Texas Workers' Compensation

Maximum Medical Improvement (MMI) and the Official Disability Guidelines (ODG)

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Material Disclaimer

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Definition of MMI

WHAT IS Maximum Medical Improvement (MMI)?

There are two definitions of MMI in the State of Texas:

- **Clinical MMI**

  OR

- **Statutory MMI**

Definition of MMI

The earlier of:

- **Clinical MMI** - The ***earliest*** date after which based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated

OR

- **Statutory MMI** (listed on DWC Form-032) - 104 weeks from date on which income benefits begin to accrue

Statutory MMI

- DD does ***NOT*** determine statutory MMI date
- Statutory MMI date should be provided on DWC Form-032 or Presiding Officer Directive, if applicable
  - 104 weeks from date on which income benefits begin to accrue
  - not applicable for claims without initiation of income benefits (i.e., temporary income benefits (TIBS))

Statutory MMI

- MMI ***cannot*** be later than statutory MMI date, but IE may reach clinical MMI prior to statutory MMI
- If statutory MMI, explain why IE was not at clinical MMI ***prior*** to reaching statutory MMI

How to Determine Maximum Medical Improvement *(MMI)*

- Understand definition of MMI
- Review *Request for DD Examination* (DWC Form-32)
- Review the medical records
- Prepare a checklist of information to obtain from medical history and physical exam
- Perform DD exam
- Make referrals, if necessary, to answer question

How to Determine MMI

Make referrals, if necessary, to answer the question (continued).

Make sure to document in your report:

1. WHY was testing necessary to determine the answer to the question
2. WHAT the results of testing were
3. HOW the results affected your medical decision making

Rule Clarification 127.10(c)(4)(A)&(B)

Any additional testing or referrals required for the evaluation of an injured employee in a network or political subdivision under Labor Code § 504.053(b):

- (A) are not required to use a provider in the same network as the injured employee; and
- (B) are not subject to the network or out of network restrictions

How to Determine MMI

Additional Testing:

- Don't abdicate your decision to a referral doctor
  - They may not have the ODG
  - May not know DWC rules, Appeal Panel Decisions, or know that a DD must conduct additional testing, if needed, to make their determination (i.e. Neuropsych testing or surgical opinion)
- Strongly consider whether testing far out from the DOI will really help in your decision making

  (i.e. MRI or EMG / NCS 18 months after the DOI)

How to Determine Maximum Medical Improvement *(MMI)*

- **Answer question from DWC Form-032**
- Answer yes or no with a **sufficient explanation** as to **why or why not?**
  - Do not answer with just a conclusion
- If at MMI, ***why is*** IE at MMI?
- If at MMI, ***what is*** date and ***why that*** date?
- If not at MMI, ***why not***?
  - What is needed to reach MMI?

How to Determine MMI

The DD defines the compensable injury for certification of MMI and IR based on:

1. Thorough review of medical records
2. DD examination findings

28 TAC § 130.1(c)3

How to Determine MMI

- Provide a rationale as to the diagnoses considered in you determination of MMI
- DD *May be* limited to the diagnoses or conditions listed on Presiding Officer's Directive (POD) if the officer directs so

How to Determine MMI

When you have defined the compensable injury, determine MMI and IR (if applicable) for those diagnoses or conditions

- **In your report, specify what you determined to be the diagnoses or conditions you assessed for MMI and IR**

How to Determine MMI

- Apply the ODG and case specific details to that diagnosis(es) or condition(s)
- Consider *Official Disability Guidelines* (ODG), including Appendix D, to determine if based on reasonable medical probability additional treatment can be anticipated to result in further material recovery or lasting improvement *(more on this later)*

Practical Considerations (MMI)

- The statutory MMI date is the latest date that MMI can be certified, with certain potential exceptions for spinal surgery.
- Date of MMI cannot be assigned if prospective or conditional
- If it is determined that the IE is not at MMI, no Impairment Rating is assigned, and you will provide a prospective date.
- MMI must be certified before Impairment Rating is assigned.

Practical Considerations (MMI)

- Consider on a case by case basis the evidence in the records (co-morbidities, complications, unforeseen sequelae etc.) tempered with the ODG or other evidence-based medicine that would support your opinion.
- ODG recommendations are not the only consideration of MMI (delayed bone healing, nerve regeneration)
- Consider whether passage of time, resumption of activities of daily living, participation in home exercise, etc. may reasonably be anticipated to result in further material recovery

Practical Considerations (MMI)

- When you see an injured employee for MMI evaluation near or after their statutory MMI date you must determine if they reached clinical MMI prior to the stat date, and if not explain why.

- For statutory MMI to be the date of MMI, further material recovery from or lasting improvement to the injury must STILL have been anticipated during the time UP TO or AFTER the statutory MMI date.

Practical Considerations (MMI)

- Expected disability duration
  - Does ***not*** equate to MMI
- ***Do not use MDGuidelines for MMI***

Practical Considerations (MMI)
MMI Explanation

- Provide a reasonable synopsis of the symptoms, findings, imaging and treatment.
- Brief discussion of the diagnoses and conditions
- What is the usual timeframe for the recovery of these types of conditions?
- What would the ODG say regarding treatment for these diagnoses or conditions?
- Are there any non-injury related factors that are limiting and will continue to limit recovery?
- Are there co-morbidities delaying recovery, but recovery is still anticipated?

Practical Considerations (MMI)

- What if IE refuses treatment even though it is recommended by ODG?
- What if IE does not need treatment, even though it is recommended by ODG?
- What if treating doctor recommends treatment?
- What if treatment is pre-authorized?
- What if treatment not otherwise recommended by ODG would result in further material recovery or lasting improvement? – **see Appendix D**

Practical Considerations
MMI & Impairment Rating (IR)

- Assign IR for current compensable injury based on IE's condition on MMI date considering medical record and certifying examination **(Rule 130.1)**
- Review the record at or near the chosen date of MMI to look for information that will help you determine the IR.
- If the record and your exam reflect that the condition is the same or similar, may use your exam findings to reflect the condition at MMI.

Practical Considerations
MMI & Impairment Rating (IR)

- (continued)
- If there are non-injury related factors that occurred between the date of MMI certified and your exam that affect the condition, do not use the findings of your exam.
- If you are seeing the claimant ATER STAT, but there was a post-STAT surgery before your exam, you may not use your exam findings. Must find something in the records pre-surgery, close to STAT to reflect the condition at STAT

CASE EXAMPLES

Case 1

- 28-year-old paramedic sustained fracture of right lateral tibial plateau 08/11/2022 (Statutory MMI 08/19/2024)
- 3 months of partial WB after ORIF surgery
- 28 post-op PT sessions through 12/15/2022
  - Improvement in knee ROM, strength and ADLs
  - Walking/standing limited to 30-60 minute intervals
  - 2.0 cm right thigh atrophy
  - Quad strength 4/5
  - Knee flexion 100º and a flexion contracture of 10º

Case 1 - MMI

FCE 12/15/2022

- Deficits in ability to squat, lift from floor level, ascend and descend stairs and climb ladder, and push/pull
- Unable to complete treadmill test of cardiovascular fitness due to knee pain and weakness
- Multiple parameters for validity showed maximal and consistent effort
- Medium physical demand (PDL) category (lifting, push/pull)

Case 1 - MMI

Ortho Follow-up Visit 12/20/2022

- Working with restrictions with 911/dispatch (sedentary work)
- Continued home/gym exercise program concurrent and post-PT
- Difficulty walking, standing, stairs due to right knee pain and limited ROM
- Slight limp
- Fracture healed, good alignment

Case 1 - MMI

Ortho Follow-up Visit 12/20/2022

- Recommended six additional visits PT over next 6-8 weeks for progression of gym and home exercise program
- Additional six visits PT denied 1/4/2023 by pre-auth/utilization review – “request exceeds ODG recommended PT”

Case 1 - MMI

DD Medical History 2/15/2023

- Continued restricted duty 911/dispatch
- Compliant with home/gym program – *"getting a little stronger, slow progress"*
- Improved ambulation, but difficulty with standing/walking greater than 30-60 minute intervals, stairs still a problem
- PT preauthorization denial appealed

Case 1 - MMI

DD Physical Exam 2/15/2023

- Right knee ROM
  - Flexion 100º and 10º of flexion contractue
  - Passive ROM is consistent with active
- Antalgic gait w/shortened stance and push-off
- 1.5 cm right thigh atrophy
- 4+/5 strength right knee extension

Case 1 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

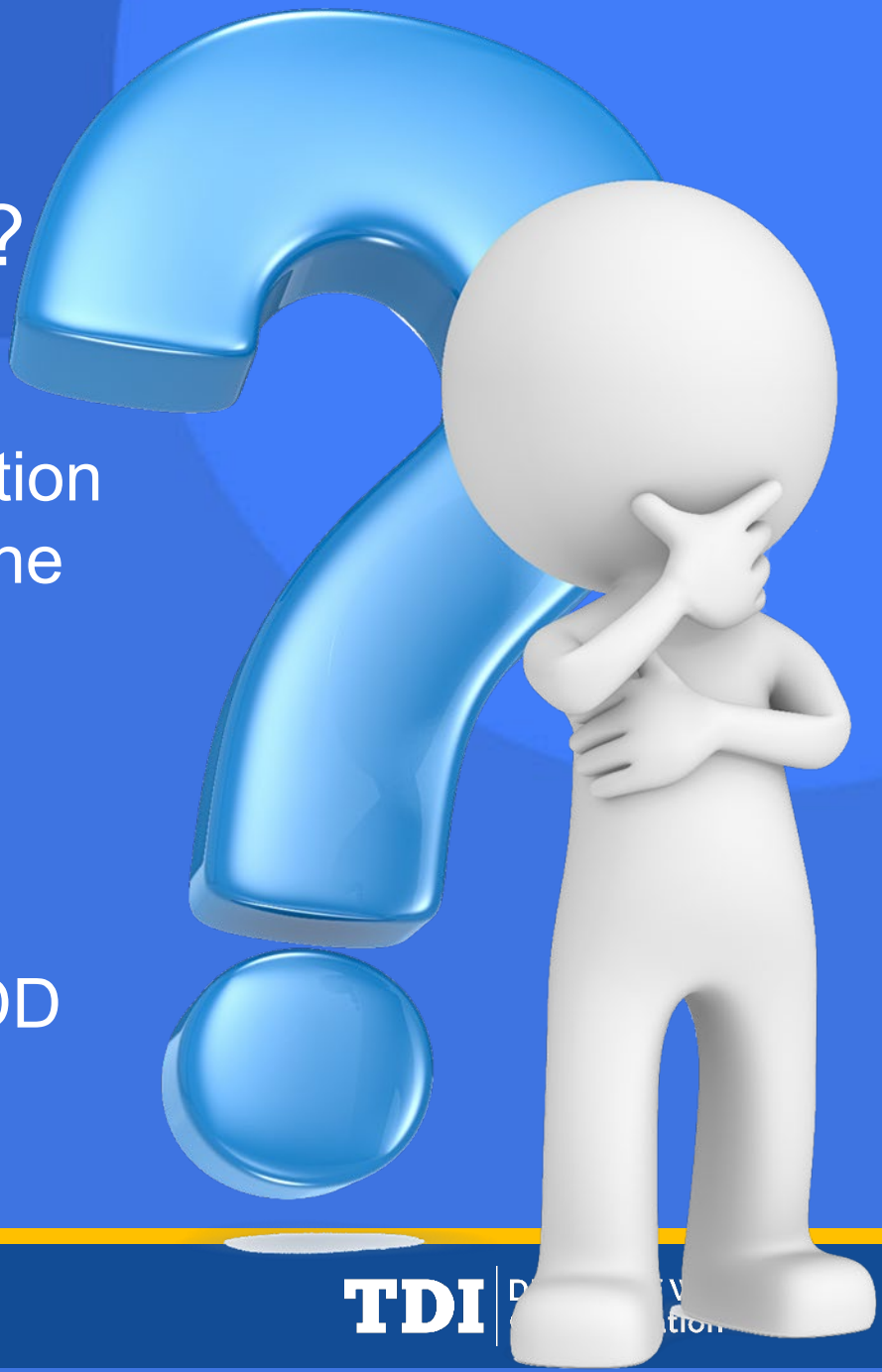
(May not be greater than statutory MMI date shown on DWC Form-032)

Case 1 - MMI

Has MMI been reached?

If so, on what date?

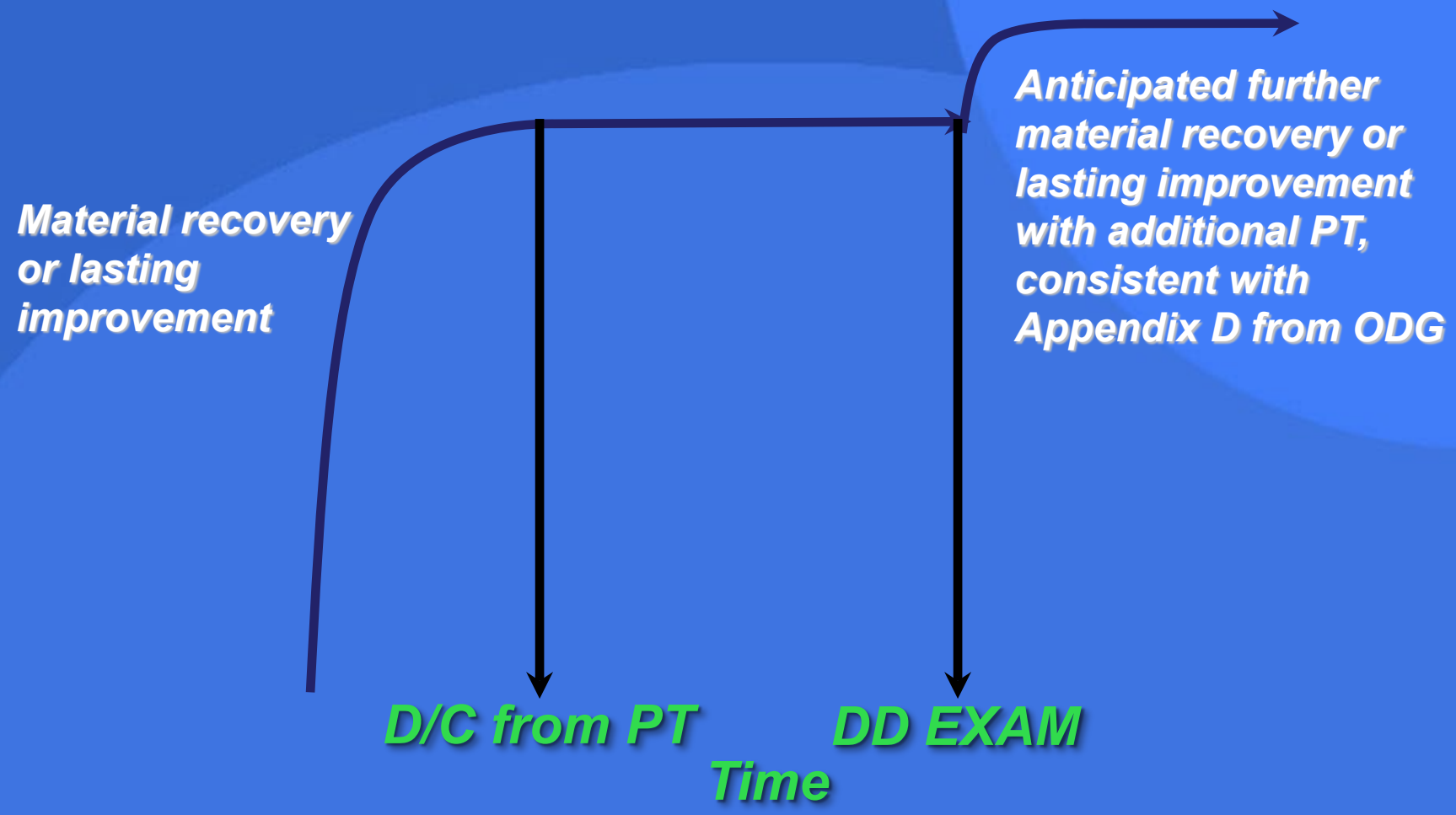
A. MMI 12/15/2022 – completion of post-operative PT and the FCE date
B. MMI 12/20/2022 – date of follow-up with orthopedic surgeon
C. MMI 2/15/2023 – date of DD exam
D. Not at MMI



Case 1 - MMI

- **IE not at MMI**
- Additional treatment (PT) in all reasonable medical probability is anticipated to result in further material recovery or lasting improvement
- Supported by ODG (including Appendix D)
- Discuss WHY based on case specific details

Not at MMI


Material recovery or lasting improvement
Anticipated further material recovery or lasting improvement with additional PT, consistent with Appendix D from ODG
D/C from PT
DD EXAM
Time

Case 1 - MMI

WOULD MMI CHANGE WITH A CHANGE IN CASE DETAILS?

1. Same age but non-compliant.
2. Middle age with lesser PDL to return to. Post fracture stiffness, mild ROM loss and atrophy. So may not be an anticipation that more therapy would result in a reduction in atrophy or improved ROM.
3. Older and goes on to rapid post-traumatic arthritis with worsening ROM and persistent atrophy. May be candidate for TKA.
4. Non-injury related findings are present

Case 2 - MMI

- 28-year-old male restaurant manager developed acute low back and then left posterior thigh pain 3 days after a slip and fall on wet floor, landing on buttocks on 06/15/2022
- Occupational medicine treatment
  - NSAIDs, muscle relaxant medication
  - 6 PT visits
  - No improvement in symptoms or activity tolerance
  - RTW with restrictions
    - Employer unable to accommodate restricted duty work

Case 2 - MMI

- Follow up 4 weeks after the DOI.
- Complaints were pain that went down the posterior left leg to the outer foot.
- Sensory exam demonstrated decreased sensation in the same distribution as the complaints.
- He had difficulty performing left toe raises.
- The left Achilles reflex was absent on the left and 2+/4 on the right.
- Positive SLR with leg pain to the calf at 45 degrees on the left.

Case 2 - MMI

- Lumbar MRI scan showed 7 mm posterolateral left L5/S1 herniated nucleus pulposus (HNP) displacing the left S1 nerve root. No other significant signs of lumbar spondylosis.
- Transforaminal lumbar epidural steroid injection (ESI) x 2 on the left at L5/S1 with short term improvement

Case 2 - MMI

- Left L5/S1 hemi-laminotomy/discectomy 01/15/2023
  - At 6 weeks post-op, partial relief of lower extremity symptoms
  - 03/03/23 had decreased sensation left lateral foot and lower extremity strength 4+/5
  - 03/08/23 RTW without restrictions
  - Completed 18 PT visits 3/15/2023
  - Handwritten PT discharge summary illegible

Case 2 - MMI

Surgeon Follow-up Exam 04/01/2023

- Working without restrictions since 3/8/2023
- Taking OTC analgesics as needed
- Intermittent low back pain
- SLR produced LBP without neural tension signs
- Lumbar flexion fingertips to mid shin, slightly decreased lumbar extension, both with increased LBP

Case 2 - MMI

Surgeon Follow-up Exam 04/01/2023 (cont'd)

- Left Achilles DTR decreased
- Decreased sensation left lateral foot
- Lower extremity strength 5/5
- No dural tension signs on the left
- "Patient is concerned about continued low back pain"
- Recommended MRI scan without contrast to "rule out recurrent disc herniation"

Case 2 - MMI

Repeat Lumbar MRI Scan With Contrast 04/05/2023

- Post-operative changes without any evidence of recurrent or residual disc herniation

Case 2 - MMI

Surgeon Follow-up 04/12/2023

- IE taking OTC analgesics as needed
- Performing home exercise program per PT
- Working without restrictions
- Exam unchanged from 4/1/2023
- Discussed MRI results, no additional surgery recommended and possible referral for additional interventional pain management
  - IE does not want to pursue
- Continue home exercises, OTC medication, return as needed

Case 2 - MMI

DD Exam 07/15/2023

- Chief complaint low back pain
- Normal gait
- Lumbar range of motion as follows
  - flexion to 50º degrees (sacral value of 40º)
  - lumbar extension 20º
  - both with increased left lower back pain

Case 2 - MMI

DD Exam 7/15/2023

- Left straight leg raise limited to 54º where it produces left low back pain, without dorsiflexion aggravation
- Right SLR 65º limited by hamstring tightness
- Left Achilles DTR decreased and numbness to pinprick over left lateral foot
- Lower extremity strength 5/5 bilaterally

Case 2 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

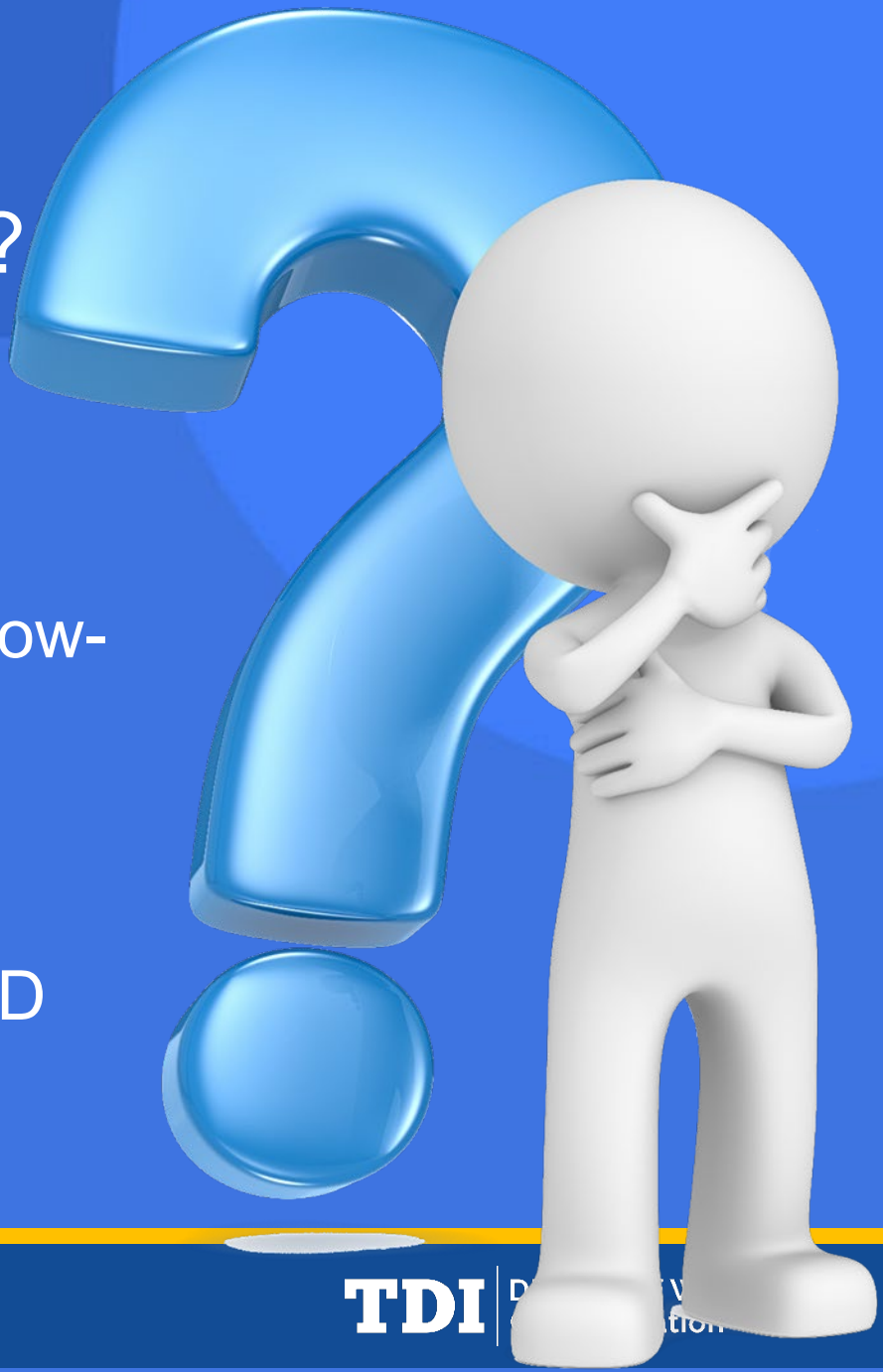
If so, on what date?

(May not be greater than statutory MMI date shown on DWC Form-032)

Case 2 - MMI

Has MMI been reached?
If so, on what date?

A. MMI 3/15/23 – date of PT discharge
B. MMI 4/1/2023 - date of follow-up with surgeon
C. MMI 4/12/2023 - date of follow-up with surgeon
D. MMI 7/15/2023 - date of DD exam
E. Not at MMI



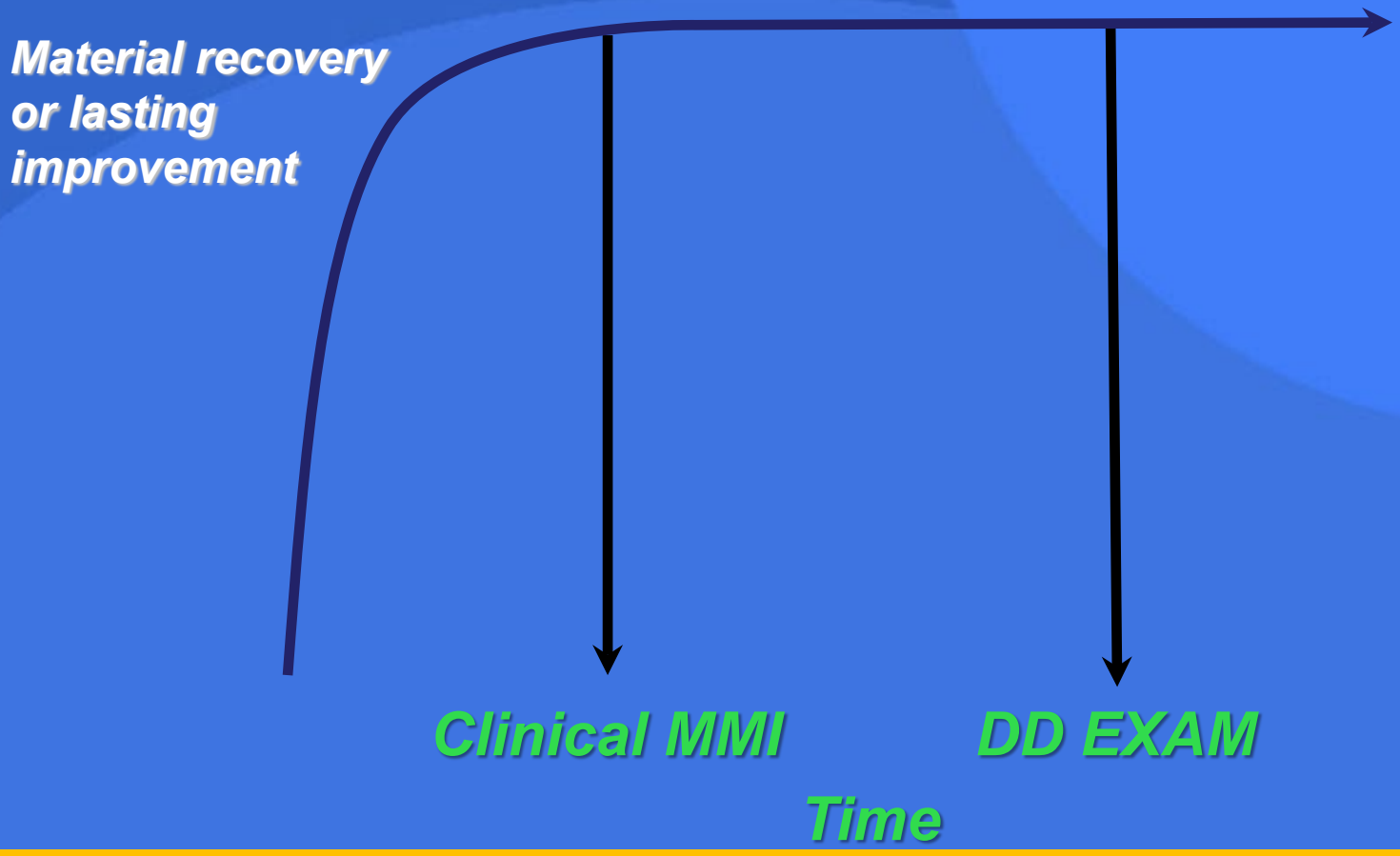
Case 2 - MMI

- IE at MMI 4/1/2023
- Additional treatment and/or time after 04/01/23 in all reasonable medical probability not likely to result in further material recovery from or lasting improvement
- What about repeat MRI scan 4/5/23?
- What about additional interventional pain management discussed/refused on 4/12/23?

MMI Before DD Exam

- IE reaches clinical plateau (MMI) prior to DD exam with no intervening change in condition or a reasonable expectation of improvement
- If medical condition is unchanged between the chosen date of MMI and your exam, may use physical exam findings at DDE for IR on MMI prior to date of DDE
- ***Explain this in your report!***

MMI Before DD Exam



Case 3 - MMI

- 26-year-old laborer sustained tears of right medial meniscus and ACL on 04/28/21 after twisting valgus injury on a planted foot
- Statutory MMI 05/08/23
- Initial dispute about compensability of injury, eventually resolved in IE's favor at CCH 12/15/2021

Case 3 - MMI

Extensive Treatment

- Medication
  - NSAIDs, muscle relaxants, acetaminophen
- 24 visits pre-op PT 2/1/22-7/1/22
- Arthroscopic meniscectomy, ACL repair surgery 11/15/22
- 30 visits post-op PT 12/1/22-5/5/23

Case 3 - MMI

Post-op PT on 5/5/2023 Documents

- Right knee ROM
  - Flexion 100º
  - Flexion contracuture 10º
- 2 cm right thigh atrophy
- 4/5 strength right knee extension
- Work hardening recommended

Case 3 - MMI

- Sustained recurrent medial meniscus tear (“Bucket Handle”) in work hardening 5/15/23
- Underwent arthroscopic medial meniscectomy 6/30/23
- Completes additional 12 post-op PT 8/15/23.

Case 3 - MMI

DD Exam 9/1/23

- Right knee ROM
  - Flexion 100º
  - No flexion contracture
- 1 cm right thigh atrophy
- 5/5 strength bilateral lower extremity
- Normal gait

Case 3 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

(May not be greater than statutory MMI date shown on DWC Form-032)

Case 3 - MMI

Has MMI been reached?

If so, on what date?

A. 05/05/2023, date of post-op PT visit

B. 05/08/2023, date of statutory MMI

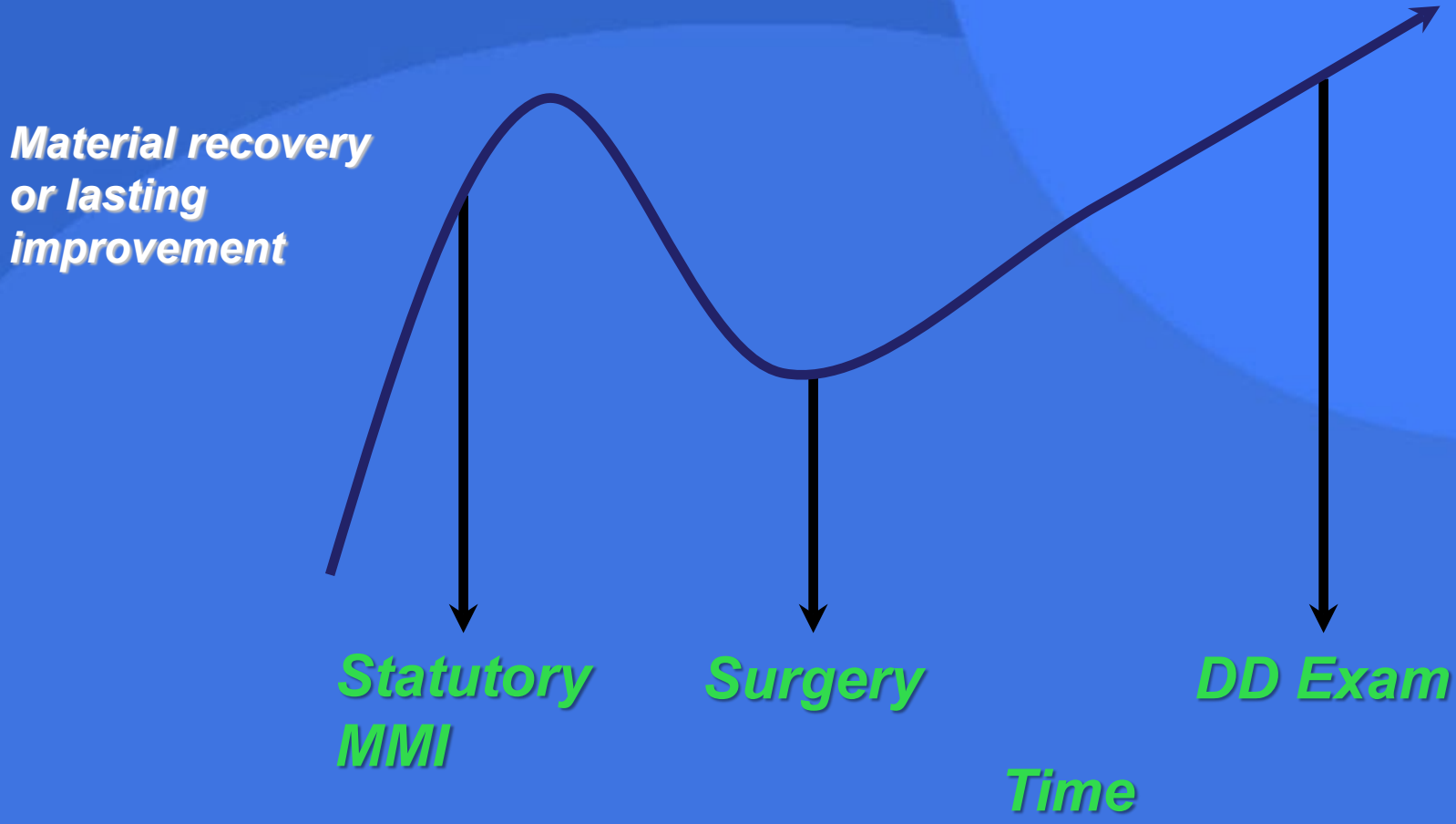
C. 09/01/2023, date of DD Exam

D. Not at MMI

Case 3 - MMI

- IE at MMI, statutory MMI 5/8/23
- What is IR based on?
  - ROM at PT discharge 5/5/23
  - Not 9/1/23 - DD exam findings which occurred **after** post-statutory MMI surgery and do not reflect IE's condition at MMI

DD Exam After Statutory MMI With Surgery After Statutory MMI



Case 4 - MMI

- 29-year-old retail stock clerk injured right shoulder lifting box above shoulder height 01/30/2023
- Statutory MMI 02/08/2025
- Treated with NSAIDs and “Codman exercises”
- Returned to restricted duty work 02/04/2023
- Symptoms worsened with RTW
- MRI scan 03/12/2023 with partial tear right supraspinatus, increased signal in subacromial bursa consistent with inflammation and Type II acromion

Case 4 - MMI

- Subacromial corticosteroid injection 3/15/23
- 9 visits of PT 3/18/2023 – 4/15/2023 with some improvement in ROM, strength, activity tolerance

Case 4 - MMI

- **PT Discharge 4/15/2023**
  - Flexion 160º
  - Extension 30º
  - Abduction 140º
  - Adduction 20º
  - External rotation 40º
  - Internal rotation 40º
  - 4+/5 strength of right supraspinatus and infraspinatus
- **Ortho Follow-up 4/22/23**
  - “Continue home exercise program, follow-up 1 month”

Case 4 - MMI

DD Exam 6/05/22

- Reports continued home exercise program and RTW with improvement
- Right shoulder ROM
  - Flexion 180º Extension 50º
  - Abduction 170º Adduction 40º
  - External rotation 80º Internal rotation 80º
- 5/5 strength of supraspinatus, infraspinatus and subscapularis bilaterally
- Normal sensation

Case 4 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

(May not be greater than statutory MMI date shown on DWC Form-032)

Case 4 - MMI

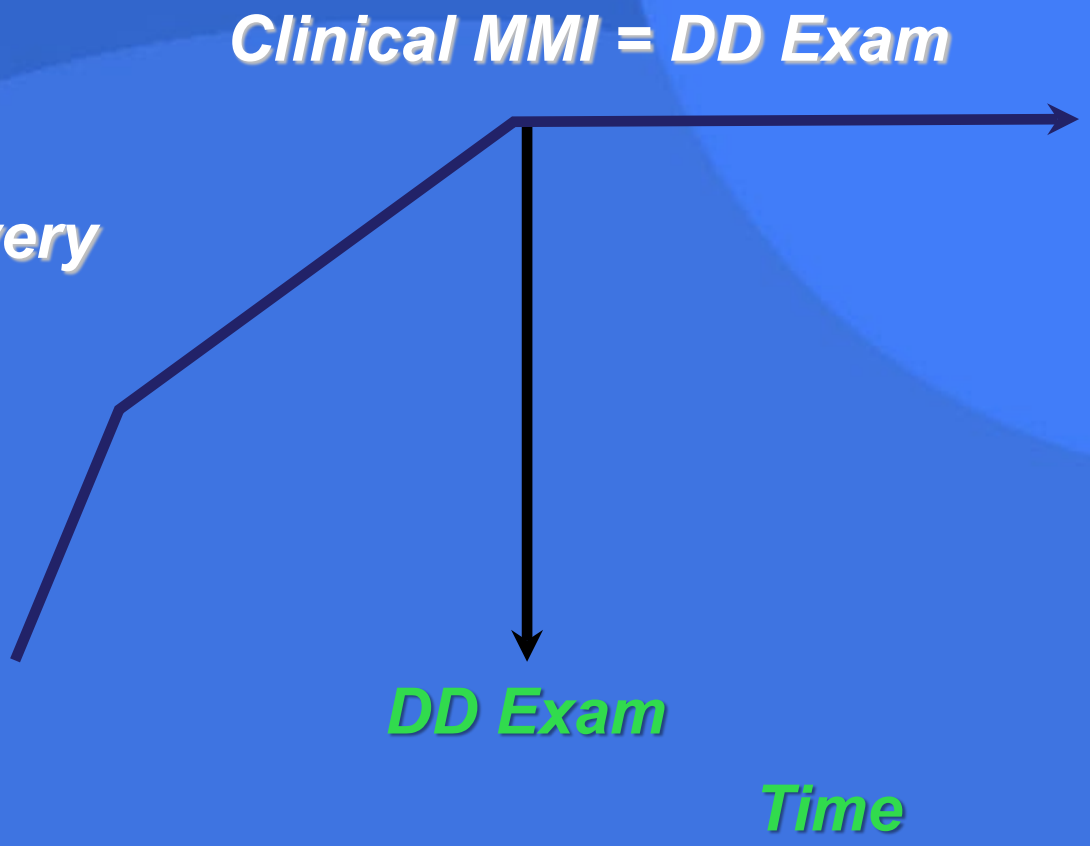
Has MMI been reached?
If so, on what date?

A. 4/15/2023, date of PT discharge
B. 4/22/2023 date of ortho follow-up
C. 6/5/2023, date of DD exam
D. Not at MMI

Case 4 - MMI

- IE at MMI, DD exam 6/5/23
  - Additional treatment, time, etc. not reasonably anticipated to result in further material recovery or lasting improvement
  - PT discharge 4/15/2023
  - Restricted ROM, mild weakness and activity intolerance that reasonably is anticipated to improve with continued HEP and RTW as retail stock clerk
  - Ortho follow-up 4/22/2023
  - No documentation of medical condition

MMI on Date of DD Exam



MMI on Date of DD Exam

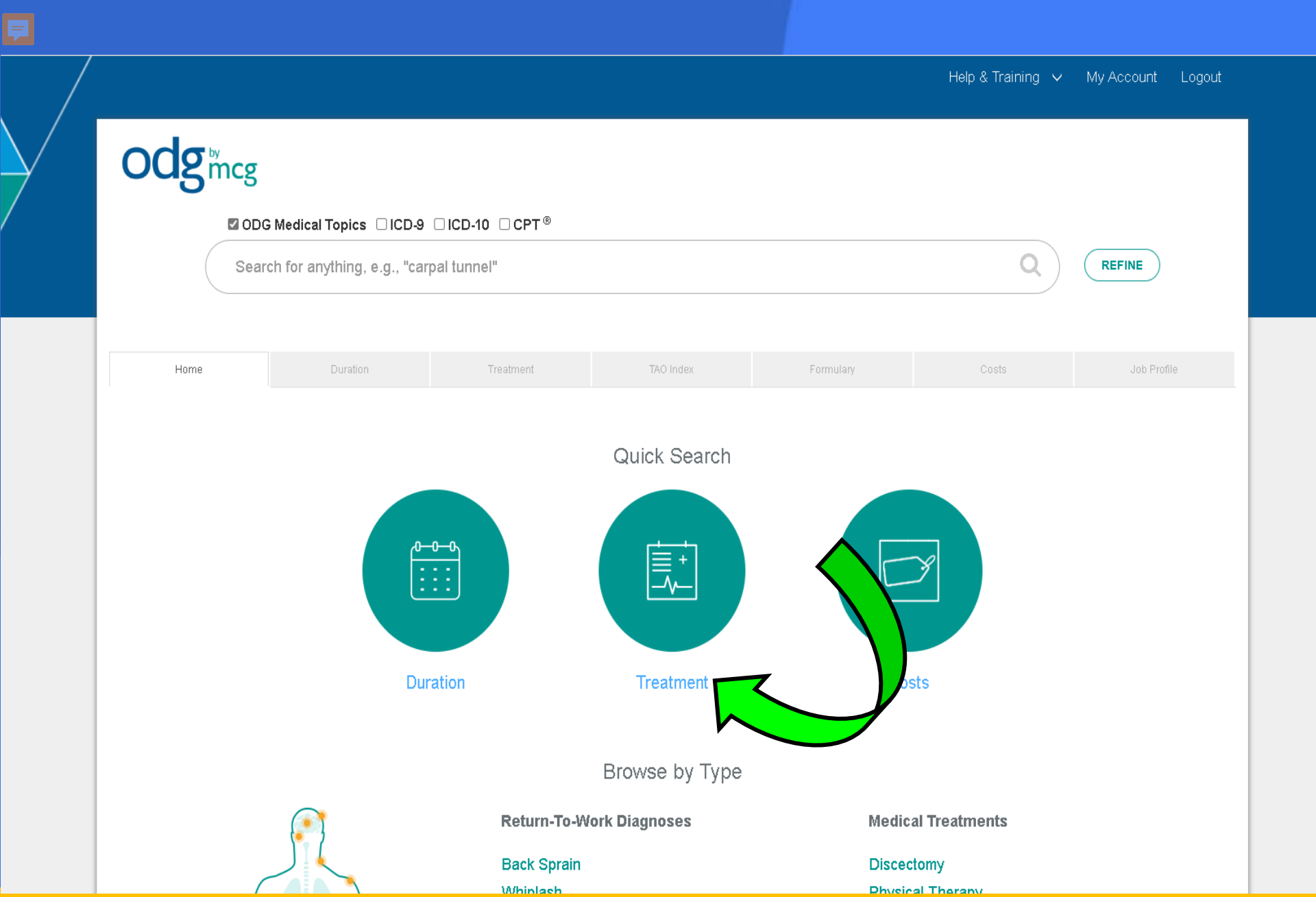
- Clinical findings from prior records show reasonable anticipation of further material recovery or lasting improvement but that anticipation is no longer present as of DD exam
- Poor records, do not document medical condition at earlier date than DDE
- Reached clinical plateau on date of DD exam and no additional lasting material recovery or improvement expected

MMI and ODG

- Based on medical records, medical history, and physical exam, is there evidence IE has reached MMI?
  - ***Explain***
- Can additional treatment/testing per ODG including Appendix D, be reasonably anticipated to result in further material recovery or lasting improvement? If so, IE is not at MMI.
  - ***Explain***
- If not at MMI, what is needed to reach MMI?
  - ***Explain***

Using ODG

- Recommended Treatment
  - Low back, physical therapy example
- Appendix D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ODG Medical Topics
ICD-9
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Search for anything, e.g., "carpal tunnel"
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Formulary
Costs
Job Profile
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Treatment
Browse by Type
Return-To-Work Diagnoses
Back Sprain
Medical Treatments
Discectomy

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ODG Medical Topics ICD-9 ICD-10 CPT®

Search for anything, e.g., "carpal tunnel"

REFINE

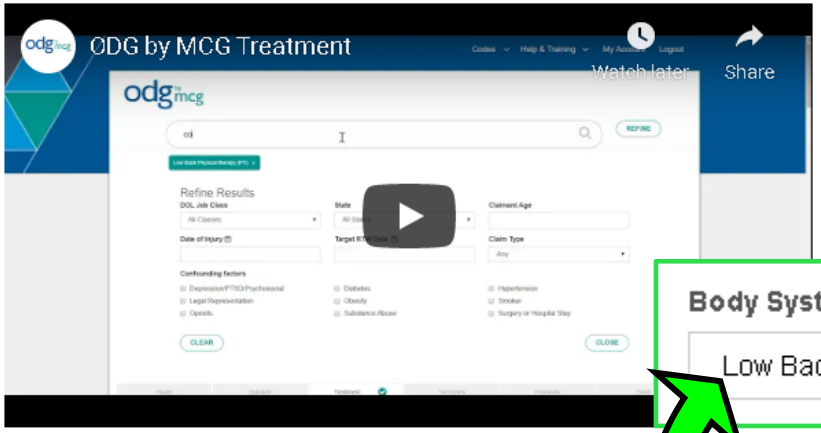
Home | Duration | Treatment | TAO Index | Formulary | Costs | Job Profile

Treatment Info

Search Treatment

Treatment

Enter search terms above, or see video below for tutorial.



Filter Treatment

RESET

Recommendation

All Recommendations

Category

All Categories

Body System

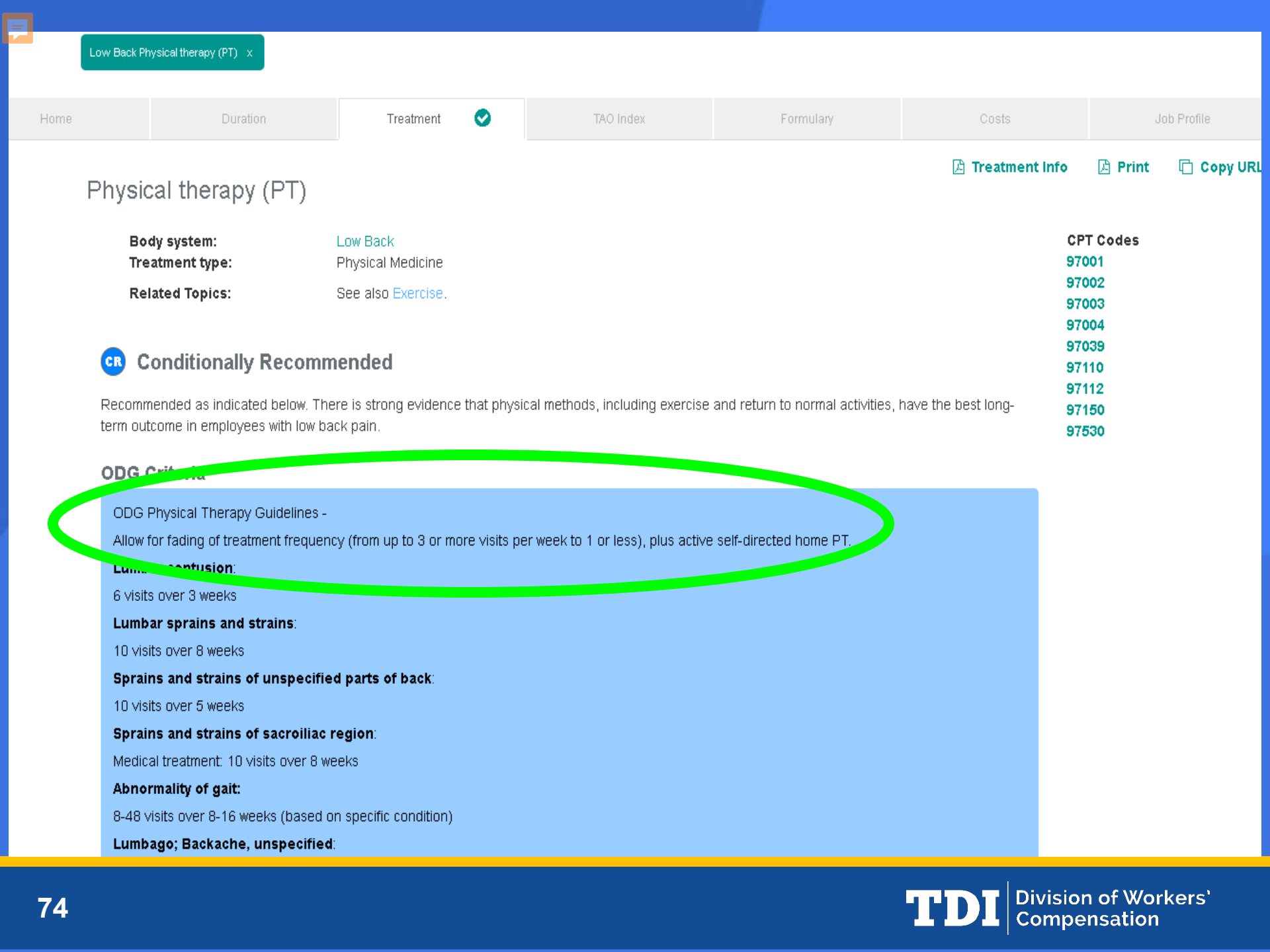
All Body Systems

Body System

Low Back

TDI Division of Workers' Compensation

- NR Percutaneous image guided lumbar decompression (PILD) - Low Back
- NR Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) - Low Back
- O Percutaneous neuromodulation therapy (PNT) - Low Back
- O Percutaneous vertebroplasty (PV) - Low Back
- O PGE1 - Low Back
- O Pharmaceuticals - Low Back
- O Phototherapy - Low Back
- CR Physical therapy (PT) - Low Back
- R Pilates - Low Back
- O Pin removal - Low Back
- O PIRFT - Low Back
- CR Piriformis injections - Low Back
- O Plasma disc decompression - Low Back
- O Platelet-rich plasma (PRP) - Low Back


Low Back Physical therapy (PT) x
Home
Duration
Treatment
TAO Index
Formulary
Costs
Job Profile
Treatment Info
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Physical therapy (PT)
Body system: Low Back
Treatment type: Physical Medicine
Related Topics: See also Exercise.
CPT Codes
97001
97002
97003
97004
97039
97110
97112
97150
97530
CR
Conditionally Recommended
Recommended as indicated below. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain.
ODG Physical Therapy Guidelines -
Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.
6 visits over 3 weeks
Lumbar sprains and strains:
10 visits over 8 weeks
Sprains and strains of unspecified parts of back:
10 visits over 5 weeks
Sprains and strains of sacroiliac region:
Medical treatment: 10 visits over 8 weeks
Abnormality of gait:
8-48 visits over 8-16 weeks (based on specific condition)
Lumbago; Backache, unspecified:

ODG Physical Therapy Guidelines -

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active

Lumbar contusion:

6 visits over 3 weeks

Lumbar sprains and strains:

10 visits

Sprains a

10 visits

prains a

Medical treatment: 10 visits over 8 weeks

Abnormality of gait:

8-48 visits over 8-16 weeks (based on specific condition)

Lumbago; Backache, unspecified:

9 visits over 8 weeks

ODG Physical Therapy Guidelin

Allow for fading of treatm quency (from up to 3 or more visits per week to 1 or less), plus active

Lumbar contusion:

6 visits over 3 weeks

Lumbago; Backache, unspecified:

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy:

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:

10-12 visits over 8 weeks

Curvature of spine:

12 visits over 10 weeks

Fracture of vertebral column without spinal cord injury:

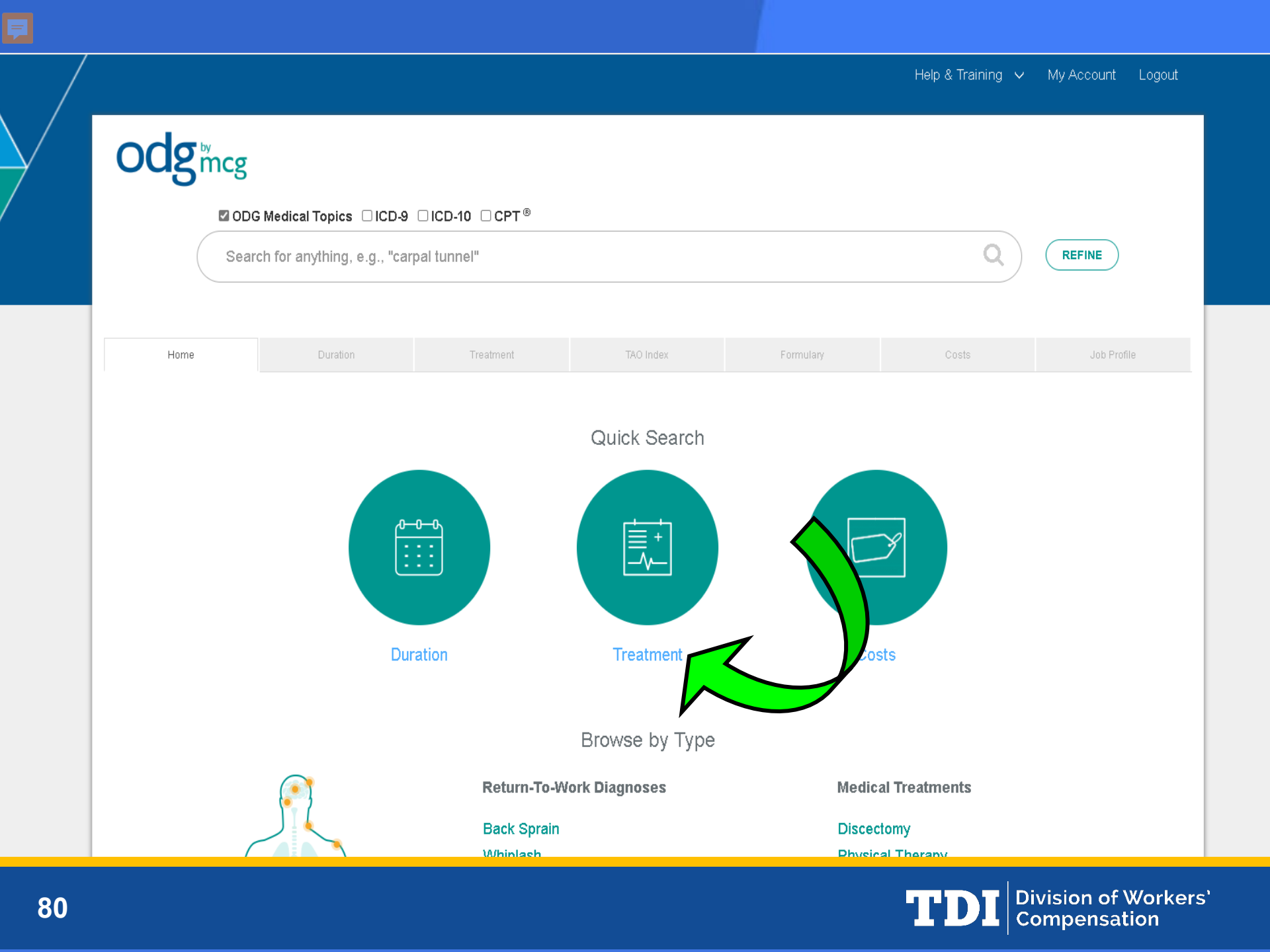
Medical treatment: 8 visits over 10 weeks

Active Treatment versus Passive Modalities: The use of active treatment instead of passive modalities is associated with substantially better clinical outcomes. In a large case series of patients with acute low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). A recent RCT comparing active spinal stabilization exercises (using the GDS or Godelive Denys-Struyf method) with passive electrotherapy using TENS plus microwave treatment (considered conventional physical therapy in Spanish primary care), concluded that treatment of nonspecific LBP using the GDS method provides greater improvements in the midterm (6 months) in terms of pain, functional ability, and quality of life. (Arribas, 2009) In this RCT, two active interventions, multidisciplinary rehab (intensive, bio-psychosocial PT) and exercise (exercises targeted at trunk muscles together with stretching and relaxation), reduced the probability of sickness absence, and were more effective for pain than self-care advice at 12 months. (Rantonen, 2012)

Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. (Luijesterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

Post-surgical (discectomy) rehab: A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as

Appendix D of ODG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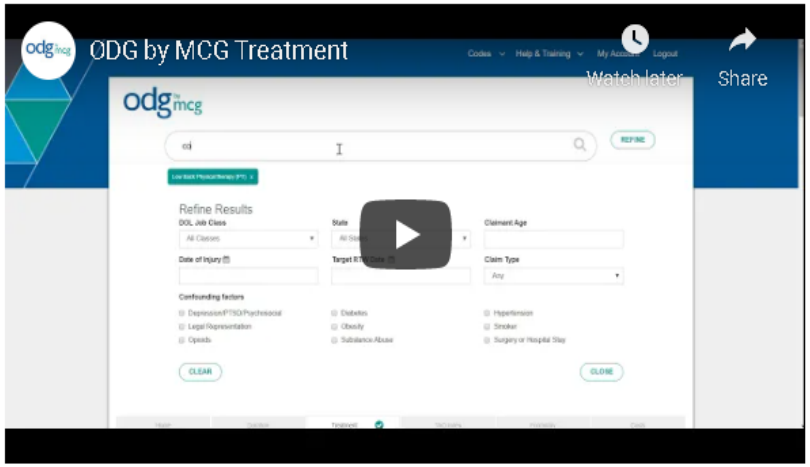

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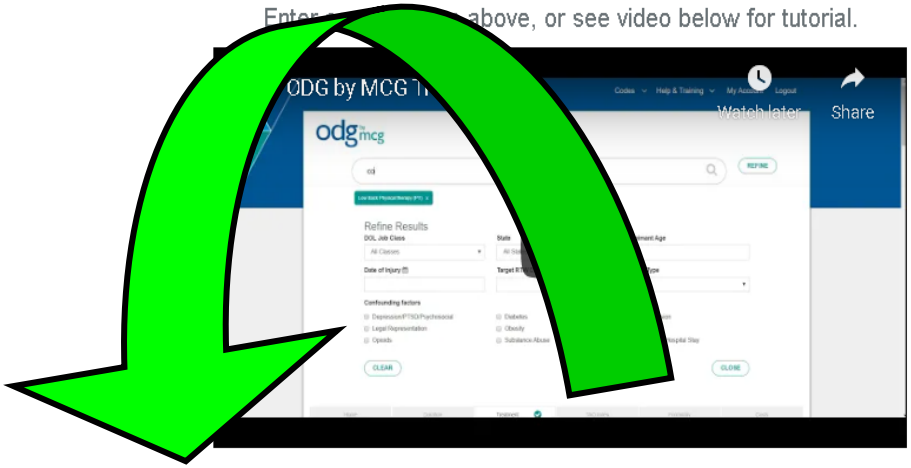

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Appendix D

Documenting Exceptions to the Guidelines

The purpose of this section is to outline a process for allowing patients to receive appropriate medical treatment even if it is not covered in ODG. As explained in Appendix B, Methodology:

> "These publications are guidelines, not inflexible proscriptions, and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions and also help payors make reimbursement determinations, but they cannot take into account the uniqueness of each patient's clinical circumstances."

ODG and Exceptions

Appendix D, Documenting Exceptions to the Guidelines defines *"a process for health care providers and insurance carriers to follow to help ensure appropriate medical treatment is provided in light of consideration of exceptional factors in individual cases"*

ODG and Exceptions

The purpose of APPENDIX D *"is to outline a process for allowing patients to receive appropriate medical treatment even if it is not covered in ODG."*

As explained in Appendix B, Methodology:

"These publications are guidelines, not inflexible proscriptions, and they should not be used as sole evidence for an absolute standard of care"

"Guidelines can assist clinicians in making decisions for specific conditions and also help payors make reimbursement determinations, but they cannot take into account the uniqueness of each patient's clinical circumstances."

Appendix D –
Documenting / Considering ODG Exceptions

FOR PROVIDERS OR DESIGNATED DOCTORS:

A. Conditions NOT commonly seen in Workers' compensation

B. Treatments that ARE addressed in the Guidelines but are NOT recommended

Appendix D – *Documenting / Considering ODG Exceptions*

A. Conditions not commonly seen in Worker's Compensation

1. Documenting objective signs of functional improvement for treatment conducted
   a. ***Work and/or Activities of Daily Living Functions***
   b. ***Physical Impairments,*** i.e. ROM, muscle flexibility, strength, or endurance deficits, exercise capacity
   c. ***Approach to Self-Care and Education*** (compliance)

Appendix D – *Documenting / Considering ODG Exceptions*

A. Conditions not commonly seen in Worker's Compensation *(continued)*

2. Patient co-morbidities
3. Ongoing care for chronic conditions
    a. For intermittent or temporary worsening of the condition
    b. Length and intensity of treatment usually less than the initial acute injury
4. Any additional evidence to support medical necessity of medical care at issue (EBM)

Appendix D –
Documenting / Considering ODG Exceptions

B. Treatments in ODG but NOT recommended

<u>Patient co-morbidities</u>

1. Explain HOW and WHY the IE is different from the participants in the clinical studies that support a negative recommendation or exclusion
2. Specifics of the IE, injury or condition can sometimes result in an injured worker falling outside the type and demographics of participants in high-quality studies

Appendix D – *Documenting / Considering ODG Exceptions*

B. Treatments in ODG but NOT recommended *(continued)*

<u>Documenting functional improvement for treatment conducted:</u>

1. Goal is to restore prior level of function, especially return to work
2. How is function (not just symptoms of pain) expected to improve following the requested treatment based on:
    - Previous outcomes
    - Mechanism of injury
    - Specific effects of treatment
    - Documenting measurable points of future benefit

Treatments That are Covered in ODG but Not Recommended

Example - Co-morbid Conditions Supporting Performance of Treatment Not Recommended by ODG

- 45-year-old chronic diabetic patient complains of low back and leg pain following work related lifting injury
- On exam, pain in non-dermatomal distribution
- Lower extremity nerve conduction velocity study may be indicated to assess for peripheral neuropathy (alternate explanation for symptoms / complaints)

Treatments That are Covered in ODG but Not Recommended

Example - Functional Improvement Supporting Treatment Exceeding ODG

- 36-year-old fireman sustains medial meniscal tear while working and undergoes arthroscopic meniscectomy
- Completes ODG recommended level of post operative PT with documented and specific objective functional improvement, but still has objective functional deficits
- Additional course of physical rehabilitation to address functional deficit is reasonable

Situations Not Addressed in ODG

Examples - Non-occupational Conditions

- Dental implants for patient with broken teeth from work compensable injury
- Renal ultrasound study for hydronephrosis for patient with work compensable cervical spinal cord injury
- Cosmetic surgery for patient with work compensable burn injury

Situations Not Addressed in ODG

Example - Unusual Presentations

- Severely comminuted femoral condyle fracture in 30-year-old as result of compensable motor vehicle accident
- Orthopedic surgeon recommends total knee replacement (TKR) due to severity of fracture
- While TKR is not typically indicated in 30-year-old patient, it is reasonable in this circumstance given inability to reduce severely comminuted femoral condyle fracture

Maximum Medical Improvement and ODG

Thank you

Certification of Successful Completion

Certification or recertification as a designated doctor requires a certificate of successful completion of all required DWC training, including recorded presentations and live webinars

Certification of Successful Completion

1. A designated doctor must submit the DWC attestation to validate viewing the recorded presentations.
2. Live webinar participation is confirmed by registration and attendance during the live event
3. A certificate of successful completion is emailed to the designated doctor after completing the entire course
4. The certificate of successful completion must be submitted with the complete**d certification application or recertification application**

Find the DWC attestation of completion at: https://www.tdi.texas.gov/wc/dd/documents/ddattestation.pdf

View all required and optional training at: https://wwww.tdi.texas.gov/wc/dd/training.html