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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 on X. X was the X. X stated the X. X denied hitting head or loss of consciousness. X reported whiplash injury. The diagnoses were memory impairment, brain concussion without loss of consciousness due to whiplash, posttraumatic headache, post concussive symptoms, anxiety, and tinnitus.

On X, X was seen by X, NP / X, MD via telehealth for headache evaluation. X complained of headaches that were less than before and were located on the left side of X head. X noted that lying down provided relief and X was effecting. Aggravating factors included bright light. Headaches were described as throbbing and rated X. Headaches were resolved for a period of time; however, returned since returning to work. X was pending X. X also endorsed X. X reported X would forget X badge or keys at home. X reported losing X train of thought. X also complained of anxiety significantly worsened after the accident. X denied depressed mood or increased irritability. X also denied loss of balance or dizziness. X complained of intermittent tinnitus. X noted blurry vision prior to accident that had not worsened after accident. X complained of difficulty sleeping that fluctuated and depended on X pain level. There was pain located at neck and lower back and seeing X. Per the note, MRI of the brain on X showed 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: “The Official Disability Guidelines recommend X. In this case, the claimant sustained a X. The neurologic examination is X, including X. Headache and mild post-concussive cognitive complaints alone are explicitly listed in the Official Disability Guideline indications where an X is not recommended. As such this is not medically necessary. Therefore, the request for X is not medically necessary.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “The request for an X is not medically necessary. As noted in ODG's Head Chapter X. Here, however, there was no record of the claimant's presenting with signs or symptoms of an X. Pursuit of X is not indicated or appropriate in the X. Therefore, the Appeal for X is not medically necessary.”

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

X who was injured on X. I have thoroughly reviewed provided records including peer reviews. In this case, the claimant has X. The claimant denies hitting head or losing consciousness. While it is possible the patient could have some degree of X. As cited by peer reviews, based on ODG Criteria, an X does not appear necessary as the patient did not have a X. The request X is not medically necessary and the determination is upheld.

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