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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** February 22, 2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Transitional care functional capacity evaluation/mental health evaluation (FCE/MHE).

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

**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)

I have determined the requested transitional care is not medically necessary for the treatment of this patient. Specifically, the requested functional capacity evaluation is not medically necessary for treatment of the patient's medical condition. The requested mental health evaluation is not medically necessary for the treatment of this patient.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury on XX/XX/XX. The mechanism of injury was reportedly when he was lifting heavy objects. He was diagnosed with lumbar sprain and lumbar intervertebral disc displacement. Other therapies were noted to include medications, home exercise program, physical therapy, transcutaneous electrical nerve stimulation (TENS) unit, and at least two epidural steroid injections with the most recent occurring XX/XX/XX. It was documented that he received 95% pain relief from the epidural steroid injections. On XX/XX/XX, the patient had complaints of radiating pain from the lumbar spine. On physical

examination, it was documented the patient had positive straight leg raise and moderate to severe spasms. There was tenderness and decreased range of motion. A request has been submitted for transitional care functional capacity evaluation/mental health evaluation (FCE/MHE).

The URA has indicated that the requested services are not medically necessary. Specifically, the URA's initial denial noted there is no clinical rationale for the requested services. On appeal, the URA noted there is insufficient objective information to support a functional capacity evaluation at this time. The patient has chronic pain. Per the URA, Official Disability Guidelines (ODG) do not support work ability for patients with this presentation.

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

According to the Official Disability Guidelines (ODG), a functional capacity evaluation is recommended prior to admission into a work hardening program. The guidelines indicate that a functional capacity evaluation should be considered if there have been prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's ability, and closer at maximum medical improvement. The clinical documentation submitted for review did not provide a rationale for the requested functional capacity evaluation. There was no documentation noting an anticipated admission into a work hardening program. There was also lack of information noting prior unsuccessful return to work attempts. The guidelines further note that psychological evaluations are recommended. However, there was lack of information noting the patient's current psychological status to warrant testing. There is no rationale for the requested mental health evaluation. All told, the requested services are not medically indicated for the treatment of this patient.

Therefore, I have determined the requested transitional care is not medically necessary for the treatment of this patient. Specifically, the requested functional capacity evaluation is not medically necessary for treatment of the patient's medical condition. The requested mental health evaluation is not medically necessary for the treatment of this patient.

**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 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 JUDGMENT, 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)