MRI right knee 3/5/09
MRI lumbar spine 2/28/09

ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient injured her right knee and lumbar spine. She is obese and has difficulty squatting and going up and down stairs. An MRI showed a posterior medial meniscal tear. There is no evidence of osteoarthritis noted on the MRI.

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

I disagree with the denial of the requested services. The denial was based on studies that show that some patients have asymptomatic meniscal tears, particularly in those with degenerative disk joint disease, and the patient's obesity. The patient does not have degenerative joint disease noted on the MRI, and the patient is not asymptomatic – she is very symptomatic with medial joint line tenderness, inability to squat, and has joint

pain. Locking or catching are not an absolute necessity for arthroscopic evaluation and treatment of the knee. This patient has an internal injury that requires arthroscopic management. The DDE did not put the patient at MMI because of the upcoming knee surgery which the designated doctor did not disagree with.

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)**