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Notice of Independent Review Decision

DATE OF REVIEW: 3/17/10

IRO CASE #:

Description of the Service or Services In Dispute
Right Knee Arthroscopy Posterior Cruciate Ligament Reconstruction & subsequent post op functional bracing, continuous passive motion machine, hinged brace, and physical therapy.

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:

X Upheld	(Agree)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, 1/7/10, 1/6/10, 12/17/09
Letter medical necessity, Dr.
Clinical and PT notes, 8/09 – 2/10 and Knee Center
MRI 6/29/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient slipped and fell on the right knee in xx/xx. Treatment records from the original injury were not provided until the patient presented to her current treating physician on xx/xx/xx. The treating physician described the knee as swollen and painful with some loss of motion. The treating physician stated that the patient had some physical therapy. In one examination a 1+ posterior draw was noted. The treating physician stated that there continued to be some pain and lack of full motion.

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

I agree with the decision to deny the requested services. The MRI of 6/25/09 describes an attenuation of the posterior cruciate ligament, but not a complete tear. It also describes a Grade II signal in the posterior horn of the meniscus. There are described Grade III to IV chondromalacia patella with effusion. Also described was tri-compartmental degenerative joint disease with focal spur projecting into the articular weight bearing cartilage of the medial femoral condyle.

A posterior reconstruction is a major operation, and results are not always predictable. The records do not indicate that the patient has significant instability, nor significant findings of

posterior cruciate instability on examination. Degenerative changes are present, which might limit the results of ligament reconstruction, even if it were necessary. Therefore, the requested services are not medically 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)