Applied Assessments LLC

An Independent Review Organization
900 Walnut Creek Ste. 100 #277
Mansfield, TX 76063
Phone: (512) 333-2366
Fax: (888) 402-4676
Email: admin@appliedassessmentstx.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Functional capacity evaluation XX XX XX

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

Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX was diagnosed with a nondisplaced XX of the XX XX of the XX XX, XX of the XX XX, XX of the XX XX, and XX XX of XX XX of XX XX. XXXX also had a history of XX XX being treated with XXXX. XXXX was seen by XXXX for follow-up of XXXX work-related injury to the XX XX. On XXXX, XXXX continued to complain of XX XX pain and XX that was slowly improving. The pain was described as moderate XX and XX, rated at XX/10, and alleviated by nothing. Aggravating factors included walking and weightbearing. The associated symptoms included XX. On examination, a XX and XX XX was noted. The XX was XXXX. XX XX examination revealed XX over the XX XX and XX of the XX XX and XX. XXXX was diagnosed with XX XX of the XX XX of the XX XX. A second request was made for evaluation with functional capacity evaluation for consideration of more therapy after XX XX XX fracture. On XXXX had a written request from XXXX XX for questions that needed to be answered. The examination findings were unchanged from prior. A third request was made for a functional capacity evaluation. Per the note, XXXX was at MMI in XXXX. XXXX had not recommended XXXX be placed at MMI at the time, as XXXX did not find that XXXX was fully rehabilitated yet. XXXX recommended light duty at the time as XXXX felt XXXX was capable of light duty.

The treatment to date included medications (XXXX) and modified duty work status. Per a utilization review decision letter dated XXXX, the request for functional capacity evaluation, as an outpatient for the submitted diagnosis of nondisplaced XX of XX XX of XX XX between XXXX, was denied by XXXX as not medically necessary. Rationale: "The Official Disabilities Guidelines recommend performing a functional capacity evaluation to determine the suitability of returning to a specifically identified job and just prior to preauthorization / admission and upon completion of a work hardening program. A functional capacity evaluation was recommended to evaluate for additional therapy. However, the records indicate that the patient's previous treatment did not include injections, surgery, or prior XX therapy. There was no indication that the patient had any prior unsuccessful return to work attempts or was unable to perform a specific job. Therefore, the request for functional capacity evaluation for the submitted diagnosis of XX XX of XX XX of the XX XX is not medically necessary." Per a utilization review decision letter dated XXXX, the prospective request for reconsideration of functional capacity evaluation XX units, as an outpatient for the submitted diagnosis of XX XX of XX XX of the XX XX between XXXX was not certified. The prior denial was upheld as not medically necessary. Rationale: "When considering the date of injury, nothing the injury sustained, tempered by the physical examination reported there is no specific objective data presented to complete a functional capacity evaluation. There is no notation of multiple prior unsuccessful attempts to return to work, there is no indication for any medical proportions or work restrictions, and there are no reasonably expected permanent complex work restrictions assigned. Therefore, when noting the specific parameters identified in the Officially Disability Guidelines there is no clinical basis presented for this evaluation."

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

The ODG supports a functional capacity evaluation as an option in select circumstances including when and individual has reached or is about to reach maximum medical improvement and permanent disability ratings will be required or when there been multiple previous unsuccessful return to work attempts. The documentation available indicates that additional physical therapy is been recommended a functional capacity evaluation was advised to determine if additional therapy would be required. As the provider indicated that the injured worker was only able to return to XX duty, there is no indication of function capacity evaluation be required as there is no documentation of an unsuccessful attempt to return to work or an indication that the injured worker has reached or is close to reaching maximum medical improvement. The documentation also indicates that the injured worker is not fully been rehabilitated.
Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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

☐ AHRQ- 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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL