

Case Number:	CM13-0063254		
Date Assigned:	12/30/2013	Date of Injury:	09/07/2010
Decision Date:	03/21/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Ophthalmologist and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient was injured on 09/07/2010 with chronic exposure to carbon monoxide from a broken oven that was leaking gas. Prior treatment history has included speech therapy and medications. A clinic note dated 04/16/2012 indicates [REDACTED] symptoms were headaches, anxiety attacks and/or a period of rapid heart beating, dizziness, periodic numbness and tingling in the legs and arms, tingling in the lips, that had resolved, and memory problems. A consultation report dated 09/18/2013 indicates visual acuity of 20/30- in both eyes distance and 20/200 near. Vestibular ocular reflex showed with lateral head movements side to side, the 20/50 acuity line became blurred. The amount of time to come back to baseline was one minute. This result indicated that the visual and vestibular systems are not working optimally together and that there may be significant vestibular deficits. Subjective refraction, right eye: +1.50 - 0.75 x 117, visual acuity 20/20; left eye: +1.50 - 0.50 x 45, visual acuity 20/20; Near: Right eye: +1.25, visual acuity 20/20, Left eye: +1.50, visual acuity 20/20. Clinical impression was visual field (enlarged blind spot), visual field constriction, vestibular dysfunction, visual discomfort/photophobia, headaches, and presbyopia. Recommendation was optokinetic nystagmus and visual balance testing will be done on the next appointment to assess the visual-vestibular component. Additional prism testing for balance will be done as well. A VEP and optokinetic nystagmus tests were done on 09/25/2013. Optokinetic nystagmus test showed lateral rotations induced disorientation and body sway which took up 60 seconds to recover. Vertical rotations induced disorientation and body sway which took up 60 seconds to recover. Visual balance test showed no sway or imbalance present during the test. Clinical assessment was VEP testing indicates that the patient can benefit from application of base in prism and binasal occlusion in the overall treatment protocol. There was a significant increase in amplitudes with these applications. The abnormal VEP is the result of lack of summation of the binocular findings compared to the monocular

findings. Application of base in prism and binasal occlusion demonstrated improved ambulation in the office setting.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Optokinetic nystagmus and visual balance testing: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Review of Ophthalmology, 2nd Edition Chapter 4, page 54

Decision rationale: Visual balance testing is not a well established ophthalmological test without scientific backing for the treatment of patient's reported symptoms. Review of medical records indicates report of an abnormal brain MRI in 2010 in the area of the right middle ear reported as inflammation. This report would explain the patient's abnormal oculo-vestibular reflex and there are no indicated ophthalmic treatments by the American Academy of Ophthalmology for treatment of neurological or middle ear problems.

additional prism testing and visual evoked potential testing: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 173.

Decision rationale: VEP or prism testing is not indicated in the evaluation of a middle ear inflammatory syndrome. Review of medical records indicates report of an abnormal brain MRI in 2010 in the area of the right middle ear reported as inflammation. This report would explain the patient's abnormal oculo-vestibular reflex.