

# Medical Assessments, Inc.

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Amended April 26, 2018

October 6, 2017

**IRO CASE #:** XXXXXX

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

Neuropsychological Cognitive Testing x 16 hours

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

The Reviewer is a Board Certified Neurologist 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 XX who sustained an injury on XXXX in a XX.

XXXX: MRI of the lumbar spine. Revealed mild spinal canal narrowing to disc bulges with encroachment on the L4 and L5 nerve roots. XX also had evidence of advanced left and mild to moderate right neuroforaminal narrowing with grade one anterolisthesis of L5 and S1 and likely bilateral L5 pars defects.

XXXX: Chart notes by XX. It is recommended that the claimant will benefit from vestibular therapy due to XX work related head injury. According to ODG guidelines vestibular therapy, which includes habituation and adaptation improves gait, balance/coordination, dynamic visual acuity and decreases symptoms vestibular impairment. Diagnosis: Postconcussional syndrome, Dizziness, vertigo or giddiness.

XXXX: Infrared Video Electronystagmography Report by XX. Impression: Abnormal study. The above electronystagmographic abnormalities are predominantly consistent with a right side peripheral vestibular disorder. The right side unilateral weakness recorded in the bithermal caloric is a nonspecific anatomic localizing finding, but it most likely denotes a lesion involving the right horizontal semicircular canal and or its afferent pathway. Clinical and imaging correlation suggested.

XXXX: UR performed by XX. Rationale for denial: It is noted that the claimant had already returned to work and XX currently driving. There was no objective evidence of a cognitive deficit on any of the examinations. There is nothing in the records therefore that establishes the need for neuropsychological testing. In addition, standard neuropsychological testing does not exceed four to eight hours. The request in this case for 16 hours greatly

exceeds what would be consistent with the standards of care. The necessity of this service is not supported by the records and non-certification is recommended.

XXXX: UR performed by XX. Rationale for denial: The history and documentation do not objectively support the request for 16 hours of neurocognitive testing. In this case, the claimant has been able to drive XX personal vehicle without problems and has been working. Albeit light duty. No specific deficits requiring this type of testing have been described. It is not clear whether conservative care for XX complaints has been completed including rehabilitation for dizziness. The medical necessity of this request has not clearly been demonstrated.

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

**Amended:** The document "additional records" is regarding XX sleep study. This is outside of the field of orthopedic surgery. I cannot make any comments on this issue.

My decision is unchanged from my prior report.

XX who sustained head injury on XXXX in XX without loss of consciousness or amnesia XX. On XXXX chart note by XX indicated XX has been driving XX personal vehicle and has returned to work. Diagnosis: post concussional syndrome, dizziness, vertigo, or giddiness.

There has been no cognitive deficits documented on any of the examinations and there has been no indication that rehabilitation was done for dizziness.

The history and documentation for severe traumatic brain injury does not support request or Neuropsychological Cognitive testing x16. Therefore the request for Neuropsychological Cognitive Testing x 16 hours is non-certified.

**ODG Guidelines:**

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.

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. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive 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 concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The computer-based programs Immediate Post-Concussion 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](#)) The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, it should be performed by a trained neuropsychologist. Baseline NP testing is not required as an aspect of every assessment, but it may be helpful to add useful information to the overall interpretation of the tests. Persistent symptoms (>10 days)

are generally reported in 10–15% of concussions, at which point investigations may include formal neuropsychological testing and conventional neuroimaging to exclude structural pathology. ([McCroory, 2013](#)) In cases of multiple concussions/ persistent impairment, professional athletes should be referred for neurologic and neuropsychological assessment, and amateur athletes should have formal neurologic/ cognitive assessment and risk factor counseling. ([Giza, 2013](#))

**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)