

NOTICE OF INDEPENDENT REVIEW DECISION

June 17, 2004

MDR Tracking #: M2-04-1241-01
IRO Certificate #: IRO4326

The ___ 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 ___ 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, 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 ___ physician reviewer who is board certified in Family Practice, by the American Board of Family Practice, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1976, and who provides health care to injured workers. This is the same specialty as the treating physician. 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.

Clinical History

This patient sustained a work-related injury on ___ when a television fell on her head and she suffered a closed head injury. She was also diagnosed with cervical strain/sprain, thoracic myositis/myofasciitis, and strain/sprain of the right shoulder. The patient complained of severe headaches and dizziness and her primary treating physician referred her to Behavioral HealthCare Associates and she was given a comprehensive neuropsychological evaluation in order to assess her level of cognitive functioning and to identify possible residual cognitive deficits secondary to the work-related injury. Based on the evaluation, the clinical neuropsychologist recommended that the patient undergo cognitive retraining.

Requested Service(s)

Cognitive retraining for 6 hours per day, 3 days per week, for 12 weeks

Decision

It is determined that the proposed cognitive retraining for 6 hours per day, 3 days per week, for 12 weeks is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that this patient is experiencing cognitive dysfunction following a traumatic injury to the brain. The localized trauma resulted in corresponding cognitive

deficits. Since this patient continues to suffer from subjective cognitive complaints as a result of this trauma, cognitive retraining for 6 hours per day, 3 days per week, for 12 weeks would be appropriate treatment for 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,

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 17th day of June 2004.