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Notice of Independent Review Decision

DATE OF REVIEW: 10/6/09

IRO CASE #:

Description of the Service or Services In Dispute
left knee revision Oxford to total knee replacement

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:

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

Adverse determination letters, 9/11/09, 8/14/09, 8/12/09, 7/28/09, 7/27/09
Clinical notes, Dr. 1/08 – 7/09
X-ray reports of the knee 5/16/07, 12/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has apparently had revision unicondyle to total knee arthroplasty. The patient is almost xxxx years out from this procedure and continues to have knee pain, mainly on the lateral joint line, which was the un-operated side. A review of the medical records shows that the patient has had extensive conservative care, including multiple steroid injections, with only temporary relief of symptoms. As of the last clinical note provided, the patient had ROM of 0-130 degrees, mild lateral crepitus on the lateral aspect of the joint, with no quadriceps atrophy. Knee x-rays show that the implants were in good condition, with no distinct abnormalities.

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

I agree with the denial of the requested services. The operating surgeon does not document any abnormalities on the lateral joint line to support the need for conversion to a total knee arthroplasty. In addition, the records do not indicate consideration or discussion of joint fluid therapy to see if that would help reduce the symptoms. The patient has had multiple steroid injections, and although conservative care has been attempted, it is not completely or adequately documented. There is inadequate documentation to support the medical necessity of the requested total knee arthroplasty.

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)**