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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 Overturned (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. The mechanism of injury was documented as X. The diagnoses included traumatic brain injury without loss of consciousness, memory impairment, adjustment disorder with depressed mood and irritability and anger. X was seen by X, MD / X, MD on X for an evaluation of memory impairment since the X. X was involved in the X. X was noted to have multiple fractures. X reported having trouble remembering things that were supposed to be short term. X gave an example of X. X could record the information on the phone but then forgot. X forgot where X placed objects at home. X forgot what X wanted to say when having a conversation. X had infrequent headache but it was not bothersome. X had neck pain one to two times per week. It was relieved by heat pad. X mood was sometimes irritated. X felt useless and was unable to work. Sometimes X thought "it would be better if X was off" but never had an active plan or intention to act on it. X had no trouble going to sleep with X. The Montreal Cognitive Assessment (MOCA) score was X with X recall. Cranial nerve examination was X. Upper and lower extremity muscle strength was X. Deep tendon reflexes were X in upper and lower extremities. Sensation was intact to light touch, pinprick and vibration in upper and lower extremities. Romberg test was X. Dr. X suspected X. X were recommended. A functional capacity evaluation was completed on X by X, PT, DPT indicating X demonstrated the ability to perform within the light physical demand category, which was below X job category. Based on the sitting and standing abilities, X may be able to work full time within the functional abilities outlined. X job was classified within the medium physical demand category. X could lift X pounds to below waist height, X pounds to shoulder height and X pounds overhead. X could carry X pounds. X could pull and push X horizontal force pounds. X demonstrated an occasional tolerance for above shoulder reach, firm grasp, sustained kneeling, stair climbing and walking. X demonstrated an ability to perform dynamic balance, bending, forward reaching, fine coordination, pinching, and simple grasping with frequent tolerance. Sitting and standing were demonstrated on a constant basis. The functional activities that X was to avoid within a competitive work environment included crawling and squatting. An office

note dated X completed by X, DO was included in the records. A X referral were recommended. The note was incomplete. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, PsyD, with the following rationale: “No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines recommend X. There should be a behavioral change, cognitive deficits, memory loss symptoms, or mental status abnormality and results of testing will impact treatment. The time for testing administration, scoring, and interpretation in number of minutes/hours as well as frequency should be documented. The claimant has short-term memory loss, difficulty with word finding, headaches, neck pain, irritability, depression, and feeling of uselessness due to X. On exam, the claimant is oriented X, intact comprehension, MOCA X, X recalls, intact cranial nerves II to XII, X strength, intact sensation and reflexes, no involuntary movements, no tremors, normal stance and gait, can heel and toe walk, and positive Romberg. Prior treatments were medications. The provider requested X. However, the request is not supported as the time for testing administration, scoring, and interpretation in number of minutes/hours were not indicated. There were also no latest office visit notes submitted. Therefore, the request for X is non-certified. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines state that X may be indicated when X. The request for X was previously denied as the time for testing administration, scoring, and interpretation in number of minutes/hours were not indicated, and no latest office visit notes submitted. In this case, the claimant sustained injury due to X. They present with memory impairment, depressed mood, irritability, feelings of uselessness subsequent to the injury. Romberg was positive on physical examination. Laboratory tests were X. The request for X was resubmitted. While this test may be considered given complaints of memory loss symptoms and irritability subsequent to the injury, a more recent office visit note supporting the request was still not provided for review. The office visit that was submitted was X months ago. Therefore, the request is still not warranted. As such, the request for X is non-certified. “I have thoroughly reviewed provided records including provider notes and peer reviews. This includes the medical records that were provided for the IRO that were not available for the URA reviews, additional

records were provided with exam date X. The patient has X. X is warranted in order to better diagnose patient's potential cognitive deficits to guide treatment. The request clearly meets the cited ODG guidelines. Request for X is necessary. X is medically necessary and certified.

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

I have thoroughly reviewed provided records including provider notes and peer reviews. This includes the medical records that were provided for the IRO that were not available for the URA reviews, additional records were provided with exam date X. The patient has X. X is warranted in order to better diagnose patient's potential cognitive deficits to guide treatment. The request clearly meets the cited ODG guidelines. Request for X is necessary. X is medically necessary and certified.
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)**