Notice of Independent Review Decision

January 3, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
92546 Vestibular-Ocular reflex Test; 92548 Platform Posturography; 95930 Visual Evoked Potential; 92082 Visual Fields; 92541, 92542, 92544, 92545 Electro-Nystagmography; 96111 ImPact Neuro-Cognitive Test

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

Board Certified in Occupational Medicine, Diplomate American Board of Preventive Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 12-9-11 OD., Letter of Medical Necessity.
- 9-12-12 OD., office visit.
- 10-2-12 DO., Medical Review.
- 10-25-12 OD., Letter.
- 11-9-12 MD., Medical Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

12-9-11 OD., the evaluator noted that the claimant was referred to his office for a comprehensive neuro-optometric rehabilitation evaluation secondary to complaints of poor eye teaming, double vision, poor peripheral vision on his right side, poor depth perception, tracking issues and photophobia subsequent to a work related head injury. A comprehensive neuro-optometric and neuro-sensory examination was both performed, which confirmed specific visual deficits. The claimant presents with visual tracking and teaming issues (which can lead to double vision and significantly reduced depth perception). Overall, the claimant shows binocular dysfunction (decreased depth perception), photophobia and visual spatial dysfunction (visual tracking deficit). Based on the evaluator’s evaluation, he feels that the claimant suffers from: Diagnosis Codes: Lack of coordination, Nonspecific abnormal oculomotor studies, Diplopia. The evaluator would like to recommend a course of Vision Rehabilitation Therapy to be carried out in his office. The initial course of therapy would be 12 sessions which would occur twice a week for six weeks. After completion of the sessions a re-evaluation will be completed to gauge changes on the visual system and any next steps that would need to be taken.

9-12-12 OD., the claimant having problems with focusing issues while wearing the glasses. (Back and between the computer and paper work) moderate blurry vision with near work, wear glasses when driving 75% of time, cannot wear glasses when he walks, “sickening” and nauseating, the claimant admits glasses help overall. Miscellaneous sensory motor testing: mild left midline shift- without lenses-no
IRO REVIEWER REPORT - WC


10-2-12 Ephraim Brenman, DO., performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guideline; the request for appeal of vestibular-ocular reflex test, impact neuro-cognitive test, electro-nystagmography, visual field, visual evoked potential, platform posturography, and otoacoustic emission test is non-certified. He noted the claimant does not have any dizziness or abnormal findings on caloric irrigation to justify the tests requested for vestibular function. There was also no note of any hearing deficits to justify the request for otoacoustic emission. The claimant was not noted to have had a moderate or severe traumatic brain injury to justify the request for neuropsychological testing. Finally, the claimant was not noted to have a persistent significant impairment in visual acuity while wearing glasses to necessitate the performance of tests for visual field and visual evoked potential.

10-25-12 OD., the evaluator noted that he has requested the following testing: Vestibular-ocular reflex test, impact neuro-cognitive test, electro-nystagmography, visual field, visual evoked potential, platform posturography. Per your notice of Adverse Determination dated 10-2-12, the evaluator would like to appeal the decision based on the following grounds: The evaluator is attempting to analyze function of the visual system which has been adversely affected by the mTBI. Based on the following diagnosis, the evaluator will make a case for the testing: lack coordination (visual-spatial disorientation), abnormal oculomotor studies, and memory disturbance. Please reconsider your adverse decision for this testing as it is necessary to complete a comprehensive Neuro-Optometric rehabilitation evaluation.

11-9-12 MD., performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guideline; the request for appeal of vestibular-ocular reflex test, impact neuro-cognitive test, electro-nystagmography, visual field, visual evoked potential, platform posturography, and otoacoustic emission test is non-certified. The treatment plan is not consistent with the clinical review criteria. The evaluator noted that the documentation submitted for review lacks exam findings and subjective complaints to warrant the multiple neuroophthalmology tests.

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

In reviewing the records, it is noted that the claimant complains of focusing issues while wearing the glasses. The vestibular-ocular reflex test is performed by moving the head from side to side. There is no complaint of vertigo and the caloric test was
actually negative. Therefore, the vestibular ocular reflex test and platform posturography is not indicated.

Regarding the visual evoked potential, this test is usually performed in infants and children, to diagnose disorders of the optic nerve, and to detect tumors or other problems affecting the brain and spinal cord. This test usually does not produce a specific diagnosis about what is causing the abnormality. This test can confirm sometimes a diagnosis of multiple sclerosis. There is no indication that this claimant has an optic nerve disorder or multiple sclerosis. Therefore, the performance of visual evoked potential is not indicated.

Regarding the electronystagmography, this test is usually done to determine whether a balance or nerve disorder is the cause of dizziness or vertigo. There is no indication that this claimant has vertigo or dizziness. Therefore, the request for this test is neither reasonable or medically indicated.

The visual field test is also not in order as the patient does not have visual defects.

Regarding the request for neurocognitive testing, there is no relationship between cognitive deficits and double vision. Therefore, the request for this test is not indicated.

In summary based on records reviewed and as documented above, the request for 92546 Vestibular-Ocular Reflex Test; 92548 Platform Posturography; 95930 Visual Evoked Potential; 92082 Visual Fields; 92541, 92542, 92544, 92545 Electro-Nystagmography; 96111 ImPact Neuro-Cognitive Test is not reasonable or medically necessary.


Sensitive and specific measures are needed to identify patients with vestibular impairments. The purpose of this clinical perspective is to describe the sensitivity and specificity of dynamic and static platform posturography for detecting vestibular disorders. The sensory organization test (SOT) of dynamic posturography (EquiTest), the motor "perturbation" test, and Romberg's tests on a static (fixed) force platform each had over 90% specificity. This finding means that nearly all of the subjects who should have tested negative, did test negative on each type of assessment. The sensitivity of the SOT was evaluated across five studies involving a total of 836 patients with peripheral vestibular deficits (PVDs). Abnormalities in the SOT were detected in only 40% (n = 338) of the cases. Static platform posturography sensitivity was evaluated across six studies involving a total of 571 patients with PVDs, and abnormalities were detected in 53% (n = 302) of these cases. Tests of spontaneous and positional nystagmus and the horizontal
component of the vestibuloocular reflex (VOR), by comparison, detected PVDs in
48% of 798 patients with suspected vestibular impairment. For patients with
vestibular deficits associated with central nervous system disease, a total of 389
cases were identified in five studies and SOT abnormalities were found in 54% (n =
209) of these cases. The motor perturbation test was abnormal in 35% (n = 41) of
119 patients with central vestibular disease. In conclusion, the sensitivity of static
posturography appeared to be slightly better than that of dynamic posturography for
detecting PVDs, but the level of sensitivity for each posturography test, as well as for
tests of horizontal VOR function, was considered to be low. Combining either type of
posturography with other tests of vestibular function, however, increased the overall
sensitivity of detecting vestibular deficits to 61% to 89%. It was concluded that
dynamic and static platform posturography as well as tests of VOR function lack
adequate sensitivity to detect vestibular impairment when applied in isolation.
Posturography appears to detect vestibular deficits in some patients who had normal
VOR assessments and, therefore, provides supplemental rather than redundant
information about vestibular dysfunction.

Feb;112(2):203-9.
Head-shake vestibulo-ocular reflex testing: comparison of results with rotational
chair testing.
Goebel JA, Hanson JM, Langhofer LR, Fishel DG.
Source: Department of Otolaryngology-Head and Neck Surgery, Washington
University School of Medicine, St. Louis, MO 63110.
The currently accepted "gold standard" for rotational testing of the vestibulo-ocular
reflex uses a servo-controlled chair for sinusoidal whole-body rotation. Previous
work in our laboratory has shown good concordance between conventional
rotational chair testing and head-on-body (or "head-shake") testing for gain and
phase values of the vestibulo-ocular reflex as recorded and analyzed on our
rotational chair system's software. In this article we describe results obtained from
10 normal subjects and 20 patients with reduced caloric responses using a portable
system being developed in our laboratory that allows an examiner to generate both
whole-body and head-on-body rotational stimuli. Test frequencies within the range
0.25 to 1.0 Hz were chosen for comparison with results obtained by conventional
rotational chair testing. Visual conditions for all tests included both visually enhanced
vestibulo-ocular reflex (real earth-fixed target) and mentally enhanced vestibulo-
ocular reflex (imagined earth-fixed target, in darkness or with vision obscured)
paradigms. Our results show general agreement between head-shake and rotational
chair testing and both manual whole-body rotation and head-shake testing on our
portable system for vestibulo-ocular reflex gain and phase testing, with the largest
differences noted at 1.0 Hz. Portable rotational testing was well tolerated by young
and elderly subjects alike. We expect manual whole-body rotation and head-shake
testing will be useful adjuncts for examining vestibulo-ocular reflex function when
more formal rotational chair testing is not possible.
Per John Hopkins Medicine - Evoked potential studies: Reasons for the procedure: Evoked potential studies may be used to assess hearing or sight, especially in infants and children, to diagnose disorders of the optic nerve, and to detect tumors or other problems affecting the brain and spinal cord. The tests may also be performed to assess brain function during a coma. A disadvantage of these tests is that they detect abnormalities in sensory function, but usually do not produce a specific diagnosis about what is causing the abnormality. However, the evoked potentials test can confirm sometimes a diagnosis of multiple sclerosis.

Per US National Library of Medicine, electronystagmography is used to determine whether a balance or nerve disorder is the cause of dizziness or vertigo.

Per USA National Library of Medicine, neurocognitive testing: Mental status testing is done to check your thinking ability, and to determine if any problems are getting better or worse. It is also called neurocognitive testing.

Per ODG 2012 neuropsychological testing: Recommended for severe traumatic brain injury with restrictions below, but not for concussions. For concussion/mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Neuropsychological testing is one of the cornerstones of severe traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The computer-based programs Immediate Postconcussion Assessment and Cognitive Testing (ImPACT), CogSport, Automated Neuropsychological Assessment Metrics (ANAM), Sports Medicine Battery, and HeadMinder may have advantages over paper-and-pencil neuropsychological tests such as the McGill Abbreviated Concussion Evaluation (ACE) and the Standardized Assessment of Concussion (SAC). (Cantu, 2006)
A 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

☒ 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 (See References and Summary above)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)