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Notice of Independent Review Decision

IRO Reviewer Report

X

IRO Case #: X

Description of the service to in dispute: X

A description of the qualifications for each physician or other health care provider who reviewed the decision: X.

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

Overturned

Information Provided to IRO for Review:

X

Patient Clinical History [Summary]:

The member is a X who sustained an injury on X. The member reported an injury sustained when a X. Subsequently, the member developed cognitive symptoms, including headaches, confusion, memory loss, and speech difficulty.

The member was diagnosed with a posterior cruciate ligament avulsion from the femur; a high-grade radial oblique tear in the mid-posterior horn extending to the posterior body; a high-grade combination of radial

and horizontal cleavage tears in the posterior horn of the medial meniscus; an anterior medial condylar impaction fracture; a complete avulsion of the biceps femoris from the fibula with proximal retraction; avulsion of the conjoined fibular collateral ligament attachment; complete avulsion of the popliteus tendon from the lateral femoral notch; a tear of the lateral capsule; chronic grade 3 chondrosis of the patella; grade 4 chondrosis of the lateral trochlea; a large joint effusion with synovitis; and an unspecified injury of the head, initial encounter.

According to the peer review dated X, the clinical summary stated that the treatment included X. The member is X on X.

On X, X, FNP, provided a neurologic consultation for X, MD. The member reported an injury sustained when a X. Subsequently, the member developed cognitive symptoms, including headaches, confusion, memory loss, and speech difficulty. The member did not lose consciousness after the accident. Magnetic resonance imaging revealed X. Initially, the member did not recognize the member's X. The member is engaged in a X on X, X, and X. The member has not been under the care of a neurologist since the X. The member was using X. After being discharged from the hospital, the member has not been using it for a X. The member has a history of X. The member had a X on X. The member is reported to have cognitive impairment and memory issues, likely secondary to the X. Headaches, light, and noise sensitivity are related to the X. Right lower extremity complications resulted from the crush injury. The member was given a X. The date of the X was not disclosed.

On X, X, PsyD, requested X. The request includes X. Dr. X requested X.

According to the neurobehavioral status examination dated X, the member was X. The member's right leg sustained most of the damage. The member denied loss of consciousness. Since the accident, the member has experienced right leg pain, short-term memory loss, and communication struggles. The provider is requesting X. The neurobehavioral status examination revealed that the member's overall mental status seemed X. X appeared disturbed, as the member used a X.

The member was oriented to the day, year, person, and place. Speech rhythm and pace are X. Work situation, verbal fluency, and expressive language seemed X. The post-traumatic stress disorder (PTSD) checklist score is X, which is below the usual cutoff of X. On the neurobehavioral symptom inventory, the member had a score of X.

1. X.

Overtured

The Analysis and explanation of the decision include clinical basis, findings, and conclusions used to support the decision. In this case, the member sustained an injury on X. The member reported an injury sustained when a X. Subsequently, the member developed cognitive symptoms, including headaches, confusion, memory loss, and speech difficulty. The treatment included X. The member is X on X. Magnetic resonance imaging revealed X. Initially, the member did not recognize the member's X. Based on the medical records reviewed, the relationship between the member's X. The neurobehavioral symptom inventory yielded a score of X, indicating ongoing complaints across cognitive, affective, and somatic domains. A X is a standard, evidence-based approach for assessing the etiology and impact of cognitive symptoms, particularly in cases with complex clinical presentations. It is expected to clarify the nature and severity of the member's symptoms, identify contributing factors, and guide the development of targeted interventions. Given the X. This evaluation will play a critical role in supporting the member's recovery by informing treatment planning, enhancing functional restoration, and promoting independence and overall quality of life. The requested X is medically necessary.

A description, and the source of the screening criteria or other clinical basis used to make the decision:

ODG by MCG

Last review/update date: X

Neuropsychological Testing