



# Texas Medical Foundation

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## NOTICE OF INDEPENDENT REVIEW DECISION

February 23, 2005

### Requestor

Bionicare Med Technologies, Inc  
ATTN: Kim  
3060 Ogden Ave., Ste 100  
Lisle, IL 60532

### Respondent

American Home Assurance Co. c/o ARCFMI  
ATTN: Raina Sims  
P.O. Box 115114  
Carrollton, TX 75011-5114

RE: Injured Worker:  
MDR Tracking #: M2-05-0694-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery, Inc. licensed by the Texas State Board of Medical Examiners (TSBME) in 1978, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 45 year-old male injured his left knee on \_\_\_ while driving a forklift that ran into a deck. He has been treated with medications, therapy, epidural steroid injection and surgery.

### Requested Service(s)

Proposed purchase of a bio-1000 system

### Decision

It is determined that there is no medical necessity for the proposed purchase of a bio-1000 system to treat this patient's medical condition.

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Rationale/Basis for Decision

Medical record documentation indicates this patient has received extensive treatment for his injury to his left knee that occurred more than 2 ½ years ago. Current sports medicine literature indicates the use of a transcutaneous electrical nerve stimulation (TENS) unit only in the acute phase of an injury. He is no longer in the acute phase of his injury. Therefore, the proposed purchase of a BIO-1000 cartilage stimulator is not medically necessary to treat this patient's medical condition.

This decision by the IRO 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,



Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment

cc: \_\_\_\_\_, Injured Worker  
\_\_\_\_\_, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), 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 23<sup>rd</sup> day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Attachment**

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M2-05-0694-01**

**Information Submitted by Requestor:**

- Letter of Medical Necessity
- Progress Notes
- Durable Medical Equipment
- Claims

**Information Submitted by Respondent:**

- Progress Notes
- History and Physical
- Procedure Notes
- Diagnostic Tests
- Lab
- Physical Therapy Notes
- Orthopedic Notes
- Review Determination
- Court Documents