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Notice of Independent Review Decision

DATE OF REVIEW: 03/25/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Items in dispute: Additional twenty (20) day neuro therapy sessions.

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Employer's First Report of Injury or Illness
2. Lumbar spine x-rays dated 08/18/07.
3. Pelvis x-rays dated 08/18/07.
4. Office visits/progress notes with Medical Center 08/23/07, 08/24/07, 08/30/07, 09/26/07, 01/03/08, 01/18/08, & 02/29/08.
5. CT of the head/brain dated 08/23/07.
6. Ophthalmic evaluation dated 08/28/07.
7. Neuropsychological evaluation dated 11/14/07.
8. Neuropsych treatment notes dated 11/21/07.
9. Acute brain injury treatment program evaluation and plan of care dated 12/05/07.
10. Acute brain injury treatment program progress notes dated 12/07-3/08.
11. Office visits with Dr. 02/05/08 and 02/12/08.
12. Initial request for 20 days of rehab therapy (Denial) dated 02/15/08.
13. Peer review by Dr. dated 02/18/08.

14. Appeal letter from case manager, dated 02/19/08.
15. Appeal request for 20 day of rehab (Denial) dated 03/04/08.
16. Request for IRO dated 03/05/08.
17. Position statement from UR Nurse dated 03/11/08.
18. Letter from attorney for carrier dated 03/14/08.
19. ***Official Disability Guidelines.***

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a female who previously worked as a concierge at a nursing home. She reported that a patient attempted to give her a hug and caused her to fall and strike her head (left temporal and occipital area) on a desk. The notes indicate there was an approximate two to three minute loss of consciousness.

Initial treatment with Dr. consisted of treatment for symptoms to include concussion with loss of consciousness, posttraumatic headaches, reactive depression, panic like anxiety attacks, and posttraumatic vestibulopathy. Despite treatment, the employee complained of ongoing difficulty concentrating, inability to multi task, intermittent headaches, back pain, and poor balance. A CT scan and MRI studies revealed no acute changes and/or structural abnormalities. EEG and EKG were also unremarkable. An electronystagmography revealed central vestibular dysfunction.

On 11/14/07, the employee was seen for a neuropsychological evaluation and eluded as a result of her headaches and poor balance that she had fallen many more times at home causing additional injuries to her head. The employee also reported "thoughts of doom" but reported no suicidal intent or plan. A battery of tests were performed. Intellectual functions were found to be low average to average. Psychological testing revealed severe depression, BDI was 37. Personality testing to include MMPI-2 was also performed. The results indicated a valid profile and revealed severe anxiety with thought disruption. Motor functions were only borderline to mildly deficit, and visuospatial and perceptuomotor functions were low average. In summary, the psychiatric evaluation, neuropsychological testing, self report measures and personality testing failed to support brain injury or primary memory disorder. The employee's testing performance was noted to be inconsistent and was indicative of a psychiatric presentation rather than a head injury. It was indicated that she was experiencing severe depressive symptoms, agitation with panic attacks and loss of sleep, and presentation of a very dependant personality type. This was stated to all be a result of her fall at work. In summary, the employee was recommended as having a good prognosis for return to work and said to have no evidence of severe brain injury that would cause any permanent impairment.

The employee was recommended for a psychiatric consultation, possible sleep study, and individual adjustment counseling.

Despite the findings on neuropsychological evaluation that indicated there was no brain injury, the employee was evaluated for admission to an acute brain injury day treatment program. The findings on this evaluation significantly conflicted to the observations of the reviewing neuropsychologist. The program evaluation determined the employee to have significant balance and memory issues, hypersensitivity to sounds, distraction, difficulty staying on track without being cued, difficulty following directions, difficulty with word recall, and impaired problem solving. As a result, the employee was recommended for specialized brain injury day therapy to include interdisciplinary therapy. Therapy recommendations included physical, occupational, speech, and cognitive therapy. Goals were to become independent with mobility, activities of daily living, and social interactions and behaviors, to become independent with compensatory strategies, to become more understanding of her deficits, and to develop her own personal treatment plan with realistic goals.

The employee entered into the program and completed two days of treatment starting 12/18/07 then furloughed until 01/08/08 when she completed subsequent sessions. Upon initial entry, the employee was noted to have good balance but some poor reaction time. When she returned, she again noted poor reaction time and memory loss in the short term. Some concern was expressed about her memory and forgetfulness regarding treatment procedures and tasks, anxiety levels, and insight. Due to “funding” issues, there was another furloughs gap in therapy. However, with completed treatment, gains were noted to include able to manage increased levels of distraction, visual motor reaction times were increased, frequency and intensity of night terrors were decreased, and balance and endurance were improved.

The employee followed up with her treating physician on 01/18/08. At that time, she reported she was doing much better and indicated she was almost ready to return to work. However, the employee subsequently learned her “care” had not been paid for and suffered significant regression. This news, as well as some personal family issues, caused her to remain depressed.

On 02/05/08, Dr. recommended the employee needed to be under the care of a psychiatrist and indicated she was stable from a neurological organicity point of view.

After completion of approximately twenty days in the brain injury therapy program, an additional twenty days was requested. This was denied on initial utilization review on 02/15/08 by Dr. The reviewer denied the additional therapy indicating lack of overall specific functional goals and treatment endpoint. It was also indicated there was no objective physical examination and no indication of efficacy with the sessions completed.

On 02/18/08, Dr. performed a peer review. He opined there was little likelihood that the psychiatric illness was a result of the injury but rather a result of her personal conflict with having to return to work due to her husband’s disability. It

was noted her injury did not extend beyond concussion, and at that time the reviewer opined this should have resolved.

A letter of appeal was presented on 02/19/08 by case manager. She appealed the initial denial indicated the employee was making gains in the program but was in need of further care for completion of goals.

On 03/04/08, the request for reconsideration/appeal was denied by Dr. He indicated there was insufficient evidence of objective improvement with the initial sessions.

On 03/11/08, utilization review nurse issued a position statement due to the findings on neuropsychological evaluation, completion of twenty sessions of therapy without sufficient evidence of objective improvement, peer reviewer opinion and UR denials, that the carrier denied any and all preexisting conditions in the form of depression. Accepted injury included concussion and back strain only.

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

I would agree with the initial and reconsideration review denials for continuation. This employee was determined by objective neuropsychological testing and by imaging to not have a traumatic brain injury. It was also determined that her complaints were more psychological in nature. It was also opined that her subjective complaints were not related to the injury but rather a preexisting condition. As such, given the clinical presentation, I would agree continuation was not medically necessary.

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

1. ***Official Disability Guidelines***, Return To Work Guidelines (2007 Official Disability Guidelines, 12th edition) Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5th edition) Accessed Online
2. Mittenberg W, Canyock EM, Condit D, Patton C. Treatment of post-concussion syndrome following mild head injury. J Clin Exp Neuropsychol. 2001 Dec;23(6):829-36.
3. Szymanski HV, Linn R. A review of the postconcussion syndrome. Int J Psychiatry Med. 1992;22(4):357-75.
4. Tiersky LA, Anselmi V, Johnston MV, Kurtyka J, Roosen E, Schwartz T, Deluca J. A trial of neuropsychologic rehabilitation in mild-spectrum traumatic brain injury. Arch Phys Med Rehabil. 2005 Aug;86(8):1565-74