

**Envoy Medical Systems, L.P.**  
**1726 Cricket Hollow Dr.**  
**Austin, TX 78758**

**PH: (512) 248-9020**  
**FAX: (512) 491-5145**  
**IRO Certificate**

**DATE OF REVIEW: 12/10/10**

**IRO CASE #:**

Description of the Service or Services In Dispute  
4 hours of neuropsychological testing

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Physician Board Certified in Anesthesiology and Pain Management

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters, 11/18/10, 11/4/10  
Carrier letter to IRO 12/6/10  
notes, 2010  
Notes, Dr., 2008-2010, Neuropsychological evaluation 2/20/09  
Medical, Dr. notes 2008-2010  
Operative report 5/20/08  
Notes 2008, Dr.  
ETMC notes 2008  
Peer review 11/15/09, 11/25/09, Dr.  
Impairment rating 7/15/10, Dr.  
Toxicology report 6/25/10  
Report, Dr., 5/4/10, 11/14/08  
MRI report 3/24/08  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

In, the patient was injured in a rollover motor vehicle accident. Neck, back, shoulder, arm, low back, and knee pain resulted. Rotator cuff surgery was performed in May 2008. In November 2008 the patient was found to be at MMI with four percent impairment. Additional physical therapy was performed. Neuropsychological evaluation was performed 2/22/09. Numerous diagnoses were opined, and medications were utilized. Cervical surgery was performed in October 2010. There was extensive psychotherapy after the neuropsychological evaluation.

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

I agree with the denial of the requested neuropsychological evaluation. A neuropsychological evaluation has been performed, and extensive psychotherapy provided. ODG do not endorse repeating neuropsychological evaluation. Psychotherapy has already been thoroughly explored.

**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
- AHCPR- 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
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)