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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: FCE

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Neurological Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for FCE is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 03/20/13, 03/12/13
Referral form dated 02/19/13
Office visit note dated 02/19/13, 08/21/12, 03/20/12, 09/20/11, 03/22/11, 12/21/10, 05/04/10, 06/08/10, 11/09/10
MRI scan review dated 05/03/10
Operative report dated 10/28/10

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is listed as xx/xx/xx. The mechanism of injury is described as helping a patient in a xx. Treatment to date includes lumbar laminectomy and discectomy on 08/07/09, epidural steroid injections, EMG/NCV, revision surgery on 10/28/10 with total laminectomy, total facetectomy, neural foraminotomy and bilateral discectomy L5-S1. Office visit note dated 08/21/12 indicates that the patient is ambulatory with a cane in his right hand. He has had recent epidural steroid injection which did not help him at all. Office visit note dated 02/19/13 states that the patient is ambulatory without assistive devices with antalgic gait. He has back pain and leg pain. He has been evaluated for social security disability. The patient was recommended to undergo a functional capacity evaluation to document his disability.

Initial request for functional capacity evaluation was non-certified on 03/12/13 noting that per the clinical information provided for review, the requested functional capacity evaluation is not being recommended for a return to work but for a social security disability determination. Further treatment recommendations being made regarding provocative discography were noted, and there is no indication that the patient has been established as at or near maximum medical improvement. As the patient has not worked in the last four years and the provided requested functional capacity evaluation is not for return to work determination, the request would not meet guideline recommendations regarding functional capacity evaluation. As

such, medical necessity is not established. The denial was upheld on appeal dated 03/20/13 noting that the patient is proceeding to file for SSI and the office records indicated that a functional capacity evaluation was to be done to document his abilities. This would not be as related to his work injury as the patient does not appear to be focused on a return to work, but a disability.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx and has undergone extensive treatment to include surgical intervention x 2. Per office visit note dated 02/19/13, the patient has been evaluated for social security disability, and the patient was recommended to undergo a functional capacity evaluation to document his disability. Thus, the requested functional capacity evaluation is not being requested to facilitate return to work, but to aid in the patient's SSI determination. The patient has not worked in at least four years, and there is no indication that the patient intends to return to work. The submitted records fail to establish that the patient is at or near maximum medical improvement. As such, it is the opinion of the reviewer that the request for FCE is not recommended as medically necessary.

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)