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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured in a work-related motor vehicle accident (MVA) on X, sustaining a X. X reported that while X. X tried to correct the direction, but X was X. X stated X. The X. X returned to work X. The diagnosis was posttraumatic stress disorder (X), seizure disorder (X), transient confusion (X), post-concussion headache (X),

postconcussional syndrome (X), and cognitive impairment (X).

X underwent a X by X, PhD, on X. Dr. X noted X continued to show X. There was noticeable contribution of X. Continued consultation with X regarding X was recommended. X was recommended. X recommended. X were recommended. X was seen by X, MSN, APRN / X, MD on X and X. Per a X Brief X of Progress dated X, by Dr. X, X was originally tested on X and subsequently approved to attend the X to address X. X sustained a X. X original X indicated difficulty with X. Apparently, X was released to work with light duty restrictions prior to beginning the X as recommended. X stated X was completing the X. X stated X became startled when X heard an impact wrench nearby, jumped back, and fell against the safety chain. The safety chain broke, causing X to X. X reported remembering difficulties sleeping, and was able to recall increased difficulties with reading comprehension, saying the wrong word in conversation and not noticing it (someone else pointed it out), periods of confusion, lack of observation causing safety concerns, increased frequency of headaches (daily, severe), declined balance and coordination (spilled drinks on X, unsteady, off balance), and significant sleep disturbance. X continued to exhibit an involuntary, right eye twitch. X continued to have pain in X back and hands. X anxiety and depression appeared to have increased due to the secondary trauma, as well. X was tested on X using selected subtests of The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS); STROOP Neuropsychological Screening Test; Digit Span; Controlled Oral Word Association (COWA); Animals Test; Trail Making Test A&B; MOCA; Clock Drawing; and Wechsler Adult Intelligence Scale- Fourth Edition (WAIS-IV)-Selected Subtests to determine current cognitive functioning regarding learning, memory, verbal fluency, working memory, attention, visual-spatial skills, and language in order to make comparisons to X initial testing since X had sustained a X. The testing demonstrated the following results: Though X demonstrated X; X exhibited further decline in these already damaged areas of functioning since X second work-related X. Even X areas of X had declined, especially X visual independent retrieval (previously in the average range was now in the impaired range). Prior to X, X language abilities were in the borderline to average ranges. However, since X, X language scores ranged from borderline to impaired. X exhibited significant aphasia and paraphasia since X as well as impaired auditory attention, fluency, working memory, processing speed, and information retrieval. X was tested by Dr. X on X. X completed the following tests: Clinical Interview; Neuropsychological Symptoms Checklist (NSC); Neurobehavioral Symptoms

Inventory (NSI); Patient Competency Rating (PCR); Beck Depression Inventory, Second Edition (BDI-II); Beck Anxiety Inventory (BAI); Mini Mental Status Exam; Wechsler Adult Intelligence Scale 4th Edition (WAIS-IV): Vocabulary, Digit Span, Similarities, Block Design, Coding, Symbol Search, Matrix Reasoning, Arithmetic; \Vide Range Achievement Test-Fourth Edition (WRA T-4): Word Reading, Mathematics, Spelling; Trails Making A &. B; Rey Auditory-Verbal Learning Test (RAVLT); Rey Complex Figure Test and Recognition Trial (Rey-O/RCFT); Controlled Oral Word Association (COWA) and Animals Test; The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS): Line Orientation, Picture Naming; Clock Drawing; Grooved Pegboard Test (GPD); Delis-Kaplan Executive Functioning System (D-KEFS): Design Fluency subtest; STROOP Color Word Test. On the Mini Mental Status Exam, X demonstrated a mildly impaired performance (MMSE = X) when compared to others X age. X was able to repeat three words on immediate recall after one trial, and X was not able to independently recall any words after a short delay. X was able to recall two words with multiple choice cues, and X was unable to recognize the last word with a multiple-choice cue. X experienced difficulty when asked to perform serial Ts (X); be also showed difficulty spelling the word "WORLD" backwards (X). X could name items presented to X, and X could read a sentence independently. Yet, X demonstrated difficulty following a 3-step command (X). X overall intellectual functioning was in the borderline range. According to the examination, X simple visual attention and tracking was in the borderline range (Trail Making Test A). X processing speed was in the borderline range (WAIS-IV) Processing Speed Index). X overall verbal ability was in the borderline range (WAIS-IV VCI). X general vocabulary was in the borderline range (Vocabulary). X phonemic verbal fluency was in the borderline range (COWAT). X semantic verbal fluency was in the mildly impaired range (Animals). X confrontation word retrieval was in the average range (RBANS Picture Naming Subtest). X ability to copy a complex figure was in the low average range (ROCFT Copy). X visual attention and tracking was in the borderline range (WAIS-IV Coding), and X ability to distinguish matching visual items under time constraints was in the low average range (WAIS-IV Symbol Search). X visuospatial problem solving was in the high average range (WAIS-IV Block Design), and X visuospatial abstract reasoning was in the borderline range (WAIS-IV Matrix Reasoning). X visuospatial judgment was in the average range (RBANS Judgment of a Line), and X spatial awareness was in the low average range (Clock Drawing Test). When memory was defined as a storage unit, X auditory memory appeared improved as X was able to recognize more words than X originally learned when given multiple

choice cues, as X originally learned X words and was able to recognize X words with multiple choice cues. This was significant as X appeared to have improved regarding the ability to retain auditory information. However, X continued to need repetition of information to learn the expected amount of information for X intellectual capacity, and X exhibited significant difficulty independently recalling information X had learned without cues. When memory was defined as a storage unit, X visual memory appeared to continue to be impaired since X had difficulty attending to visual stimulus and even more difficulty learning and recalling visual information. X cognitive flexibility had improved from severely impaired to low average, which was significant and wonderful. However, X continued to exhibit significant impairment regarding processing speed, verbal fluency, and inhibition. X overall fine motor functioning had also significantly improved from the impaired range since X original testing. The current diagnostic impressions were as follows: Regarding X neuropsychological test scores, X demonstrated improvements as well as significant residual deficits in X neurocognitive functioning. X auditory memory, bilateral fine motor functioning, and cognitive flexibility had all improved significantly. However, X continued to demonstrate impaired functioning regarding processing speed, working memory, general vocabulary and expressive language, verbal fluency, inhibition, independent retrieval, spatial awareness, problem solving, and visual memory. X continued to exhibit significant postconcussive symptoms with associated posttraumatic anger and posttraumatic headaches. X cognitive, psychological, and physical functioning remained persistent X years post-injury and continued to affect X ability to return to work, complete X ADLs independently, and affect X social relationships. X would benefit from X. X reported and continued to demonstrate symptoms meeting criteria for X. Therefore, Dr. X continued to believe X met criteria for the following diagnoses: X).

On X, X was seen via telemedicine for a follow-up of chronic conditions. X reported continuing to experience X headaches per week, rated at X. These headaches remained a persistent issue for X. In addition to X headaches, X described ongoing nightmares. X also reported X had been vomiting every day for about the X months. This new symptom had been a notable change in X health status. X also mentioned that X slept a lot, which raised concerns among X family members. On examination, X was in no acute distress. X was cooperative, alert, and oriented. Cognitive function was intact. Judgment and insight were good. Mood / affect was full range. Clear speech was noted. The assessment included X. Medications were refilled. X was

referred for X. On X, X presented for a follow-up. X described persistent symptoms of weakness and dizziness, noting that most of the time X felt as though X was not fully present and suspected that X. These sensations of fatigue and feeling “not there” had become a regular part of X experience. In addition to these ongoing symptoms, X reported experiencing a little pain that day, though X did not elaborate on its severity or location. These physical complaints continued to affect X daily life. The pain was rated at X without medications. X were refilled. A referral for X was provided.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, MD. Rationale: “Regarding X, the Official Disability Guidelines recommend it as an option for patients with X. Patient situation and expectations must be appropriate for neuropsychological testing. Comprehensive neuropsychological evaluation and testing are not indicated. The claimant is more than X years out from the initial injury and X. They have had X. Given this history, X do not appear to be medically necessary at this point in time. As such, the request for X is non-certified.”

In an appeal letter dated X, X, MD formally appealed the denial of preauthorization for a X. The denial determination dated X appeared to be based on a significant misinterpretation of X current clinical status and a reliance on outdated assumptions. This denial contradicted established guidelines, such as those from the American Academy of Neurology (AAN) and the Official Disability Guidelines (ODG), which recommended X. The evaluation remained medically necessary to address a new, conflicting clinical picture and to guide appropriate treatment. The denial rationale was systematically flawed, and Dr. X would address each point using the recent medical records provided with the initial request. The denial stated X was "more than X years out from the initial injury". While this timeframe was accurate (DOI X), it was clinically irrelevant as a basis for denial. The medical necessity for this evaluation was not based on the original injury date but on a new and significant discrepancy in recent clinical findings. On X, an NP exam note stated "X." Dr. X subsequent X on X confirmed active, symptomatic diagnoses of "Cognitive impairment" (X) and "Transient confusion" (X). This direct conflict between two recent clinical assessments, less than X months apart, was the primary driver for the request. A X was the objective gold standard to resolve this clinical ambiguity, as supported by

AAN guidelines emphasizing re-evaluation in cases of diagnostic discordance or new symptom emergence, regardless of time since initial injury. Dr. X further noted that the reviewer's assertion that X "symptoms have remained relatively unchanged" was factually incorrect and unsupported by the recent medical records. The progress note from X documented a new, significant symptom: X "X". Dr. X examination note documented X severe, persistent symptoms of weakness, dizziness, and feeling "as though X is not fully present" and "not there". Dr. X wrote, “The clinical picture is clearly not static. The emergence of new symptoms (e.g., daily vomiting, leading to potential dehydration and further functional decline) and the presence of conflicting cognitive assessments prove that the patient's condition is dynamic and warrants a new, objective evaluation to clarify the etiology of X current presentation and prevent further deterioration.” It was noted that the denial's reliance on "X" and a "X" was the central flaw in this determination. Any testing data from X (over X years ago) was clinically obsolete. Per APA guidelines, the validity of X data typically did not exceed X years, especially in cases with new, confounding variables. It had zero utility in diagnosing or managing X current status in late X. X current clinical picture was vastly different from X. The X testing could not possibly address the primary diagnostic question that day: differentiating the X of X original X from X active "Seizure disorder" (X), X active "Post-traumatic stress disorder" (X), and the potential X. Summarizing the medical necessity of the request, Dr. X wrote that this evaluation was not a request for repeat testing; it was a request for a new evaluation to answer new and critical diagnostic questions that X-year-old data could not address. The X was medically necessary to resolve conflicting data, establish current baseline, perform differential diagnosis, and guide treatment, potentially facilitating return to work and reducing long-term disability costs. Dr. X opined, “To deny this evaluation is to deny the only objective tool available to understand and appropriately treat X complex presentation, risking unnecessary suffering and inefficiency. I urge you to overturn this denial and approve the medically necessary evaluation as requested. We request a written response to this appeal within X days.”

Per a utilization review decision letter dated X, the prior denial was upheld by X, MD. Rationale: “Proceeding with a X. While it was noted that there was vomiting and severe, persistent symptoms of weakness, dizziness, and feeling ‘as though they are not fully present’ and ‘not there’ over the past X of months, and prior request was also noncertified in review X on X during which vomiting and was also noted but there were no significant changes. This claim is X years old and the X was already

done. There would need to be a major significant change in clinical information to complete another testing. There was no mention of continued vomiting on X. Based on this, the prospective request for X is non-certified."

On X, X, MD formally requested an Independent Review to overturn the adverse determination regarding the medical necessity of a X. The previous denials (Review #X were based on the erroneous assertion that the X condition was 'static' because the injury occurred in X, and that prior testing from X was sufficient. These determinations failed to account for X recent clinical destabilization, the obsolescence of X-year-old data, and a critical diagnostic conflict in the recent medical record that only objective testing could resolve. The denial stated that 'symptoms have remained relatively unchanged.' This was factually incorrect based on the submitted medical records. In X, X presented with a new onset of daily vomiting persisting for X months, alongside chronic headaches and nightmares. During the X on X, X reported a worsening distinct sensation of 'not being fully present' and feeling 'not there' most of the time. The emergence of these symptoms indicated a dynamic, unstable clinical picture, not a static one. To deny evaluation on the basis of 'chronicity' ignored the active, evolving neurological symptoms currently being treated. A primary indication for X was to resolve discrepancies in clinical presentation. X recent records presented a conflict that clinical interview alone could not solve: On X, a Nurse Practitioner's screening noted "X." On X, Dr. X neurological assessment diagnosed active "Cognitive Impairment" (X) and "Transient Confusion" (X) based on X deteriorating presentation. This direct conflict between an "X" screening and an "X" specialist diagnosis necessitated a tie-breaker. A X was the gold standard for objectively quantifying X. The denial relied heavily on the fact that X underwent testing in X. Reliance on data that was nearly X years old was clinically unsound. X was typically considered valid for X years. A gap of X years rendered the previous profile obsolete for current treatment planning. Data from X could not account for X cognitive aging, the progression of X comorbid seizure disorder, or the long-term effects of chronic pain and PTSD. Dr. X was treating X as X presented in late X, not as X appeared in X. X was currently prescribed a X. X in particular, was widely known to be associated with cognitive side effects, including difficulties with word-finding, memory, and processing speed. It was medically necessary to perform current testing to differentiate whether X reported "not fully present" sensations and transient confusion were sequelae of X, manifestations of X seizure disorder, or iatrogenic cognitive side effects of X medication. Without objective data, they risked

treating medication side effects as X. Dr. X concluded as follows: “The denial rationale hinges on the timing of the original injury while ignoring the current clinical reality. X is demonstrating new, conflicting, and worsening symptoms that X-year-old data cannot explain. This evaluation is not a ‘re-do’ of X; it is a critical diagnostic tool required to establish a current baseline, resolve the diagnostic conflict between providers, and ensure X treatment plan is targeted and safe.”

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

Per the submitted documents, the claimant has been treated for symptoms resulting from a history of X. Diagnoses include seizure disorder, transient confusion, syncope and collapse, post-concussional syndrome, and post-concussional headache. The records show X was noted to have daily vomiting persisting for X months in X, as well as chronic headaches and nightmares. On X, a Nurse Practitioner’s screening noted “X.” The neurological exam on X indicated the claimant reported a sensation of ‘not being fully present’ and feeling ‘not there’ most of the time. Dr. X neurological assessment on X indicated diagnosis of active “Cognitive Impairment” (X) and “Transient Confusion” (X). I agree that the conflict between an “X” screening and an “X” specialist diagnosis questions the clinical picture on the claimant. There is a lack of recent lower-level cognitive exam and objective examination findings that support the need for the requested testing. Therefore, the request for X is not medically necessary.

Upheld

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