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**NOTICE OF INDEPENDENT REVIEW DECISION**

May 19, 2006

**Re: IRO Case # M2-06-1198 -01 \_\_\_ amended 5/27/06**

Texas Department of Insurance, Division of Workers' Compensation:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Division of Workers' Compensation cases. Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that the Division of Workers' Compensation assign cases to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurology, and who has met the requirements for the Division of Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Denial letters
3. Medical records Dr. Sundaresan

4. Medical records, Dr. Bartel
5. Medical records, Dr. Herren
6. Medical records, Dr. Huff
7. Medical records, Dr. Schaffer
8. Medical records, Dr. Butera

#### History

The patient was injured in \_\_\_ when a stack of tires fell on his head, neck and back. He suffered a closed head injury, as well as injury to his cervical and lumbar spine.

Medical records from 1998 indicate a diagnosis of cervical spondylosis and myelopathy. The patient complained of neck pain that extended into his arms and numbness of the right leg. He was dropping things and having unsteadiness on his feet. A 1999 history and physical indicated decreased range of motion of the neck and low back, and upper extremity weakness, and on 2/9/99 an ACDF was performed. The patient was doing well in April 1999, but in June 1999 he was continuing with discomfort in his neck and dizziness. Apparently, he had fallen multiple times since his surgery, and his legs had given out intermittently. He was given trigger point injections.

In May 2000 it was noted that the patient was having progressive loss of strength in his arms and legs, with numbness and tingling in his hands, and spasms in his legs. He had to use a cane. He was taking multiple medications. Physical examination showed spastic quadraparesis. An MRI showed continued spinal stenosis at three levels. The fusion was solid. The patient was still diagnosed with cervical myelopathy. On 8/22/00 the patient complained of pain and stiffness in his arms and legs. An MRI showed stenosis and cord compression. It was noted that the patient had had periodic confusion in the past, with some amnesia following this. There was concern about the patient's confusion after seizures.

A 5/1/01 report notes the patient's history of cervical and lumbar disk disease, and a history of a closed head injury and seizure disorder. In May 2001 the patient underwent a C5-6 posterior laminectomy and foraminotomy. A post-operative infection developed, and the patient underwent another operation for irrigation and debridement.

In October 2001 the patient had numbness in his hands and weakness, and in 2002 neck and back pain with numbness in the hands, and depression were noted. On 4/4/02 the patient claimed seizures on a daily basis for a month, and had a seizure in his physician's office. On 4/9/02 the patient said that he had had five seizures in the last week. A family history of seizures was noted. The patient was put on additional medications. A 4/9/02 EEG showed abnormal left temporal spike and slow focus, which was consistent with a complex partial seizure disorder. On 6/10/02 no new seizures were noted. The patient continued with pain, and underwent a 6-week physical therapy program and injections in addition to medications, without relief. He continued to have severe low back pain and spasms in the neck and back. He had trouble with balance and required a cane. He also had nausea and vomiting.

On 7/22/02, the patient's neurologist noted further seizures, confusion and memory problems. A 9/4/02 orthopedic evaluation revealed good straight leg raising, abnormal ankle reflexes, and diminished range of motion in the neck. The patient was diagnosed with cervical spondylosis, a herniated disk at C5-6, a herniated disk at L5-S1, chronic pain syndrome in both areas, a closed head injury and seizure disorder. Intra-thecal narcotic treatment was recommended.

In September 2002 it was reported that the patient has episodes of psychotic depression and aggressive behavior, and that he was suicidal and emotionally fragile. In November 2002 he underwent placement of a lumbar intra-thecal catheter for a trial with narcotic medication. He was getting 50%-60% overall

reduction in his pain with the narcotic infusion. The patient had a seizure in the hospital with abnormal

behavior, which resolved. On 12/13/02 back pain, short-term memory loss, nervousness and depression were noted. The patient was doing better with intra-theal administration of narcotics and in December 2002 an infusion pump was implanted for narcotics.

On 3/10/03 it was noted that the patient continued to have low back pain radiating into the legs, with the legs giving out. The pain pump was helping. The patient reported two or three seizures over the past three months. He had pain in the back and neck, requiring medication adjustments. A sleep study indicated sleep apnea, and central apnea. Aggressive treatment of depression was recommended.

A 5/27/05 CT scan of the cervical spine showed post-operative changes C3-7. The patient's problems with pain and numbness continued. Epidural steroid injections were administered on November 2005. The patient was evaluated by a psychiatrist on 2/1/05. The psychiatrist noted that the patient had recurrent lifetime episodes of depression, and now had positive thoughts of death. He was not violent, aggressive or combative. The patient was noted to suffer from short-term memory loss, and had problems reading and focusing. He was diagnosed with Depressive Disorder, Cognitive Disorder and Psychotic Disorder. His medications were increased. An MRI of the brain with contrast was recommended because of the patient's history of traumatic brain injury and cognitive symptoms. Formal psychological testing for further evaluation was also recommended.

#### Requested Service(s)

Psychological testing, psychiatric sessions, repeat MRI of the brain.

#### Decision

I agree with the carrier's decision to deny the requested psychiatric sessions at this time, and I disagree with the decision to deny the requested psychological testing and repeat MRI of the brain.

#### Rationale

The patient suffered cerebral and neck trauma from a \_\_\_ injury. The medical records provided for this review indicate that the patient had cognitive symptoms that vary from memory problems, intermittent confusion and a seizure disorder. Unfortunately, the records do not reveal any evidence of a report of an MRI scan of the brain, or any evidence of any past cognitive neuropsychological studies. The majority of the medical records since 1998 reflect mostly on the patient's cervical and lumbar problems. The records provided for this review do not indicate there ever being an adequate cognitive neurologic examination of the patient to assess his cognitive abilities. Based on the history of the injury, the development of seizures, and the various comments in various progress notes, in all medical probability the patient was likely having cognitive symptoms, which include memory loss, concentration difficulties and depression, which are not uncommon symptoms following traumatic head injury. It is also evident from the patient's history, that the patient had a history of pre-existing depression, and he appears to have more than likely developed worsening depressive symptoms following the head injury. The records indicate that the patient has a focal left temporal seizure focus, which has produced complex partial seizures that have been well described in his history and that appear to be somewhat better, but still continue to occur.

An MRI of the brain with contrasts is reasonable and necessary. Even if the patient had had an MRI around the time of the \_\_\_ injury, the patient still continues to have seizures and cognitive and psychological symptoms that appear to be present 10-15 years from the time of injury. Important information can be gained from a new MRI. It would be important to know if the patient had focal atrophy in the region of the seizure focus, or if there is evidence of low density abnormalities or

significant atrophy that would correlate with his cognitive symptoms. If there were fairly diffuse

atrophy, which is greater than expected for his age, or multiple low density lesions and scarring, this would increase the probability that the patient would have significant organic cognitive deficits, as well as a reason for the focal cerebral disorder. Even if the patient had an MRI early after his head injury, none of these findings would necessarily be present then. The likelihood of chronic sub-dural hematomas, arterial venous malformations, or other structural lesions are probably much less likely a reason to do the MRI.

A complete battery of neuro-psychological testing is also medically necessary, whether or not the patient had a detailed study in the past. Many cognitive disorders due to brain injury improve with time, and this patient continues to have significant symptoms 10 – 15 years after his injury. A neuro-psychological battery would give very important information related to detailed functioning of the brain, and could help sort out which symptoms are due to psychological issues, and which are due to cerebral structural disturbance. It would be important to evaluate the patient's memory, executive function, visual perception, personality and depression. This is important for future treatment. If testing shows that the patient has significant cognitive deficits due to structural changes of the brain, this may require cognitive retraining, which is different from psychotherapy. On the other hand, if there is a strong psychological component to many of the symptoms, as evident on the testing, then perhaps counseling, psychotherapy and antidepressants may be the treatment to consider. If previous cognitive neuro-psychological testing was performed, it would be important to compare the previous results to the current results.

Psychotherapy would not be medically necessary prior to the MRI of the brain and detailed neuro-psychological testing. The outcome of these tests can help in deciding what further treatment is necessary. If the patient turns out to have significant cognitive disturbance as a primary problem, psychotherapy may not be needed, and cognitive retraining may be required. If, on the other hand, the patient turns out to have predominantly psychological issues with minimal cognitive problems, then perhaps counseling and psychotherapy should be considered after the results are obtained.

This medical necessity decision by an Independent Review Organization is deemed to be a Worker's Compensation decision and order.

### **YOUR RIGHT TO APPEAL**

If you are unhappy with all or part of this decision, you have a right to appeal the decision. The decision of the Independent Review organization is binding during the appeal process.

If you are disputing a decision other than a spinal surgery prospective decision, the appeal must be made directly to the district clerk in Travis County (see Texas Labor Code sec. 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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Daniel Y. Chin, for GP

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 30<sup>th</sup> day of May 2006.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: North Texas Neurology Assoc., Attn Sandy Benigno, Fx 940-761-3832

Respondent: ACE USA/ESIS, Attn Rayetta Martin, Fx 713-403-3139

Texas Department of Insurance, Division of Workers' Compensation: Fx 804-4871 Attn: