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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: 12/16/09

IRO CASE #:

Description of the Service or Services In Dispute
Inpatient right knee unicompartmental arthroplasty

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

Adverse determination letters, 11/2/09, 10/22/09
Letter 9/25/09, Dr.
Clinical notes 2009 Dr.
PT Notes District 2009
PT evaluation 5/7/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his right knee in xx/xx. He stepped onto a large rock when getting out of a truck and twisted his knee, falling to the ground. He suffered a bucket handled tear to his medial meniscus with a large amount of joint effusion, osteonecrosis of the medial tibial condyle, and choondromalacia. He underwent arthroscopic knee surgery on 4/24/09 with a partial medial meniscectomy, tricompartmental chondroplasty, and syovectomy, as well as medial and suprapatellar plica excision. Post-operatively he did not do that well, with continued pain, swelling and stiffness in the knee, despite cortisone injections and physical therapy and viscosupplementation. The most recent evaluation showed an antalic gait, varus alignment, minimal effusion and medial joint line tenderness. X-rays show arthritic changes with joint space narrowing in the medial compartment. No instability was noted.

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

I disagree with the decision to deny the requested services. The services were denial based on ODG guidelines, with the reviewer noted that the surgery was clinically necessary. THE ODG guidelines are guidelines, not strict rules. Although the patient has a high BMI and is under age 50, clinically he has completed all conservative treatments, is still symptomatic and desires potential relief from this procedure. Therefore, the requested services are medically reasonable and necessary.

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)