

Maturus Software Technologies Corporation  
DBA Matutech, Inc  
881 Rock Street  
New Braunfels, TX 78130  
Phone: 800-929-9078  
Fax: 800-570-9544

Notice of Independent Review Decision

July 13, 2015

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Neuropsychological testing (96116 Neurobehavioral Status Examination 4 hours and 96118 Neuropsychological Assessment 20 hours)

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

American Board of Psychiatry and Neurology

**REVIEW OUTCOME:**

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

Upheld (Agree)

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was involved in a motor vehicle accident (MVA) on xx/xx/xx.

performed an Initial behavioral medicine assessment on May 11, 2015. The following records were reviewed:

*"On April 8, 2015, noted the patient was rear-ended while trying to make a right turn causing his vehicle to T-bone another vehicle. The patient's chief complaint was neck, low back, right hip, left shoulder pain, and soreness around the back of his head after being hit. The patient reported mild changes in vision from left eye. Pain had been constant since the accident. The patient complained of slowed mental processing. He was off work at this time. The diagnoses were lumbar sprain, neck sprain and traumatic brain injury. On April 27, 2015, released the patient back to work with restrictions. The patient notes he was quite reticent to be responsible for driving while at work and did not think he was equipped to do so at this time due to concerns with concentration, persistent*

*headaches, and being quite drowsy. On April 9, 2015, a magnetic resonance imaging (MRI) of the cervical spine without contrast showed neural foraminal narrowing visible at levels described above, specifically on the right at C3-4 and C6-7 on the right. There were no features to suggest a ligamentous Injury or paraspinous hematoma or Inflammatory changes at present. On April 9, 2015, MRI of the brain without gadolinium revealed no acute or subacute posttraumatic findings visible here. There were only some very mild involuntional changes associated with age visible.”*

Currently, the patient was using meloxicam, cyclobenzaprine, tramadol HCl and Limbitrol. The patient self-rated his pain on a scale of 1 to 10, with 10 being the worst, as 5/10. When asked to quantify the level of interference his pain had on his recreational, social, and familial activities, he rates these all as 8/10; for pain Interference with normal activities as 8/10; and change in ability to work. 8/10. The patient was diagnosed with migraines approximately 20 years ago and began taking Limbitrol 10/25 q h.s. for his migraines and was presently taking this medication. The patient noted experiencing difficulty with household chores, yard work, exercise, driving for more than 1 hour, sitting for more than 2 hours, standing for more than 2 hours, walking for more than 15 minutes, bending, squatting, crawling, and lifting 10 pounds. Patient's specific complaints are memory loss, disorganized, losing track of his task, having to write things down, lower motivation, fear of doing things that will promote a headache or muscle spasms. He notes that bright fluorescent lights promote headaches. The patient also noted his left eye was now drooping since his accident. On mental status examination, mood was dysthymic and anxious. His affect was constricted. His memory for remote events was intact and recent events impaired. He was goal-directed. He did not hallucinate or appear delusional. He did not present with any current risk factors. When asked to rate targeted symptoms on a scale of 1 to 10, with 10 being the worst, he reported the following: pain 6/10, irritability 3/10, frustration 3/10, muscle tension 9/10, nervousness 4/10, sadness 3/10, sleep problems 4/10 and forgetfulness 9/10. The patient scored 26 on the Beck Depression Inventory-II (BDI-II), Indicating moderate depression. The patient's score on the Beck Anxiety Inventory (BAI) was 24, reflecting moderate anxiety. The patient was diagnosed with rule out mild neurocognitive disorder due to traumatic brain injury with behavioral disturbance, Major Depressive disorder, single episode, moderate; somatic symptom disorder, with predominant pain, persistent, moderate; posttraumatic stress disorder; and anxiety disorder, unspecified. It was recommended the patient participate in formalized neuropsychological testing in order to best determine current level of neurocognitive and psychological functioning.

On May 26, 2015, requested authorization for neurobehavioral status examination and neuropsychological assessment. The service was requested to 05/26/2015, with a two-month window to facilitate scheduling.

Per a utilization review dated June 1, 2015, the request for neuropsychological testing was denied. Rationale: *“Neuropsychological testing is recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days In this case, There is inadequate/insufficient evidence to determine whether an association exists between mild TBI, neurocognitive deficits and long-term adverse social functioning including unemployment, diminished social relationships, and decrease in the ability to live independently. In cases of multiple concussions/persistent impairment, professional athletes should be referred for neurologic and neuropsychological assessment, and*

*amateur athletes should have formal neurologic/cognitive assessment and risk factor counseling. Neuropsychological testing is recommended in the guidelines, but the patient has already had a Neurophysiological evaluation. Thus, repeat testing is not medically necessary. The request is recommended for non-certification."*

On June 15, 2015, requested approval for neurobehavioral status examination for four hours and neuropsychological assessment for 20 hours. She stated, *"Please allow me to address denial. He has not had a neuropsychological evaluation. initiated contact with our clinic on 5-6-15 (where he referred for treatment) and he had a psychological evaluation on 5-11-15, which recommended a neuropsychological evaluation. In the psychological evaluation the clinician looks over the patient's psychological history, administers several tests, and utilizes clinician observation to see if he meets DSM-5 criteria to see if he has a traumatic brain injury which would deem the medical necessity for a neuropsychological evaluation. This request includes 20 hours of professional time to administer, interpret, score, and report the results of a forensic-quality neuropsychological test battery. A forensic-quality test battery includes the provision of sufficient psychological testing to establish a diagnosis, testing to determine test effort, testing to identify efforts to feign or malingering test results, and efforts to determine the presence of over and under reporting of cognitive, psychological, and somatic symptoms."*

Per a reconsideration review dated June 19, 2015, the appeal for neuropsychological testing was denied. Rationale: *" Upon discussion. was able to give a partial list of the claimant's complaints including headaches, light sensitivity, poor concentration, forgetfulness, difficulty with concentration; decision making; and organization, fatigue, poor frustration tolerance, depressive symptomatology, anxious symptomatology and PTSD like symptoms. the providers are requesting 4 hours of 96116 and 20 hours of 96118 to determine if the claimant has cognitive difficulties, and to rule out a mild neurocognitive disorder. was only able to provide a partial list of assessments the provider plans to administer, which included the Mayer, WASI, Trails, MMPI, a grip strength test, a peg board test, a forced choice test, the NART and other assessments. According to the supporting documents provided, neurobehavioral information suggesting the presence of deficits has already been gathered. The scope of the requested neuropsychological assessment is not medically necessary to confirm or rule out a neurocognitive disorder. Furthermore, this assessment is being requested in addition to existing information. Therefore, non-certification of this request is recommended."*

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

The patient was involved in an injury on xx/xx/xx in which he did sustain trauma to his head. The patient is described as having mild neurocognitive deficits as a result of his TBI. The specific question is whether or not a full neuropsychological battery of testing will benefit him. His MRI showed "no acute or subacute posttraumatic findings visible here. There were only some very mild involuntional changes associated with age visible." The patient has a history of a seizure disorder, but there is no mention of this having worsened after the accident. There is no mention of a neurological examination, but the record does not indicate the presence of a hemiparesis, visual field cuts or

anosmia. There is no mention of loss of consciousness, posttraumatic amnesia or current disorientation or confusion. Thus, it is correct that he is diagnosed with mild cognitive impairment, according to the DSM-5 definition. ODG is quite clear that neuropsychological testing is “recommended for severe traumatic brain injury but not for concussions. For concussion/mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury.” The patient is also diagnosed with constant pain, lumbar sprain, neck sprain, eye injury, depression and anxiety as well as PTSD like symptoms. Many of the patient’s complaints, such as memory loss, disorganized, losing track of his task, having to write things down, lower motivation, fear of doing things that will promote a headache or muscle spasms, can be explained by his other diagnoses. Therefore, it is unclear as to how the patient’s treatment would be different if neurocognitive testing does show some mental changes.

The previous two reviewers, both psychologists, have correctly interpreted the ODG to conclude that extensive neuropsychological testing is not medically necessary for this patient.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINE**