

*Magnolia Reviews of Texas, LLC*

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**8/22/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cognitive rehabilitation program x 80 hours for cervical spine**

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

Psychologist

**REVIEW OUTCOME:**

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

Overturned (Disagree)

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 male who reported an injury on XX/XX/XXXX. The mechanism of injury occurred when the vehicle that the patient was riding in flipped over halfway. The patient is being reconsidered for a cognitive rehabilitation program x80 hours for the cervical spine. The patient has previously been treated with medications, activity modification, physical therapy, and 2 previous injections. The specific location to which the injections were administered was not noted. However, it is noted that the aforementioned injections did help the patient with severe headache pain slightly. There was mention of an unofficial CT myelogram having been performed. However, the objective interpretation of the report was not provided in the medical records. Functional capacity evaluation performed on 06/04/2015 indicates the patient was unable to complete the cardiovascular and VO2 max test secondary to fatigue. The patient demonstrated a lack of cardiovascular fitness due to deconditioning. The patient's VO2 max was below average and below what was considered to be normal for the patient's age, height, and weight, according to Guyton's Textbook of Physiology. The patient would be unable to safely perform his job demands based on comparative analysis between the required job demands and the patient's functional evaluation outcomes. Neuropsychological evaluation performed on 02/19/2015 indicates the patient has significant impairments in the domains of attention and working memory, verbal reasoning, visual memory, processing speed, and nondominant motor and sensory. Initial assessment and evaluation for an outpatient medical rehabilitation program dated 06/04/2015 indicates the patient denied having received any psychological and/or psychiatric treatment prior to this injury. The patient has previously undergone a lumbar fusion in 2000. The patient endorsed drinking caffeinated beverages in the form of coffee 1 to 2 cups in the morning and 1 to 2 cups in the p.m. The patient rates his pain 8/10 on

the VAS. Due to his head injury, the patient reported blurred vision, flashing lights in vision, loss of hearing in both ears, ringing in the ears, muscle weakness, trouble walking, coordination problems, balance problems, problems with dropping things, numbness and tingling of the skin, pain, headaches, and forgetfulness. Functionally, the patient reported difficulty with activities of daily living. Upon completion of the evaluation, the patient diagnoses include mild neurocognitive disorder due to traumatic pain injury, ICD-9 code 331.83; somatic symptom disorder with predominant pain, persistent, ICD-9 code 300.82; adjustment disorder, with mixed anxiety and depressed mood, ICD-9 code 309.28; closed head injury with no loss of consciousness, ICD-9 code 854.01; memory disturbance, ICD-9 code 780.99; and headache, ICD-9 code 784.0.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Per Official Disability Guidelines, head chapter, in regard to cognitive rehabilitation program, it states that interdisciplinary rehabilitation programs are recommended. The 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 physiatrist or another specialty, such as neurology or neurosurgery, 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. Outpatient day treatment programs are indicated if the treatment is provided under medical prescription and the patient is able to benefit from intensive therapy and the patient requires treatment from multiple rehabilitation disciplines, is diagnosed with mild to moderate post-concussion syndrome, requires neurobehavioral treatment for mild behavioral deficits or demonstrates moderate to severe cognitive dysfunction. Total treatment should generally range up to 4 to 6 months. Suggestions for treatment post-program should be well documented and provided to the referral physician; the patient may require time-limited, less intensive post-treatment with the program itself; & defined goals for these interventions and planned duration should be specified. The patient reported blurred vision, flashing lights in vision, loss of hearing in both ears, ringing in the ears, muscle weakness, trouble walking, coordination problems, balance problems, problems with dropping things, numbness and tingling of the skin, pain, headaches, and forgetfulness. Functionally, the patient reported difficulty with activities of daily living. The patient has significant deficits in attention/working memory, processing speed, verbal reasoning, visual memory and non-dominant motor/sensory. Individual modalities to be completed within the rehabilitation program include six sessions of individual psychotherapy, six session of biofeedback, six hours of cognitive skills training and up to 20 hours of group therapy. As such, the request for cognitive rehabilitation program x 80 hours for cervical spine would be medically necessary at this time.

## IRO REVIEWER REPORT TEMPLATE -WC

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

#### -ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Chapter: Head (Acute & Chronic) (updated 06/25/15), Interdisciplinary rehabilitation programs (TBI)

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 psychiatry or another specialty, such as neurology or neurosurgery, 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.

Treatment is provided under medical prescription by a Psychiatrist, Neurologist or other physician with brain injury experience, &

- Provide services that are within the scope of services provided under CARF as a brain injury rehabilitation program, &
- Patient able to benefit from intensive therapy (equal to or greater than 4 hours per day, 5 days per week), & at least one of the following:
  - Patient requires neurobehavioral treatment for mild behavioral deficits, or
  - Patient demonstrates moderate to severe cognitive dysfunction, or
  - Patient requires treatment from multiple rehabilitation disciplines, or
  - Patient diagnosed with mild to moderate post-concussion syndrome, or
  - Patient is unable to feed orally, &
- Care provided is NOT custodial care, but is focused on recovery and progress is demonstrated.
- Patient ambulates 50 feet with supervision.

Total treatment duration should generally range up to 4 to 6 months; &

If treatment duration in excess of 6 months is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided; &

Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility; &

At the conclusion and subsequently, re-enrollment in repetition of the same or similar rehabilitation program only if medically warranted for the same condition or injury or exacerbation of injury; &

Suggestions for treatment post-program should be well documented and provided to the referral physician; the patient may require time-limited, less intensive post-treatment with the program itself; &

Defined goals for these interventions and planned duration should be specified.

For individual outpatient therapies, see specific entries in ODG.