



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 11/14/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Performance Test or Measurement (EG Musculoskeletal, Functional, Capacity), with written report, each 15 minutes.

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

M.D. Board Certified in Occupational Medicine and Urgent Care.

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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	10/25/2012
Adverse Determination Letters	9/04/2012-10/03/2012
Review Reports	8/31/2012-10/05/2012
Matrix Rehabilitation Evaluation Notes	8/22/2012
History, Physical and Neurological Examination Follow Up Note Request for Reconsideration	7/23/2012 8/22/2012-10/17/2012 9/25/2012



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Interval History	8/22/2012-10/17/2012
Pre- Authorization Request Visit Notes	8/23/2012 7/11/2012-8/10/2012
MRI Report	7/17/2012

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a worker with neck and left shoulder pain reportedly associated with an injury of xx/xx/xxxx.

Thus far, he has been treated with the following: Analgesic medications; unspecified amounts of physical therapy; an MRI of the cervical spine on July 17, 2012, demonstrating a large left C5-C6 paracentral disc herniation with associated spinal cord impingement; unspecified amounts of chiropractic manipulative therapy; consultation with neurosurgeon who apparently declined to intervene operatively; and extensive period of time off of work. The most recent progress report October 17, 2012 is notable for comments that the claimant reports persistent neck and shoulder pain, is presently on Vicodin and Tizanidine for pain relief, is status post injection therapy and manipulative therapy, reports diminished pain, 2 to 3/10, comments that the claimant exhibits normal upper extremity reflexes with well preserved 5/5 upper extremity strength with apparently absent biceps reflex, otherwise, symmetric reflexes noted. Recommendations are made for the claimant to return to sedentary work. The claimant states that he will contemplate surgical options.

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

Per ODG references the requested Physical Performance Test or Measurement (EG, Musculoskeletal Functional Capacity), with written report, each 15 minutes is not medically necessary.

There is no indication or evidence that the claimant has attempted to return to regular work on a trial basis, as suggested by the criteria below. There is no evidence of prior unsuccessful return to work attempts. There is no evidence, furthermore, that the claimant is at or approached maximum medical improvement. There is a comment made that the claimant is presently contemplating a surgical remedy. Accordingly, for all of these reasons, the proposed functional capacity evaluation does not appear to be appropriate or indicated at this point in time.



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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE KNOWLEDGE BASE
- 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