

True Resolutions Inc.
An Independent Review Organization
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Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine And Rehab

Description of the service or services in dispute:

MR cognitive rehabilitation program 80 hours/units

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)

12/24/14, request for a review by an independent review organization,

Patient Clinical History (Summary)

This patient is a male. On 04/02/14, he was seen for complaints of arm pain. He denied progressive weakness, numbness, or tingling. An EMG was reviewed showing evidence of chronic nerve injuries to the right median and radial nerves. There was no acute denervation to suggest ongoing nerve injury. It was noted his nerve injuries were improving. On 06/10/14, a psychological evaluation cleared this patient for a spinal cord stimulator trial. On 08/19/14, this patient was taken to surgery for a spinal cord stimulator trial. On 08/25/14, he was seen back in clinic and reported greater than 60% pain relief with improved range of motion in function and 50% reduction in medication use. On 10/06/14, the patient was seen back in clinic and wanted to proceed with permanent placement of a spinal cord stimulator. Imaging studies were to be ordered to make sure there was enough room for the stimulator and its leads. On 11/13/14, a request was made for 80 hours of cognitive rehabilitation program. On 11/24/14, a reconsideration request for cognitive rehabilitation program was submitted.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 11/18/14, a notice of adverse determination/partial was submitted. It was noted that based on the clinical information provided, the request for an MR cognitive rehabilitation program 80 hours was not recommended as being medically necessary. Per a peer to peer consultation, it was noted this patient has had 10 sessions of individual psychotherapy with minimal benefit and there had been no effort to provide cognitive rehabilitation on a lower level of care. It was noted this patient has not responded positively to treatment. The request was non-certified. On 12/09/14, a notification of reconsideration adverse determination was submitted noting that the requested service was not medically necessary. A peer to peer was performed, in which it was noted that it would not be expected for this patient to make much progress with mono-therapy. They were changing the patient's brain functioning however slow. It was noted the patient's physical testing indicated that he was not using his right arm or hand at all and he declined much of the physical testing. However, he reported pain at 9-10/10. He continued to take narcotic medications, and his intelligence scores were below normal. The request was non-certified. It was noted his progress was

poor and did not meet Official Disability Guidelines criteria for approval. Guidelines indicate that up to 13-20 sessions over 7-20 weeks of individual sessions may be considered reasonable, if progress is being made. The submitted records failed to identify progress being made with this patient, and the records indicate that he has a poor prognosis. The records indicate that his cognition was poor prior to his injury and he has barriers to his program. It is the opinion of this reviewer that the request for an MR cognitive rehabilitation program 80 hours/units is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- AHCPR-Agency for Healthcare Research and Quality Guidelines

- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)