

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97750 Functional Capacity Evaluation, 16 Units: DOS: 8/25/10

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

MD, Board Certified in Occupational Medicine
Diplomate, American Academy of Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This male was involved in a motor vehicle accident on xx/xx/xx. He works as xx. He was driving and was stopped at a traffic light when he was rear ended by an SUV. He was seen at an emergency dept. for complaints of neck and low back pain and stiffness. X-rays were negative for bony injury. He attended physical therapy for his injury. On xx/xx/xx he complained of headaches and neck stiffness. His neck pain was improved. He has never had any arm pain or radicular complaints or findings. An FCE was performed on 8/25/10 with complaints of neck pain. No specific reason was provided for the necessity of this FCE. This stated that his required PDC was medium and he was capable of returning to work in a PDC of medium work. The conclusion was that he was able to return to work without restrictions. MRI scan of the cervical spine on 8/30/10 showed herniated discs at C6-7 and C3-4 without nerve impingement.

An adverse determination for this FCE was issued on 9/7/10. Reasons for the denial were that no specific reason was given for why the FCE was needed, no documentation of unsuccessful return to work attempts were noted, and no conflicting reports regarding fitness for duty were provided. This FCE was not felt to be consistent with the ODG guidelines. A trigger point injection was done on 9/19/10. He has been seen since that date for a consult with Dr. on 11/3 for neck discomfort. He had no arm complaints or radicular signs or symptoms. He was working light duty at that time. He had full range of motion of the neck. Dr. felt no surgery was appropriate. He was seen in f/u with his PCM on 11/19 and had only mild, intermittent discomfort at the cervical spine. Overall he was better and he was released to return to work without restrictions.

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

There was no medical necessity for a FCE on 8/25/10. The injured worker was responding well to conservative therapy and had minimal symptoms or objective findings on exam. There is no indication that he was unsuccessful at attempts to return to his former work or that he was in need of any further therapy or work hardening to facilitate his return to work. There were no conflicting reports on his medical status. This request is not in accordance with the ODG recommendations for a FCE. The reviewer finds that medical necessity does not exist for 97750 Functional Capacity Evaluation, 16 Units: DOS: 8/25/10. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)