

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

01/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cognitive rehabilitation program x80 hours 97799

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work related injury on xx/xx/xx when he xxxxx. The patient stated that he injured his right shoulder and struck his head. xxxxx consultation dated xxxxxx indicated the patient utilizing Motrin, Norco, and Norco for ongoing pain relief. The patient rated his pain as 8/10 and described it as an aching, burning, and stabbing sensation in the right shoulder and hip. The patient reported difficulties with activities of daily living since the injury. The patient stated he had difficulty falling asleep and subsequently awakens through the night secondary to pain. The patient had a dysphoric mood with a flat affect. The patient underwent a battery of psychological evaluations including BDI which revealed a score of 33 indicating severe depression and 25 on BAI reflecting moderate anxiety and 30 FABQ-W and 18 on FABQ-PA indicating significant fear

avoidance. Neuropsychological evaluation dated 11/21/13 indicated the patient sustaining a concussion without loss of consciousness. The patient previously underwent psychological diagnosis of PTSD. The patient also reported a history of dyslexia as an adolescent. The patient reported persistent headaches along with anosmia and memory problems, tinnitus, slow thinking, and distractibility. The patient voiced no suicidal or homicidal ideation. Neuropsychological examination was abnormal. Findings were related to the head injury from xx/xx/xx. The patient had functional memory tasks that were low. The patient had cognitive abilities to drive. However, the patient was not recommended to return to his present occupation secondary to lacking a functional capability. Functional capacity evaluation dated 12/05/13 indicated the patient demonstrating sedentary physical demand level. The patient was recommended for cognitive rehabilitation program at this time. Clinical note dated 12/13/13 mentioned the patient complaining of dizziness and instability with a gait disturbance. The patient also had continued complaints of insomnia. The patient underwent no therapies at this time. Clinical cognitive rehabilitation program request dated 12/17/13 indicated the patient had been working. The patient underwent 12 physical therapy sessions. However, this appeared to have addressed ankle complaints. Utilization review dated 12/27/13 resulted in denial for cognitive rehabilitation program as there was no documentation regarding that regarding confirmation that the patient had completed all lower levels of care. Additionally no information was submitted confirming plans to return to work. Utilization review dated 01/03/14 resulted in denial as no information was submitted regarding return to work plans. Additionally, it was unclear if the patient had completed all other conservative measures.

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

Clinical documentation submitted for review notes the patient sustaining a head injury. Cognitive rehabilitation program would be indicated provided that the patient meets specific criteria, including completion of all conservative treatment and having a job to return to or is willing to reenter the workforce. Clinical notes mentioned the previous completion of 12 session course of physical therapy for the ankle. However, no other information was submitted regarding completion of any conservative treatment addressing cognitive complaints. Additionally, it is unclear if the patient is planning to return to the workforce as no information was submitted regarding his future plans. Given the as such it is the opinion of this reviewer that the request for a cognitive rehabilitation program for 80 hours is not recommended as medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

**X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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/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-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:

- 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)