

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145

Notice of Independent Review Decision

DATE OF REVIEW: 9/14/10

IRO CASE #:

Description of the Service or Services In Dispute
Total right 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)
<input checked="" type="checkbox"/> 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, 8/6/10, 7/14/10
Reconsideration request 7/20/10
DDE report 3/8/10, Dr.
FCE report 3/8/10
Clinical notes, 1/2010 - 7/2010 Dr.
Notes 2006 - 3/2010 Orthopedics, Sports & Spine
MRI report right knee w/o contrast 1/30/09, 8/9/06
MMI assessment 12/11/06, Dr.
Operative reports 3/26/09, 9/5/06
ODG guidelines

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male who in xx/xxxx injured his right knee. This case is confusing because of multiple treating physicians and injuries. The records provided indicate that the patient was injured secondary to a fall at work in xxxx, and subsequently underwent knee arthroscopy. He had a second injury, and also underwent knee arthroscopy, and again underwent arthroscopy after the injury, consisting of a lateral meniscectomy and debridement of some arthritis. After that injury, there is mention of a subsequent injury on x/x/xx, resulting in shoulder surgery.

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 proposed surgery as not medically necessary. Although x-rays were not provided for this review, it appears that the patient has osteoarthritis of the knee. It is unclear how much of the osteoarthritis was exacerbated by injury. Despite the limited information provided, and the uncertain relationship between the work injury and the patient's current condition, it appears that the proposed surgery is medically necessary, based on

physicians' descriptions of significant arthritic findings, and significant pain that has not been alleviated by conservative care.

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)