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Notice of Independent Review Decision

DATE OF REVIEW: 10/09/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One Right Knee Arthroscopic Lateral Release, Debridement, and Medical Meniscectomy. Outpatient.
CPT: 29873, 29877, 29881

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) <u>X</u>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The patient sustained an injury in xx/xxxx while at work and was reported as twisting or possibly falling. Upon physical examination of the right knee, reports indicate there was tenderness at the medial joint line, effusion and positive McMurray's. An MRI done on 6/10/14 and read by radiologist revealed a degenerative linear tear but no frank tear of the medial meniscus. There were some minor degenerative changes of the patellofemoral and medial compartment.

It was reported that a cortisone injection had been done previously, patient had also been on NSAID's, and had physical therapy although that is somewhat confusing as there were only two documented physical therapy sessions (7/07/14 & 7/22/14). Apparently, patient continues to be uncomfortable.

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

Opinion: I agree with the benefit company's decision to deny the requested service(s).

Rationale:

The only findings of patella disease are on MRI with mild degenerative changes. There is no report of 'tilt' subluxation, etc. As far as the meniscectomy goes, apparently the changes were thought to be degenerative. It's always possible that there's a full thickness tear that is not apparent by radiology and further examination would be of benefit.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)