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Notice of Independent Review Decision

Date notice sent to all parties: 10/21/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Neuropsychological assessment - 20 hours

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

Board Certified in Psychiatry and Neurology
Board Certified in Pain Medicine
Fellow of the American Psychiatric Association

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Neuropsychological assessment - 20 hours - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Initial Behavioral Medicine Consultation dated 10/21/11 dated 02/08/13
Request for evaluation and treatment dated 07/23/13
Report dated 07/23/13

Preauthorization requests dated 07/25/13 and 09/04/13

Utilization Review Determinations dated 08/30/13 and 09/16/13

Undated patient face sheet

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

examined the patient on 10/21/11 for an initial behavioral medicine consultation. She injured her right eye, right cheek, and bilateral hands on xx/xx/xx when she missed a step and fell forward, hitting her face against some concrete steps. She had facial muscle drooping and twitching. There was a reference made to 16 different medications the patient was using, including over-the-counter medical foods. She scored 18 on the BCI-II, which indicated mild depression and scored 26 on the BAI which indicated severe anxiety. Her mood was dysthymic and her affect was constricted. The diagnoses were pain disorder with both psychological factors and a general medical condition, major depressive disorder, single episode-moderate, and injury to right eye, right cheek, and bilateral hands. There was no mention made of a head injury. A brief course of individual psychotherapy was recommended for a minimum of six weeks. examined the patient on 07/23/13. She had paid for her own carpal and cubital tunnel release. She was on a small amount of pain medication, but the surgeon requested it be continued until she fully recovered. She was doing well in regard to her facial reconstruction surgery. Hydrocodone twice a day and Ambien were prescribed. She was not ready to go back to work. noted, as the patient had some depression, etc. and benefited from some counseling, he requested a neuropsychological evaluation for OMR to see if she had any residual effect from possible brain injury from the head injury. On 07/25/13, provided a preauthorization request for neuropsychological counseling. It was noted was the requesting provider. It was noted following a brain injury, neuropsychological testing was recommended by peer reviewed medical guidelines. noted "Patients who suffer TBI are at increased risk of developing a range of psychiatric disorders and 12 months after sustaining a traumatic injury, 31% of patients report a psychiatric disorder. On 08/30/13, provided a non-certification of the requested neuropsychological assessment - 20 hours. On 09/04/13, provided a reconsideration for the requested neuropsychological testing. He noted was not a neuropsychologist, but a physical medicine and rehabilitation physician. It was felt he acted out of the scope of his expertise. On 09/16/13, a psychiatrist also provided a non-certification of the requested neuropsychological assessment - 20 hours.

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

There is no medical documentation provided for my review to objectively support any type of severe traumatic brain injury. There is no documentation to support even a mild traumatic brain injury, specifically a concussion. There are multiple co-morbid medical conditions inferred based on the initial psychological evaluation

and the ODG does not support this level of neuropsychological assessment for alleged mild traumatic brain injuries/concussions, as apparently referenced by the requester.

According to the ODG, neuropsychological testing is recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/TBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive deficits and long term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The computer-based programs, including Immediate Postconcussion Assessment and Cognitive Testing (ImPACT), CogSport, Automated Neuropsychological cal Assessment Metrics (ANAM), Sports Medicine Battery, and HeadMinder, may have advantages over paper-and-pencil neuropsychological tests such as the McGill Abbreviated Concussion Evaluation (ACE) and the Standardized Assessment of Concussion (SAC) (Cantu, 2006). The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, it should be performed by a trained neuropsychologist. Baseline NP testing is not required as an aspect of every assessment, but it may be helpful to add useful information to the overall interpretation of the tests. Persistent symptoms (>10 days) are generally reported in 10–15% of concussions, at which point investigations may include formal neuropsychological testing and conventional neuroimaging to exclude structural pathology (McCrory, 2013). In cases of multiple concussions/persistent impairment, professional athletes should be referred for neurological and neuropsychological assessment and amateur athletes should have formal neurological/cognitive assessment and risk factor counseling (Giza, 2013). Therefore, the requested Neuropsychological

Assessment - 20 hours is not appropriate, medically necessary, or supported by the ODG and the previous adverse determinations should be upheld at this time.

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)