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Notice of Independent Review Decision

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:
X with a date for injury X. A X. X did not lose consciousness (LOC), but experienced severe headaches, nausea and a sensation of pressure in X head that felt overwhelming. The diagnosis was traumatic brain injury without loss of consciousness, initial encounter (X).

X was seen by X, MD on X and X. On X, X was seen for chief complaints of nausea and headaches. X sustained a head injury at work on X when a X. Following the injury, X was evaluated in the emergency room, where X was advised to take it easy and avoid flying for a few days. X also reported severe double vision, difficulty processing visual information, trouble reading and writing, forgetfulness, and worsening memory. X experienced ringing in the ears initially, which had mostly resolved. X described swaying sensations when walking, imbalance,and episodes of vertigo, especially at night, sometimes accompanied by nausea upon waking. X denied loss of consciousness or bleeding at the time of injury but recalled seeing stars and feeling close to fainting. X had a deep indentation at the site of injury, which had since improved to a small indentation in the front of the head. Pain was mostly located in the back of the head, moving to the forehead. On examination, X was well developed and was in mild distress. X was awake, alert, and oriented. Speech was fluent. Short-term memory was grossly intact. Fund of knowledge reads / repeats well. Pinprick sensation was intact. An X was noted. Spine examination showed X. Kemps test, Spurling test, and Compression test were X. Straight leg raise was X. The assessment included X. X had persistent occipital headaches following a closed head injury. The pain was described as originating in the occipital region and radiating to the forehead, consistent with occipital neuralgia. The history of trauma, ongoing severe pain (X), and associated symptoms support this diagnosis. X were indicated for both diagnostic and therapeutic purposes. On X, X presented for a follow-up. X reported that X symptoms have improved compared to previous visits but have not fully resolved. X continued to experience episodes of nausea and intermittent headaches, though X noted that the headaches were less frequent than before. X stated that X headaches occurred approximately X or X times per week, and they were no longer lasting all day. X rated X current headache intensity as moderate. The pain was described as throbbing, sometimes feeling as ifher “head is going to explode,” and X localized the discomfort primarily to the back of X head, though it could vary. X reported that X symptoms were not constant, now coming and going throughout

the week. X denied receiving additional medication for symptom relief and noted that improvement tends to occur spontaneously over time. On examination, X was in mild distress. X was awake, alert, and oriented. Speech was fluent. Short-term memory was grossly intact. Fund of knowledge reads / repeats well. Pinprick sensation was intact. Finger taps, finger to nose, and rapid alternating movements were symmetric. An X was noted. Spine examination showed X. Dr. X opined that X would benefit from X.

A CT scan of the brain dated X showed X. A CT scan of the cervical spine revealed X. An MRI of the brain dated X was X. Per an addendum dated X, enhanced images showed X.

Treatment to date included X.

Per an adverse determination letter and peer review dated X, the request for X was denied by X, MD. Rationale: “ODG Criteria, “X is not recommended for any of the following: X.” The patient had a head injury to frontal region of the head and developed headaches (HA) with post-concussion syndrome. There is X. The request for an X is not medically necessary. Therefore, the request for X is non-certified.”

On X, X, MD documented an appeal letter and requested reconsideration of non-certification issued on X, regarding the authorization of the X. The previous determination did not fully reflect X current clinical presentation nor the progression of X symptoms following the injury sustained on X. X continued to experience persistent headaches originating in the occipital region and radiating to the frontal area, described as throbbing and moderate to severe in intensity. These episodes occurred multiple days per week and significantly affect X quality of life and functional capacity. Although the initial impact occurred in the frontal region, the mechanism of acceleration-deceleration produced X. These findings were consistent with X. X had completed an appropriate course of X. Despite these efforts, symptoms persisted and continued to interfere significantly with X daily activities and work performance. Given the lack of response to X. The requested procedure was medically necessary for both diagnostic and therapeutic purposes. In cases of X. For these reasons, Dr. X respectfully requested reconsideration of prior determination and approval of X. This intervention was medically justified, safe, and necessary for continued recovery and improvement in functional

capacity.

Per a peer review dated X and utilization review letter dated X, the prior denial was upheld by X, MD. Rationale: “The guidelines do not typically support X. The guidelines note that X is not recommended for X. The most recent office visit note submitted for review indicates that the claimant reports X symptoms have improved but have not fully resolved. The claimant’s symptoms are not constant, now coming and going throughout the week. Therefore, the requested Appeal: X is not medically necessary.”

X, MD completed an appeal letter on X regarding denial of X. After reviewing the letter and cross-referencing it with X clinical history and current functional status, it was opined that the requested procedure was reasonable and medically necessary. The previous determination did not fully reflect the severity, chronicity, and neurological pattern of X condition, nor X documented X. Since the incident, X developed persistent and debilitating headache symptoms with progressive involvement of the occipital region, consistent with occipital neuralgia and cervicogenic headache. X symptoms included headaches beginning in the posterior scalp and radiating anteriorly; occipital and uppercervical tenderness to palpation; Tinnitus was described as ringing or “bell-like” sounds; visual disturbances, including intermittent blurry and double vision, especially with neck rotationor exertion; cervical pain radiating upward into the scalp; episodes severe enough to require emergency evaluation; and exacerbation with neck movement and partial reliefwith rest or short-term analgesics. These clinical features directly align with the diagnostic profile of X. X pain distribution had clearly evolved into an occipital pattern, contrary to the prior reviewer’s conclusion that X lacked symptoms localizing to this region. X had completed X. These interventions have not produced meaningful or sustained functional improvement. X remained significantly symptomatic and functionally impaired. The requested X: X.X. Contrary to the rationale in the denial letter, this request adhered to guideline-supported practice. The Official Disability Guidelines (ODG) explicitly recognize the use of X. Given X ongoing severe headaches, functional limitations, neurological symptoms, reproducibleoccipital tenderness, and exhaustion of X, the X was medically necessary to advance X care in an evidence-based and targeted manner. Without this intervention, X would continue to experience debilitating symptoms that impede X daily life and may lead to unnecessary healthcare utilization. For

these reasons, Dr. X respectfully requested approval of the X. This procedure was clearly indicated, consistent with clinical presentation, guideline-supported, and essential in determining the next step in treatment plan.

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

The ODG states, "X : X; X is NOT recommended for any of the following X: X." In this case, there is lack of documentation that other responsive modalities have not been tried for X management. There is no neurological assessment provided that diagnoses the type of headache the claimant is experiencing that support use of X. The diagnostic work up is incomplete for a formal diagnosis to be made. Therefore, the requested X is not medically necessary.

X is not medically necessary

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE