



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

May 2, 2005

Requestor

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

Respondent

Zurich American Insurance Company
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
Fax#: (512) 867-1733

RE: Injured Worker:
MDR Tracking #: M2-05-1028-01
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 22 year-old male injured his right knee on ___ when his foot was wedged between 2 boards on a platform and he turned his body and twisted his knee. He has been treated with medications and therapy.

Requested Service(s)

Purchase of Bionicare Bio-1000 system

Decision

It is determined that there is no medical necessity for the purchase of Bionicare Bio-1000 system.

Rationale/Basis for Decision

The medical record does not provide sufficient documentation to substantiate the purchase of a Bionicare Bio-1000 system. Based on the information provided, the patient underwent an arthroscopy in May 2004. However, the operative report and imaging study reports, such as an MRI or CT scan, were not provided for review. The Bionicare Bio-1000 system requested has limited proven efficacy. TENS units have been shown effective in the acute post-operative period as an adjunct to pain management and galvanic stimulation has been shown effective for muscle rehabilitation and preservation in circumstances of neural injury. Therefore, the Bio-1000 system requested is not medically necessary to treat this patient's 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:vn

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 2nd May day of 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: