Case Number:	CM14-0146326		
Date Assigned:	09/12/2014	**Date of Injury:**	01/29/2013
Decision Date:	10/24/2014	**UR Denial Date:**	09/05/2014
Priority:	Standard	**Application Received:**	09/09/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Ophthalmology 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 expert 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 is a 30 year-old male with a history of severe traumatic brain injury on 1/29/2013 after falling 30 feet, causing a subdural hematoma status post craniotomy. The patient developed a 3rd nerve palsy, oculomotor dysfunction, hemiplegic, and is wheelchair bound and nonverbal; patient communicates with finger gestures. The patient has been evaluated by an optometrist for neuro vision rehabilitation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthoptic/Pleoptic Training: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Ophthalmology Practice Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Other Medical Treatment Guideline or Medical Evidence: 1. Joint Statement - Learning Disabilities, Dyslexia, and Vision. Council on Children With Disabilities, American Academy of Pediatrics (AAP) and American Academy of Ophthalmology (AAO), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) Pediatrics, and American Association of Certified Orthoptists (AACO). Pediatrics 2009;124;837- 44. 2. American Academy of Ophthalmol

Decision rationale: The current peer-reviewed ophthalmic literature does not support the use of vision therapy in the treatment of traumatic brain injury. According to the American Academy of Ophthalmology (AAO), "the claim that vision therapy improves visual efficiency cannot be substantiated."While orthoptic vision therapy is not well recognized outside optometric literature and is considered experimental and investigational by ophthalmologists and others in the medicalcommunity, this conclusion is not limited to those in the medical field. The United Kingdom's College of Optometrists commissioned a report (Jennings, 2000) to critically evaluate the theoryand practice of behavioral optometry (vision therapy). The report which followed concluded that there was a lack of controlled clinical trials to support behavioral management strategies. Theevidence in support of vision therapy as of 2008 was recently reevaluated and published (Barrett, 2009). The available evidence was reviewed under ten headings: (1) vision therapy foraccommodation/vengeance disorders; (2) the underachieving child; (3) prisms for near binocular disorders and for producing postural change; (4) near point stress and low-plus prescriptions; (5)use of low-plus lenses at near to slow the progression of myopia; (6) therapy to reduce myopia; (7) behavioral approaches to the treatment of strabismus and amblyopic; (8) training central andperipheral awareness and syntonics; (9) sports vision therapy; (10) neurological disorders and neuro-rehabilitation after trauma/stroke. The report found a continued lack of controlled trials inthe literature to support behavioral optometry approaches. With the exception of the treatment of isolated convergence insufficiency and the use of prisms and visual rehabilitation in patients withbrain disease/injury, the large majority of behavioral management approaches was not found to be evidence-based, and thus cannot be advocated. Such as, Orthoptic/Pleoptic Training is not medically necessary.