

March 23, 2005

Bionicare Medical Technologies
Attn: Kim
3060 Ogden Avenue, Suite 100
Lisle, IL 60532

VIA FACSIMILE
United Pacific Ins.
C/O TPCIGA
Attn: Daniel Flores

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0678-01
TWCC #:
Injured Employee:
Requestor: Bionicare Medical Technologies
Respondent: TPCIGA for United Pacific Ins.
MAXIMUS Case #: TW05-0017

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 orthopedic surgery 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 male who sustained a work related injury on _____. The patient reported that while at work he injured his left knee. Treatment for this patient's condition has included physical therapy, medications, knee surgery and the use of a bio 1000. The current diagnosis for this patient is localized secondary osteoarthritis. The purchase of the bio 1000 has been recommended for further treatment of this patient's condition.

Requested Services

Purchase of a bio 1000 for use on left knee.

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

Documents Submitted by Requestor:

1. Established Patient Report 6/11/04, 7/7/04, 8/20/04, 9/10/04
2. Bionicare BIO 1000 Prescription 7/9/04

Documents Submitted by Respondent:

1. Notice of Reconsideration 12/15/04

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 male who sustained a work related injury to his left knee on _____. The MAXIMUS physician reviewer also noted that treatment for this patient's condition has included physical therapy, medications, knee surgery and the use of a BIO 1000. The MAXIMUS physician reviewer further noted that the current diagnosis for this patient includes localized secondary osteoarthritis and that the purchase of a BIO 1000 has been recommended for further treatment of this patient's condition. The MAXIMUS physician reviewer indicated that the BIO 1000 has not been proven efficacious in the treatment of this patient's condition. The MAXIMUS physician reviewer explained that there is no data supporting the use of the BIO 1000 device for the treatment of this patient's condition. 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 23rd day of March 2005.

Signature of IRO Employee: _____
External Appeals Department