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DATE OF REVIEW: 5/16/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Work conditioning 2 times a week x 5 weeks up to 4 hours per visit.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., Board Certified in Physical Medicine & Rehabilitation with a sub-specialty in Sports Medicine.

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 that the requested for work conditioning 2 times a week x 5 weeks up to 4 hours per visit is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX year-old XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as the patient XXXX. The patient was status post open reduction internal fixation of the pelvic region from XXXX with a total hip replacement six months later and revision for total hip replacement in XXXX. The patient's current injury had caused a fracture around XXXX prosthesis. XXXX subsequently underwent open reduction and internal fixation of the fracture. The patient had made significant progress as of XXXX. XXXX had attended 24 sessions of therapy and was requesting work conditioning. The request was denied, and the rationale stated that there was no functional capacity evaluation to determine the patient's current physical demand level. Additionally, there was no documentation of a comprehensive evaluation determining the motivational, psychosocial and behavioral factors to determine successful participation in goals to recovery having been identified. Furthermore, the current request exceeded guideline recommendations with no exceptional factors clearly identified. The patient's pain level as of XXXX was rated at a 5 to 8. XXXX medications included XX, XX, XX and XX. On examination, the patient had limited hip range of motion on the right due to pain both actively and passively. XXXX knee examination was painful during passive range of motion maneuvers. X-rays were obtained noting the reconstruction plate and screw fixation in the left hemipelvis. At the time, the patient was being recommended for Supartz injections for the knees. This request pertains to a work conditioning program. A request has been submitted for work conditioning 2 times a week x 5 weeks up to 4 hours per visit.

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

According to the Official Disability Guidelines, in order to meet criteria for a patient undergoing a work conditioning program, there must be documented evidence that the patient failed to respond to a sufficient course of nonoperative treatment measures. Additionally, this physician has requested an excess of the total number of hours allotted for this type of treatment for patients undergoing a work conditioning program. The guidelines support up to three hours of work conditioning for total of 10 visits over 4 weeks. In this patient's case, the provider has requested a total of 10 visits at 4 hours per visit equaling 40 hours of work conditioning. Based upon these findings, the current request cannot be authorized. In sum, the requested work conditioning 2 times a week x 5 weeks up to 4 hours per visit is not medically necessary per Official Disability Guidelines.

Therefore, I have determined the requested for work conditioning 2 times a week x 5 weeks up to 4 hours per visit is not medically necessary for treatment of the patient's medical condition.

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**

1. Official Disability Guidelines Treatment Index. Hip and Pelvis Chapter. Work Conditioning/Work Hardening. 2018.

☐ **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)**