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### Notice of Independent Review Decision

**Date notice sent to all parties:** 10/14/15

**IRO CASE #:**

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

Neurobehavioral status examination, four hours, and neuropsychological assessment, 20 hours

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

Licensed by the Texas State Board of Examiners of Psychologists  
Certified in Psychology

**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 of the health care services in dispute.

Neurobehavioral status examination, four hours – Upheld  
Neuropsychological assessment, 20 hours - Upheld

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The Employee's First Report or Injury was difficult to read, but she had injured her right knee, neck, and lower back when she was pushed down. On xxxx, she was diagnosed with a lumbar, neck, thoracic, and knee/leg sprains/strains. Cervical, thoracic, and bilateral knee x-rays on 02/02/15 revealed no acute abnormalities. A thoracic MRI

dated 02/24/15 revealed mild spondylosis without evidence of an extruded disc herniation or high grade spinal stenosis. The lumbar MRI dated 02/24/15 revealed mild bilateral facet arthrosis at L5-S1 and disc desiccation at L4-L5 with minimal generalized disc bulging. A cervical MRI that day revealed postoperative status for a multilevel fusion. performed a Designated Doctor Evaluation on 06/23/15 and noted 7/8 positive Waddell's signs. A lumbar MRI dated 07/07/15 revealed the stress reaction of L4 and L5 pedicle was slightly less prominent than on the previous study. There was prominent facet hypertrophy at L4-L5 with mild facet arthropathy at L3-L4 and L5-S1. On 02/26/15, the carrier filed a DWC PLN-11 limiting the compensable injury to a neck sprain, thoracic sprain, lumbar sprain, and bilateral knee sprain evaluated the claimant on 03/16/15 and it was noted her past medical history was significant for high blood pressure, depression, and anxiety and a past surgical history for cervical fusion in 2005. She had undergone lumbar medical branch blocks at L4-L5 and L5-S1 on 07/28/14 with relief that lasted for one day. Her mood was noted to be euthymic with a congruent affect. Tramadol, Gabapentin, Methocarbamol, and Motrin were prescribed and she was referred to a licensed pain counselor. On 04/17/15, again documented the claimant had a euthymic mood with a congruent affect. It was noted they received approval for a counselor referral placed the claimant at MMI on 06/23/15 with a 0% whole person impairment rating examined the claimant on 07/10/15. She was frustrated because she continued with significant pain. noted the claimant appeared to have very high VAS endorsements and he would submit the claimant for a psychological evaluation and intake. She noted a past history for alcohol abuse performed an initial behavioral medicine assessment on 08/07/15. She noted she was injured while restraining a youth and he began to resist, throwing her to the floor. It was noted she endorsed the following symptoms indicative of head trauma to include loss of consciousness, frequent and/or severe headaches, dizziness/balance problems, memory problems or confusion, and hearing loss. She rated her level of interference of pain at 10/10. Her current level of functioning was noted to be 40%. Her mood was noted to be anxious and her affect was blunted. On BDI-II testing, she scored a 46, which indicated severe depression and on BAI testing, she scored a 40, which was reflective of significant anxiety. She scored a 75 on the PTSD checklist. It was felt she met all of the DSM-V criteria for the diagnosis of posttraumatic stress disorder (PTSD). On MMSE, she scored 28/30. The diagnoses were somatic symptom disorder, with predominant pain, persistent, moderate, PTSD, major neurocognitive disorder due to TBI, and major depressive disorder, single episode, severe without psychotic features. Individual therapy and neuropsychological testing, full battery, were recommended. reexamined the claimant on 08/08/15. She noted she had a lot of depression and denied suicidality. Her neurological examination was unremarkable, but her psychological examination was notable for depression. The impression here was traumatic event causing closed head injury with concussion, headaches, dizziness, and depression consistent with post concussive syndrome, cervical strain, thoracic strain, lumbar strain, and bilateral knee contusions, as well as anxiety and depression. A brain injury program and an MRI of the brain were recommended and Alprazolam, Fluoxetine, Gabapentin, and Tylenol #3 were refilled. On 08/12/15, the carrier filed a DWC PLN-11, disputing any and all psychological conditions, including, but not limited to anxiety and depression. On 08/24/15, provided a preauthorization request for four hours of a neurobehavioral status examination and 20 hours of a neuropsychological assessment. An MRI of the brain on 08/27/15 revealed disproportionate atrophy and white matter

disease for the stated age and no convincing acute intracranial process was seen. On 08/27/15, provided an adverse determination for the requested neuropsychological assessment and neurobehavioral status examination. On 09/04/15, provided a reconsideration request for the neurobehavioral status examination and neuropsychological assessment. The carrier filed another DWC PLN-11 on 09/17/15, noting they disputed all psychological conditions, including, but not limited to PTSD. On 09/23/15, provided another adverse determination for the requested neurobehavioral status examination and neuropsychological assessment.

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

There is no indication in the medical records reviewed that the claimant disclosed a head injury and/or loss of consciousness on the date of injury until seven months later during an initial behavioral medicine assessment on 8/7/2015. Given the lack of documented objective evidence to support this diagnosis, it cannot be confirmed as being related to the work injury. The symptoms reported could be relative to her depressive symptomology. The ODG guidelines specify that 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. However, there is no indication of a head injury or concussion in the records until about seven months later. Therefore, the neuropsychological testing is not indicated based on available information.

Between the date of injury and the behavioral medicine assessment on 8/7/2015, there is no indication or documentation of head injury, migraines, or loss of consciousness. Additionally, the assessment noted that the claimant experienced headaches and mood symptoms suggestive of head trauma. She denied a history of mental health treatment; however, on 3/16/15 during the clinical visit at, her medical history was noted to be remarkable for anxiety and depression. It remains unclear as to whether her mood symptomology are resulting from or exacerbated by the work injury. Additionally, it is unclear as to whether the claimant sustained a head injury with loss of consciousness during the work injury given that there is no mention of it in the medical records until the behavioral medicine assessment.

In addition, the ODG disability guidelines specify that neuropsychological testing is recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. There are no medical records to support the claim that claimant sustained a head injury. It is also unclear if she sustained a head injury related to her injury on or after the initial date of injury related. There is no available support for this diagnosis or to suggest that a head injury was sustained during the work-related incident. The requested neurobehavioral status examination, four hours, and neuropsychological assessment, 20 hours, are neither reasonable nor necessary nor are they supported by the ODG. Therefore, the previous adverse determinations should be upheld at this time.

**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)

Texas Labor Code