

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1460-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	Bionicare
Name of Physician: (Treating or Requesting)	James Harris, MD

May 10, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Bionicare
James Harris, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

The records indicate that this individual underwent subtotal medial meniscectomy and chondroplasty of the medial femoral condyle. At that time, she was a 49-year-old female with DJD of the knee involving her right knee and medial compartment disease. In a letter dated February 2, 2005, he indicates that Ms. ___ was managed for posttraumatic degenerative changes in her right knee following on-the-job injury of ___. She has undergone surgical and conservative treatment and remains symptomatic.

REQUESTED SERVICE(S)

Purchase of Bio-1000 BioniCare pulse electronic stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

BioniCare is a device approved by the FDA as an adjunct for controlling pain. It is a very expensive device costing \$4400 or more, and it is felt to be indicated to reduce the possibility of total knee replacement and has some effect to that end. Most devices of that price range are made available to Worker's Compensation patient on a rental basis for a month to determine the effectiveness before purchase. It would be reasonable and medically prudent as is with other medical devices provided to Worker's Compensation participants in the State of Texas to provide a rental of this device for a period of 1-3 months and if proven effective then there would be clinical evidence to indicate its appropriate use in this particular patient. To buy a device on the possibility that it might work especially the device of such great magnitude is medically inappropriate. Given the fact that the device is ineffective, the patient will in fact go onto total knee replacement. It would be best to reserve the use of those funds for the cost of total knee replacement.

This decision was based on the typical standards of treatment with electrical stimulator devices in the State of Texas currently utilized under Worker's Compensation.

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 (20 Tex. Admin. Code 142.5©).

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 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a 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

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the 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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 12th day of May 2005.

Signature of IRO Employee: _____
Printed Name of IRO Employee: Cindy Mitchell