

# CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 15, 2014

**IRO CASE #:**

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

IP-Brain Injury Rehabilitation

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

This physician is Board Certified in Neurology with over 34 years of experience.

**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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained a traumatic brain injury on xx/xx/xx as a result of a fall while at work. He was leaning forward when he fell and struck the back of his head on a metal surface. He did lose consciousness at the accident scene. There are no initial Glasgow Coma scale (GCS) scores available. He was initially transferred via EMS and then transferred via helicopter. Initial imaging studies revealed a skull fracture to the maxilla which continued through the cochlea. Also noted were bilateral frontal contusions and left anterior temporal contusions. He was comatose for several days. He was admitted for approximately 2 weeks and was discharged to rehabilitation for post-acute neuro rehabilitation. He returned home under the supervision of his parents. He has not had any further rehabilitation since he has been home and has experienced several medical complications such as recurrent pain, headaches, memory loss and seizures. He also has persistent hearing loss to his right ear and complains of some loss of smell. He has been on multiple medications, including Hydrocodone for a previous injury. A follow-up MRI on October 10, 2014

showed encephalomalacia of the frontal lobes bilaterally and the right anterior temporal lobe.

On October 13, 2014, the claimant was screened at home in order to determine his appropriateness for admission program for post-acute rehabilitation. It was noted that the claimant had sleep wake cycle issues. His short term memory problems and impulsiveness have led to occasional emotional outburst. On October 10, 2014 he was taken to the ER for edema to his lower extremities and complaints of a severe toothache. He was prescribed Lasix and Tylenol #3. The claimant was noted to demonstrate good sitting and fair standing balance. He was full weight bearing and transfers independently. He was also able to ambulate about his home and community. He had good endurance and fair strength. He was independent with all basic activities of daily living, including dressing, grooming, bathing, toileting and feeding. He required supervision to minimal assistance with his advanced level ADL's such as housekeeping, laundry, meal preparation, shopping, and budgeting/banking. He communicated verbally with good speech intelligibility. He was also able to follow 3 step commands, and can read and write short sentences. He had good social skills. He does become easily frustrated and easily angered at times. He had complaints of depression. His stated rehabilitation goals include improving his memory, coping skills, frustration tolerance, and to become more independent. Following completion of rehabilitation he will live with his parents who would continue to provide supervision and assistance. Current medications include: Norco 10/325 mg 3 x daily, Keppra 500 mg 2 x daily, Depakote 500 mg ER 3 x daily, Clonazepam .5 mg 3 x daily, Norvasc 10 mg daily, Hydralazine 50 mg 3 x daily, Lopressor 50 mg 2 x daily, Tylenol #3 with Codeine 1-2 tabs every 4-6 hours as needed, Seroquel 300 mg at night, Lasix 20 mg daily. Past Medical History is positive for a MVA in xxxx. He hit a tree head on and was hospitalized for 2 months requiring extensive surgery with hardware placement to his left lower extremity, upper extremity, and left hip. Assessment: 3MS and MINI Mental Status Examination (MMSE) were administered. Relative strengths were noted in the areas of temporal orientation, spatial orientation, naming of simple objects, verbal fluency, verbal reasoning, sentence repetition, visual constructional skills, and auditory comprehension. Relative weaknesses were noted in the areas of immediate auditory attention, mental flexibility, and verbal/auditory memory. He scored 82/100 on the 3MS and 26/30 on the MMSE. It was felt the claimant had the needs in the areas of Physical Therapy, Occupational Therapy, Speech/Language Pathology, Neuropsychology, and Therapeutic Recreation. Recommendations: Admission for comprehensive evaluations is recommended. He should receive evaluations in the areas of Physical Therapy, Occupation Therapy, Speech/Language Pathology, and Neuropsychology. He should also be evaluated for orthotics and adaptive equipment needs. Following evaluations, a determination will be made regarding the appropriateness of comprehensive, inpatient post-acute rehabilitation services, as well as the intensity, frequency and duration of services.

On October 20, 2014 UR. Rationale for Denial: Inpatient brain injury rehabilitation is not medically necessary. Regardless of how describes this facility, it requires an inpatient stay and provides rehabilitation services. There is

no evidence that this patient has any functional impairment requiring an inpatient level of physical therapy, occupational therapy, or speech therapy. This patient is independent in most activities of daily living and does not require an inpatient level of care to attain a more advanced skill set. The patient appears to have no significant abnormality of speech. This patient does not have any functional deficits requiring intensive physical, occupational, and speech therapy, and inpatient rehabilitation is not supported as medically necessary or appropriate.

On October 24, 2014, wrote in his appeals letter that while the patient did demonstrate measurable impairment stemming from his brain injury based on gross screening (i.e., decreased advanced balance, decreased frustration tolerance, anger outbursts, decreased attention/concentration, decreased mental flexibility, and decreased verbal/auditory memory), our request was for comprehensive evaluations not residential treatment (see Summary and Recommendations section on page 4 of the screening assessment). We had hoped to engage in a comprehensive assessment and determine rehabilitation needs, if any, and make appropriate recommendations and referrals.

On November 6, 2014, UR. Rationale for Denial: Claimant sustained a head injury when he was leaning forward and fell, striking the back of his head on a metal surface, with subsequent loss of consciousness. Claimant has had prior post acute neuro rehabilitation. Claimant is having complaints of headaches, memory loss, decreased concentration, decreased problem solving, decreased auditory attention, decreased mental flexibility. However, there are no details regarding the need for inpatient stay. I would have approved outpatient treatment/evaluations only. However, unable to speak with anyone regarding the request. As such, request for inpatient rehabilitation is not medically necessary.

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

The previous adverse determinations are upheld. Upon review of the documentations that was provided, the claimant is independent in all activities of daily living and there are no contraindication for outpatient therapy. According to the 10/13/14 evaluation the claimant was independent with all basic activities of daily living, including dressing, grooming, bathing, toileting and feeding. He required supervision to minimal assistance with his advanced level ADL's such as housekeeping, laundry, meal preparation, shopping, and budgeting/banking. He communicated verbally with good speech intelligibility. He was also able to follow 3 step commands, and can read and write short sentences. He had good social skills. Therefore the request for IP-Brain Injury Rehabilitation is not found to be medically necessary.

PER ODG:

Interdisciplinary rehabilitation programs

Recommended as indicated below. 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 physiatry 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](#)) Insufficient evidence exists to determine the effectiveness of different multidisciplinary postacute rehabilitation programs for patients with moderate to severe traumatic brain injury (TBI), an AHRQ Effective Health Care Program review concludes. There was a low level of evidence that certain interventions were no different than others in terms of productivity outcomes at 1-year post-treatment. There was a low level of evidence that a comprehensive holistic day treatment program resulted in greater productivity, but not improved community integration, than the standard treatment. However, group differences no longer existed at 6 months post-treatment because the standard rehabilitation group made significant progress during the followup period. Gains made during rehabilitation appear to be sustained at followups 6 months to 1 year post-treatment. One study addressed harms and found no treatment-related harms. ([Brasure, 2012](#)) According to this systematic review, the available evidence for different types of TBI multidisciplinary rehabilitation programs does not prove the superiority of one approach over another. ([Brasure, 2013](#)) In this study to develop a prediction rule for identifying patients at risk for extended rehabilitation length of stay (LOS) after traumatic brain injury (TBI), extended LOS was defined as 67 days or longer. The model used FIM motor and cognitive scores at admission, preinjury level of education, cause of injury, punctate/petechial hemorrhage, acute-care LOS, and primary payor source, as predictors. ([Arango-Lasprilla, 2010](#)) See also [Multidisciplinary community rehabilitation](#); [Telephone intervention for TBI](#).

Physical  
medicine  
treatment

Recommended. Patient rehabilitation after traumatic brain injury is divided into Three periods: acute, subacute and postacute. In the beginning of rehabilitation the physical therapist evaluates patient's functional status, later he uses methods and means of treatment, and evaluates effectiveness of rehabilitation. Early ambulation is very important for patients with coma. Physical therapy consists of prevention of complications, improvement of muscle force, and range of motions, balance, movement coordination, endurance and cognitive functions. Early rehabilitation is necessary for traumatic brain injury patients and use of physical therapy methods can help to regain lost functions and to come back to the society. ([Colorado, 2005](#)) ([Brown, 2005](#)) ([Frankeviciute, 2005](#)) ([Driver, 2004](#)) ([Shiel, 2001](#)) See also [Exercise; Vestibular PT rehabilitation](#).

***ODG Physical Medicine Guidelines –***

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

**Fracture of skull (ICD9 801):**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

**Headache (ICD9 784.0):**

6 visits over 6 weeks

**Tension headache (ICD9 307.81):**

6 visits over 6 weeks

**Hemiplegia and hemiparesis (ICD9 342):**

Acute inpatient phase: 20-40 visits over 4 weeks

Subacute phase: 6-12 visits over 12 weeks

**Bell's palsy (ICD9 351.0):**

8 visits over 4 weeks

**Temporomandibular joint disorders (ICD9 524.6):**

6 visits over 4 weeks

Speech therapy (ST)

Recommended as indicated below. Speech therapy (ST) is the treatment of communication impairment and swallowing disorders. Speech and language therapy is defined as therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of the presence of a communication disability), and those that impair comprehension, or spoken, written, or other systems used for communication.

**Criteria for Speech Therapy:**

- A diagnosis of a speech, hearing, or language disorder resulting from injury, trauma, or a medically based illness or disease.
- Clinically documented functional speech disorder resulting in an inability to perform at the previous functional level.
- Documentation supports an expectation by the prescribing physician that measurable improvement is anticipated in 4-6 months.
- The level and complexity of the services requested can only be rendered safely and effectively by a licensed speech and language pathologist or audiologist.
- Treatment beyond 30 visits requires authorization

([McCurtin, 2012](#)) ([Brady, 2012](#))

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- 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**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**