Becket Systems

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## *Notice of Independent Review Decision*

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**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. X was X. The diagnoses were concussion without loss of consciousness, acute not intractable posttraumatic headache, postconcussion syndrome, cervicogenic headache, occipital neuralgia, balance disorder, and cognitive impairment.

X was seen by X, MSN, APRN-FNP-C on X for a follow-up of left forearm, left wrist and left elbow pain. X had a chronic condition and persistent pain, sleep disturbance, high blood pressure, and occupational restriction. X described a X. X had daily headache in the morning and evening, rated X, which was near the back of X head and moved to the crown of X head and sometimes to the neck. X complained of dizziness, eye twitches, lines in X field of vision, and two falls that occurred after the accident. The pain was constant, sometimes severe enough to affect X ability to think clearly, and X often needed to write things down to compensate for cognitive difficulties. X reported a pain level of X and noted the pain wore X down, disrupted X sleep, and contributed to significant stress. Despite these symptoms, X avoided taking pain medications like X unless absolutely necessary. Cognitively, X stated X had difficulty recalling words and sometimes X pronounced them differently. To cope, X was using lists, word association, and kept pads of paper with X wherever X went. X sleep had been notably poor, frequently interrupted by throbbing pain that woke X at X or X in the morning. This ongoing sleep disruption further compounded X sense of fatigue and impacted X daily functioning. X experienced concern about X blood pressure, noting it tended to rise during periods of pain and stress. X linked X elevated blood pressure to recent stressful life events, including the X. X had been putting X legs up to keep X feet from swelling, but denied kidney issues. X had been having issues with being irritable. These stressors exacerbated X inability to return to work due to injury-related restrictions, which led to the cessation of X benefits and difficulty securing new employment. The combination of chronic pain, sleep disturbance, hypertension and occupational stress had created a challenging environment for X overall well-being. On examination, blood pressure was 147/105mmHg and BMI was 31.24kg/m2. X appeared tearful, visibly upset and in mild distress. Tenderness to palpation was noted at the base of the skull. There was nonpitting edema of the lower extremities. X was alert and oriented, cooperative with examination. Gait was X and sensory examination was intact.

Psychiatric examination revealed X. Neurological examination showed alert and oriented times three, comprehension and language intact, general knowledge and judgment within normal variation, fluent speech, and recalled X objects immediately and after X minutes. Romberg test was X.

An electrodiagnostic study of the left upper extremity dated X showed no X. There was electrical evidence for a left sided axonal injury to the left sided ulnar and its corresponding F-wave. This may be a distal compressive injury, and it may be the X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Based on the documentation provided, the ODG by MCG Last review/update date: X Neuropsychological Testing, is not satisfied. On X, the patient saw X, NP. There is pain in the left elbow, shoulder, and neck. The patient has headaches and dizziness. Sleeping and mood difficulties are present. On the exam, balance is X. The plan is for ongoing care. In particular, there is a lack of peer-reviewed literature demonstrating that computerized cognitive testing is the standard of care. Therefore, the request for X is non-certified.”

An appeal letter was documented on X by X, MD indicating X sustained a compensable injury on X resulting in a concussion. Since the injury, X had experienced persistent and debilitating symptoms consistent with X. As documented in X medical records, including the visit with X, NP, on X, X continued to suffer from chronic headaches, dizziness, impaired balance, sleep disturbances, and mood difficulties. These symptoms were clear indicators of ongoing neurological dysfunction that required objective assessment to guide appropriate treatment. A thorough clinical history and neurological examination had been performed and documented, revealing significant cognitive concerns that were directly impacting X functional status and ability to return to work. The purpose of the requested X was to obtain objective, quantifiable data on X cognitive function, specifically in domains such as attention, memory, processing speed, and executive function, which could not be adequately assessed through a standard clinical examination alone. The denial’s assertion that ODG guidelines were not

met was incorrect. X symptoms aligned directly with the ODG guidelines. Both ODG and American College of Occupational and Environmental Medicine (ACOEM) supported the use of X. The claim of a “lack of peer-reviewed literature” was demonstrably false. X was an FDA-cleared and Medicare-approved technology for the objective assessment of cognitive function in patients with X. The validity and reliability of computerized neurocognitive assessment tools was supported by a wealth of scientific literature. The results of the X would directly and fundamentally guide the treatment plan. Objective data would allow to tailor a specific X, make informed decisions regarding pharmacotherapy and establish an evidence-based timeline and strategy for X to return to work. Without the objective data, X treatment plan remained reliant on subjective reporting, which was insufficient for X. The requested services were part of a X. The denial X. The denial of the service was preventing from receiving care that was considered the standard for X and was critical for X recovery and safe return to function.

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “While cognitive assessment can be appropriate for patients with X. The ODG recommends X. X does not meet the criteria for medical necessity, as it is not supported by ODG or current medical literature as a standard diagnostic test for X. Therefore, the request for X is upheld and non-certified.

Per a letter dated X by X sustained a work-related concussion on X. It was over X months post-injury and X continued to suffer from severe, debilitating symptoms consistent with X. X condition was not an acute, self-limited X. X symptoms as on X included significant cognitive impairment with documented difficulty recalling words, processing speed deficits (difficulty to think clearly), and memory loss requiring compensatory strategies (writing everything down); vestibular and visual dysfunction including persistent dizziness, impaired balance (Romberg positive) and visual disturbances (lines in X field of vision); and sleep disruption including waking consistently at X or X am due to the pain, compounding fatigue and cognitive issues. A standard clinical examination was no longer sufficient. This advanced, objective testing was required to quantify X functional deficits and guide X complex, multi-disciplinary treatment plan. The denial misinterpreted or

narrowly applied the ODG guidelines: X symptoms aligned perfectly with the ODG criteria for "X." X was over X weeks post-injury, far exceeding the threshold cited by ODG for neuropsychological testing. ODG recommended X. The reviewer's claim that the test lacked sufficient peer-reviewed evidence was incorrect. X was an FDA-cleared and Medicare-approved technology for this exact purpose. The reviewer's methodology was flawed. The individual CPT codes were analyzed as if they were separate, unrelated requests. These components were part of a single, integrated, comprehensive assessment protocol. The test was not just a "X" but it combined with the X. The results of this test would directly and fundamentally guide X treatment plan. Without this objective data, X treatment remained reliant on subjective reporting, which was X. The denial was preventing X from receiving medically necessary, evidence-based, and FDA-cleared care that was critical for X recovery. The denial was based on a flawed application of ODG and an incorrect assessment of the test's validation and purpose.

The claimant is a X who sustained a work-related concussion on X after being X. X continues to experience chronic daily headaches (X), dizziness, impaired balance, visual disturbances, cognitive slowing, and memory loss, all of which have persisted for over X months despite X. Current management includes X. Based on these findings, the claimant meets clinical criteria for the X. Objective assessments like X. Therefore, it is this reviewer's opinion that medical necessity is established for the services in dispute: X is medically necessary and certified.

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

The claimant is a X who sustained a work-related concussion on X after being X. X continues to experience chronic daily headaches (X), dizziness, impaired balance, visual disturbances, cognitive slowing, and memory loss, all of which have persisted for over X months despite X. Current management includes X. Based on these findings, the claimant meets clinical criteria for the X. Objective assessments like X. Therefore, it is this reviewer's opinion that medical necessity is established for the services in dispute: X and the prior denials are overturned. X is medically necessary and 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)**