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Notice of Independent Review Decision

May 21, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MR cognitive rehabilitation program 80 hour/unit – outpatient

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

Psychiatrist

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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:

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, sustained multiple injuries. he hit his head severely. He also started having headaches, bilateral shoulder pain, neck pain radiating to left arm, dizziness, ringing in ears and occasional vertigo.

2012: On xxxxxx, evaluated the patient for headaches, bilateral shoulder pain and neck pain that radiated down his left arm. The patient also had ringing in his ears, dizziness and occasional vertigo. The neck pain was described as constant, severe, restricted with movements and inflexibility and stiffness and pins and needles sensations. The patient had stabbing, shooting and sharp pain radiating to the left shoulder, left arm, left forearm and left hand. The neck pain was made

worse by turning the head to the left and right, looking up and looking down. He also had shoulder pain which he described as constant, moderately severe restricted movement and inflexibility and stiffness as well as sharp and stabbing pain. The right shoulder pain was made worse with repetition movements. He had similar pain in the left shoulder. He described the headaches as constant and moderately severe, pulsating and throbbing and migrating pain. Diagnoses were cervical disc displacement/herniation, neuralgia, neuritis and radiculitis, unspecified, rotator cuff (capsule) sprain, headache and unspecified. The patient was in moderate distress and was experiencing moderate-to-severe pain with neurological deficit, decreased ROM and muscle weakness to the cervical spine and left shoulder. The patient was utilizing Meclizine, Tylenol, lisinopril and metformin. A neurologist referral was made for evaluation of his head trauma. The patient was to participate in an active therapy regimen to restore functional mobility. Advanced diagnostic imaging would be ordered according to the medical necessity.

On September 7, 2012, evaluated the patient for chronic, persistent neck pain associated with daily headache, shoulder and upper back pain as well as panicky feeling associated with memory loss, both short and long term, difficulty concentrating and sleep loss. assessed chronic neck pain syndrome following traumatic work injury, could not rule out intervertebral disc disorder, could not rule out cervical radiculopathy, cervicogenic headache secondary to chronic neck pain syndrome, myofascial pain syndrome of the cervical and upper thoracic regions secondary to chronic neck pain syndrome and could not rule out intracranial head injury with postconcussion syndrome. prescribed Paxil and Ultram and discontinued non-steroidal anti-inflammatory drugs (NSAIDs). The patient was to follow-up to rule out intracranial pathology or intracranial disc lesion.

2013: On February 7, 2013, magnetic resonance imaging (MRI) of the cervical spine showed the following findings: (1) Cervical lordosis straightening suggestive of muscular pain or spasm. (2) At C2-C3, 3-4 mm left paracentral discal substance protrusion/herniation possibly contacting only the anterior spinal cord surface. (3) At C3-C4, 3-4 mm posterior central discal substance protrusion/herniation contacting only the spinal cord. (4) At C4-C5, 4-5 mm posterior central discal substance protrusion/herniation indenting the spinal cord and resulting was a mild-to-moderate degree of central canal stenosis.

On April 9, 2013, MRI of the brain showed mucus retention cyst in the right maxillary sinus and a small amount of fluid within left mastoid air cells.

On May 8, 2013, saw the patient for a behavioral medicine consultation to assess his emotional and congestive status and to determine the relationship to the work accident. The patient scored 33 on the Beck Depression Inventory-II (BDI-II) indicating severe depression, 15 on Beck Anxiety Inventory (BAI) reflecting mild anxiety, and his response to the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work as well as significant fear avoidance of physical activity in general. Diagnoses were cognitive disorder NOS, major depressive disorder, severe without psychotic features and pain disorder

associated with both psychological factors and a medical condition, chronic. The evaluator recommended referral to a neuropsychological evaluation and a course of individual psychotherapeutic intervention using cognitive behavioral therapy for four weeks.

On June 11, 2013, MRI of the right shoulder showed tendinopathy within the distal supraspinatus component rotator cuff with a full-thickness tear near the insertion on the greater tuberosity measuring 6.7 x 10.1 (transverse, anterior posterior) millimeters. There was fluid in the subacromial subdeltoid bursa. There was Type I acromion with the acromiohumeral space measuring 8.3 mm. There were degenerative hypertrophic changes to the acromioclavicular (AC) joint and no evidence of internal derangement.

On June 26, 2013, performed a neuropsychological evaluation on the patient. The neuropsychological testing identified multiple areas of concern including impairment in executive functioning, processing speed and motor/sensory abilities bilaterally. Relative weakness was noted in his ability for sustained attention, organizing visual information, expressive and receptive language, verbal abstraction, verbal fluency, central auditory processing and sequencing a number of clinical recommendations. opined that the patient had not yet reached at maximum medical improvement (MMI). The patient was not yet able to return to work. Ms. referred the patient to a local brain injury association for additional support. He recommended physical therapy/occupational therapy (PT/OT) to include neuromuscular reactivation. The patient was requested psychiatric support and neuropsychological therapy. also opined that the patient should not work beyond a secondary physical demand level (PDL) currently. If would determine that the patient should be placed at MMI and offered an impairment rating (IR) based on combination of psychological and neuropsychological test scores, his current IR should be 29% whole person impairment (WPI) at the current time.

On July 2, 2013, performed introduction of cervical epidural catheter under fluoroscopy, injection of contrast for performance of epidurogram and injection of corticosteroid using local anesthetic solution. The procedure was performed at C7-T1 interspace.

On July 3, 2013, noted that the patient felt better after two cervical epidural blocks. He was more functional and more active and had full range of motion (ROM) of his neck with only pain on the extremes of rotation at 70 degrees. There was mild mid cervical interspinous tenderness present. He had pain with flexion of his neck. recommended continuing with a third and final cervical epidural block.

On July 8, 2013, a cervical myelogram showed moderate-sized anterior extradural defects at C3-C4, C4-C5, C5-C6 and C6-C7. There was moderate degenerative facet joint hypertrophy at C3-C4. There was mild degenerative facet joint hypertrophy at C4-C5 and C5-C6. There was minimal degenerative spondylosis from C3-C4 through C6-C7.

A post myelogram CT showed 5 mm posterior central disc protrusion at C5-C6, which impinged upon the thecal sac and the anterior surface of the cervical spinal cord, causing moderate central spinal canal stenosis. There were 4 mm posterior central disc protrusions at C3-C4 and C4-C5, which impinged upon the thecal sac and the anterior surface of the cervical spinal cord causing mild canal stenosis in both segments. There was a 2 mm posterior central disc protrusion at C6-C7. There was a moderate degenerative facet joint hypertrophy at C3-C4. There was mild degenerative facet joint hypertrophy at C4-C5 and C5-C6.

On September 24, 2013, performed introduction of the cervical epidural catheter under fluoroscopy, injection of contrast for performance of epidurogram and injection of corticosteroid local anesthetic solution at C7-T1 interspace and C4-C5 interspace.

On October 9, 2013, noted that the patient had improved more than 70% with the cervical epidural blocks. The patient was undergoing appropriate head injury management for cognitive deficits following a traumatic injury. His affect had improved. He was utilizing Lexapro, Ambien, Norco and Neurontin. The patient was waiting for neuropsychological evaluation and treatment. He still had some myofascial trigger points in his neck and upper back area. recommended continuing to watch him closely.

From October 24, 2013, through March 19, 2014, the patient underwent outpatient medical rehab program.

On December 4, 2013, the patient noted decreased neck ROM and moderate mid cervical interspinous tenderness. The patient was having some new pain with increased activity levels that might be related to increased activity. recommended considering cervical epidural block in the future if his complaints persisted. The patient was recommended continuing with Neurontin, Lexapro and Klonopin at night. He was prescribed Naprosyn for pain associated with myofascial tenderness.

2014: On January 7, 2014, performed a physical performance evaluation (PPE) on the patient. He assessed that the patient was unable to perform regular duties and recommended a psychological evaluation and to participate in outpatient medical rehab (OMR) program.

On February 4, 2014, noted that the patient had received one ESI with excellent results of the neck pain, improved ROM, decreased headache and improved affect. He was stabilized on gabapentin and Norco. His affect had improved with Lexapro in the morning and had slept for the first time with Ambien at night. The patient wanted to go ahead with a second block. reviewed the cervical MRI and recommended cervical epidural block. The patient was also recommended to continue with cognitive behavioral support.

On March 20, 2014, performed a PPE on the patient and assessed that he was unable to perform regular job duties currently. recommended psychological evaluation and participate in outpatient medical rehabilitation program.

On March 31, 2014, expressed his disappointment. The patient was not approved for reasonable necessary treatment consistent with ODG guidelines for his herniated disc cervical radiculopathy with more than 70% improvement of neck, shoulder and arm pain complaints following the first cervical epidural block on September 24, 2013. was surprised and upset about the fact that the doctor could not cite the patient's inability to find out the date of previous injection nor read the follow up notes that determined the necessity of the injection therapy. The patient was having moderate mid cervical interspinous tenderness. He was having pain into the right shoulder arm and felt his pain had started to return particularly the pins and needles in the C5-C6 distribution on the right. The patient was asking for increased medications as the pain had started to return and he was losing the functional gains. prescribed hydrocodone in conjunction with his gabapentin, Lexapro and Ambien. The patient was also recommended to continue with the neck ROM exercise therapy. A request for second cervical epidural block was made.

On April 2, 2014, a request for outpatient MR cognitive rehabilitation program of 80 hours/units was made. The patient was currently at light medium and required heavy PDL.

Per utilization review dated April 8, 2014, the request for additional MR cognitive rehabilitation program of 80 hours/unit was non-certified with the following rationale: *“The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The patient is a male who reported an injury on xx/xx/xx. The mechanism of injury was noted to be a motor vehicle accident. The patient is diagnosed with status post closed head injury with brain contusion, posttraumatic vestibulopathy and a posttraumatic episode of confusion. His current medications were not provided in the medical records. His surgical history was not provided in the medical records. Diagnostic studies include an official CT cervical myelogram, July 8, 2013, which revealed a central disc protrusion at the C5-C6 level which impinges upon the thecal sac and the anterior surface of the cervical spinal cord, and causes moderate central spinal canal stenosis, a disc protrusion at C3-C4 and C4-C5 which impinges on the thecal sac in the anterior surface or the cervical aspect causing mild canal stenosis in both segments; a central disc protrusion at C6-C7; moderate degenerative facet joint arthropathy at C3-C4; and mild degenerative facet joint hypertrophy at C4-C5 and C5-C6; and mild degenerative spondylosis from C3-C4 through C6-7. Other therapies were not provided in the medical records. The patient saw on August 29, 2012 for neurologic consultation. The patient's symptoms were noted to include dizziness, vertigo, loss of balance, passing out spells, and headaches. It was noted that following his injury, the patient was diagnosed with cervical disc displacement/herniation, neuralgia, neuritis, and radiculitis, rotator cuff sprain, headache, and concussion. It was noted that the patient presented with a rather classic history of a closed head injury with features*

of vestibular dysfunction, cognitive issues, headache, disorder of balance, and disequilibrium and awareness, and intermittent confusion. He was recommended to have a video ENG, initiate vestibular exercises, brain MRI, ambulatory EEG study, and possible neuro-psychometric testing. The patient saw on January 31, 2013 for his chronic neck and head pain. It was noted that his sleep had improved with medications and a recommendation was made for an MRI. At his follow up appointment on February 25, 2013, it was noted that the patient's symptoms had not changed and he continued with episodes of violent vertigo, dizziness, falling tendencies, and disorientation. It was noted that the patient may be having partial complex seizure spells, intermittent tinnitus bilaterally, disequilibrium, loss of balance, but no hearing loss. His treatment plan continued to include a video ENG and vestibular exercises. According to the ODG cognitive skills retraining is recommended, especially when the retraining is focused on relearning specific skills. It further for the concussion/mild traumatic brain injury, comprehension neuropsychological/cognitive testing is not recommended during the first 30 days post injury. It further states that rehabilitation program emphasizing cognitive behavioral approaches to the retaining of planning and problem solving skills can be effective in treating deficits in reasoning, planning, content formation, mental flexibility aspects of attention awareness, and purposeful behavior. As the patient was noted to have a history of a posttraumatic brain injury/concussion with symptoms of dizziness, vertigo, loss of balance, pawing out, and headaches, cognitive rehabilitation would be supported. However, in the absence of recent clinical notes with documentation of current symptoms and physical examination findings as well as previous treatment, recommendation cannot be made. My staff received a return call on 04/08/2014 at 3:24 pm CST, and I was unavailable, a message was left requesting a return phone call. I called the number listed on 04/08/2014 at 3:40 pm CST, discussed the case who confirmed the clinical information submitted for review but offered no additional information to support the request. As such the request remain non-certified."

On April 10, 2014, performed a medical evaluation on the patient and rendered statutory maximum medical improvement (MMI) on April 10, 2014, with a WPI of 9%.

Per utilization review dated **April 11, 2014**, the request for medical necessity of OP cervical epidural steroid injection was non-certified with the following rationale: *"The patient is a male who was injured on xx/xx/xx due to a motor vehicle accident. He is currently diagnosed with chronic neck pain syndrome associated with cervical disc protrusion and cervical radiculopathy. A request is made for an outpatient cervical epidural steroid injection. The records include an MRI of the cervical spine dated February 7, 2013, which showed, as ready 3-4 mm left paracentral discal substance protrusion/herniation that may contact only the anterior spinal cord surface at C2-C3; 3-4mm posterior central discal substance protrusion/herniation that contacted only the spinal cord; and 4-5 mm posterior central discal substance protrusion/herniation that indents the spinal cord and resulting in a mild to moderate degree of central canal stenosis. A cervical CT-myelogram dated July 8, 2013, showed, a 5 mm posterior central disc protrusion*

at C5-C6 which impinges upon the thecal sac and the anterior surface of the cervical spinal cord causing moderate central spinal canal stenosis; 4 mm posterior central disc protrusions at C3-C4 and C4-C5, which impinges upon the thecal sac and the anterior surface of the cervical spinal cord causing mild canal stenosis in both segments; 2 mm posterior central disc protrusion at C6-C7; moderate degenerative facet joint hypertrophy at C3-C4; mild degenerative facet joint hypertrophy at C4-C5 and C5-C6; and minimal degenerative spondylosis from C3-C4 through C6-C7. The records indicate that he has had cervical epidural injection on April 16, 2013, July 2, 20, and September 24, 2013. As per medical report dated October 9, 2013, his neck, shoulder and arm pain have improved more than 70% with the cervical epidural blockade. His other treatments include medications (gabapentin, Norco, Lexapro and Ambien) and cognitive behavioral support. He was most recently evaluated on February 4, 2014. At this time, it notes that the patient has received one ESI with excellent result of neck pain, improved range of motion, decreased headaches and improved affect. He has moderate mid cervical interspinous tenderness, pain with flexion and coughing. He has impulse pain below the elbow on the right. He has some mild decreased pin prick sensation as well. The request is made for this ongoing treatment. Although the records mention benefit with the most recent ESI, a clarification should be made as to its clinical details (date given and levels included). The referenced guideline requires at least 50% pain relief for six to eight weeks for the blocks to be repeated. As such, at this time, the medical necessity of this request is not established.”

On April 17, 2014, a request for reconsideration of outpatient MR cognitive rehabilitation program of 80 hours/units was made. The patient was currently at light medium and required heavy PDL.

Per a utilization review referral form dated April 18, 2014, a request for cervical epidural injection under fluoroscopy with IV contrast was made.

Per reconsideration review dated April 28, 2014, the request for MR cognitive rehabilitation program of 80 hours/units was non-certified with the following rationale: “The patient is a male who sustained multiple injuries on xx/xx/xx, when the truck he was driving crashed and rolled over. He is currently diagnosed with closed head injury/concussion. An appeal request was made for additional 80 hours/units of MR cognitive rehabilitation program. The previous request was non-certified because there were no recent clinical notes with documentation of current symptoms and physical examination findings as well as previous treatment. Updated documentation submitted for this appeal includes the April 10, 2014 MMI examination report, the April 17, 2014, request for reconsideration, the March 20, 2014 Physical Performance Evaluation, and the March 19, 2014 initial evaluation report. As a result of his accident, the patient sustained injuries to his head, neck, mid back, shoulders, and left upper extremity. It was reported that his head injury caused him to have problems with his vision (occasionally blurry/double vision), coordination, balance, memory, speech language skills, decision making, problem solving, concentration, and sleep. He also suffered from black out spells, as well as from severe headaches, neck pain, and shoulder

pain. He has been evaluated to date with various diagnostic studies inclusive of x-rays, MRIs, and CT myelogram. His EEG on April 2, 2013 was reported to be normal, while his brain MRI on April 9, 2013 showed no intracranial abnormality. His initial treatments consisted of medications, PT, steroid injections for the shoulders, cervical ESIs (on April 16, 2013, July 2, 2013 and September 24, 2013), and eight sessions of individual psychotherapy from May 29, 2013 to October 23, 2013. Eventually, he was enrolled in a cognitive/medical rehabilitation program to address his residual neuro-cognitive problems. He reportedly participated in the program from October 24, 2013 to March 15, 2014 and completed 160 of 160 hours of treatment. In the April 10, 2014 evaluation report, it was stated that the patient was still experiencing dizziness, headaches, memory loss, radiating cervical pain, bilateral shoulder pain, and occasional trembling in both arms and hands. He reported that he is only able to do very basic activities of daily living and that his level of function is better when he takes his medication. Upon examination, it was determined that he has reached statutory maximum medical improvement with a whole person impairment rating of 9 percent. It was opined that while he has made significant improvement in his outpatient medical rehabilitation and brain injury program, his level of continued instability and memory function would likely benefit from continuing the program to its completion. According to the April 17, 2014, request for reconsideration report, the patient has already completed 160 hours in the OMR program. A comparative analysis of his symptoms prior to treatment and as of March 19, 2014, was performed and noted an increase in pain, irritability, frustration, muscle tension, nervousness, depression, sleep problems, and forgetfulness. His T-scores in the Mayo-Portland Adaptability Inventory were seen to have improved in the abilities, adjustment, and participation categories. A review of his neuro-cognitive rehabilitation symptom checklist noted no change in his problem solving complaints, and improvement of his speech and language deficits and average hours slept. Worsened/increased scores were documented with regard to his documentation and attention complaints, memory complaints, behavioral complaints, and interpersonal activity. The patient reported improvement in several activities of daily living, as well as improvement of his headaches and vision problems (nearly gone). He also noted that he no longer has black out spells or problems with driving. It was summarized that the patient has made significant gains while in the program, but continues to have cognitive impairments. It was also mentioned that he still experiences most of the symptoms he had prior to starting the program, but most of them have improved significantly. It was stated that he is currently functioning at Light Medium PDL, while his required PDL is heavy. His current medication regimen was noted to consist of albuterol, Ambien, escitalopram, hydrochlorothiazide, lisinopril, metformin, Neurontin, Norco, potassium bicarbonate, tramadol, and Zofran. Continuation of the current program for an additional 80 hours was recommended. It is noted that the patient has already undergone 160 hours of treatment in his cognitive rehabilitation program and has already shown improvement in several functional outcomes. Given the substantial amount of treatment already provided and the improvements already made, it is unclear why his remaining deficits and goals could not be addressed without further intensive supervision in the context of a cognitive rehabilitation program. In agreement with the previous

determination, the medical necessity of this request is not substantiated at this time."

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

The patient is documented to have received comprehensive cognitive rehabilitation treatment from October 24, 2013 to March 15, 2014 and completed 160 of 160 hours of treatment. A request was then made for an additional 80 hours of cognitive rehabilitation therapy with the rationale that the patient could still continue to improve further with such therapy. The request has been denied by two different reviewers. The second reviewer noted that a comparative analysis of his symptoms prior to treatment and as of March 19, 2014, was performed and noted an increase in pain, irritability, frustration, muscle tension, nervousness, depression, sleep problems, and forgetfulness. His T-scores in the Mayo-Portland Adaptability Inventory were seen to have improved in the abilities, adjustment, and participation categories. A review of his neuro-cognitive rehabilitation symptom checklist noted no change in his problem solving complaints, and improvement of his speech and language deficits and average hours slept. Worsened/increased scores were documented with regard to his documentation and attention complaints, memory complaints, behavioral complaints, and interpersonal activity. The patient reported improvement in several activities of daily living, as well as improvement of his headaches and vision problems (nearly gone). He also noted that he no longer has black out spells or problems with driving. It was summarized that the patient has made significant gains while in the program, but continues to have cognitive impairments. It was also mentioned that he still experiences most of the symptoms he had prior to starting the program, but most of them have improved significantly.

Thus, it does appear that although some gains have been made, in many areas, the patient has not shown much improvement. He has also been assessed as having reached MMI as of April 10, 2014, so in the opinion the patient is not expected to make further improvements even with treatment.

According to Texas Labor Code, the goals of treatment are that it cures or relieves the effects naturally resulting from the compensable injury; it promotes recovery; or it enhances the ability of the employee to return to work or retain employment. It is therefore relevant to note that the patient no longer has black out spells or problems driving. Thus, he should be able to retain some type of driving related employment.

In summary, the second reviewer seems to have produced a correct opinion in stating that the ODG requirements have not been met. The employee is currently assessed as having reached MMI; the employee is now able to drive, and should therefore have transferrable skills for employment; and finally, the requesting clinic has not provided any evidence that continued treatment will result in a further improvement in symptoms.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES