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**Notice of Independent Review Decision**

DATE OF REVIEW: 8/14/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Knee Arthroscopy with OATS (Osteochondral Autograft Transfer System) Procedure and Lateral Release; Outpatient; CPT: 69866, 29873

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

Physician Board Certified Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

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

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

Patient reportedly sustained an injury in xx/xxxx when her knees gave way. She had bi-lateral knee pain and, as best I can tell, this particular case refers to her left knee. Patient's course of treatment consisted of evaluation and eventually surgery. At the time of surgery ( 5/17/13) it was noted that with arthroscopy of the left knee she had a chondral lesion to the medial femoral chondyle which was debrided. There were no meniscal injuries or substantial other arthritic changes other than some chondromalacia of the patella. The ACL was intact.

By the patient's history, apparently she was worse after that surgery. She had an extensive amount of conservative care including steroid injections, visco supplementation, physical therapy, NSAIDs, and pain medication. Patient apparently felt it was too painful to return to work. She was seen by several physicians in evaluation period and MMI completed.

The current request is for OATS (Osteochondral Autograft Transfer System) procedure with osteochondral grafting and lateral release.

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 services. **Rationale:** As I interpret the guidelines for an osteochondral transplantation to be done, there must have been drilling or microfracture. While this requirement is debatable, under these guidelines, this case does not fit the criteria.

**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)