Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Day Program Post Acute Brain injury 40 visits

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The physician is Board Certified in Physical Medicine and Rehabilitation with over 17 years of experience.

REVIEW OUTCOME:

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

☒ Partially Overturned (Agree in part/Disagree in part)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
08-21-13: Assessment and Plan of Care
08-27-13: UR performed
08-30-13: Progress Note
09-05-13: Labwork
09-12-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He reported that he recalled running and then he was ejected from the impact and landed about 2 to 3 times. He thinks he lost consciousness due to the head pain that was not present before. He sustained multiple burns to 15% of his body that included head, neck, upper chest, hand, arm, and left leg. He was taken to the ER and underwent grafting procedures to his hands and elbow on June 17, 2013. He had complicated medical course due to infection and mitral valve endocarditis. He fell and underwent CT scan that showed evidence of septic emboli with parenchymal

abscess formation to both frontal lobes. On July 8, 2013 he had a repeat CT scan of the brain that showed bihemispheric ring enhancing lesion that were consistent with brain abscess. Mr. underwent intervention and then was transferred to Specialty hospital on July 26, 2013 where he underwent continued acute medical rehabilitation. He became stable and was referred to Neurorecovery Center for participation in an outpatient medical day program for post-acute brain injury rehabilitation.

August 21, 2013, the claimant was referred for an outpatient medical day program for post-acute brain injury rehabilitation. He presented with deficits with orientation, short and long term memory, organization, comprehension, sequencing, attention, impulsivity and becoming easily frustrated. He reported with expressive aphasia and mild depression. He was reported to require minimal assistance with cues and supervision for grooming, dressing, bathing, transfers, and eating. He had right sided weakness and is continent of bowel and bladder. The claimant was reported to be very motivated to participate in an outpatient medical day rehabilitation program so that he can become more independent a possibly return to work. Recommendations: He would benefit from an outpatient neuro-medical brain injury rehabilitation program. He would be admitted into the outpatient day program brain injury rehabilitation program with the following objectives: 1. Physical and Cognitive Function: a. Physical therapy and fitness to improve ambulation, ROM, strength and endurance, B. Occupation therapy to improve upper body ROM, ADL, and safety awareness, C. Speech therapy, D. Implement a cognitive therapy program to enhance basic and abstract comprehension and memory recall, E. Develop and implement compensatory strategies to improve problem solving, decision making skills and reasoning and judgment, F. Individual counseling to address adjustment to disability. 2. Independent Living Skills: A. Enhance his performance for basic and advanced activities of daily living for community re-entry, B. Introduce advanced life skills and evaluate accuracy in calculations, planning, self care and financial responsibility, C. Develop safe and consistent routines to rebuild daily responsibilities and increase ability to participate in structured activities, D. Evaluate and determine the level of assistance necessary for community living. 3. Family Training & Education: educate and train family as necessary to assist with the transition home. 4. Estimated Length of Stay: Estimated stay of 40 visits.

August 27, 2013, performed a UR. Rationale for Denial: According to ODG, insufficient evidence exists to determine the effectiveness of multidisciplinary post acute rehabilitation programs for patients with moderate to severe traumatic brain injury (TBI). Since the effectiveness of these programs has not been established, the medical necessity of this request is unsubstantiated. It would be reasonable to consider outpatient speech and cognitive therapy if the patient has not received it as an outpatient.

August 30, 2013, the claimant was seen for a follow up for MSSA brain abscess after d/c 8/22/13. It was reported he was feeling well since d/c and reported some fatigue, appetite increasing and strength improving. Assessment: 1. Organism-MSSA. 2. Bacteremia. 3. Cellulitis and abscess of brain. Treatment: Pt has

been off abx 2 weeks without any obvious symptoms of recurrence. Will draw ESR to compare to baseline and if rising, will eval for recurrence.

September 12, 2013, performed a UR. Rationale for Denial: As noted the original reviewer suggested the worker may be more appropriate at this time for individual physical rehabilitation services in terms of speech and cognitive therapy on an out-patient basis. This opinion has not been addressed in this appeal. Following the review of records, peer-to-peer discussion occurred allowing for more detailed assessment of the clinical history, physical findings and medical decision-making leading to the expressed Plan of Care. The physician discussed the extent of the worker's current deficits, also noting the worker left the prior in-patient program prematurely from the standpoint of executive function and cognitive rehabilitation. The worker and his wife are supportive of additional treatment as it has become increasingly evident to both that the current level of psychosocial and cognitive behavioral deficit will more likely than not prevent the worker from having the opportunity to re-enter the job force. The worker has not undergone a comprehensive reassessment as will be necessary to address the potentially catastrophic event and its late effects regarding his future. The worker showed some of these deficits by virtue of not remaining in the facility for the duration of the session as desired by the team. The worker lives close enough to the facility to be accommodated by a six-hour per day out-patient program that includes addressing physical, cognitive, emotional and vocational aspects of continued recovery. There was discussion regarding the previous reviewer's opinion that the worker could be adequately accommodated through out-patient speech therapy and cognitive therapy, which is in essence what has been proposed by the facility; however, the format is more integrated and vocationally driven than would be individual sessions for one hour two to three times per week as was proposed. The depth and content of the twenty minute peer-to-peer discussion is not fully reflected n this brief synopsis; however, at the conclusion, the physician accepted the proposal of a two-week introductory trial during which time the worker could be more fully evaluated such that the foundation for long-term planning for the worker's accommodation to any permanent deficits and the rehabilitation Plan of Care for those deficits to be identified that are likely to be amendable to structured therapeutic services can be identified and introduced. To the best of the physician's knowledge there is no currently active field nurse case manager assigned to the worker whose expertise as an intermediary can be tapped. The negotiated Plan of Care is for the worker to participate in a two-week (sixty hour) introductory trial that combines the evaluation phase and the implementation of therapeutic activities.

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

The initial adverse determination for the request of Outpatient Day Program Post Acute Brain injury 40 visits is partially overturned. The 2nd UR physician negotiated with the requesting provider an acceptable compromise of a two week trial of the comprehensive program as medically reasonable and necessary to gauge compliance and progress with a multidisciplinary team to address residual multiple physical, cognitive, speech, psychological and vocational issues. Therefore, I find that only 10 visits out of the 40 requested visits, or 60 hours of outpatient day program post acute brain injury are medically necessary at this time.

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 physiatry 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. (Colorado, 2005) (McAllister, 2002) (Mittenberg, 2001) (Szymanski, 1992) (Wood, 2004) See also Multidisciplinary community rehabilitation.

Multidisciplinary institutional rehabilitation	Under study. Insufficient evidence exists to determine the effectiveness of multidisciplinary postacute rehabilitation programs for patients with moderate to severe traumatic brain injury (TBI), a new AHRQ Effective Health Care Program review concludes. Interventions that could be classified as comprehensive holistic day treatment programs were the most often studied model of care. These interventions are characterized as integrated intensive programs delivered to cohorts of patients focusing on cognitive rehabilitation and social functioning. Eight studies that addressed primary outcomes and were assessed to have a low or moderate risk of bias were graded to evaluate effectiveness and comparative effectiveness. There was insufficient evidence on effectiveness. There was a low level of evidence that certain interventions were no different than others in terms of productivity outcomes at 1-year post-treatment. There was a low level of evidence that a comprehensive holistic day treatment program resulted in greater productivity, but not improved community integration, than the standard treatment. However, group differences no longer existed at 6 months post-treatment because the standard rehabilitation group made significant progress during the followup period. Gains made during rehabilitation appear to be sustained at followups 6 months to 1 year post-treatment. Interpretation of community integration from scales is complicated by little attention to minimal clinically important differences. One study addressed harms and found no treatment-related harms. (Brasure, 2012)

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)**