I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Functional Capacity Evaluation

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Request dated 03/09/12
Utilization review determination dated 02/10/12
Utilization review determination dated 02/2812
Clinical records Dr. dated 02/01/12, 03/01/12, 09/13/11, 10/04/11, 10/31/11, 11/28/11, 01/04/12, 01/19/12
Request for reconsideration dated 10/07/11
Request a change treating Dr. dated 09/06/11
Designated Dr. examination dated 04/12/11
Behavioral health evaluation dated 05/13/11
Request for individual psychotherapy dated 02/25/11
Behavioral health initial interview dated 02/21/11
EMG/NCV study dated 09/21/10
Clinical records Dr. dated 09/13/10
Clinical records DC dated 08/09/10
MRI of the lumbar spine dated 09/03/10
Physical performance evaluation dated 09/02/10
DWC form 69 dated 07/07/10
Impairment rating dated 07/07/10
Clinical records Dr. dated 06/22/10, 07/08/10, 07/09/10,
Radiographic report spine dated 06/23/10

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male. On the date of injury a coworker backed into him with a golf cart, impacting his right hip and right forearm. The claimant initially came under the care of Dr. x-rays were performed and no significant findings were indentified. Records indicate that the

claimant was placed at clinical maximum medical improvement by D. C. on 07/07/10 with a 0% impairment rating.

The records indicate the claimant underwent a functional capacity evaluation on 09/02/10. The claimant was found to be capable of a light to medium PDL. He is noted to require a medium PDL. The claimant was referred for MRI of the lumbar spine on 09/03/10. This study notes loss of lordosis suggestive of muscle spasm. Multilevel disc bulges, facet arthrosis, without evidence of disc herniation or peripheral stenosis. At L5/S1 there is a mild disc bulge in neural foraminal stenosis without neural compression. The claimant underwent EMG NCV on 09/21/10. This study was reported to be suggestive of left L5 radiculopathy. The lumbar paraspinal musculature was normal. Records indicate that the claimant was referred for behavioral health evaluation on 02/21/11. This study notes grossly elevated scores.
BDI was 49, BAI was 30. The claimant will was recommended to undergo individual counseling. Records indicate the claimant change treating providers to Dr.. The claimant is reported to have continued low back pain from the neck to the sacrum aggravated by any activity. On examination he is noted to have diffuse tenderness, decreased range of motion, positive left straight leg raise, reflexes are intact the claimant was provided oral medications and recommended to perform a home exercise program. Records indicate that the claimant underwent designated doctor examination on 04/12/11. He opines that the claimant requires a repeat MRI scan and should be seen by orthopedist. Records indicate a recommendation for chronic pain management program and functional capacity evaluation.

The initial request was evaluated by Dr. on 02/10/12. He notes that the claimant is reported to have pain along the entire spinal column. He is neurologically intact. He has previously undergone two FCEs in the past. He notes that this request is not consistent with ODG.

The appeal request was reviewed by Dr. on 02/22/12. He notes exam findings include generalized tenderness over the cervical, thoracic and lumbar spine; range of motion is reported to be decreased. A repeat MRI has been requested. Prior treatment has included a chronic pain management program. He opines that an additional evaluation with a formal functional capacity evaluation is not supported.

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

The initial clinical records indicate that the claimant sustained a thoracic strain, which was resolved resulting in a 0% impairment. Records indicate that the claimant continued to receive treatment for subjective complaints not wholly validated by imaging studies and serial physical examinations. The clinical records further indicate that the claimant has undergone at least two prior functional capacity evaluations. The claimant is apparently participating in a chronic pain management program. Additional functional capacity evaluations would not be indicated or warranted until completion of the program. Based upon the submitted clinical records the reviewer finds there is insufficient data to establish the medical necessity for a Functional Capacity Evaluation.

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 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)