Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.com

Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES 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 (Disagree)

☐ Partially Overtuned (Agree in part/Disagree in part)

☒ 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. While securing the X. X did X. The diagnoses were other symptoms and signs with cognitive functions and awareness (X), postconcussion syndrome, brain concussion with loss of consciousness of 30 minutes or less, anxiety, depression, posttraumatic vertigo, tinnitus of both ears, posttraumatic headache, cognitive impairment and otorrhea of left ear. X was seen by X, MD on X via telemedicine for the evaluation of X. X had multiple injuries, including X elbow, low back, shoulder and head. X started to have pain in X head and in all areas at the site of the accident. X was involved in another incident where previously where X was in a X. X had X, which was later confirmed by X workplace. X stated as a result of that X, X had started having headache, memory changes, nosebleeds, and leakage of fluid from X left ear when X woke up in the morning. X had tremors and other neurological symptoms including weakness and fatigue. X stated the symptoms from X original accident had not worsened. Since the accident on X, X experienced daily headache, which intensified in the afternoon, often reaching a severity of X. Alongside the headache, X reported ongoing dizziness, frequent nausea, occasional vomiting and significant balance impairment, sometimes requiring to steady X against the walls after sneezing. X did note that with headache, X was experiencing photophobia to a lesser extent than phonophobia. X had nausea and X did have scintillation and blurred vision in the left eye. X continued to feel weak and fatigued at all times. X described memory difficulties such as forgetting simple tasks and leaving doors or keys unattended. X also noted that X left the water on in X house and forgot to turn off X car and had been noted to have difficulties with understanding things that were being told to X and following directions. Sleep had been disrupted, with frequent awakenings during the night. Sensitivity to light and sound had worsened since the head injury, prompting X to use sunglasses and avoid loud environments. X denied any history of epileptic seizures. X noted mood disturbance since the most recent accident and stated X was depressed, but was anxious previously after the X. X had been both depressed and anxious. X managed X headache with over the counter X, which provided partial relief. X had not received X for X dizziness or memory issues. X incident with X prior had left lingering symptoms of dizziness, headache and

nausea. X controlled X hypertension with X. On examination, X was noted to be alert and oriented to person, place, time, and situation, grossly, recent remote, memory and attention and concentration in order to be intact. Expressive and receptive speech modalities were intact. Mood and affect were appropriate for the situation and judgment and insight were fair. Expressive and receptive speech modalities were intact. X were prescribed. A brain wave study, X, or X were recommended to assess brainwave activity and identify any irregularities contributing to cognitive or emotional symptoms, to provide insights to potential areas of dysfunction or imbalance in brain activity, to improve cognitive performance and emotional regulation, to guide treatment decisions and optimize brain function and to help inform targeted therapies aimed at enhancing brain function and overall mental well-being. X rehabilitation were recommended. Treatment to date included X. A letter was documented by X, MD on X to request authorization for the X. This assessment was medically necessary to objectively evaluate the X. The recent X had caused a severe and debilitating exacerbation of X condition. X was experiencing daily headache, persistent dizziness, nausea, significant balance impairment, photophobia, and phonophobia. X had profound cognitive complaints including memory loss, difficulty concentrating, and executive dysfunction. These symptoms represented a significant decline from X pre-injury baseline and severely impacted X functional capacity. A clinical history and neurological examination confirmed significant cognitive impairment consistent with postconcussion syndrome. The brain view/OCAT was an FDA-cleared, multimodal assessment tool essential for obtaining objective, quantitative date on the brain function. This request was supported by extensive peer-reviewed literature validating the use of such assessments in post-concussion syndrome. The results of the X would directly guide and optimize the treatment plan. The data would quantify the extent of cognitive impairment, identify specific neurophysiological abnormalities, establish an objective baseline and inform return to work decisions. This comprehensive approach was consistent with the ODG and ACOEM guidelines, which supported computerized cognitive testing when results directly impacted care, management and return to work planning. Give the documented concussion, persistent cognitive symptoms and the need for an objective basis to guide treatment and ensure a safe return to work, the X was medically necessary. Per a utilization review adverse determination letter dated X, the request for X, was denied by X, DO. Rationale: “In this case, in the submitted records, there is no significant

audiological, visual or objectively measured cognitive deficits documented upon exam to support further testing. Secondly, there is no documentation of a clear rationale for performing the requested X over the standard diagnostic procedures including standard audiometry and vestibular function study. In addition, the provider is requesting a X. Without submission of high-level evidence-base medicine research which would support that the results from this specific assessment are clinically meaningful and how these results will specifically impact the treatment plan and facilitate recovery, this request is not medically necessary." Per an appeal letter dated X by X, MD, the denial dated X was based on clear misreading of the submitted medical records and a fundamental misunderstanding of the requested procedures. The denial rationale was factually incorrect and contradicted the very evidence-based guidelines. X had profound cognitive deficits that severely impacted X daily function. The statement of "there is no significant audiological, visual or objectively measured cognitive deficits documented upon exam to support further testing" was false and ignored the extensive documentation in the X progress note consisting of cognitive deficits, audiological deficits and visual deficits. There was documentation of specific, severe and functionally-limiting cognitive failures. The neurologic review of systems was positive for memory loss. A gross screening could not qualify the extent of the specific executive function and memory deficits that X was reporting in X daily life. The history of present illness documented phonophobia and assessment included a formal diagnosis of X. There was X. X was not "over" standard tests and it incorporated the correct ones. The components of X were not alternatives. The X. A vestibular component was identified and X was referred for X. The X was necessary to assess the X. The X progress note explicitly and repeatedly detailed the exact rationale and impact on the treatment plan. The objective date was essential to guide X. Without this data, the therapies remained generic and less effective. X met the ODG criteria perfectly. X evaluation was X weeks after X injury. X records was filled with documented cognitive deficits and memory loss symptoms. X met the ODG criteria for testing. The X was FDA-cleared for objective cognitive assessment. The clinical utility of computerized neurocognitive assessment tools for X. The objective assessment was medically necessary to quantify X deficits, create an effective and targeted rehabilitation plan, and inform critical return-to-work decisions for X safety-sensitive occupation. Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, the claimant has a

history of X. The claimant recently sustained a X. The claimant complains of daily headaches that intensified in the afternoons to rated X, accompanied by dizziness, frequent nausea, occasional vomiting, and significant balance problems. The headaches are associated with both photophobia and phonophobia, more pronounced with sound, and visual symptoms including scintillation and blurred vision in the left eye. The claimant endorses persistent weakness, fatigue and notable memory difficulties, such as forgetting simple tasks, leaving doors open, leaving keys unattended, leaving water running, and forgetting to turn off a car, as well as difficulty understanding and following directions. The claimant reports worsening of sensitivity to light and sound, prompting use of sunglasses and avoidance of loud environments. The claimant has significant medical history of X that was managed with X. Review of systems is notable for balance difficulty, coordination problems, dizziness, headaches, irritability, memory loss and pain. The claimant has been diagnosed with postconcussion syndrome, brain concussion with loss of consciousness of X minutes or less, anxiety and depression, posttraumatic vertigo, tinnitus of both ears, posttraumatic headache, cognitive impairment, and left ear otorrhea. Documentation does not support this testing for management of the condition. There is no evidence that standard neuropsychological testing cannot be sufficient to guide rehab services and that each rehab provider cannot assess the claimant for status and progress accordingly. Documentation does not support the need for the testing when the claimant has established diagnosis of postconcussion syndrome, brain concussion with loss of consciousness of X minutes or less, anxiety and depression, posttraumatic vertigo, tinnitus of both ears, post-traumatic headache, cognitive impairment, and left ear otorrhea which can guide treatment. The diagnostic procedures requested would not be expected to significantly impact the plan of care. Therefore, this request is not medically necessary." Per an appeal letter dated X by X, MD, the denial dated X was clinically flawed, based on critical misapplication of ODG guidelines and failed to recognize the medical necessity of objective data for guiding treatment in a X case. X was superimposed upon a prior X. Dr. X denial was predicted on the idea that "standard" testing was sufficient. It failed to appreciate the severity of the documented, multi-system deficits, which were far beyond what a simple screening could calculate. X had profound executive function and memory deficits including forgetting simple tasks, leaving doors open, leaving keys unattended, leaving water running and forgetting to turn off the car. X had severe sensory and visual deficits including both photophobia

and phonophobia, more pronounced with sound, and visual symptoms including scintillation and blurred vision in the left eye. X had persistent neurological and audiological deficits. X had daily headache, intensified in the afternoons to X. X had significant balance problems, which sometimes required bracing against walls, tinnitus of both ears and leakage of fluid from the left ear. X data would target X to specific deficit domains for cognitive rehabilitation. The X evoked potentials would help determine if X significant balance problems were peripheral (inner ear) or central (brain-based), which dictated the entire vestibular rehabilitation approach. X data would provide the specific cognitive benchmarks required to determine if and when X could safely resume any driving duties. Regarding prognosis and disability, X was critical to determine if the deficits were temporary or permanent, which was essential for guiding long-term claim management and vocational rehabilitation. The argument that "standard neuropsychological testing" was sufficient was flawed as X reported severe functional failures. This X was superimposed with a X. X X was associated with cognitive, visual and audiological deficits. Regarding misapplication of ODG guidelines, it was critical to distinguish the X. X occupation of a X required sustained attention, divided attention, rapid decision making and executive function. The potential consequences of premature return to duty clearance based on grossly intact telemedicine screening included a X. Authorizing this assessment was a most cost-effective path forward. An early comprehensive assessment facilitated an appropriate treatment targeting, safe return to work planning and a significant reduction in total claim costs and liability risk.

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

Based on the attached records, the patient does not meet current evidence-based indications for a X. Contemporary guidelines and recent reviews state that X, lack validated clinical utility for diagnosing or defining X. The patient's ongoing cognitive and post-concussive symptoms do support further evaluation through established methods such as formal neuropsychological testing and structured cognitive rehabilitation, but there is no guideline-supported reason to pursue a X based assessment. Therefore, it is this reviewer's opinion that the services in dispute: X are not medically necessary and the prior denials are upheld.

Non-certified.

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**