

January 29, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-0577-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology. The physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to for independent review. In addition, the physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 33 year-old male who sustained a work-related injury on \_\_\_\_. The patient reported that while working as a roofer, he fell from a roof causing a severe head injury. The patient was evaluated at a medical facility where he was diagnosed with a subdural hematoma. On 12/19/00 the patient underwent a right frontal bur hole trephinations with evacuation of liquified acute hemorrhage and placement of Camino fiberoptic subdural intracranial pressure monitor. The patient was treated with physical and speech therapy during 2/01. The diagnoses for this patient have included status post subdural hematoma, depression and personality change due to head trauma.

### Requested Services

Chronic Pain Management Program times 20 sessions.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The physician reviewer noted that this case concerns a 33 year-old male who sustained a work related injury to his head on \_\_\_\_. The physician reviewer also noted that the patient was diagnosed with a subdural hematoma and underwent right frontal bur hole trephinations with evacuation of the acute hemorrhage and placement of Camino Fiberoptic Subdural Intracranial Pressure Monitor. The physician reviewer further noted that postoperatively the patient was treated with speech and physical therapy.

The physician reviewer indicated that the patient continues with personality changes and depression and has been recommended for a chronic pain management program. The physician reviewer explained that the documentation provided does not indicate demonstrate that the patient would benefit from a chronic pain management program. The physician reviewer noted that the patient is presently under the care of a neurologist and has been evaluated and found to have significant depression. The physician reviewer explained that the patient denies any pain at this time and the compensable injury is a traumatic brain injury. The physician reviewer also explained that a chronic pain management program is not indicated for the treatment of the emotional and behavioral problems resulting from the traumatic brain injury. Therefore, the physician consultant concluded that the requested chronic pain program times 20 sessions is not medically necessary to treat this patient's condition at this time.

This decision 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)** days of your receipt of this decision. (20 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)** 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/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744  
Fax: 512-804-4011

**A copy of this decision should be attached to the request.**

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

Sincerely,

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 29<sup>th</sup> day of January 2004.