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NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 31, 2005

Requester/ Respondent Address:

TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

Bionicare Medical Technologies
Attn: Kim Safka
Fax: 888-900-7354
Phone: 888-999-2361

University of Texas System
Attn: Louise Reinhardt
Fax: 512-499-4367
Phone: 512-499-4663

RE: Injured Worker:

MDR Tracking #: M2-05-0856-01

IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 an orthopedic surgery reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Medical documents from Azaler Orthopedic and Sports Medicine Clinic
- Operative report dated 10/4/04 from Ambulatory Surgery Center of Tyler

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- Bio 1000 prescription dated 11/8/04
- Letter of medical necessity dated 12/10/04 from Kim Safka, Authorization Coordinator of Bionicare

Submitted by Respondent:

- Medical documents from Azaler Orthopedic and Sports Medicine Clinic
- Operative report dated 10/4/04 from Ambulatory Surgery Center of Tyler
- Designated Doctor Exam report dated 4/16/03 by Dr. E. Hugh Heck
- Required Medical Exam report dated 3/28/03 by Dr. G. Peter Foox
- MMI and impairment rating dated 1/18/02 from Azaler Orthopedic and Sports Medicine Clinic

Clinical History

The claimant has a history of chronic knee pain allegedly related to a compensable injury on _____. The claimant allegedly had onset of knee pain walking up a hill while employed at UT Health Center. The claimant underwent arthroscopic chondroplasty of the patella on 2/4/04. One month later the claimant had persistent complaints of knee pain and was prescribed a Bionicare DME.

Requested Service(s)

Purchase of Bio-1000 system.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally following arthroscopic surgery of the knee a patient is treated with usual and customary conservative measures of treatment during the postoperative period to regain strength and range of motion. These measures include, but are not limited to, oral non-steroidal anti-inflammatory medications, injections, bracing and physical therapy. Specifically pertaining to patellar chondroplasty, a vigorous quad rehab program is initiated. This is complemented by physical therapy and bracing. Meticulous attention to return of quad strength is generally documented including muscle circumference above the kneecap. Upon review of all information sent with the IRO request, there is no documentation of exhaustion of usual and customary postoperative measures of conservative treatment to manage the claimant's postoperative condition. Notwithstanding a lack of documentation of exhaustion of usual and customary

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measures of postoperative treatment, the requested DME does not have substantial support in peer reviewed literature, using scientific, evidence-based studies (randomized, controlled, double-blinded). There is no clearly documented clinical rationale to support the use of the requested DME in this clinical setting.

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 a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
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 other party involved in this dispute.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder