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Notice of Independent Review Decision

**April 17, 2015**

**IRO CASE #:**

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

Neurobehavioral status examination 4 hours, 4 units and neuropsychological assessment 20 hours, 20 units

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

Psychiatrist

**REVIEW OUTCOME:**

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

X Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

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 patient is a female who was assaulted on xx/xx/xx. She tried to restrain due to aggressiveness and was choked tightly. She was lightheaded and was not aware she was choked until the following morning.

**2014:** On August 7, 2014, the patient was seen for neck pain. On examination, there was mild tenderness to the right side of the neck. assessed alleged assault and neck pain and released the patient to regular duty work.

On August 20, 2014, saw the patient for generalized anxiety and assessed posttraumatic stress disorder (PTSD) and referred the patient to .

On August 21, 2014saw the patient in the emergency room (ER) for anxiety. She noted the patient remained hypodynamically stable and provided counseling and Xanax and Desvenlafaxine Succinate.

In a correspondence wrote she treated the patient for acute stress disorder and displayed symptoms that coincided with significant trauma. She exhibited severe anxiety due to the traumatic incident, had obsessive thoughts of death, hyper-vigilance, diminished interest in activities at home and in other setting. The patient should be continued to be seen by her primary care physician (PCP) to address her medication issues. opined that the patient could not continue to work for any client/patient at as her symptoms were too severe to provide adequate care for them.

On September 15, 2014, A Certification of health care provider was completed documenting she had seen the patient on August 27, 2014. The patient was undergoing individual therapy. Her severe anxiety symptoms were the cause for her to seek leave.

On November 26, 2014, saw the patient for head and neck symptoms. He assessed headaches and cervical strain. The patient's extent of injury was difficult to determine due to the loss of consciousness on behalf of the patient surrounding the initial injury. It did however appear that the patient's past medical history of depression and anxiety had been exacerbated by this incident. He ordered UDS ordered magnetic resonance imaging (MRI) of the brain, Neurology consultation functional capacity evaluation (FCE), physical rehabilitation follow up in one month. This was planned to gain more information as to the patient possibly having PTSD, brain injury, concussion, post concussive syndrome and a worsening of her pre-existing anxiety and depression.

Urine drug screen (UDS) dated November 26, 2014, was positive for amphetamines

On December 2, 2014, the patient was seen for an initial rehabilitation evaluation and was recommended physical therapy (PT) three days for two week and then two days for two weeks.

On December 5, 2014, functional capacity evaluation (FCE) was performed. It was noted that the patient had taken leave from August 6, 2014. The patient had difficulty with activities of daily living. She demonstrated functional deficits that would benefit from additional medical attention, including therapy and/or diagnostic testing. The patient was unable to perform her regular job duties. The patient had subjective complaints that did not match objective presentation either due to an exacerbation in their condition, or a potential lack of motivation due to the mental or emotional status. The evaluator recommended an MRI of the area of complaint and injury, a psychological evaluation, due to head trauma/loss of consciousness during work-related injury and she should be referred for neurological consultation, if not already done. The patient did not meet the requirements, safety, and performance ability to do her job safely, effectively, and confidently (without restrictions) and was not capable of performing the job duties (without restrictions) until they demonstrated objective improvement and the ability to perform safely and efficiently at their place of employment.

On December 6, 2014, performed a designated doctor evaluation (DDE) and opined that the patient had not yet reached maximum medical improvement (MMI) and would do so on June 5, 2015.

On December 9, 2014, performed an MMI/IR evaluation and assessed the patient had not reached maximum medical improvement (MMI) and would do so on March 9, 2015.

On December 10, 2014, MRI of the brain was unremarkable. There was an incidental note of 1.8 cm retention cyst in the left maxillary sinus.

From December 17, 2014, through December 29, 2014, the patient attended six sessions of PT consisting of electrical stimulation, moist heat therapy/cold therapy, ultrasound, manual therapy, paraffin and therapeutic exercises.

On December 24, 2014, gave prescription for Tramadol, Trazodone and Zoloft. He recommended additional therapy sessions.

On December 30, 2014, UDS was positive for amphetamines.

**2015:** From January 6, 2015, through January 20, 2015, underwent four chiropractic therapy sessions with modalities to include chiropractic adjustments, electrical stimulation, moist heat/cold therapy, ultrasound, manual therapy, paraffin and HEP. On January 20, 2015, recommended an outpatient medical rehabilitation program to further address the continued mental and physical aspects of injury.

On January 21, 2015, saw the patient for OMR program evaluation. It was noted that the patient had DDE on December 5, 2014, and the report was still pending. The patient continued with high anxiety levels and strong desire to not be around others. prescribed neuropsychological evaluation and testing, OMR/brain injury program and neuropsychological evaluation and testing. A urine drug screen (UDS) was ordered and prescribed Trazodone and Zoloft.

On January 21, 2015, UDS was negative.

On January 23, 2015, functional capacity evaluation (FCE) was performed and the patient was placed in the light physical demand level (PDL) versus very heavy PDL per his job description.

On January 28, 2015, performed initial behavioral medicine assessment to assess her emotional status and to determine her stability for some level of behavioral medicine treatment and/or a return to work program. The patient was utilizing Trazodone, Zoloft and Klonopin. On the Beck Depression Inventory-II (BDI-II) the patient scored 41 placing her in the severe depression category and on the Beck Anxiety Inventory (BAI) the patient scored 37 reflecting severe anxiety. The diagnoses were posttraumatic stress disorder, unspecified

neurocognitive disorder, major depressive disorder single episode, severe without psychotic features and anxiety disorder, NOS. The patient was recommended neuropsychological testing (full battery) as moderate and severe TBI were often associated with objective deficits on neuropsychological testing and six individual therapy sessions.

On February 19, 2015, the patient underwent peer review.

On February 20, 2015, saw the patient in follow up and noted she was recommended neuropsychological evaluation and the decision was pending. She was status-post DDE on December 5, 2014, with an extension granted to February 6, 2015. It was notified that the report should be ready on or about March 2, 2015. ordered UDS and recommended continuing Trazodone and Zoloft.

On February 20, 2015, UDS was negative except for higher specific gravity and high levels of cotinine (consistent with tobacco use).

Per utilization review dated February 25, 2015, the carrier denied the request for neurobehavioral status examination four hours, four units and neuropsychological assessment 20 hours, 20 units with the following rationale: *“Patient was choked on the job. The patient states she lost consciousness, but it is not clear if she did or for how long. She is diagnosed with PTSD. Has extreme testing scores on depression and anxiety. I do not have any documentation of any indication of head trauma, and the patient has major psychological issues. Although requestor states the patient has symptoms consistent with head trauma, the medical documentation for this is missing from the information provided to me. I spoke with at 10:30 AM on 2/25, and pointed out the lack of documentation. found information from the treating which states the extent of injury is difficult to establish at this time it appears that the patient past history of depression and anxiety are exacerbated by the injury. The treating referred the patient for a neuro consult. does not have any documentation from the neuro consult. points out that the patient was choked and that this caused loss of consciousness. I told that without documentation that she sustained some sort of head trauma, and based solely on patient symptom reports of some loss of consciousness in the context of severe depression, anxiety and PTSD, the request for a complete neuropsych battery is not justified. Determination: Non-authorized.”*

On March 4, 2015, the patient underwent peer review.

On March 10, 2015, performed maximum medical improvement/impairment rating (MMI/IR) evaluation and was certified not to have reached MMI. She was currently enrolled and participating in a psychological counseling. She had completed a short course of therapy with good improvement.

On March 18, 2015, noted the request for neuropsychological evaluation and testing was denied and reconsideration was submitted. The patient currently had head and neck contusions. She was status-post DDE with who opined that she

had not met MMI and gave diagnosis of head injury to the face/neck and post-concussion syndrome. The patient was utilizing Klonopin, Trazodone and Zoloft. On examination, the patient described a funny sensation to palpation over the sternocleidomastoid muscles bilaterally of the cervical spine region, however denied this sensation causing her any pain. recommended continuing medications and ordered UDS. MRI of the brain was ordered.

On March 18, 2015, UDS was negative.

Per reconsideration review dated March 19, 2015, the carrier denied the appeal for neurobehavioral status examination four hours, four units and neuropsychological assessment 20 hours, 20 units with the following rationale: *“Based on clinical information, peer to peer review, TDI-DWC/Medicare Policy LMRP-V15B requiring appropriate intervention for condition and ODG Head Injury Chapter. There is inadequate/insufficient evidence to determine whether an association exists between mild Traumatic Brain Injury and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationship and decrease in the ability to live independently. Attention, memory and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patient's to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids (Cifu, 2009). Neuropsychological testing is one of the cornerstones of severe traumatic brain injury evaluation and contributes significantly to both understanding of injury and management of individual. The computer-based programs Immediate Postconcussive Assessment and Cognitive Testing (ImPACT), CogSport, Automated Neuropsychological Assessment Metrics (ANAM), Sports Medicine Battery and HeadMinder may have advantages over paper and pencil neuropsychological tests such as the McGill Abbreviated Concussion Evaluation (ACE) and the standardized assessment of concussion (SAC). ODG Head Injury Chapter: There is evidence of an association between sustaining a mild TBI resulting in loss of consciousness or amnesia and the development of unprovoked seizures or ocular and visual motor deterioration. There is also evidence of an association between mild TBI and Parkinson disorder and between mild TBI and Alzheimer's dementia when the injury included loss of consciousness. The initial assessment for concussion involves a screen for psychiatric problems such as post-traumatic stress disorder, depression and anxiety that can either overlap with brain injury or resemble one (Cifu 2009). Neuro-imaging is not recommended in patients who sustained a concussion/mTBI beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted (Cifu 2009). Patients who suffer TBI are at increased risk of developing a range of psychiatric disorder and 12 months after sustaining a traumatic injury, 31% of patients report a psychiatric disorder. Early identification of emergent psychiatric disorder and prompt early interventions to prevent psychiatric illness might facilitate optimal recovery from TBI (Bryant, 2010).”*

On March 26, 2015, evaluated the patient for headaches and memory issues. The headaches were located in the frontal region and occurring approximately four times a week. They were associated with difficulty tolerating light and noise. She was seeking counseling on her own due to severe anxiety. She had some mild anxiety in 2005 and some depression treatment in 1999. She was currently utilizing Zoloft, Trazodone and Clonazepam. Examination revealed she was very anxious with emotional lability. diagnosed postconcussion syndrome, chronic posttraumatic headache and panic attacks. recommended neuropsychological testing, extended EEG with 24 hour study and no driving. Zomig nasal spray samples were given. She was recommended to return in three weeks.

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

Official ODG regarding neuropsychological testing states that such testing is recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/ mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual.

On 01/28/2015, the patient underwent an initial Behavioral Medicine Assessment. On the NSC – Neuropsychological Symptom Checklist. endorsed the following symptoms:

“Change in sense of taste, bad taste, wears glasses, blank spots in vision, ringing in ears, muscle weakness, muscle twitching, tremor/shakiness especially with panic attacks, numbness, tingling skin, feeling pins and needles, headaches, forgetting where you are, having memory problems, can't think as quickly as before, find it hard to think clearly, more easily distracted, can't concentrate, remembering how to write, trouble with words when talking, understanding others, following conversation, trouble with writing, experiencing sadness and depression, feeling stressed with tension and anxiety, experiencing anger or keeping her temper,

worry or guilt, loss of interest.”

The patient’s date of injury was xx, so this assessment was done almost 6 months afterwards. It notes specific deficiencies in the areas of concentration, with distractibility and difficulty thinking, speaking and understanding conversations. Thus, since the patient is demonstrating significant problems in the areas of attention, memory and executive functioning more than 30 days after her anoxic episode/concussion, she does meet precisely the ODG recommendations for neuropsychological testing. Thus, this request for testing should be approved.

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

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