

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: 817-779-3288
Fax: 817-385-9613
Email: pureresolutions@irosolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sept/13/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 hours of neuropsychological testing

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

Board Certified Family Practice

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)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The patient swerved to miss a deer when the car flipped over on the driver's side. She reports that when the car flipped a heavy ice chest hit her in the head. Diagnostic interview dated 02/05/13 indicates that the patient complained of multiple cognitive difficulties since the injury including processing speed, attention, word finding, memory, spelling, changes in depth perception. The patient also complained of personality changes. Provisional diagnosis is cognitive disorder NOS. The patient was recommended for additional neuropsychological testing to objectively evaluate the patient's complaints. Medical peer review dated 08/23/13 indicates that the reviewer opines that the patient has some element of psychiatric illness (i.e., depression), unrelated to the incident of xx/xx/xx. Initial evaluation dated 05/14/14 indicates that the patient underwent fusion surgery on 01/24/14 and now presents for physical therapy. Diagnostic interview dated 08/12/14 indicates that the patient reported that many of her instrumental activities have been disrupted as a result of her cognitive difficulties. The patient reported that she frequently bumps into curbs with her vehicle's tires when driving. She has difficulty remembering to pay her bills on time. Current medications include Lyrica, Percocet and Tizanidine. Provisional diagnosis is cognitive disorder nos.

Initial request for 6 hours of neuropsychological testing was non-certified on 07/22/14 noting that the patient underwent a neuropsychological evaluation in March 2013. There was no recent physician's progress report submitted for review. The denial was upheld on appeal dated 07/25/14 noting that there is still no updated progress report from the requesting physician with objective findings that warrant the requested neuropsychological testing.

There are no clear objective findings of severe traumatic brain injury following the work related injury.

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

The patient sustained injuries in xx/xxxx and presented in February 2013 with multiple cognitive complaints. The patient subsequently presented in August 2014 with similar complaints. There are no interim records provided to establish that the patient has been followed for these complaints. It is unclear if the patient has undergone any diagnostic testing to establish the presence of traumatic brain injury. It is unclear if the patient has received any treatment since the motor vehicle accident to address her subjective complaints. Therefore, the requested testing is not in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for 6 hours of neuropsychological testing is not recommended as medically necessary.

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

- ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- 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
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)