

Notice of Independent Review Decision

DATE OF REVIEW: July 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional Brain Rehabilitation Program x 30 days (June 2, 2014-July 31, 2014)

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

This case was reviewed by a physician who holds a board certification in Occupational Medicine and is currently 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
Pre-Admission Evaluation Report	04/23/2014
Initial Progress Summary	05/20/2014
Utilization Review Authorization Request	06/05/2014
Peer review report	06/10/2014
Letter -Denial	06/11/2014
Reconsideration Request	06/12/2014
Letter -Denial-2 nd Denial	06/18/2014
A request for an IRO for the denied services of, "Additional Brain Rehabilitation Program x 30 days (June 2, 2014-July 31, 2014)"	07/01/2014

EMPLOYEE CLINICAL HISTORY [SUMMARY]:



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This is a male who sustained injury on xx/xx/xx when he fell down. He was found supine on the ground and co-workers state he was unconscious for about two to four minutes and then woke becoming combative. He sustained injury to the head and fractures of the ribs, face, spine, right index finger. He complained of severe headaches and pain in neck and back. He was transported to Hospital. A CT scan of the head was performed on xx/xx/xx which showed increased scalp swelling overlying a stable non-displaced fracture of the left calvarium. He was also noted to have a diminished subdural hemorrhage over the left temporal lobe which had nearly completely resolved. There was also a subtle subarachnoid hemorrhage associated with the right sylvian fissure. He was discharged on xx/xx/xx after the pain was controlled. Since then he has been experiencing posttraumatic headaches, anxiety and depression and was treated with little success for a traumatic brain injury. On 05/20/2014, he was admitted for comprehensive day treatment brain injury rehab. He has been treated with 7 days stay in a rehabilitation facility/rehab program. A request was placed for an additional 30 days of day treatment rehabilitation which has been denied.

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

This is a male who sustained a significant brain trauma after a fall. The request is for 30 days of day treatment rehab. ODG indicates the patient would benefit from 13-20 sessions of outpatient (OP) cognitive behavioral therapy (CBT) as the patient needs to be able to return to home and community activities with increased independence during participating in cognitive behavioral therapy. As per ODG, 13-20 sessions of cognitive behavioral therapy as an outpatient are appropriate. The request for 30 days of day treatment rehab exceeds the guidelines recommendation and is partially certified for an initial 13 sessions with documentation of improvement. Additional sessions will be reconsidered pending report of objective functional improvement and rationale for additional sessions.

ODG – Head – Behavioral Therapy

Recommended. Behavioral therapy is not the same as cognitive therapy. Cognitive therapy focuses on retraining skills such as attention, memory, executive function, etc. Behavior therapy is working on extinction of socially inappropriate behaviors (hitting, yelling, cursing, etc) and reinforcement of socially acceptable behaviors (cooperation, compliance, etc). A patient can be high functioning cognitively and not behaviorally. They may have the cognitive skills to return to work but if they have socially unacceptable behavior, they may not be able to remain at a job. Dealing with behavior after brain injury is an important reason why patients may need inpatient rehabilitation and cannot simply do therapy on an outpatient basis (if the family cannot handle the patient at home). (Bratton, 2007) See also Cognitive therapy.



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ODG – Head – Cognitive skills retraining

Recommended, especially when the retraining is focused on relearning specific skills. For concussion/ mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury. (Cifu, 2009) Training needs to be focused, structured, monitored, and as ecologically relevant as possible for optimum effect. Rehabilitation programs emphasizing cognitive-behavioral approaches to the retraining of planning and problem-solving skills can be effective in ameliorating identified deficits in reasoning, planning, concept formation, mental flexibility, aspects of attention and awareness, and purposeful behavior. (McDonald, 2002) Computer-assisted cognitive retraining (CACR) can be an effective adjunct to a comprehensive program of cognitive rehabilitation. (Lynch, 2002) Cognitive and specific skills retraining needs to be guided by the patients' real daily living needs and modified to fit the unique psychological and neuropsychological strengths and weaknesses of the patient. (Ownsworth, 1999) (Park, 2001) (Webster, 1988) (Carter, 1983)

ODG – Head – Cognitive therapy

Recommended with restrictions below. For concussion/ mild traumatic 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/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) 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



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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-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. (IOM, 2011) See also Mindfulness therapy; Multidisciplinary community rehabilitation.

ODG Psychotherapy Guidelines:

- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (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.)
- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.



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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)