



IRO# 5356
5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100

Notice of Independent Review Decision

DATE OF REVIEW: 05/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Functional Capacity Evaluation

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

This case was reviewed by a Texas licensed DO, DC, specializing in Plastic Surgery, General Surgery, Chiropractic. The physician advisor has the following additional qualifications, if applicable:

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Functional Capacity Evaluation	97750	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		18		
2	IRO Record Receipt		5	04/13/2010	04/13/2010
3	Designated Doctor Report	DO	18	01/28/2010	02/08/2010
4	Diagnostic Test		5	05/21/2009	05/21/2009
5	Diagnostic Test		2	01/30/2009	01/30/2009
6	IRO Request		9	04/09/2010	04/14/2010
7	Office Visit Report	MD	15	07/10/2009	01/20/2010
8	Office Visit Report	MD	9	05/05/2009	07/21/2009
9	Office Visit Report	DC	13	03/31/2009	03/10/2010
10	Peer Review Report	DC	6	03/17/2010	03/26/2010

11			1	03/11/2010	03/11/2010
12	Peer Review Report		3	04/16/2009	04/16/2009
13	Initial Denial Letter		13	03/16/2010	03/25/2010
14	Archive		99	04/27/2010	04/27/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

First available medical record to review is a Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 04-13-10. Apparently this request for an FCE to be performed by the attending DC provider has been denied twice by different peer review DC physician advisers due to not all levels of care have been exhausted. There is a Report of Medical Evaluation performed by xxxxx xxxxxx performed on 01-28-10 in which DO documents mechanism of injury for this year old Hispanic male who injures his low back while attempting to open a door, he used extra force to open it, and developed sudden onset of low back pain believes that he has not at MMI.

xxxxxxx submits an initial evaluation dated 03-31-09 in which the DC provider states that this patient was initially evaluated at xxxxx at the request of his employer. X-rays a lumbar spine MRI scan were obtained and identified this protrusion at the level of L5-S1. He performed a physical therapy program the did not reduce his pain and was never referred for a specialist evaluation and treatment recommendations. The pain level continued and limited his ability to perform ADL's and perform at work, and he therefore decided to change treatment physicians. now requesting all medical records for further review. He'll be referred for medical evaluation and medication management. Pending review of his imaging studies, will be referred as medically necessary to expedite his recovery.

There is supplemental information on which includes Review of Medical History and Physical Examination submitted on 01-08-10 by. states that the patient complains of constant pain in the lower back aggravated by certain positions and motions. Some weakness in his lower back and tingling sensation the posterior aspect of both lower extremities that extends down to the level of the knees. Coughing and wheezing exacerbate the pain in the low back. According to he was initially evaluated by an occupational medicine clinic on January 8, 2009 and has not returned to work as instructed by his doctor and has since been terminated by his employer. Past medical care includes physical examination, plain film radiographs, and a physical medicine treatment regimen. Working diagnosis was bilateral lumbar intravertebral disc disorder. He was released to restricted work duty after having undergone physical therapy, medication management, and a follow-up office visit was planned. As he continued to suffer from low back pain, a lumbar MRI scan was performed on January 30, 2009 with impression: #1) 2 mm disc protrusion at the L5-S1 level with bilateral foraminal narrowing greater on the left and right. He then changed his treating physician to a chiropractic provider with his working diagnoses of #1 myospasm spasm #2 lumbar intravertebral disc disorder, and lumbar radiculitis. He was then referred by the DC provider to an orthopedic and a pain management specialist. There is also a referral made for electrodiagnostic studies to be performed of the lower extremities. Initial examination with the orthopedic surgeon was performed on May 5, 2009 and he recommended continued oral medications. The lower extremity electrodiagnostic study was performed on May 21, 2009 with impressions of mild left S1 nerve root involvement. An office visit with the orthopedic specialist noted that additional oral medications we'll be prescribed as well as a lumbar epidural steroid injection to be performed bilaterally at the L5 and S1 levels. This patient underwent bilateral lumbar epidural steroid injections at the L5-S1 level on July 15, 2009. Per the pain management specialist, the patient noted approximately 70% overall improvement. He advises to proceed with a second lumbar epidural steroid injection. The second lumbar epidural steroid injection was not approved per the ODG guidelines via the workers compensation insurance carrier. Current medications at that point included Darvocet-N 100 and he was to continue a home exercise program. states that this patient is in favor of waiting for a second lumbar epidural steroid injection and his opinion is such that he should be allowed to proceed with pain management treatment approach. states "I anticipate that he will achieve maximum medical improvement once he completes third epidural steroid injection and he would approach MMI by May 1, 2010 ". reevaluates the patient via a report submitted on 01-28-10 in which he provides Mr. xxxx with an 8% whole person impairment based on the Guides to Evaluation of Permanent Impairment 4th edition. His working diagnosis at that point included lumbar spine strain/sprain. There is a Report of Medical Evaluation submitted from D.O. dated 02-18-10 in which he is providing the patient with an 8% whole person impairment and DC agrees with that assessment. There is a Rebuttal submitted to the Designated Doctor

dispute and the impairment rating from Center dated 02-08-10 in which he lays out the rationale for his disagreement of the initial 5% impairment rating. believes this patient is entitled to an 10% whole person impairment and he suggests that the D.O. provider modifies his report accordingly. Downtown Performance Medical Center submitted a lower extremity electrodiagnostic study dated 05-21-09, and an unknown provider cements impressions of #1) needle EMG/NCV studies of the bilateral lower extremities and related paraspinal muscles revealed findings suggestive of a mild left S1 nerve. Clinical correlation is recommended. #2) lumbar disc protrusion/herniation at L5/S1 with bilateral foraminal narrowing. #3) muscle spasms. Recommendations from this unknown provider include #1) follow-up with the treating Dr. for appropriate protocol. #2) continue with physical therapy and pharmaceutical protocol as directed. #3) follow-up with orthopedic surgeon. #4) consider pain management follow-up and appropriate DME recommended. MRI and Diagnostics submits impressions of an MRI scan lumbar spine and M.D. (radiologist): L5/S1, 2 mm subligamentous disc protrusion. No extrinsic compression against the exiting nerve roots. Bilateral neural foraminal narrowing, moderate, slightly more on the left than the right. L1-L5 unremarkable. M.D. (invasive pain management) submit his initial consultation notes dated 07-10-09 for persistent low back and lower extremity radiculopathy. is prescribing Meloxicam, Hydrocodone, Flexeril, and a pain relieving gel. He advised the patient to take all medications as prescribed, and to return to the office in 30 days. He is now ordering a lumbar epidural steroid injection, and a follow-up consultation note submitted on 09-21-09 from states that the patient previously underwent a lumbar epidural steroid injection on 07-15-09 in which he received at least a 50% reduction in his symptoms for a few months. Current medications are to remain the same, and he is to return to the office in 30 days. wants to repeat the lumbar epidural steroid injection and physical therapy. A letter of reconsideration is submitted by on 12-22-09 relating to the denial to repeat the lumbar epidural steroid injection. An additional follow-up consultation note submitted by on 01-20-10 in which he states the patient is not taking any medication at this time and he is refilling his Meloxicam, Hydrocodone, Flexeril, and pain relieving gel. Black care includes take all medications as prescribed and he has a return office visit scheduled in 30 days. There also going to request a repeat lumbar epidural steroid injection.

M.D. (orthopedic spine surgeon) submits an office visit note dated 05-05-09, and states under plan of care he will secure the results of the lower extremity electrodiagnostic studies. He is also to continue with oral pain medication and he is now prescribed patient Mobic 7.5 mg one twice a day, dispensed #60 and Vicodin 5/500 mg one every eight hours as needed for pain, dispensed 90 and a transdermal compound containing ibuprofen, Ketoprofen, Baclofen, and Lidocaine to be applied topically and massaged into sore area for 5 minutes four times a day. He is also to avoid stressors the lumbar spine and we will evaluate the patient in 6 weeks for further treatment options.

The patient is reevaluated by on 06-05-09 in which he notes the pain level is reported as 5/10. At this time, is prescribing a Medrol Dosepak and several additional sessions of physical therapy. He is also ordering a repeat lumbar epidural steroid injection to be performed bilaterally at L5/S1. He is also writing the patient prescriptions for Mobic 7.5 mg one twice a day, dispensed 60, Vicodin 5/500 mg one every eight hours as needed for pain, dispensed 90, and Flexeril 10 mg one at bed time, dispensed 30 as well as the transdermal compound consisting of Ibuprofen, Ketoprofen, and Cyclobenzaprine to be applied topically and massaged into the sore area for 5 minutes four times a day.

A 07-21-09 office visit note from notes that the patient did improve with an initial lumbar epidural steroid injection of 70% to the low back. He reports that the patient states that the numbness and tingling is always present in the lower extremity. Pain is decreased temporarily in the lower extremities as well as lumbar spine. He states that his current pain level is 3-4/10. At this time believes the patient is a candidate for a repeat lumbar epidural steroid injection. He is now refilling his medications of Vicodin 5/500 mg one every 12 hours, Mobic 7.5 mg one twice a day, dispensed 60, Flexeril 10 mg one at bed time, dispensed 30, and a transdermal compound to be applied topically once again.

A follow up evaluation submitted by the chiropractic provider on 01-13-10 notes that the patient is complaining of increasing lower back pain causing further difficulty with his daily activities. His pain level is rated 7/10; constant in nature and sharp pressure with aching pain sensations. The pain travels down the bilateral legs to the knees left greater than right. He will remain in off work status and his treatment plan at this time includes follow-up with for a second LESI. Advised patient to perform a home stretching program to maintain flexibility. Due to severity of depression, anxiety, and mood swings, patient is referred back to to address psychological concerns. He is to follow up with the DC provider in 4 weeks.

A follow up evaluation is submitted by the chiropractic provider on 02-10-10 notes that the patient is complaining of increasing lower back pain level VAS 7/10. He experiences pain daily and is neglecting many required home duties secondary to pain. Provocative activities are listed as standing or walking for 15 minutes, bending, lifting, twisting, and remaining in static positions. Palliative activities are listed as pain medications. Working diagnoses remain the same and the chiropractic providers' working diagnosis remains unchanged and his plan of care includes follow-up with for the second LESI. Perform an FCE to determine physical demand and work level. Refer for a mental health evaluation to determine if the patient is a work hardening or conditioning candidate. Advised patient to perform and a stretching program to maintain flexibility, followed at to address psychological concerns, and has a follow up evaluation with him in 4 weeks. A Texas Workers Compensation Work Status Report is submitted 02-10-10 by DC in which he is keeping the patient totally off work through 03-10-10. A follow up evaluation is submitted by the chiropractic provider on 03-10-10 notes that the patient is complaining of increasing lower back pain level VAS 8/10. At this time, Dr. Davis is requesting an FCE to determine the patient's physical demand level pending approval by carrier. Once again, working diagnoses from the DC remains the same, as does the treatment plan. He remains in off work status.

A Texas Workers Compensation Work Status Report is submitted by the chiropractic provider on 03-10-10 maintaining the patient's off work status through 04-07-10.

xxxxxx submits Rebuttal of Peer Review Physician Report dated 03-17-10 in which dispute's the denial of the functional capacity evaluation service requested by the insurance carrier. A 03-26-10 second Rebuttal of Peer Review Physician Report also by once again opines his rationale as to why a functional capacity evaluation is required at this time.

M.D. submits a peer review report for the insurance carrier dated 04-16-09, offers that this patient has in fact received the required maximum amount of physical therapy maneuvers as would be deemed necessary by the ODG guidelines. Other than the actual denials from via physician review, no other medical records are enclosed for review at this time.

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

DENIAL Upheld.

In my opinion, after review of the enclosed medical records, I have to agree with the prior two DC providers that have acted as physician reviewer for this particular functional capacity evaluation request. This patient's overall low back pain appears to continue to increase, and clearly all treatment options have not as yet been exhausted. It is exceedingly doubtful that this patient would be able to return to work at this point, and therefore performance of a functional capacity evaluation at this time would appear to be premature, and a great waste of medical resources. The request for a functional capacity evaluation is not medically necessary at this time.

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

<p>Functional capacity evaluation (FCE)</p>	<p>Recommended prior to admission to a Work Hardening (WH) Program. See enties for Work conditioning, work hardening in each body-part chapter, for example, the Low Back Chapter. Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. (Lechner, 2002) (Harten, 1998) (Malzahn, 1996) (Tramposh, 1992) (Isernhagen, 1999) (Wyman, 1999) Functional capacity evaluation (FCE), as an objective resource for disability managers, is an invaluable tool in the return to work process. (Lyth, 2001) There are controversial issues such as assessment of endurance and inconsistent or sub-maximum effort. (Schultz-Johnson, 2002) Little to moderate correlation was observed between the self-report and the Isernhagen Work Systems Functional Capacity Evaluation (FCE) measures. (Reneman, 2002) Inconsistencies in subjects' performance across sessions were the greatest source of FCE measurement variability. Overall,</p>
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however, test-retest reliability was good and interrater reliability was excellent. ([Gross, 2002](#)) FCE subtests of lifting were related to RTW and RTW level for people with work-related chronic symptoms. Grip force was not related to RTW. ([Matheson, 2002](#)) Scientific evidence on validity and reliability is limited so far. An FCE is time-consuming and cannot be recommended as a routine evaluation. ([Rivier, 2001](#)) Isernhagen's Functional Capacity Evaluation (FCE) system has increasingly come into use over the last few years. ([Kaiser, 2000](#)) Ten well-known FCE systems are analyzed -- All FCE suppliers need to validate and refine their systems. ([King, 1998](#)) Compared with patients who gave maximal effort during the FCE, patients who did not exert maximal effort reported significantly more anxiety and self-reported disability, and reported lower expectations for both their FCE performance and for returning to work. There was also a trend for these patients to report more depressive symptomatology. ([Kaplan, 1996](#)) Safety reliability was high, indicating that therapists can accurately judge safe lifting methods during FCE. ([Smith, 1994](#)) FCE is a burdensome clinical tool in terms of time and cost, so this RCT evaluated the effectiveness of a short-form FCE protocol, and concluded that a short-form FCE appears to reduce time of assessment (43% reduction) while not affecting recovery outcomes when compared to standard FCE administration. Such a protocol may be an efficient option for therapists performing fitness-for-work assessments. ([Gross, 2007](#)) Credibility of both the FCE and FCE evaluator is critical. If the evaluatee complains of evaluator bias, lack of expertise, or poor professional conduct, the FCE can be considered useless. ([Genovese, 2009](#))

Guidelines for performing an FCE:

If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive.

It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants.

Consider an FCE if

1. Case management is hampered by complex issues such as:

- Prior unsuccessful RTW attempts.
- Conflicting medical reporting on precautions and/or fitness for modified job.
- Injuries that require detailed exploration of a worker's abilities.

2. Timing is appropriate:

- Close or at MMI/all key medical reports secured.
- Additional/secondary conditions clarified.

Do not proceed with an FCE if

- The sole purpose is to determine a worker's effort or compliance.
- The worker has returned to work and an ergonomic assessment has not been arranged. ([WSIB, 2003](#))

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

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 05/04/2010.