



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: October 19, 2015

DATE OF REVIEW: 10/19/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Neuropsychological Testing x 16 hours

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

Texas State Licensed MD Board Psychologist

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 or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:

The injured employee reportedly sustained an injury while working when she xxxxxx hitting the back of her head, her shoulder, and her back. She who complains of neck, head, and shoulder pain. She has had diagnostics, a consult, and medications for her injury. A note dated 7/31/15 notes that the patient reports her neck pain as 10/10. She noted having severe head, neck, low back, and bilateral shoulder pain. She was told she had a contusion.

She was seen and had a CT scan of the head which was reportedly normal and she was told she had a contusion. They attempted to send her back to work but she did not feel she was ready. She reported having a constant headache which she rated as 10/10. She reported that she sustained a loss of consciousness but it is not clear for how long. She complained of lower back pain which she rated as 10/10. She reported having bilateral shoulder pain which she rated as 10/10.

She was noted to be taking lisinopril-hydrochlorothiazide, alprazolam, and acetaminophen-hydrocodone. She was diagnosed with headache, neck sprain, post-traumatic headache-unspecified, disorder of bursae and tendons in shoulder region-unspecified, sprains and strains of the back-lumbar, and neuralgia,



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neuritis, and radiculitis-unspecified. Recommendations included a consultation MRIs, physical therapy, and fitness of duty restrictions was outlined.

A medication list that is undated, notes that she was taking hydrocodone, alprazolam, lisinopril, Tramadol, Robaxin, and one other medication that is unreadable. MRIs of the lumbar spine and cervical spine were reviewed. A Neurologic Consultation dated 8/20/15 notes that the physician is not sure if the patient lost consciousness. The patient reported having difficulty concentrating, focusing, and feeling tired and weak. She complained of dizziness, positional vertigo and near fainting. She loses her balance, cannot hear well out of both of her ears, cannot sleep well, and has headaches. She reported having panic attack-type episodes. She was noted to have obtained 25/30 on the MMSE and “a very high score” on the Assess MD test for depression noting moderate depression. The impressions includes concussive post-traumatic closed head injury with questionable loss of consciousness, no amnesia; post-concussion syndrome; exacerbation of underlying depression/generalized anxiety disorder and panic attacks; and post-traumatic lumbosacral and cervical spine intervertebral disc trauma with intermittent predominantly sensory upper and lower extremity radicular symptoms.

The physician recommended a neuropsychological evaluation, continued treatment, and provided education, and ergonomic instructions were given, medications were given, and he recommended a random EEG for intermittent confusion and disorientation, he recommended an infrared video ENG, and he recommended she return in six weeks. The physician reported that the neuropsychological evaluation is necessary as “Failure to deal with her mood and affective disorder most likely will either delay or make the successful resolution of her symptoms difficult” and “because there may be some underlying neuropsychological type overlay features in her history and physical examination.”

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

The information submitted notes that the patient sustained an injury at work in which she landed on the back of her head. She has reportedly experienced some symptoms associated with a post-concussive syndrome since to include headaches, vertigo, dizziness, loss of balance, difficulty concentrating, difficulty focusing, feeling tired, feeling weak, decreased hearing, and poor sleep. She apparently has concurrent psychiatric symptoms that increased as well following her injury. There is no description of the tests to be given or the rationale for 16 hours of testing. There are no diagnostics of the head submitted. She has not yet had a psychological evaluation to assess her current symptoms of psychological distress. There is insufficient rationale to establish necessity for a 16 hour neuropsychological assessment, per ODG guidelines. Therefore, the denial of these services is upheld.

ODG: Head Chapter: Neuropsychological testing: Recommended for severe traumatic brain injury with restrictions below, but not for concussions. For concussion/ mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI.



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There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neuro cognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, 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 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 severe traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The computer-based programs Immediate Postconcussion 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). (Cantu, 2006)

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)

REFERENCES:

1. Cifu, 2009
2. Cantu, 2006