



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 08/07/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Thirty (30) day inpatient stay for physical medicine procedure (97999)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Physical Medicine & Rehabilitation
Fellowship Trained in Pain Management

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

Thirty (30) day inpatient stay for physical medicine procedure is not medically necessary.

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a xx year old male who was reported to have sustained work related injuries on xx/xx/xx while employed by xxxxx. The employee was reported to have sustained a fall, striking his head with a reported loss of consciousness. The employee was transported by EMS to Medical Center, underwent multiple diagnostic tests including a two view of the left shoulder, which showed no fracture or dislocation. Chest radiographs were normal. A CT of the head was performed which revealed no evidence of acute intracranial abnormality, and a CT of the cervical spine was performed. This study reported multilevel cervical spondylosis with no evidence of acute injury. The employee was subsequently discharged from Medical Center with a diagnosis of contusion of the left shoulder and concussion with loss of consciousness.

Records indicate that the employee underwent an EEG on 12/18/07. This study reported a normal background EEG with the presence of a left temporal sharp activity that occurred during drowsiness only and not during stage 1 or 2 sleep.

The employee underwent an infrared video ENG on 01/08/08. This was reported to be an abnormal study in that there was no suppression of nystagmus with fixation on torsion swing. Vestibular function was reported to be normal.

Records include an MRI of the brain performed on 01/15/08. This study was reported to be normal. Records indicate that the employee returned to work.

The employee underwent additional diagnostic studies to include a CT of the head on 01/22/08. This study was again reported to be normal.

Records indicate that the employee was admitted to the Medical Center on 01/22/08. It was reported that he presented with suicidal ideations. He wanted to overdose and had command hallucinations to kill himself. It was further noted in this report that the employee had multiple stressors including significant family issues.

The employee later underwent a repeat EEG on 01/23/08, and this study was reported to be normal.

MRI of the brain was performed on 01/24/08. This study was again reported to be normal.

Records indicate that the employee was later seen by Dr., who recommended admission for rehabilitation. The employee was subsequently admitted on 02/06/08.

The employee is reported to have had balance problems as well as issues with depression and has received at least three months of inpatient rehabilitation treatment. A request was placed for additional treatment at CNS.

The case was initially evaluated on 06/23/08 by Dr.. Dr. found that the additional inpatient stay was not medically necessary. He reported that there was no indication from the available documentation that the employee had any significant brain injury component occurring to justify the need for additional treatment at an inpatient brain injury rehabilitation program. The employee's previous diagnostic work up was reportedly normal, and there are no medical instability issues or cognitive dysfunction that was occurring to justify the need for inpatient treatment. There was no indication the employee had any problems with significant coma associated with the head injury as well as no indication of any agitation or other behavioral issues that would be associated with the recovery pattern of a typical brain injury. The employee has not undergone any surgical intervention for the reported head injury, and therefore, there are no postoperative indications to justify the need for postoperative treatment. Dr. suggested that the employee would be treated in a less intense setting such as outpatient therapy. He recommended follow up evaluation by a neurologist to establish if there was a residual brain injury.

This case was subsequently appealed and reviewed on 07/02/08 by Dr. Dr. non-certified the request and reported there were no indications of recent decline in level of function based on prior assessment in June, 2008 that would indicate ongoing need for employee rehabilitation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.

I would concur with the two previous reviewers. The employee was reported to have sustained a left shoulder injury and closed head injury as a result of a fall occurring at work. The initial medical records indicate that the employee sustained a brief loss of consciousness.

The employee was initially evaluated at Medical Center, underwent diagnostic testing and was released. The records include multiple diagnostic tests including CT, MRI, EEG and vestibular function testing which were all reported as normal. The records indicate that the employee has undergone repeat imaging studies with no new abnormalities identified. The employee has participated in a cognitive rehabilitation program over the past several months. This is a very in-depth program.

Given that the employee has undergone an extensive course of rehabilitation in the absence of objective data that supports a significant traumatic brain injury, further inpatient treatment would not be considered medically necessary or appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. ***Official Disability Guidelines***