

July 16, 2003

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TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
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MDR Tracking #: M2-03-1327-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurology. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ was a 49-year-old gentleman who worked for the town of ___ as a city vehicle maintenance foreman and voluntary fire department chief. In the latter part of ___ he had been involved in putting out two separate fires one month apart and it was determined from his history that he inhaled a significant amount of smoke and then started to feel quite ill.

His wife stated in the history that she was aware that he was having headaches, numbness and tingling the day following the fire. He started to get confused, he lost his direction and could not remember how to drive to his son's school. The confusion continued to progressively get worse. Much of this information was obtained from the medical records and from ___, a physical medicine and rehabilitation physician who had evaluated ___ on June 26, 2001. Around December of 1996 he started to have numbness, tingling and weakness in his left leg along with slurred speech. He was hospitalized in ___ and found to have abnormal spinal fluid with high lymphocyte count and a gradual progressive dementia.

They did a cerebral arteriogram at that time, an MRI of the brain that showed low-density areas on the right anterior limb of the internal capsule but had a normal cerebral angiogram at that time. He was then sent to the ___ for further opinion and evaluation. His evaluation there showed him to have mild anemia. The physical examination at that hospital showed him to be cognitively impaired with poor memory, non-insight, poor judgment, poor calculations but normal speech. His thought processes were inappropriate. An MRI of the brain was evaluated from the outside hospital, and it showed some abnormal lesions in the region of the putamen and both anterior limbs of the internal capsule.

He turned out to have eighteen white cells in the spinal fluid, all lymphocytes. A repeat cerebral angiogram showed vasculitis and he was started on Cytoxan and Coumadin. He was discharged in January of 1997 on Coumadin and Cytoxan. Neuropsychological testing at that time showed the patient to have significant cognitive impairment with frontal lobe abnormalities, memory disturbance and a disturbance in executive function. It was recommended that he have repeat psychological testing in three to six months and a repeat MRI. In a letter dated November 17, 1998 by ___ confirmed that the patient had cerebral vasculitis. The repeat neuropsychological testing in 1998 showed minimal improvement, and also showed marked frontal dysfunction and an inability for the patient to return to work and function independently. An MRI from ___ on September 8, 1998 showed no changes in the MRI as compared to 1997. There are medical records from February 20, 2001 from ___ who gave him an impairment rating based on disturbance of complex integrated cerebral function at a Class II level, giving him a 25% percent impairment rating. Because of the ongoing cognitive problems, behavioral and personality changes and frontal lobe abnormality, he was admitted to the ___ on January 20, 2003. He was recommended a sixty- to ninety-day rehabilitation program to try to improve his behavior, cognitive disturbance and overall function, and to try to improve his ability to enter into the community with the least deficits as possible. On October 7, 2002 he underwent a neurocognitive evaluation, which is recommended residential treatment, and intense neuropsychiatric intervention for his behavioral and cognitive problems. This is what led him to being admitted to the ___ on January 20, 2003.

In review of the detailed discharge summary from the ___ by ___, the program director, the following information is noted: During the admission, the patient was motivated and cooperative; he made significant gains in improving hygiene, daily functioning and controlling social behavior. He was given Depo-Provera injections for his sexual disinhibition. Certain goals for treatment were established in this facility. One of the goals was to establish a regular sleep pattern with routine wake and sleep hours. This goal was met on February 10, 2003. One of the plans was to monitor sleep pattern and report to the medical team and possibly consider a sleeping agent. This plan was met on February 10, 2003. Another plan was to evaluate his sexual dysfunction with a goal to try to improve it. This goal was partially met on March 20, 2003. The Depo-Provera given to him during his hospital stay tended to decrease his libido and in turn affect his sexual disinhibition. Another goal was to improve his emotional ability, and this was met in March of 2003.

Also, it was determined to observe this gentleman for depression and mood disorder. This goal was partially met on March 20, 2003. There was also a challenge to the patient to demonstrate acquired skills by participation in outings to various community centers and redirect behaviors as necessary. This goal was partially met on March 20, 2003. There was a significant amount of progress noted in ___ condition. His hygiene improved significantly by the time of discharge. He became to be much more independent where he could bathe without cues and wore clean clothes, which he apparently laundered himself. It was recommended after meeting with his wife at the time of discharge that he was to consider some kind of part-time work volunteering. She had told the physicians that her husband could perform volunteer work for the church several afternoons each week and would continue to challenge him in participation when he was discharged.

It was noted in the letter that funding was apparently denied for ___ continued inpatient treatment and he was discharged to his family care on April 11, 2003. In April of 2003 there is a neurobehavioral report by ___, the program director, who stated that he was participating in cognitive rehabilitation one time a week and he was very compliant with rules and his behavior was quite acceptable. He still continued to have some difficulty observing appropriate boundaries with female patients. There was a report from the ___ at the time of discharge on April 11, 2003 that stated that ___ was participating regularly and he met his goals. He was not as punctual as he should be. His grooming and hygiene was better. He was not able to be very productive in endurance and wandered off other than scheduled break times. This information was obtained from ___ report at the time of discharge in April of 2003. In addition, he had difficulty maintaining attention. He did remain, however, appropriate in behavior. He also demonstrated an awareness in safety skills and judgment. The follow-up care, as recommended by the Rehabilitation Center for the patient's wife, was to follow-up with a primary care physician and/or neurologist within four weeks of discharge. He also recommended that ___ receive regular follow-up visits and blood work every four to six months. He received Progesterone injections and measures of his testosterone levels. He needed continuing psychological counseling on a regular basis. In the letter written by ___ with regards to ___, dated March 3, 2003, the sexual dysfunction portion of his treatment was extended to April 30, 2003 as well as evaluation and treatment for affective disorder which was also projected to April 30, 2003.

There is a letter from ___ dated April 3, 2003 stating that ___ had a six-year history of behavioral issues and personality problems that required detailed rehabilitation. He reiterated that the patient had predominately frontal lobe dysfunction and problems with impulse control and poor hygiene. He believed that there was marked improvement and emotional ability and better insight to his deficit. He still continued to have a lot of sexual inhibition activity.

A letter written by ___, medical claims specialist, states that on May 5, 2003, ___ was in jail in ___. He had tried to help a patient escape from the rehabilitation center. He had apparently rammed his vehicle into their cars and was apprehended by the police. He also had two shotguns and he remained sexually inappropriate.

REQUESTED SERVICE

Two months of additional inpatient rehabilitation is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Based on examination and review of the medical records, the reviewer finds that this patient clearly has a severe frontal lobe disorder that goes back to 1996. This disorder is due to many factors that include toxic exposure and underlying vasculitis of the brain. His significant frontal lobe deficit that has affected all phases of his personality to include impulsive behavior, inappropriate sexual behavior, short attention span, poor motivation and poor compliance in activities. Despite a three-month detailed program of rehabilitation in all spheres, he did make some improvement, but still has very significant impairment of his frontal lobe part of his brain. He really is unlikely to be able to function on his own. This was clearly evident in May of 2003 when his very inappropriate behavior landed him in jail. Clearly, his wife is having a major problem living with him and dealing with his major personality and cognitive difficulties.

It also appears from the previous records that many of the goals of rehabilitation in the first three months of 2003 were partially or completely met, and many of the goals still had required further room for improvement.

With due respect to the rehabilitation people who have done a good job, it appears that ___ still has a marked disturbance in frontal lobe function that does not allow him to remain independent in the community, or possibly even to live in a home setting without major disruption in his family. One to two months of further inpatient rehabilitation is unlikely to improve any of his current deficits significantly enough to allow him to live more independently in his environment.

As a result, the reviewer does not recommend any further inpatient rehabilitation for two months or otherwise at this time.

The reviewer finds that another one or two months of therapy and rehabilitation as outlined is unlikely to make any major improvement in this patient's behavior and cognitive function that will allow him to remain independent in the community.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 17th day of July 2003.