

# AccuReview

An Independent Review Organization

569 TM West Parkway

West, TX 76691

Phone (254) 640-1738

Fax (888) 492-8305

Notice of Independent Review Decision

**[Date notice sent to all parties]:** December 2, 2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Cognitive Rehabilitation Program 80 hours/unit initial trial

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

This physician is Board Certified in Psychiatry Medicine with over 28 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

05-07-14: Initial Behavioral Medicine Assessment. The claimant sustained a work-related injury to the head, chest, lumbar spine, left shoulder and left hand on xx/xx/xx. She was involved in a head on collision where a pick-up truck hit her head on. Since the accident, she has experienced frequent severe headaches, dizziness and balance problems, memory problems and unexpected outbursts of anger. Diagnosis: 7993.59 Unspecified Neurocognitive Disorder; 296.23 Major depressive Disorder, Single episode, Severe, With anxious distress, With mixed features; 300.00 Unspecified Anxiety Disorder; 300.82 Somatic Symptom Disorder, With predominant pain, Persistent, Moderate; R/O 309.81 Posttraumatic Stress Disorder. Secondary Problem areas identified that are impacting her recovery include: Based on the information gathered through the initial interview with our office and the claimant's emotional presentation and verbal report, we would determine that the work accident pain and ensuing the functional limitations have caused this claimant's disruption in lifestyle, leading to poor coping and

maladjustment and disturbances in. The claimant appears to have been functioning independently prior to the work injury of DOI: xx/xx/xx. Treatment Recommendations: The initial evaluation that was completed in our office suggests that the claimant would greatly benefit from: 1. Claimant should be referred for psychotropic medication consultation; 2. A course of individual psychotherapy session using CBT approaches and basic self-management strategies coupled with relaxation exercises to facilitate a health adjustment and improve coping with their overall condition. This should assist the claimant in developing tools and skills for the management of their injury-related disturbances in mood and sleep; 3. Neuropsychological assessment in order to evaluate the nature and severity of cognitive symptoms related to this work accident. Treatment Goals for Individual Psychotherapy: by the end of treatment, the claimant will report employment of CBT techniques at least once a day with the result of: Depression, Anxiety, Educate patient regarding Fear-avoidance, and Sleep. Requested services: Psychotropic evaluation, Individual Psychotherapy sessions, and Neuropsychological Assessment.

05-30-14: Neurobehavioral Status Examination. Diagnosis: 799.59 Unspecified Neurocognitive Disorder; 296.23 Major Depressive Disorder, single episode, severe, with anxious distress, with mixed features; 300.00 Unspecified Anxiety Disorder; 300.82 Somatic Symptom Disorder, with predominant pain, persistent, moderate; R/O 309.81 Posttraumatic Stress Disorder. Conclusions: The claimant was referred for a Neurobehavioral Status Examination at the directive of her treating doctor to screen her cognitive status and to determine the relationship to the work accident. The claimant apparently was hurt at work on xx/xx/xx when she was involved in a head on collision. While it is unclear that she sustained a head injury, it is not clear if she has persistent physical and/or psychological complaints related to this head injury or is unconsciously or consciously embellishing her symptoms. It is recommended that a full neuropsychological evaluation be completed as soon as possible to provide additional information regarding her condition. Testing should incorporate (her published standards) multiple symptoms validity/test effort measures to determine if the claimant is unconsciously or consciously embellishing her symptoms. It is possible that her injury has led to chronic physical and psychological sequelae, and if this is true, she may still experience neurogenic recovery. If she has experienced a physical head injury, she could benefit from treatment in a medical facility attuned to treating such injuries. If her condition is predominantly psychosomatic in focus, she may benefit from additional compassionate and caring treatment with a neuropsychiatric treatment professional attuned to such issues. If she is consciously embellishing her presentation, this needs to be identified, so that unnecessary medical treatment is not provided.

09-05-14: Neuropsychological Evaluation. MNB Results: 0-Premorbid: 48, average; OTBM: 39, mildly impaired; DTMB: 39, mildly impaired; 1-attention/working: 41, below average; 2-processing speed: 37, mildly impaired; 3-verbal reasoning: 41, below average; 4-visual reasoning: 44, below average; 5-verbal memory: 41, below average; 6-visual memory: 38, mildly impaired; 7-dominant motor/sensory: 40, below average; 8-non dominant motor/sensory: 32,

mild to moderately impaired. Pre-morbid functioning is noted to be above average (48T). Her overall test battery mean was in the mildly impaired range (39T). Test results provided evidence of impaired processing speed, visual memory, and non dominant motor/sensory functioning. Conclusions: Neuropsychological testing provided evidence of cerebral impairment with significant deficits that include processing speed, visual memory, and non-dominant motor/sensory functioning. Her performance on task of speed and persistence for the dominant hand was impaired. She was generally somewhat slower in performing dominant hand motor tasks. Her performance on task of speed and persistence for the non-dominant hand was impaired. She was generally somewhat slower in performing non-dominant hand motor tasks. Her ability to perform "real0time" auditory processing tasks was impaired. She is easily over whelmed by too much verbal information being presented at one time. She is slower in processing auditory information. Her ability to organize verbal information into a usable form is also limited. Her recall of visually presented information was impaired. She had significant forgetting of visual information, suggesting reduced overall efficiency of new learning for visual information. Based on the results of testing, claimant will most likely benefit from participation in neurocognitive rehabilitation program that entails working on the following identified areas of weakness: visual spatial skills, organizing visual information, dominant hand motor speed and persistence non-dominant hand motor speed and persistence, fine motor control, hand-eye coordination, verbal distraction, central auditory processing, delayed recall of verbal information, recognition of verbal information, cognitive processing speed, sequencing and negativity. At this time, claimant's diagnosis for the DSM 5 are as follows: 799.59 Unspecified neurocognitive disorder, 296.23 Major depressive disorder, single episode, severe, with anxious distress, with mixed features, and 300.00 Unspecified anxiety disorder, 300.82 Somatic symptom disorder, with predominant pain, persistent, moderate and 309.81 Posttraumatic Stress Disorder.

10-08-14: Functional Capacity Evaluation. Assessments: The claimant cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: 1. Claimant should continue care with their treating doctor to help her condition, minimize and correct as well as reduce muscle spasms, decrease joint adhesions, increase ROM and decrease the perception of pain. 2. Any referrals the treating doctor feels is necessary that will help the claimant's condition. 3. Claimant recommended to participate in the Outpatient Medical Rehabilitation (OMR) program. 4. Based on the findings, the claimant may benefit from a referral to a functional restoration program. 5. According to the objective findings from the testing including: PILE lifting, static lifting, the clinical examination, and all other activities previously mentioned in this report; it is my opinion that this claimant does not meet the requirements, safety, and performance ability to do their job safely, effectively, and confidently (without restrictions). The claimant is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and effectively at their place of employment.

10-10-14: Initial Assessment/Evaluation for Outpatient Medical Rehabilitation Program. Diagnosis: 799.59 Unspecified neurocognitive disorder; 309.81 posttraumatic stress disorder; 296.23 major depressive disorder, single episode, severe, with anxious distress, with mixed features, and 300.00 unspecified anxiety disorder; 300.82 somatic symptom disorder, with predominant pain, persistent, moderate. Treatment Recommendation/Plan: Concur with AT's recommendation that the claimant participate in the Neurocognitive Behavioral Program. The claimant had a Neuropsychological Evaluation performed by PhD on 08/13/14 which provided evidence of cerebral impairment with significant deficits that include the following: visual spatial skills. The claimant has demonstrated motivation and compliance and she desires to get better and to be able to return to work. Thus, it is recommended that the claimant be approved to participate in the Neurocognitive Behavioral Program in order to improve cognitive functioning as well as increase her functional tolerance for a safe and successful return to work while reducing psychological distress and facilitating medical case closure.

10-17-14: Follow Up. CC: Neck pain, low back pain, left shoulder pain, left hand pain and chronic headache. PE: Lumbar pain on ROM all directions. Left shoulder pain on abduction greater than 30 degrees. There is tenderness over the left shoulder on compression and reflexes are normal and the left upper extremity. Left hand there is generalized tenderness over the left hand although she has fair ROM of all fingers. The pain is increased on movement of the wrist. Impression: Possible lumbar disc disease, Left shoulder possible internal derangement, possible left hand contusion. Plan: 1. Claimant is currently being treated concerning her left shoulder and she has appointment concerning her lower back. The claimant stated that her hearing is pending concerning other injured areas which are not considered compensable now. X-ray of the left hand and wrist are normal. 2. A head injury/neuropsychological evaluation have been completed. Recommend that the claimant participate in the Outpatient Medical Rehabilitation Program. 3. Form 73 completed: Yes, as follows modified work with no lifting, please refer to Form 73. 4. F/U in one month.

10-17-14: Evaluate & Treat. Services Requested: Evaluate & Treat: Work programs: Outpatient Medical Rehabilitation and Brain Injury Program.

10-21-14: Request for 80 Hours of a Cognitive Rehabilitation Program Preauthorization. The claimant is currently at SEDENTARY; her required PDL is MEDIUM. ICRP Day Treatment Design: Physical rehabilitation (4-6 hours daily) Rehab modalities are intended to increase strength, stability and balance, with the long-term goals of reducing pain and preparing the claimant for a return to work. Special emphasis will be placed on proprioception, neuromuscular re-education and gait training if necessary and depending on the extent of injury. Modalities involve proprioception exercises, gait training, spinal stabilization, postural awareness and core training, strengthening of the upper and lower extremities, passive and active stretching, sitting/standing tolerance, upper and lower extremity strengthening/conditioning, neuromuscular reduction, work stimulation, biomechanics, ergonomic training, isometrics, and kinetic training, free-weight and universal gym training, aerobic conditioning, and ADL training. Passive modalities

will be applied to reduce elevations in pain secondary to her response to increased active modalities. Medication Management: The claimant is medically assessed by a ROS, and physical completed by the medical director. The claimant's progress and response to treatment is assessed daily throughout their participation in the program by treatment staff. Individual Psychotherapy: 1-3 hours weekly. Vocational Counseling: 1-5 hours weekly. Educational Group Therapy: 1-2 hours daily. Biofeedback Training: 1-3 sessions weekly. Cognitive Skills Training: 1-3 sessions weekly.

10-24-14: UR. Reason for denial: Adverse determination for requested treatment: Cognitive Rehabilitation Program 80 hours/unit initial trial. It is documented that on the date of injury, that claimant was involved in a motor vehicle accident with no loss of consciousness. A medical document dated 10/21/14 indicated that there were difficulties with word finding. There were symptoms of numbness on the right side of the face as well as in the right lower extremity. A Physical Performance Evaluation report dated 10/8/14 indicated that objectively, the claimant was capable of sedentary work activities. It was documented that the claimant was with a pre-injury occupation of a medium duty level. A medical document dated 10/17/14 indicated that subjectively, there were symptoms of pain in the cervical region, the low back region, the left shoulder, as well as the left hand. There were symptoms of a chronic headache. It is documented that a cervical MRI obtained on 2/6/14 revealed findings consistent with the presence of a disc protrusion at the C4-5 level. It is documented that a left shoulder MRI obtained on 2/6/14 revealed findings consistent with the presence of small joint effusion. There are instances whereby the above noted reference would support consideration of the requested services. However, in this specific case, for the described medical situation, medical necessity for this specific request is not established. The records available for review indicate that there was no loss of consciousness with the described mechanism of injury. The records available for review do not provide any documentation to indicate that radiographic testing of the brain has been accomplished to determine whether there is the presence of significant pathology in the brain that would be considered a result of an injury sustained in the workplace. As such, presently, for the described medical situation, medical necessity for this specific request is not established.

11-03-14: Request for Preauthorization Reconsideration: Cognitive Rehabilitation Program Request. It is clearly the opinion of the reviewer that a claimant experience a loss of consciousness due to their injury and have a diagnosis to indicate a radiographic testing of the brain be completed prior to admission into the OMR program. The claimant had a Neuropsychological Evaluation on 08/13/14 which provided evidence of cerebral impairment with significant deficits that include the following: visual spatial skills, organizing visual information, dominant hand and non0dominant hand motor speed and persistence, fine motor control, hand-eye coordination, verbal abstraction, central auditory processing, delayed recall of verbal information, recognition of verbal information, cognitive processing speed, and sequencing. Claimant's Description of Head Injury: She wears glasses due to myopia. She has numbness and

reduced sensation in the right of her face and right leg, foot and toes. She reported changes in taste. Her ears hurt "as if they were hammered from behind" and her hearing has decreased. She suffers from migraines and her vision becomes blurry with her severe headaches. She reported these severe headaches start with neck pain and radiate to the left side and back of her head. These headaches occur several times daily and she stated she is never without a headache. She has experienced 2 black out spells and stated she has word finding problems and speech problems such as slurring. She is having difficulties understanding what is written, for example she would not understand a note from her children's school. The claimant reported problems with attention and concentration, dizziness and balance problems, memory problems and unexpected outbursts of anger, sleep problems to include trouble falling asleep and staying asleep.

11-10-14: UR. Reason for denial: After speaking on 11/6/14, we had a very long discussion regarding this request. He stated that the neuropsychological testing showed cognitive deficits and that the requested treatment is to primarily address cognitive issues. verified that the MMPI was invalid. It is noted that the claimant had extreme memory complaints and that malingered pathology was probable. Overall performance on the MMPI was exaggerated or over reported to the extent that the testing was invalid. IQ testing showed low average on verbal comprehension. confirmed that this score is typically preserved after TBI. did not provide specific detail on how the pre-morbid level was determined for the MNB test other than stating it was a scientific method. We discussed the variability seen within the domains of the MNB test. He did not provide detail on validity testing for the MNB. Instead he referred to the report of validity within the body of the report. It was noted that validity testing suggested intermittent suboptimal or insufficient effort but it was felt that most of the examination was probably valid and likely to represent the claimant's current functioning. confirmed that the claimant remained under treatment for various musculoskeletal complaints. Recommend adverse determination. There is insufficient evidence of cognitive deficits attributable to the 11/10/2014 reported head injury to justify such an intensive multi disciplinary cognitive rehab program. The claimant sustained a head injury without loss of consciousness and no clear evidence of neurological deficits. Although the claimant has persistent subjective complaints, there is no clear anatomic explanation for her multitude of symptoms. Neuropsychological testing is interpreted as showing cognitive deficits. However, it is unclear that any deficits are not commiserating with the claimant's baseline status. IQ testing that is resistance to TBI showed low average intelligence. It is unclear why the claimant's pre-morbid baseline for the MNB would be at the average level in light of this finding. Significant variability within the domains of the MNB was not adequately addressed. Moreover, the exaggerated responses and possible malingering were not addressed as well. Given that the MMPI is a part of the neuropsychological evaluation, there is inadequate explanation as to why those results can be for the requested cognitive rehab program.

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

The previous adverse determinations are upheld and agreed upon. For the described medical situation, medical necessity for this specific request is not established and therefore the denial is upheld. The records available for review indicate that there was no loss of consciousness with the described mechanism of injury. This provider concurs with previous reviewer that there is no clear anatomic explanation for the multitude of symptoms that are attributed to this injury. Her MMPI tests indicate that her symptoms are likely exaggerated, or embellished. Therefore, after reviewing the medical records and documentation provided, the request for Cognitive Rehabilitation Program 80 hours/unit initial trial is non-certified.

Per ODG:

Cognitive behavioral therapy (CBT)	<p>For specific guidelines, see <a href="#">Cognitive therapy for amputation</a>; <a href="#">Cognitive therapy for depression</a>; <a href="#">Cognitive therapy for opioid dependence</a>; <a href="#">Cognitive therapy for panic disorder</a>; <a href="#">Cognitive therapy for PTSD</a>; <a href="#">Cognitive therapy for general stress</a>; <a href="#">Cognitive behavioral stress management (CBSM)</a> to reduce injury and illness; <a href="#">Dialectical behavior therapy</a>; <a href="#">Exposure therapy (ET)</a>; <a href="#">Eye movement desensitization &amp; reprocessing (EMDR)</a>; <a href="#">Hypnosis</a>; <a href="#">Imagery rehearsal therapy (IRT)</a>; <a href="#">Insomnia treatment</a>; <a href="#">Mind/body interventions</a> (for stress relief); <a href="#">Psychodynamic psychotherapy</a>; <a href="#">Psychological debriefing</a> (for preventing post-traumatic stress disorder); <a href="#">Psychological evaluations</a>; <a href="#">Psychological evaluations, IDDS &amp; SCS</a> (intrathecal drug delivery systems &amp; spinal cord stimulators); <a href="#">Psychosocial /pharmacological treatments</a> (for deliberate self harm); <a href="#">Psychosocial adjunctive methods</a> (for PTSD); <a href="#">Psychotherapy for MDD</a> (major depressive disorder); <a href="#">PTSD psychotherapy interventions</a>; <a href="#">Stress management, behavioral/cognitive (interventions)</a>; <a href="#">Telephone CBT</a> (cognitive behavioral therapy); <a href="#">Computer-assisted cognitive therapy</a>. Studies show that a 4 to 6 session trial should be sufficient to provide evidence of symptom improvement, but functioning and quality of life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. (<a href="#">Crits-Christoph, 2001</a>) CBT, whether self-guided, provided via telephone or computer, or provided face to face, is better than no care in a primary care setting and is also better than treatment as usual, according to a meta-analysis. A subanalysis showed the strongest evidence for CBT in anxiety. For depression alone, CBT compared with no treatment had a medium effect size, computerized CBT had a medium effect, and guided self-help CBT for both depression and anxiety produced a small effect size. (<a href="#">Twomey, 2014</a>) See <a href="#">Number of psychotherapy sessions</a> for more information.</p> <p><b>ODG Psychotherapy Guidelines:</b></p> <ul style="list-style-type: none"> <li>- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.</li> </ul> <p>(The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)</p> <ul style="list-style-type: none"> <li>- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.</li> </ul>
Cognitive	Recommended with restrictions below. For concussion/ mild traumatic

therapy	<p>brain injury, 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/mTBI. 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) Cognitive behavioral psychotherapy and cognitive remediation appear to diminish psychologic distress and improve cognitive functioning among persons with traumatic brain injury (TBI). (McDonald, 2002), (Mittenberg, 2001) (Szymanski, 1992) (Tiersky, 2005) (Wood, 2004) The overall benefit of in-hospital cognitive rehabilitation for patients with moderate-to-severe TBI was similar to that of home rehabilitation. (Salazar, 2000) For mild TBI, a referral for psychological services should be strongly considered three or more months post-injury if the individual is having difficulty coping with symptoms or stressors or when secondary psychological symptoms such as intolerance to certain types of environmental stimuli or reactive depression are severe. Treatment may include individual psychotherapy, marital therapy, group therapy, instruction in relaxation and related techniques, cognitive/behavioral therapy, social skills training and interventions/consultation in the community. (Colorado, 2005) There is a significant association between masculine role adherence and good outcomes among men with traumatic brain injury, but resistance to psychological help should still be discouraged. (Schopp, 2006) Psychological support services can help alleviate the distress that patients experience after traumatic brain injury and should be offered not only on a short-term basis, but for up to 2 years, according to the McGill Interdisciplinary Prospective Study. Even patients who do not require intervention in a rehabilitation setting on a long-term basis should be considered for psychological support services. (deGuise, 2008) 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. Early identification of emergent psychiatric disorders and prompt early interventions to prevent psychiatric illness might facilitate optimal recover from TBI. (Bryant, 2010) Despite shortcomings in the evidence supporting cognitive rehabilitation therapy (CRT) for individuals with traumatic brain injury (TBI), ongoing use of this therapy remains recommended according to the IOM. The variation among patient characteristics, severity of injuries, and CRT interventions has made it difficult to know how effective a specific CRT intervention is in the long-</p>
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	<p>term recovery of a specific individual, but the conclusions based on the limited evidence regarding the effectiveness of CRT does not indicate that the effectiveness of CRT treatments are limited, and the limitations of the evidence do not rule out meaningful benefit. (<a href="#">IOM, 2011</a>) See also <a href="#">Mindfulness therapy</a>; <a href="#">Multidisciplinary community rehabilitation</a>.</p> <p>ODG Psychotherapy Guidelines:</p> <ul style="list-style-type: none"><li>- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.</li></ul> <p>(The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)</p> <ul style="list-style-type: none"><li>- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.</li></ul>
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**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)**