

May 18, 2005

VIA FACSIMILE
Dallas ISD
Attn: Lou Ann DeArment

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0528-01
TWCC #:
Injured Employee:
Requestor:
Respondent: Dallas ISD
MAXIMUS Case #: TW04-0529

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurology and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The patient reported that while at work she injured her right knee. Treatment for this patient's condition has included physical therapy and medications. The purchase of a BIO 1000 has been recommended for continued treatment of this patient's condition.

Requested Services

Purchase of a BIO 1000 cartilage stimulator.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Information on the BIO 1000
2. Office Notes 9/16/04, 10/21/04

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to her right knee on _____. The MAXIMUS physician reviewer also noted that the patient has been treated with physical therapy, medications and the use of a BIO 1000. The MAXIMUS physician reviewer further noted that the purchase of the BIO 1000 has been recommended for continued treatment of this patient's condition. The MAXIMUS physician reviewer indicated that the BIO 100 is being prescribed for the treatment of osteoarthritic pain and effusion of the knee. The MAXIMUS physician reviewer noted that the BIO 1000 is an electrical stimulator "designed to replace the bodies natural electrical field", and designed to prevent the need for therapy by regaining cartilage. The MAXIMUS physician reviewer explained that there is no data supporting the long term benefit of the use of a BIO 1000 for the treatment of this patient's diagnoses. Therefore, the MAXIMUS physician consultant concluded that the requested purchase of the BIO 1000 is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744

Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

MAXIMUS

Elizabeth McDonald
State Appeals Department

cc: Texas Workers Compensation Commission

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of May 2005.

Signature of IRO Employee: _____
External Appeals Department