

IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

03/03/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cognitive therapy 5x wk x 2 weeks 80 hours 97799

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

Board Certified Internal Medicine

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:

Cover sheet and working documents
Neuropsychological evaluation dated 04/04/13
PPE dated 12/18/13, 11/04/13
Cognitive rehabilitation program request dated 12/30/13
Individual psychotherapy treatment reassessment summary dated 02/18/13
Reconsideration dated 01/10/14
Utilization review determination dated 01/03/14, 02/06/14
Reassessment for continuation in OMR dated 12/13/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient was involved in a rollover motor vehicle accident. Neuropsychological evaluation dated 04/04/13 indicates that the patient reported loss of consciousness. The patient reports significant neurocognitive issues following his head injury. Neuropsychological testing provided evidence of possibly unreliable data based on the patient's inconsistent/poor effort during this examination. Unequivocal evidence of impairment was noted for visual memory and visual reasoning. It also appears that the patient is expressing significant subjective distress from a psychological perspective despite providing an invalid MMPI-2-RF protocol. PPE dated 11/04/13 indicates that required PDL is heavy and current PDL is light. Per reassessment for continuation in OMR dated 12/13/13, the patient has participated in an outpatient medical rehabilitation program (neurocognitive). Mayo T score for abilities decreased from 88 to 79, adjustment from 78 to 62 and participation from 69 to 57. Pain level remains 6. Medications are listed as metaxalone, Naprosyn, Remeron, Terocin lotion, Tramadol and Venlafaxine. PPE dated 12/18/13 indicates that current PDL is sedentary to light. Request for authorization dated 12/30/13 indicates that treatment to date includes physical therapy x 13, left shoulder cortisone injection, individual psychotherapy x 6 and work hardening x 20 days in September 2012.

Initial request was non-certified on 01/03/14 noting that overall his progress does not seem significant. It was also unclear how many sessions he has completed in the program. As per guidelines, a total of up to 13-20 weeks is recommended with evidence of functional improvement. Reconsideration dated 01/10/14 indicates that ODG guidelines do not mention time limits of program. The patient has completed 160 hours of the program. The denial was upheld on appeal dated 02/06/14 noting that considering that the patient does not demonstrate significant improvement from the completed 160 hours of his cognitive rehab program, other treatments should be considered rather than pursuing a continued therapy that provides no complete benefit. confirmed that the patient did show some small gains between 11/01/13 and 12/13/13 on the Mayo-Portland Adaptability Inventory. The patient has remained with severe limitations in the adjustments category. He has gone from severe to moderate-severe in the participation category between 09/23/13 and 11/01/13, but he remained stable with moderate-severe limitations in the participation category from 11/01/13 to 12/13/13. The patient's self VAS symptom rating and neurocognitive symptoms rating scores are stable or worse when comparing 11/01/13 to 12/13/13 evaluations. Finally, the patient is currently unemployed. The patient has no documented cure or relief, no progress towards recovery and no enhanced employability.

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

Based on the clinical information provided, the request for cognitive therapy 5 x wk x 2 wks 80 hours is not recommended as medically necessary, and the two previous denials are upheld. Most recently the patient has completed 160 hours of a

cognitive rehabilitation program. The submitted records fail to document significant improvement in the program, and therefore efficacy of treatment is not established, and continued participation in the program is not supported. Per reassessment dated 12/13/13, Mayo T score for abilities decreased from 88 to 79, adjustment from 78 to 62 and participation from 69 to 57. Pain level remains 6. VAS neurocognitive symptoms rating scale increased for problem solving complaints from 63 to 68 with a goal of 34, speech and language deficits increased from 37 to 40 with a goal of 20, concentration and attention complaints from 31 to 32 with a goal of 16, memory complaints from 110 to 104 with a goal of 52, behavioral complaints remained 39 with a goal of 19. Given the lack of significant improvement in the program to date, ongoing sessions are not 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

Official Disability Guidelines Head Chapter

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 psychiatry 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.

Official Disability Guidelines Mental Illness and Stress Chapter

Cognitive behavioral therapy (CBT)

For specific guidelines, see Cognitive therapy for amputation; Cognitive therapy for depression; Cognitive therapy for opioid dependence; Cognitive therapy for panic disorder; Cognitive therapy for PTSD; Cognitive therapy for general stress; Cognitive behavioral stress management (CBSM) to reduce injury and illness; Dialectical behavior therapy; Exposure therapy (ET); Eye movement desensitization & reprocessing (EMDR); Hypnosis; Imagery rehearsal therapy (IRT); Insomnia treatment; Mind/body interventions (for stress relief); Psychodynamic psychotherapy; Psychological debriefing (for preventing post-traumatic stress disorder); Psychological evaluations; Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators); Psychosocial /pharmacological treatments (for deliberate self harm); Psychosocial adjunctive methods (for PTSD); Psychotherapy for MDD (major depressive disorder); PTSD psychotherapy interventions; Stress management, behavioral/cognitive (interventions); Telephone CBT (cognitive behavioral therapy). 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. (Crits-Christoph, 2001) See Number of psychotherapy sessions for more information.

ODG Psychotherapy Guidelines:

Initial trial of 6 visits over 3-6 weeks

With evidence of symptom improvement, total of up to 13-20 visits over 7-20 weeks (individual sessions)