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IRO Certificate #4599

**Notice of Independent Review Decision**

**DATE OF REVIEW: 11/7/11**

**IRO CASE #**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Repeat MRI, Any lower extremity, (per denial letter: CPT code 73721)  
Requested: Repeat MRI of left knee.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Physician Board Certified in Physical Medicine and Rehabilitation

**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 letter, Org, 10/5/11  
Request fax, 9/8/11  
Letter dated 8-5-11, Health Centers, along with the history and physical forms, treatment plan, and X-ray report.  
Alivio letter of 7/21/11 by Dr.  
ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Summary of events: patient is a male injured xx/xx/xx causing left medial meniscus tear. Patient underwent left knee arthroscopy surgery eventually April 2006. He nevertheless has had some significant residual pain syndrome in the knee. He was examined 8-5-11, with symptomatology of locking, catching, pains in the knee. And also was found to have a positive McMurray's (meniscus) sign.

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

I disagree with the benefit company's decision to deny the requested services. The patient had locking and catching symptoms which are more compatible with a meniscus abnormality versus degenerative joint disorder only. Also the positive McMurray sign for meniscus problem is not generally a finding with DJD only.

ODD guidelines do state "repeat MRIs are recommended if needed to assess knee cartilage/repair tissue", etc.

**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)**