

C-IRO Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

18 sessions of comprehensive outpatient brain injury therapy and a neuropsychological evaluation

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

M.D., Board Certified Neurology

REVIEW OUTCOME:

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Request for IRO 03/19/12

Utilization review determination 02/17/12

Utilization review determination 03/14/12

Treatment records 07/27/11

Neurologic consultation 08/23/11

72 hour ambulatory video EEG 08/31/11

Clinical records 09/15/11-02/23/12

Clinical records 09/22/11 and 10/12/11

MRI cervical spine 10/10/11

BITS initial plan of care 02/02/12

Prospective review 03/20/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained a fall at ground level striking the back of his head with a brief loss of consciousness on xx/xx/xx. He was evaluated at the and admitted. He had complaints of headaches and dizziness his Glasgow coma score was 15. A CT showed a small occipital fracture. He was discharged and seen in follow-up by on 08/23/11. The claimant is noted to be neurologically stable until he sustained an injury at work. He was stripping floors stepped on a strip of wax and fell backwards. He can't remember what happened. He was evaluated at local hospital. He was admitted for three days and advised to wear a C-collar afterwards. Scattered records suggest a subdural hematoma and hemorrhage in the right frontal lobe. CT is quite suggestive of rather diffuse axonal sheer injury with a possible diffuse hemorrhage. He's noted to be diabetic. He still complains of headaches and dizziness. He is noted to be somewhat dysphonic. On examination he remains concerned and puzzled he has spontaneous bursts of crying and frustration type behavior very short lived. He is congruous as much as can be in the history taking process and seems goal oriented. He looks younger than his stated age. He is 5'10"

tall and weighs 200 pounds. The remainder of his examination was grossly unremarkable. Cognitive intellectual behavioral functions were tested throughout the interview. He scored 23/30 that is considered mild to moderate severity of cognitive impairment with normal orientation problems with registration normal tension calculation errors on recall. Normal language, one error on repetition. Reflexes were 1+ and symmetric. Romberg's test was negative. Babinski's was negative. There was no clonus. Tandem gait was normal. There seems to be a left upper extremity drift without pronation. He is neurovascularly intact. Sensory is normal.

He is opined to be status post close head injury with concussion. It was recommended that he obtain a brain MRI ambulatory EEG he was kept off work. He was restricted from driving. 72 hour ambulatory video EEG study was reported as normal. He was started on Topamax for his headaches. He was continued off work on 09/23/11. He was seen by. He has complaints of pain radiating into the parascapular area left shoulder and right shoulder. He reports headaches. He has been wearing a cervical collar since his injury. His physical examination is grossly intact. Radiographs of the cervical spine note anterior and posterior spearing of the cervical spine. There is a loss of disc height throughout the cervical region. In the posterior aspect of the soft tissue there appears to be a small area of increased density. MRI of the cervical spine was performed on 10/10/11, which shows moderate bilateral neural foraminal narrowing at C4-5 C5-6 moderate central canal stenosis at these levels. The claimant saw on 10/12/11. He has continued neck pain graded as 4/10. His pain is reported to be 100% axial. He was provided hydrocodone for pain relief. There is no evidence of fracture or subluxation of the cervical spine. There is mild disc bulging with facet arthropathy causing mild to moderate stenosis. He was discontinued on the cervical collar. He has significant loss of range of motion. As a result he was referred for physical therapy and was kept off work.

On 10/17/11 the claimant saw. He is noted to be upset because he was let go from his job. His headache is reported to be controlled with Topamax. He reports being depressed. Physical examination is unremarkable. A multidisciplinary approach to his residual symptoms including psychiatric evaluation management of his depression has been recommended. He was continued on oral medications. Records include a plan of care dated 02/02/12. On 02/23/12 the claimant saw. He reports that his symptoms are not as bad but that he has been having headaches and dizziness. It is recommended that he participate in a comprehensive total traumatic brain injury program.

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

This man sustained a traumatic brain injury as a result of a slip and fall occurring on 07/27/11. There is some reference to a possible subdural hematoma. Subsequent imaging studies are reported to be normal. CT or MRI of the cervical spine notes stenosis at C5-6 C4-5 and C5-6. 72 hour ambulatory video EEG is reported as normal. The claimant does not have any significant objective findings on physical examination. The claimant does have subjective complaints of headaches with some reported cognitive deficits, however per the recommendations of previous reviewers the claimant was to be referred for neuropsychological evaluation to assess the nature and degree of cognitive deficits prior to participation in the program. There is little benefit to performing a rehabilitative program if there is no baseline data from which to gauge patient response. Based upon the submitted clinical information it is the opinion of the reviewer that the requested 18 sessions of comprehensive outpatient brain injury therapy and a neuropsychological evaluation is not supported as medically necessary.

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

[] ACOEM-AMERICA 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**
- 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)**