



**MEDICAL EVALUATORS
OF TEXAS** ASO, L.L.C.

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: December 4, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Cognitive Rehabilitation Program – 80 hours/units - Outpatient

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

This case was reviewed by a board certified Physical Medicine and Rehabilitation physician licensed and practicing in the state of Texas.

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

Type of Document Received	Date(s) of Record
Initial Clinical Interview & Assessment	07/11/2013
Record review	07/10/2013
Neurocognitive rehabilitation interdisciplinary plan and goals of treatment	07/11/2013
Neuropsychological Evaluation	07/31/2013
Initial Assessment/evaluation for Outpatient Medical Rehab Program	09/30/2013
FCE	10/07/2013
H&P report	10/08/2013
Cognitive Rehabilitation Program Request	10/11/2013
An adverse determination notice	10/17/2013
Reconsideration of Cognitive Rehabilitation Program Request	11/01/2013
An adverse determination after reconsideration notice Corporation	11/11/2013



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A request for an IRO for denied services of, "Cognitive Rehabilitation Program – 80 hours/units – Outpatient"	11/21/2013
A letter	11/26/2013

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who sustained work related injury on xx/xx/xx when she slipped and fell hitting her head. She reported no loss of consciousness but she reported continued deficits of altered mental status associated with head injury. She has been diagnosed with head laceration, contusion and post concussion syndrome. She had excisional debridement of wound with closure. She had MRIs and treatment with neurologist. She had FCE on 10/07/2013 and was tested at light category. She had complete neuropsychological evaluation done on 07/31/2013. She also had behavioral medicine consultation and was diagnosed with depressive disorder, pain disorder with medial and psychological factors, and cognitive disorder. She was recommended participation in complete neuropsychological evaluation. There is a request by her treating doctor for cognitive rehabilitation treatment.

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

The claimant since her injury continues to experience severe neurocognitive symptoms including frequent severe dull headaches, gait disturbance, blurred vision, double vision, visual field flashing lights, memory loss, psychomotor retardation, slowed reading and writing capabilities, withdrawal from social activities, depression, and functional difficulties with activities of daily living. She has completed and extensive preliminary workup which included neuropsychology evaluation.

Her current medical status would most likely place her in the severe concussion category. Based on ODG criteria, the claimant appears to be an appropriated candidate. "There is evidence that individual Trauma-focused cognitive behavioral therapy/exposure therapy (TFCBT), stress management and group TFCBT are very effective in the treatment of post-traumatic stress disorder (PTSD). Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TFCBT is superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT was also more effective than other therapies. (Bisson, 2007) (Deville, 1999) (Foa, 1997) (Foa, 2006) Cognitive therapy is an effective intervention for recent-onset PTSD. (Ehlers, 2003) Empirical research has demonstrated consistently that Cognitive Behavioral Therapy (CBT) is supported for the treatment of PTSD. It has been demonstrated that CBT is more effective than self-help, de-briefing, or supportive therapy in preventing more entrenched PTSD symptoms. Importantly, it is unclear if supportive therapy was of any clinical value



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in the treatment of PTSD since it appeared to impede psychological recovery. Strengths of CBT is difference in the safety and efficacy of providing treatment, working through traumatic memories, and helping the person through to re-frame one's interpretations of both the event and PTSD symptoms. Most importantly, CBT tended to have no to few side effects, unlike medications and could be employed efficiently for acute symptom treatment. (Warren, 2005) Cognitive Therapy (CT) is effective with civilian men and women exposed to combat and noncombat trauma. (VA/DoD, 2004) (Lovell, 2001) (Marks, 1998) CT is effective for women with PTSD associated with sexual assault. (Resick, 2002) Cognitive behavior programs, including exposure therapy, are currently the treatment of choice for PTSD."

As such, I feel that that the outpatient cognitive rehabilitation program should be certified to help facilitate the claimant's improved ADL's, social functioning, and ultimately return to work.

ODG Criteria for Cognitive therapy for PTSD:

Recommended. There is evidence that individual Trauma-focused cognitive behavioral therapy/exposure therapy (TFCBT), stress management and group TFCBT are very effective in the treatment of post-traumatic stress disorder (PTSD). Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TFCBT is superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT was also more effective than other therapies. (Bisson, 2007) (Deville, 1999) (Foa, 1997) (Foa, 2006) Cognitive therapy is an effective intervention for recent-onset PTSD. (Ehlers, 2003) Empirical research has demonstrated consistently that Cognitive Behavioral Therapy (CBT) is supported for the treatment of PTSD. It has been demonstrated that CBT is more effective than self-help, de-briefing, or supportive therapy in preventing more entrenched PTSD symptoms. Importantly, it is unclear if supportive therapy was of any clinical value in the treatment of PTSD since it appeared to impede psychological recovery. Strengths of CBT is difference in the safety and efficacy of providing treatment, working through traumatic memories, and helping the person through to re-frame one's interpretations of both the event and PTSD symptoms. Most importantly, CBT tended to have no to few side effects, unlike medications and could be employed efficiently for acute symptom treatment. (Warren, 2005) Cognitive Therapy (CT) is effective with civilian men and women exposed to combat and noncombat trauma. (VA/DoD, 2004) (Lovell, 2001) (Marks, 1998) CT is effective for women with PTSD associated with sexual assault. (Resick, 2002) Cognitive behavior programs, including exposure therapy, are currently the treatment of choice for PTSD. (Botella, 2009) The AHRQ study concluded that cognitive processing therapy has moderate evidence supporting efficacy for improving some outcomes for adults with PTSD, whereas the IOM report did not make a specific conclusion about cognitive processing therapy. (Jonas, 2013) See also PTSD psychotherapy interventions.



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ODG Psychotherapy Guidelines:

- Initial trial of 6 visits over 6 weeks

- With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials.

Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. (Leichsenring, 2008)

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
- 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)