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Notice of Independent Review Decision

January 6, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Vestibular rehabilitation (CPT codes 97116, 97112)

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

Board Certified Otolaryngologist

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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:

- Utilization reviews (10/28/13, 11/22/13)
- Office visits (07/02/13 - 08/05/13)
- PT evaluations (08/28/13 - 10/07/13)
- Utilization reviews (10/28/13 - 11/22/13)
- Prospective review response (12/17/13)
- Office visits (02/26/13 - 08/05/13)
- PT evaluations (08/28/13, 10/07/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was struck by an 18-wheeler on xx/xx/xx, and sustained a temporal bone fracture.

Per a utilization review dated August 13, 2012, a request for additional speech physical therapy (PT) for facial weakness to include CPT codes 97002 and 97110 and diagnostic codes 780.4 and 781.94 was approved. The following information is gathered: *“The patient is status post motor vehicle accident (MVA) with multiple traumas, including a closed head injury with left epidural hematoma requiring surgical evacuation and a left facial nerve injury. The most recent evaluation by LPT, showed gradual continued improvement in left facial nerve function. Eye closure was improved, but still demonstrated some weakness. Some eye-mouth and mouth-eye synkinesis was still present.”*

On February 26, 2013, evaluated the patient for left temporal bone fracture and facial paralysis. noted that the patient was referred for consultation. The patient had left facial paralysis after being involved in the MVA in xx/xxxx. She had undergone drainage of subdural hematoma and had bilateral clavicular fractures. She was initially intubated preventing early evaluation of her facial nerve function. Also with left hearing loss. She was following eye care with artificial tears and lube at night. Her EnoG and electromyography (EMG) showed a favorable prognosis in December. In the last exam, an early retraction pocket was noted. The patient had been hearing popping sounds from her left ear. She still had tinnitus that could be of moderate intensity at times. Examination showed decreased left facial strength and symmetry. Examination of the ears revealed mild retraction of the tympanic membrane that was tracking under the neck of the malleus. It was stable when compared to the prior examination. There was grade III/VI left facial paralysis. She had buccal and marginal movement that was still paretic. reviewed computerized tomography (CT) scan of the temporal bone. There was separation of the incudomalleal joint. The patient had a longitudinal fracture extending adjacent to the geniculate ganglion. There was no evidence that the facial nerve was sectioned. Audiogram results dated December 17, 2012, was also reviewed. The patient reported tinnitus and hyperacusis in the left ear since the time of accident. She had moderate-to-mild mixed hearing loss for that ear. Immittance was consisted with normal temporomandibular mobility, right and a mild negative middle ear pressure, left. The patient had normal hearing on the right and a very mild mixed hearing loss on the left. diagnosed left facial paralysis after temporal bone fracture. He noted that the patient's retraction pocket was stable. He recommended placing a tube or continuing to carefully follow the retraction. The patient preferred observation. Per the patient's problem lists, the patient had temporal bone fracture noted on December 1, 2011, clavicle fracture noted on December 30, 2011, facial nerve injury noted on December 30, 2011, late effect of intracranial injury without mention of skull fracture noted on January 30, 2012, and lagophthalmos, unspecified noted on June 8, 2012.

On July 2, 2013, evaluated the patient for paralytic lagophthalmos and tear film insufficiency, unspecified. The patient had a history of periorbital hematoma related to MVA with occipital hematoma status post craniotomy with CRV II injury and paralytic lagophthalmos follow-up to dry eyes. She reported stable visual acuity since the last visit. She complained of constant dryness. The patient stated that ATs dry out fast and was not really helpful. She reported that she

used Refresh ointment p.m. about three or four times a day OU. She had some relief to ointment, but reported that her dryness was bothersome. She stated that OU was sore and scratchy when her eyes were dry. also evaluated the patient for occipital hematoma status post craniotomy with left cranial nerve VII injury and paralytic lagophthalmos for six months. recommended keeping aggressive lubrication.

On July 15, 2013, evaluated the patient. The patient reported that she was presently utilizing Topamax 100 mg a day and essentially was feeling headache-free, but she stated that it caused a significant amount of burping. She was recently seen, and was recommended against any facial surgeries. The patient also continued to follow-up with neuropsychology due to severe anxiety issues. It was suggested by the psychologist that she consider a selective serotonin reuptake inhibitor (SSRI). Diagnosis was history of epidural hematoma and posttraumatic headaches. prescribed Zonegran and discussed the possibility of psychotropic medications.

On August 5, 2013, evaluated the patient for left temporal bone fracture and facial paralysis. The patient stated that she had seen a doctor, who had recommended Botox, but she was not interested in that. noted that the patient's retraction pocket was stable. He recommended placing a tube or continuing to carefully follow the retraction. The patient preferred observation. She was recommended following up six months with audiogram and facial rehabilitation.

On August 28, 2013, the patient underwent vestibular rehab re-evaluation. The patient reported that she was following eye care with artificial tears and lube at night. Her EnoG and EMG showed a favorable prognosis when evaluated in December 2012. It was noted that the patient had demonstrated slow improvement of facial movement as measured by the composite score on the Ross, Fradet and Nedzelski FGS since the initial assessment on January 26, 2013. She continued to be moderately disabled both in physical function and social well begin aspects per FDI questionnaire. She had consulted a plastic surgeon who had recommended reanimation surgery. She was hesitant to proceed as there was no guarantee regarding the results and she had a second opinion who performed Botox around her eye and right side of her mouth. felt that reanimation surgery was not necessary for her and he felt that she should continue to see improved facial movement over the years, if she continued to work with PT. after several efforts to contact office and other rehab personnel was unable to receive information on what intensive PT with Botox involved for the future. The patient continued to be concerned over her two year summative evaluation. She verbalized that she continued to need direction and updating of her exercise program to continue slow but positive progress. She was recommended returning to the clinic in six weeks and continuing with updated exercises program to work on risorius, levator group and zygomaticus isolation. She was recommended increasing number of repetition practiced but continue to minimize synkinesis.

Per the October 7, 2013, vestibular rehab re-evaluation report, the patient was found to be anxious and nervous about having to make discussions. She had worked on exercises, but remained frustrated from slow progress.

Per utilization review dated October 22, 2013, the request for five sessions of in-office vestibular rehabilitation for facial nerve injury was denied based on the following rationale: *“This is a female who sustained a left facial nerve injury in association with an MVA and closed head injury. She had regained some motor function to date. She had been evaluated as related to re-animation surgery with a variance in opinion. Based on her most recent ear/nose/throat (ENT) evaluation, it was recommended that she consider vestibular rehabilitation in the form of four visits. The patient had been previously assigned a rehabilitation program. There has been slow but continued clinical improved. The rationale for additional vestibular rehabilitation or a change in management has not been documented. Therefore, the current request is denied.”*

Pert the reconsideration review dated November 6, 2013, the appeal for in-office face, medical Botox injections was denied based on the following rationale: *“This is a non-certification of an appeal of facial Botox injections. The previous non-certification on November 4, 2013, was due to a possibility of weakening of the orbicularis oculis muscle further which may affect the patient’s blink reflex further and may make the patient’s keratitis worse. The previous non-certification is supported. Additional records were not provided for review. The guidelines indicate Botox would only be recommended for spasticity following a traumatic brain injury. There is no indication Botox is supported for the treatment of palpebral fissure. There is a possibility of weakening of the orbicularis oculis muscles further. I was able to speak and he was unable to offer any additional information that would enable certification. The request for an appeal of facial Botox injections is not certified.”*

Per reconsideration review dated November 22, 2013, the appeal for five sessions of vestibular rehabilitation for facial nerve was denied based on the following rationale: *“The appeal request for vestibular rehabilitation for the facial nerve is not supported at this time. The previous non-certification of October 24, 2013, was due to fact that the claimant been assigned a rehabilitation program and had documented, although slow, continued clinical improvement. No additional documentation has been provided for review. The previous non-certification is supported. The claimant has had prior rehabilitation with documentation of slow, but continued improvement. There is no substantial documentation supporting the need to proceed with excess vestibular rehabilitation at this time for an injury that occurred in xxxx versus continuation of the current home program. The appeal request for vestibular rehabilitation PT for facial nerve, five visits/0 done is not certified.”*

In a prospective review response dated December 17, 2013, opined as follows: The medical necessity for the proposed five sessions of in office vestibular rehabilitation for facial nerve injury at the Medical Center as requested in a patient who current was improving with her self-directed home exercise program (HEP)

was not supported. Per the Official Disability Guidelines (ODG), treatment of a work-related injury must be adequately documented and evaluated for effectiveness. Currently, as stated by the physician advisor, there was no substantial documentation supporting the need to proceed with excess vestibular rehabilitation at that time for an injury that occurred in xxxx. Documentation from the provider failed to demonstrate any potential to benefit from additional supervised rehabilitation versus continuation of the current self-directed HEP.

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

I agree, from my review of the record, that there is not sufficient evidence supporting further vestibular rehabilitation. The referring physician did mention, however, having the new therapy target specific muscle groups. Without a specific plan from the treating physician, the decision cannot be overturned.

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

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**