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***Notice of Independent Review Decision
Amendment X***

IRO REVIEWER REPORT

Date: X; Amendment 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. X stated X was checking some X. It blew up and threw X. X denied any loss of consciousness. X stated the right side of X. Initially after the X, X felt a pounding to X right ear. About X minutes after the X, X started to notice right-sided head pain and right lateral side neck pain. X stated it felt like a "X," visual changes and hearing loss to the right ear. The diagnosis was traumatic brain injury (TBI) and intractable headache. On X, X underwent X by X, MD, X. X was given a X. Unavoidable X. X tolerated the procedure well with no complications. Dr. X noted that conventional methods of treatment such as X had been tried including X but X had been X. X met criteria for X. X had significant improvement in X. X no longer had daily headaches. X mentioned that X experienced a headache about X. X had associated X. Previous X was on X and was clinically effective as demonstrated by more than X improvement in X symptoms. Frequency of treatment was X. On X, X was evaluated by X, APRN. X work injuries included X. X ongoing medications included X. The X had recently been denied, an appeal was submitted, and it was also denied. X stated the X. X was at a constant X. X also referred to X. On examination, head was X. Neurologically, X was alert and oriented with X. Cranial nerve X revealed X. Cranial nerve X revealed X. Cranial nerve X revealed the X. The assessment was X. X was on permanent work restrictions. X was to continue taking X. An IRO would be requested. No updated imaging studies were available for review. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: ""ODG by MCG Last review/update date: X: X." In this case, the patient was given X. There was greater than X improvement since the X. However, there was no documentation of an updated, detailed history and physical examination regarding the effectiveness of X. 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: "The request is not medically necessary. In this case, the request for X is denied based on ODG (Official Disability Guidelines), which do not recommend X. Specifically, ODG does not support its use for X. As such, this request is not supported at this time. Therefore, the request for is not medically necessary. "Based on the clinical

information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: ""ODG by MCG Last review/update date: X: X. In this case, the patient was given X. There was greater than X improvement since the X. However, there was no documentation of an updated, detailed history and physical examination regarding the effectiveness of X. 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: "The request is not medically necessary. In this case, the request for X is denied based on ODG (Official Disability Guidelines), which do not recommend X. Specifically, ODG does not support its use for X. As such, this request is not supported at this time. Therefore, the request for X is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is a lack of information provided regarding the patient's response to the most X. Percentage and duration of pain relief following X in X is unclear. The status of the patient's current headaches is unknown. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. X is not medically necessary and non-certified

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: ""ODG by MCG Last review/update date: X: X." In this case, the patient was given X. There was greater than X improvement since the X. However, there was no documentation of an updated, detailed history and physical examination regarding the effectiveness of X. 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: "The request is not medically necessary. In this case, the request for X is denied based on ODG (Official Disability Guidelines), which do not recommend X. Specifically, ODG does not support its use for X. As

such, this request is not supported at this time. Therefore, the request for X is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is a lack of information provided regarding the patient’s response to the most recent X. Percentage and duration of pain relief following X. The status of the patient’s current headaches is unknown. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. X is not medically necessary and non-certified

Upheld

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)**