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IRO Certificate #

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X

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

X

REVIEW OUTCOME

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

| | |
|---------------------|----------------------------------|
| Upheld | (Agree) X |
| Overtured | (Disagree) |
| Partially Overtured | (Agree in part/Disagree in part) |

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

This is a X who sustained injuries to the neck, back, and right knee after a MVA in X when X was a restrained driver who was rear ended. Airbags were not deployed. X was transported to the ER via ambulance and had CT of the cervical spine. X did physical therapy. X had cervical, lumbar, and right knee MRI on X. MRI of the right knee on X showed ACL low grade sprain without evidence of tear, status post proximal tibial internal fixation, and mild suprapatellar joint effusion. Patient underwent a right knee diagnostic arthroscopy on X. Initial denial due to no condition specified after right knee diagnostic arthroscopy such as articular cartilage defect repair or meniscus repair. ODG recommend use of knee brace based on specific clinical indications. Prefabricated knee braces are considered suitable for conditions such as instability and various post surgical rehab needs. Custom fabricated knee braces were advised for patients with significant limb contour abnormalities or skin issues. Functional knee braces were not recommended for post primary ACL reconstruction or patellofemoral pain syndrome. X is not supported by high-level evidence and post operative use is supported for 7 days per ODG. DVT prophylaxis is recommended for patients at higher risk of developing DVT including LMWH and medications as well as perioperative (hospital only) leg compression devices. Request for X was certified but then not certified due to inability to communicate with treating physician.

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

Opinion: I AGREE with the benefit company's decision to deny the requested service.

Rationale: This review pertains to the need for X after diagnostic right knee arthroscopy on X for a patient

with chronic knee pain S/P MVA in X with MRI not showing any significant ligamentous injury. The operative note was not available for review to see exactly what was found or done during the procedure. No documentation on factors making patient high risk for DVT's. At this point, 2 months after the surgery none of the above DMEs should be needed. The request(s) for the following **are not medically necessary in this case:**

X

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

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

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