Envoy Medical Systems, LP
1726 Cricket Hollow Drive
Austin, TX 78758

PH: (512) 705-4647
FAX: (512) 491-5145
IRO Certificate #XX

DATE OF REVIEW: 04/12/19

IRO CASE NO. XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX XX XX repair or reconstruction, possible XX for XX XX, CPT: XX, XX

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)

PATIENT CLINICAL HISTORY SUMMARY
XX. XX is a XX year old XX who sustained a work injury XX XX when XX XX XX XX XX and had immediate onset of pain, DOI XX, XX. Patient was seen by XX. XX-XX at XX XX, x-rays were negative for fracture or dislocation (XX). Incidental finding of significant XX changes of the XX XX. XX was diagnosed with a XX XX XX sprain, posterior XX ligament sprain, XX XX, and derangement of the XX. XX was started on XX therapy and prescribed over the counter medication and was placed on restrictive duty. An MRI of the XX XX was ordered.

MRI of the XX XX was performed XX showing chronic/XX XX versus prior partial XX involving the medial XX and small XX XX of the undersurface XX XX anterior XX, partial XX of the XX XX XX without XX, anterior XX XX XX with intact XX ligaments, advanced medial compartment XX with extensive full-thickness XX loss and moderate XX XX/reactive XX signal changes, moderate XX compartment XX with full-thickness XX XX loss, moderate XX, non-aggressive XX lesion of the XX XX XX.

PATIENT CLINICAL HISTORY SUMMARY (continued)
Patient saw XX. XX XX with complaints of XX XX pain. Noted in history was previous XX XX medial XX procedure (XX) and previous XX XX XX procedure. XX diagnosis at that time was XX XX pain with XX XX and lateral XX XX and underlying primary XX of the XX XX. XX was treated with a XX XX intra-articular XX injection. At that time, XX. XX recommended XX XX total XX.

Patient again saw XX. XX XX, reporting XX injection did not really help. XX continued with XX therapy and took XX for pain. XX. XX recommended an XX XX and also continuing with XX therapy. They also discussed arthroscopy of the XX XX.

Patient saw XX. XX again XX with continued XX XX pain. It was recommended XX have XX XX arthroscopy with partial XX XX and possible XX reconstruction. The note **does** state that the patient wishes to undergo XX and not total XX.

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) of XX XX arthroscopy XX reconstruction with possible XX.

Rationale: In my opinion, XX reconstruction for this patient is not medically necessary due to XX advanced XX.

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)