AccuReview

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August 15, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Functional Capacity Evaluation (FCE) for the XXXX for 1 visit

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Orthopaedic Surgery with over 15 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX: Clinic Note dictated by XXXX. CC: f/u XXXX. Claimant continues to have pain and is back to work with light duty and that XXXX still has significant pain that is aggravated by XXXX job. XXXX has continued to be denied PRC and ulnar shortening by WC. XXXX was denied proximal row carpectomy, ulnar shortening osteotomy XXXX surgery. XXXX missed a few OT appointments and does not have XXXX final results, does not have the function that XXXX was hopeful to achieve from XXXX previous surgery. PE: musculoskeletal: continued decreased sensation around the incision site, TTP at the ECU tendon, full pronosupination, 45 deg flex/ext at the wrist, FPL, EPL, FDS, FDP intrinsic intact, SILT to ulnar, median, BCR to all digits with palpable radial pulse. Impression and Plan: Claimant with left chronic posttraumatic wrist pain s/p Arthroscopy, TFCC debridement, ECU tendon release, and osteotomy of the lunate. Worsening pain due to denial of proximal row carpectomy, previous injections have failed. Discussed options to proceed with surgery rather than WC/ Light duty with no use of the XXXX at this time. Will release to work with FCE and Impairment rating recommendations.

XXXX: XXXX X-ray dictated by XXXX. Impression: post-operative changes to scaphoid and

lunate unchanged from previous.

XXXX: MMI dictated by XXXX. The claimant has reached MMI as of XXXX. This is the day of XXXX second to last treatment at XX. The notes indicated that the claimant had 12 sessions approved and XXXX has two sessions remaining. Additionally, any treatment beyond this date, does not support or demonstrate any specific evidence of significant objective improvement to the left upper extremities. The injury qualified for specific disorder categories of osteoplasty/resection arthroplasty of the carpal bone and resulted in a 12% impairment of the upper extremity; and a 10% whole person impairment.

XXXX: UR performed by XXXX. Reason for denial: While ODG acknowledges the FCE are recommended in claimant's in whom case management has been hampered by complex issues such as prior unsuccessful return to work attempts and/or claimants who are intent on pursing a work hardening program, here, however, there was no mention of the claimant's intent to pursue a work hardening program based on the outcome of the FCE in question. The claimant's already successful return to modified duty work, it is further noted, largely obviated the need for the FCE testing in question. ODG further stipulates that FCE testing is not recommended for the purposes of determining a claimant's effort or compliance, i.e., the role for which FCE testing was seemingly initiated here, per the attending provider's XXXX work status report. The request in question, thus, is at odds with multiple ODG criteria for pursuit for such a program of such a program. Therefore, the request is not medically necessary.

XXXX: UR performed by XXXX. Reason for denial: As noted in ODG's Fitness for Duty Chapter FCE topic, functional capacity testing is not recommended for generic assessment purposes, to determine whether an individual can or cannot do any type of job in general. ODG notes that self-report and/or interview techniques are more reliable than FCE testing for this purpose. Here, the attending provider failed to furnish a clear and compelling rationale for the FCE testing in question for the purposes of formulating the claimant's work restrictions in the face of the unfavorable ODG position on the same. The attending provider likewise failed to furnish a clear or compelling decision to pursue FCE testing. The claimant had already been given permanent work restriction and 10% whole person impairment rating through a Designated Doctor Evaluation (DDE). The information on file failed, in short, to support or substantiate the request. Therefore, the request for a functional capacity evaluation (FCE) is not medically necessary.

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

The request for Functional Capacity Evaluation (FCE) for the XXXX is denied. This claimant sustained an injury to XXXX XXXX at work. XXXX underwent XXXX surgery consisting of arthroscopy, TFCC debridement, ECU tendon release, and osteotomy of the lunate. XXXX did not recommend additional therapy for this injury. No additional surgery was planned for this patient. XXXX was placed at MMI with a 10% whole person impairment rating. Permanent work restrictions were assigned. An FCE was recommended. The Official Disability Guidelines (ODG) supports FCE for patients with unsuccessful return to work attempts. FCE is typically performed at MMI when permanent work restrictions are required. This claimant has already been assigned permanent work restrictions. There is no indication from the record that XXXX

has not been able to return to work with these restrictions. The recommended FCE is not medically necessary. After reviewing the medical records and documentation provided, the request for Functional Capacity Evaluation (FCE) for the XXXX for 1 visit is non-certified.

Per ODG: XX

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 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)**