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*Notice of Independent Review Decision*

**DATE OF REVIEW:** 4/14/10

**IRO CASE #:**

Description of the Service or Services In Dispute  
Right 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:

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, 2/10/10, 2/3/10  
Progress notes, Dr. 2008-2010  
MRI of the right knee report 5/28/08  
Imaging report 9/22/08  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured in xx/xxxx when she twisted her knee while walking up stairs. The patient had a history of right knee arthroscopy with lateral meniscectomy partial medial anterior horn, medial meniscectomy, synovectomy and chondroplasty. The patient has been treated with medications, extensive physical therapy and multiple injections. MRI report shows Grade IV chondral changes along with effusion and meniscal lesions. The patient continues with pain, swelling, and limited function, and has not responded to surgery or conservative treatment. The patient is overweight, and has lost a small amount of weight.

**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 patient has had a lesser procedure, extensive physical therapy, multiple injections and anti-inflammatories. The patient apparently continues with significant pain and inability to function. While the patient is overweight, this is not a contraindication for total knee arthroplasty. There are no other good options, and with Grade IV changes present, the patient should respond well to the proposed procedure.

**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)