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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Vision Rehabilitation 2 x week for 30-40 sessions CPT 92065 92012

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

MD, Board Certified General Surgery

REVIEW OUTCOME:

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Legal correspondence dated 09/19/11

Request for IRO dated 09/16/11

Request for IRO dated 09/20/11

Utilization review determination dated 07/13/11

Utilization review determination dated 07/29/11

Claim summary dated 09/23/11

Peer review dated 11/12/10

Peer review dated 08/09/11

Letter of medical necessity dated 07/11/11

Clinical records Dr. dated 06/24/10, 03/31/11

Letter of appeal dated 07/29/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xxxx. On this date she is reported to have been employed sustaining multiple injuries when a cover plate for fume board landed on her head and shoulder cutting her left index finger causing her to fall to the ground. Following the injury the claimant was evaluated by Dr. at Health Systems. Radiographs of the skull, right shoulder, and left index finger were negative. She was diagnosed with blunt head trauma, contusion to right shoulder, and open wound to left index finger. The claimant was seen in follow-up the following day with complaints of dizziness, light headedness, and nausea. CT of head was obtained revealing marked ventriculomegaly highly susceptible for acute hydrocephalus. However, there was no evidence of intracranial traumatic injury. The following week the claimant presented to Dr. With inability to speak. A CT of head revealed mild generalized ventricular prominence suggestive of communicated hydrocephalus. MRI of cervical spine revealed small midline disc protrusion at C4-5. The claimant was subsequently referred to Dr. neurologist who noted the claimant's speech returned back to normal after 3 days and walking had been strange. She reported feeling disoriented, trouble concentrating in the frontal headache. On examination she has anxious affect and is unable to concentrate to answer questions. She

was assessed with traumatic communicating hydrocephalus. Dr. suggested after the head injury, subarachnoid blood could have caused closure of arachnoid villi leading to communicating hydrocephalus and accounting for her headaches, trouble with gait and mental changes. MRI of brain revealed generalized ventriculomegaly involving all the ventricles; however, there was no transependymal cerebral spinal fluid absorption defect to suggest the ventricles were under pressure.

The claimant was referred to Dr. neurosurgeon, who noted the claimant's symptoms were getting better and happy with her progress. Based on imaging studies, he found no indication for any neurosurgical intervention including cisternogram and recommended observation. Records indicate the claimant was referred for neuro cognitive skills rehabilitation program.

The claimant was seen by Dr. who performed visual sensory integration testing. During the testing it was reported the claimant became disoriented when dulling eye movement skills and prism activities. She is reported to have passed out and was expected to have had vasovagal response to light. Dr. assessed saccadic eye movement deficiency, accommodative dysfunction, and visual special disorientation. In 12/05 videonystagmogram and audiometry revealed peripheral vestibular pathology with unilateral weakness for right ear.

Records indicate that the claimant was treated with oral medications. She underwent neuropsychological evaluation which was significant for situational counseling for approximately 12 months secondary to sexual harassment while in college. Cognitive function was intact in majority of cognitive domains with only limited evidence suggestive of subtle neuro cognitive deficits in aspects of attention functioning, processing speed, verbal fluency, verbal and nonverbal memory. She was recommended for additional visual retraining and individual psychotherapy.

The claimant later was seen by Dr. and was noted to have many episodes of syncope that were unexplained. An electroencephalogram was obtained and revealed evidence of epilepsy of focal origin out of the right Centro temporal region and possible generalized discharge as well. She was placed on Lamictal and Topamax. She is noted to have been involved in motor vehicle accident with brief exacerbation of seizures. Records indicate the claimant was eventually placed at maximum medical improvement with impairment rating of 28%.

She continued to receive treatment and was seen by Dr. for problems with depth perception, squinting, straining and light sensitivity. She was recommended for bone conduction therapy and further neural developmental testing. Treatment included the use of prism lenses to remediate posttraumatic vision syndrome. The claimant was seen by Dr. who was assessed labyrinthine hypofunction bilaterally, dizziness, bilateral sensorineural hearing loss, endolymphatic high drops with possible viral inflammation, coordination disorder, imbalance, polyneuropathy, and sleep disorder. Future medical staffing report indicated it was probable that the claimant had preexisting communicating hydrocephalus, and the acute head injury potentially aggravated preexisting condition. It was also reported it was feasible that the acute head trauma triggered an underlining psychogenic component.

In follow-up with Dr. the claimant is reported to experience frequent double vision of vertigo, sensitivity of light and inability to focus at times. On examination she could not voluntarily move her eyes. He assessed a history of oculomotor dysfunction, visual spatial disorientation, magnocell drop out, visual field defect, and severe photophobia. He recommended therapeutic treatment for 40 sessions of neuro-optometric rehabilitation with use of lenses and / or prisms to remediate visual process.

A peer review was performed by Dr. Dr. notes the claimant has ventriculomegaly that may be form of communicating hydrocephalus. He noted it is quite clear that there is no evidence of acute hydrocephalus because there was no transependymal CSF change, and clearly this standing was long standing and may have been there since birth. He recommended the continuation of Lamictal. He opines the claimant sustained a minor closed head injury

without evidence of cerebral injury but with significant psychological response to the event.

The records include a peer review from Dr. dated 08/09/11. Dr. notes that an exact diagnosis would be difficult and there are varied opinions from treating providers as to cause of the claimant's complaint. He notes that malingering counts in part for the claimant's symptom reports and performance during assessment, and that there may also be factors associated with factitious disorder, conversion disorder, or both. Records indicate that the claimant was seen in follow up by Dr. on 03/31/11 with no significant changes in her clinical presentation.

The records contain a letter of medical necessity from Dr. dated 07/11/11. He notes that the claimant had shown good improvement with therapeutic glasses as well as the potential for further improvement in his visual areas of visual intervention through an in office vision rehabilitation as sought. He reports that these conditions will not get better on their own and rehabilitation needs to be addressed ASAP as it is time sensitive. He discusses or he subsequently recommends 40 sessions of in office rehabilitation.

A utilization review was performed on 07/18/11 by Dr. who was board certified in ophthalmology and cited an article and conducted a peer to peer with Dr. who reported that the claimant had a wide range of visual problems including ocular movement disorder fragile visual system and ocular vestibular problems. Dr. notes that the published peer reviewed literature in ophthalmology does not support the clinical effectiveness of vision therapy as proposed in this case for the treatment of visual discomfort visual field deficit and lack of coordination. The appeal was reviewed by Dr. who non-certified the request on 08/05/11. A peer to peer was conducted with Dr. Dr. noted that the current literature indicated no real chance of reversing a long duration of visual difficulty. He further noted that the requested therapeutic modality was not supported by significant scientific evidence with two of the largest medical groups that deal with ocular problems.

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

The records indicate that this claimant sustained trauma to her head on xx/xx/xxxx. It was opined that the claimant sustained a work related injuries to the brain, right shoulder, and left index finger. The records indicate that the claimant has undergone extensive evaluations and conservative treatments and there is a clear lack of consensus regarding the claimant's diagnosis. The claimant has had chronic complaints of double vision, pain with eye movements, visual deficits, impairments in visual focusing visual spatial awareness. She has undergone psychiatric evaluation that suggested a strong psychological component. The previous reviewers note that there is a lack of consensus regarding vision rehabilitation within their field and further note that the probability of improvement six years post date of injury is unlikely. Based upon the totality of the clinical information the reviewer finds the request for Vision Rehabilitation 2 x week for 30-40 sessions CPT 92065 92012 is not medically necessary.

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

ACOEM-AMERICA 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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

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)