

Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Notice of Independent Review Decision
Page 2

415.677.2000 Phone
415.677.2195 Fax www.lumetra.com



**Notice of Independent Review Decision
Page 3**

Notice of Independent Review Decision

DATE OF REVIEW: 12/1/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Neuropsychological evaluation Halstead Reitan Battery x 8 hours

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

Certified by the American Board of Physical Medicine & Rehabilitation

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
03/31/2009		Prospective		96118	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines cited:
 Pain Chapter- Psychological Evaluations
 Head (trauma, headaches, etc., not including stress & mental disorders) -
 Neuropsychological testing

PATIENT CLINICAL HISTORY:

Notice of Independent Review Decision

Page 4

This xxxxx-year-old patient sustained injuries in a work related motor vehicle accident on xxxx. He was taken to an Emergency Room and imaging studies noted osteoarthritic changes to the cervical spine, rib fracture, skull fracture and unrelated ordinary disease of life findings (liver lesion, hiatal hernia and cerebral atrophy with mega cistern magna). It is reported that there was an altered mental status prior to the collision. His past medical history includes hypertension, treated with Cardizem. Seizure medication was started during his hospitalization.

Post hospitalization, there was a cerebrovascular evaluation noting syncope and thickening of the vessels. EEG testing was reported as normal. Improvement in the subdural hematomas was noted. The patient was followed closely. In addition, hearing testing was completed and identified some sensorineural losses. There were some vertigo issues noted post-accident and other closed head injury (CHI) maladies.

This patient's treatment has included physical, occupational, and speech therapy, and brain injury transitional services (BITS program). Improvement was noted with physical therapy. The patient was discharged from psychiatric counseling in October 2009. Neuropsychological evaluation Halstead Reitan Battery x 8 hours was requested to differentiate the deficits, provide direction for vocation exploration and document the degree of impairment.

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

In the Reviewer's opinion, as noted in the Official Disability Guidelines, such screening is recommended when there is a chronic pain or depressive situations. The Reviewer noted that the BITS program has identified the problems and has established goals that are apparently being reached. The stated purpose for the requested service, for assisting in impairment rating, is not a clinical indication as the AMA Guides to the Evaluation of Permanent Impairment, 4th edition is the basis for that determination. Therefore, the lack of appropriate interview and clinical assessment for the need for this request, that the goals have been articulated and are being reached and that this is not the basis for any impairment rating; there is no clinical indication for this testing procedure. Further as outlined in the ODG, such testing would have been indicated much earlier in the process.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

Notice of Independent Review Decision

Page 5

- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &
PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL
LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**