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Notice of Independent Review Decision

DATE OF REVIEW: July 20, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cognitive rehabilitation program – 10 additional days

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

International Neuropsychological Society

American Psychological Association

Listed in the National Register of Health Service Providers in Psychology

REVIEW OUTCOME

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

Overtured (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was assaulted on xx/xx/xx , by assailants who bound his hands and legs and assaulted him with blows to the head with a hammer. He sustained injuries to his head, shoulder, cervical and lumbar spine and bilateral wrists. The patient had a history of head Injury, shoulder injury, cervical spine injury, lumbar injury and bilateral wrist injury. Initial probable loss of consciousness (LOC) was reported. The patient was status post possible traumatic brain injury. There was a psychiatric hospital admission from July 29, 2009 to August 1, 2009, with discharge diagnosis of post traumatic stress disorder (PTSD), for which ambulatory treatment continued. Treatment for the shoulder included conservative care and superior labrum anterior-posterior (SLAP) repair on June 7, 2010, followed by postoperative physical therapy (PT). History included subjective symptoms of confusion, memory complaints, occasional dizziness and headaches. Current medications were hydrocodone, Celebrex, methocarbamol, meloxicam, propranolol, Fioricet, paroxetine, trazodone and Nexium.

In January 2011, a physical performance evaluation (PPE) revealed the patient was performing in a light physical demand level (PDL) as against his job required

PDL of light. Although he met his required job demand level, he was unable to lift and carry 20 pounds. Frustration and impatience were observed throughout the evaluation process and it was difficult to keep him focused. Therefore, the evaluator recommended participation in the neurocognitive behavioral program with focus on increasing his ability to perform repetitive tasks and on increasing strength and proprioception.

A functional abilities evaluation recommended participation in the Outpatient Medical Rehabilitation (OMR) program with focus on increasing strength, stability, coordination and proprioception.

Ph.D., saw the patient for evaluation and screening for the neurocognitive program. She diagnosed posttraumatic stress disorder (PTSD), mood disorder with depressive features, pain disorder and cognitive disorder. She noted that formalized testing demonstrated improvement's in mood and neurocognitive symptoms. The patient also reported improved sleep and was able to reduce his hydrocodone 10/325 mg to 3-4 per day (decreased from six a day). He was also feeling more capable of being able to return to work. Dr. recommended continuation in the neurocognitive behavioral program in order to increase functional tolerances for a safe and successful return to work while reducing psychosocial distress. A request was placed for 10 additional days of outpatient cognitive rehabilitation program.

On June 8, 2011, Ph.D., denied the request for 80 hours additional cognitive rehabilitation program based on the following rationale: *"A neuropsychological evaluation of March 9, 2011 reportedly found cognitive deficits consistent with a TBI (though "effort was not completely validated," per Dr.; I do not have this available for review). The patient has now completed 80 hours of a brain injury program, as of April 15, 2011, seven weeks ago. There has been no contact with the patient since that time, by either Dr. or clinicians in the program. The patient's current (as of this date) functional status and specific needs for continuation of the program are not documented and are unknown. With respect to previous performance in the program, there is an FCE and various notations of subjective reports and psychometric test results of questionable validity. These are irrelevant to assessing progress in a comprehensive brain injury rehabilitation program. Changes in cognitive skill may have been found; but there is no documented assessment with respect to use of behavioral compensatory strategies or actual changes in instrumental ADL or other parameters to suggest that the treatment has had any material effect on the patient's functional status that may have been impaired by the brain injury. The patient is still using sedative-hypnotic, hydrocodone (reduced somewhat), and a barbiturate, which are not psychologically helpful in this condition and are contraindicated vis-à-vis cognitive effects of the brain injury. Providing cognitive and behavioral rehabilitation for the putative effects of a brain injury is not likely to be effective in this context; and any improvements may not be durable, given the above regimen. I am not able to establish a basis that resumption of this treatment is both reasonable and necessary at this time"*.

Dr. in a request for reconsideration/appeal in continuation of the cognitive rehabilitation program opined: Dr. was probably not familiar with the Brief Neuropsychological Cognitive Examination (BNCE), which provided a general cognitive profile that could be used for screening, diagnosis or follow-up.

The BNCE instrument was an effective way to help evaluate the cognitive status of patients with psychiatric disorders or psychiatric manifestations of neurological diseases. The patient made progress by improving his score in working memory from severely impaired to moderately impaired. He also improved in his language score by mildly impaired to being close to reporting no impairment. His attention improved from severely impaired to mildly impaired. His executive functioning improved from severely impaired to mild to moderately impaired. He noted improvement in problem solving complaints, concentration/attention and behavioral complaints. He also reduced his BAI from the severe range to the moderate range. He also reduced his BDI-II from the severe range to moderate range. He also reported being able to sleep better (3-4. hours before it was 2.5 hours). He was able to improve his hydrocodone usage from 6 a day to 3-4 a day. He voiced improvement in remembering and recall, evidenced by having an easier time in remembering where he placed his keys and wallet. He responded best to having his day filled with structured activities and having a print out of his schedule to know where he was supposed to be every hour. Slowly, he felt more capable of being able to return to work and voiced an interest in becoming a health care provider in a home health care setting. Due to distress of being attacked in his job as a , he did not want to return to that profession. Therefore, continued participation in the cognitive rehabilitation program was requested to address his issues contributing to his delayed recovery.

On June 27, 2011, M.D., denied the appeal for 80 hours additional cognitive rehabilitation program based on the following rationale: *“Psychological testing noted 56% anxiety/depression according to the Pain Questionnaire - Factor III, 31% perceived disability according to the Neck Disability Index, and 38% perceived disability according to the Oswestry Low Back Questionnaire. It is noted by the evaluator that, based on objective test findings, the claimant does not meet the requirements, safety, or performance ability to do his job safely, effectively, or confidently {without restrictions}. It is recommended the claimant participate in the Outpatient Medical Rehabilitation program with focus on increasing strength, stability, coordination and proprioception. Dr. writes a letter of appeal and authorization in a continuation for the cognitive rehabilitation program. Given this patient has already received 80 hours of therapy, there is insufficient information validating the need for an additional 80 hours. The records reviewed lack convincing documentation validating the progress of the first 80 hours, the progress the patient made, and further what the treating doctor could possibly need to accomplish with another 80 hours of therapy. Based on the information provided, this patient should have been sufficiently treated with the 80 hours already provided. In order to further entertain this request, this patient would need to be examined by a Board Certified Psychiatrist indicating the treatment plan and psycho pharmacotherapy plan and recommendations”.*

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

THE CLAIMANT SUFFERED A CONCUSSION, SHOULDER PAIN, NECK PAIN, BACK PAIN AND BILATERAL WRIST PAIN WHEN HE WAS TIED UP AND ASSAULTED WITH A HAMMER WHILE WORKING AS A X YEARS AGO. HE WENT ON TO DEVELOP PTSD FOR WHICH HE WAS HOSPITALIZED. HE WAS EVALUATED AND FOUND SUITABLE FOR A MULTIDISCIPLINARY NEUROCOGNITIVE REHABILITATION PROGRAM. HE COMPLETED 80

HOURS OF TREATMENT IN THE PROGRAM. 80 ADDITIONAL HOURS WERE REQUESTED AND DENIED APPARENTLY DUE TO A QUESTION OF THE CLAIMANT'S PROGRESS IN THE PROGRAM. A REQUEST FOR APPEAL INCLUDED SPECIFIC MEASURES OF IMPROVEMENT. THE APPEAL WAS REVIEWED AND THE DENIAL WAS UPHOLD. THE DOCUMENTATION PROVIDED WITH THE APPEAL SUPPORTS THAT THE CLAIMANT IS IMPROVING. THE COMBINATION OF CHRONIC PAIN, PTSD, AND A TRAUMATIC HEAD INJURY RESULTS IN A COMPLICATED SET OF SYMPTOMS AND BEHAVIOR THAT REQUIRE INTENSIVE TREATMENT. THE ODG IN THE CHAPTER ON THE TREATMENT OF HEAD INJURY NOTES THIS COMPLEXITY AND RECOMMENDS AS FOLLOWS:

Interdisciplinary rehabilitation programs Recommended. Interdisciplinary rehabilitation programs range from comprehensive integrated inpatient rehabilitation to residential or transitional living to home or community based rehabilitation. All are important and must be directed and/or overseen by a physician board certified in psychiatry or another specialty, such as neurology, with additional training in brain injury rehabilitation. All programs should have access to a team of interdisciplinary professionals, medical consultants, physical therapists, occupational therapists, speech-language pathologists, neuropsychologists, psychologists, rehabilitation nurses, social workers, rehabilitation counselors, dieticians, therapeutic recreation specialists and others. The individual's use of these resources will be dependent on each person's specific treatment plan. All phases of treatment should involve the individual's family/support system.

The request for an additional 80 hours of interdisciplinary treatment meets the ODG for medical necessity.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**