

**DECISION AND ORDER**

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

**ISSUE**

A contested case hearing was held on May 28, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Petitioner / Claimant is not entitled to physical therapy for 12 sessions and EMG of the right upper extremity for the compensable injury of \_\_\_\_\_?

**PARTIES PRESENT**

Petitioner/Claimant (hereinafter, "Claimant") appeared and was assisted by NP, ombudsman. Respondent/Carrier (hereinafter, "Carrier") appeared and was represented by EL, adjuster.

**BACKGROUND INFORMATION**

The Claimant testified that she sustained a compensable injury in July 2006 to her right shoulder in the form of a right rotator cuff strain. Noting that she received approximately two months of physical therapy, the Claimant stated it did not do that much good. She became symptomatic again in May 2008 and received eight or nine sessions of physical therapy, of a type different from the original, and she stated it did more to help her. The Claimant stated she had been instructed on home exercises but, without guidance, she was unsure on the amount of weight she should be lifting. In December 2008 she was referred to (Healthcare Provider) and Dr. N recommended further physical therapy, which her treating doctor, Dr. T, requested.

On December 22, 2008, the Carrier's first utilization review doctor denied the request, noting that it exceeded the Official Disability Guidelines-Treatment in Workers' Compensation published by Work Loss Data Institute (ODG), that the Claimant had already received extensive shoulder rehabilitation, and the remoteness from the date of injury.

On January 15, 2009, the utilization review doctor for the request for reconsideration upheld the denial of treatment. Noting that he had spoken with Dr. T, the review doctor stated that there had been no recent examinations, that he was unable to tell exactly how much physical therapy the Claimant had received, there was no documented cervical radiculopathy, and no clear indication that an EMG was needed.

On March 23, 2009, the IRO reviewer, a medical doctor with board certifications in physical medicine and rehabilitation, pain management, and electrodiagnostic medicine, upheld the earlier denials of 12 sessions of physical therapy and an EMG of the right upper extremity (RUE). Noting that the requested sessions of physical therapy exceeded the guidelines, and that there

was no justification provided for the additional physical therapy, the reviewer stated the Claimant did not meet the ODG criteria for an EMG of the RUE.

**Texas Labor Code Section 408.021** provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. **Section 401.011(22-a)** defines health care reasonably required as “health care that is clinically appropriate and considered effective for the injured employee’s injury and provided in accordance with best practices consistent with: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community.” “Evidence based medicine” is further defined, by **Section 401.011(18-a)** as the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients.

The Division of Workers’ Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the (ODG), and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the ODG. As to Physical Therapy for Shoulder Disorders, the ODG offers the following:

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Use of a home pulley system for stretching and strengthening should be recommended. (Thomas, 2001) For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. The mainstays of treatment for instability of the glenohumeral joint are modification of physical activity and an aggressive strengthening program. Osteoarthritis of the glenohumeral joint usually responds to analgesics and injections into the glenohumeral joint. However, aggressive physical therapy can actually exacerbate this condition because of a high incidence of joint incongruity. (Burbank, 2008) (Burbank2, 2008)

Impingement syndrome: For impingement syndrome significant results were found in pain reduction and isodynamic strength. (Bang, 2000) (Verhagen-Cochrane, 2004) (Michener, 2004) Self-training may be as effective as physical therapist-supervised rehabilitation of the shoulder in post-surgical treatment of patients treated with arthroscopic subacromial decompression. (Anderson, 1999) A recent structured review of physical rehabilitation techniques for patients with subacromial impingement syndrome found that therapeutic exercise was the most widely studied form of physical intervention and demonstrated short-term and long-term effectiveness for decreasing pain and reducing functional loss. Upper quarter joint mobilizations in combination with therapeutic exercise were more effective than exercise alone. Laser therapy is an effective single intervention when compared with placebo treatments, but adding laser treatment to therapeutic exercise did not improve treatment efficacy. The limited data available do not

support the use of ultrasound as an effective treatment for reducing pain or functional loss. Two studies evaluating the effectiveness of acupuncture produced equivocal results. (Sauers, 2005)

Rotator cuff: There is poor data from non-controlled open studies favouring conservative interventions for rotator cuff tears, but this still needs to be proved. Considering these interventions are less invasive and less expensive than the surgical approach, they could be the first choice for the rotator cuff tears, until we have better and more reliable results from clinical trials. (Ejnisman-Cochrane, 2004)

### **ODG Physical Therapy Guidelines –**

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

#### **Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):**

Medical treatment: 10 visits over 8 weeks

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

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

#### **Complete rupture of rotator cuff (ICD9 727.61; 727.6)**

Post-surgical treatment: 40 visits over 16 weeks

#### **Adhesive capsulitis (IC9 726.0):**

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

#### **Dislocation of shoulder (ICD9 831):**

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

#### **Acromioclavicular joint dislocation (ICD9 831.04):**

AC separation, type III+: 8 visits over 8 weeks

#### **Sprained shoulder; rotator cuff (ICD9 840; 840.4):**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

#### **Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)**

Medical treatment: 9 visits over 8 weeks

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

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

#### **Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):**

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

#### **Fracture of clavicle (ICD9 810):**

#### **8 visits over 10 weeks**

#### **Fracture of humerus (ICD9 812):**

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

#### **Work conditioning (See also Procedure Summary entry):**

10 visits over 8 weeks

The ODG has the following provisions for an EMG of Shoulder Disorders:

Electrodiagnostic testing for TOS (thoracic outlet syndrome)

Recommended as indicated below. Electrodiagnostic testing is reliable for the diagnosis of TOS. It helps localize and quantify a lesion in the brachial plexus. It is also important to rule out other segmental or systemic neuropathies. Thoracic outlet syndrome (TOS) refers to compression of the neurovascular structures at the superior aperture of the thorax. It represents a constellation of symptoms. The cause, diagnosis, and treatment are controversial. In most cases, the physical examination findings are completely normal. Other times, the examination is difficult because the patient may guard the extremity and exhibit giveaway-type weakness. (Tolson, 2004)

**Criteria for Electrodiagnostic Testing for Neurogenic Thoracic Outlet Syndrome:**

All 3 of the following criteria must be found in the affected limb:

1. Amplitude of median motor response is reduced, *And*
2. Amplitude of ulnar sensory response is reduced, *And*
3. Needle exam shows denervation in muscles innervated by lower trunk of brachial plexus.

Details Regarding the Above Noted Criteria:

Criterion #1: Using standard surface electrodes with active pick up over the abductor pollicis brevis, the amplitude of the median motor response on the affected side should be less than 50% of that obtained on the unaffected side.

Criterion #2: Using standard ring electrodes on the fifth digit, the ulnar sensory amplitude on the affected side should be less than 60% of the amplitude on the unaffected side.

Criterion #3: a) Muscles innervated by the lower trunk of the brachial plexus include the abductor pollicis brevis, pronator quadratus, flexor pollicis longus, first dorsal interosseous, abductor digiti minimi, flexor carpi ulnaris, extensor pollicis brevis, and extensor indicis; b) EMG abnormalities in TOS are most commonly seen in median and ulnar innervated intrinsic muscles of the hand -- especially the abductor pollicis brevis; c) Positive waves and fibrillations may be found, but chronic denervation changes are more common -- that is, increased motor unit amplitude, increased motor unit duration, and decreased recruitment with rapid firing of motor units are activated.

Notes: The electromyographer should rule out neuropathic conditions that might mimic TOS, specifically cervical radiculopathy, carpal tunnel syndrome, ulnar neuropathy and polyneuropathy. (Washington, 2002)

The Claimant failed to provide an evidence-based medical opinion, from a competent source, that would overcome the IRO's decision. Although Dr. N provided a May 18, 2009 letter, it does not address the issue of physical therapy, and, regarding the need for an EMG, it only indicates a review of records, history, and exam findings, without relating them to the requirements of the ODG. The preponderance of the evidence based medical evidence is not contrary to the IRO decision that the Claimant is not entitled to 12 sessions of physical therapy and an EMG of the right upper extremity.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

## **FINDINGS OF FACT**

1. The parties stipulated to the following facts:
  - A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
  - B. On \_\_\_\_\_, Claimant was the employee of (Employer).
  - C. The IRO determined that the requested services were not reasonable and necessary health care for the compensable injury of \_\_\_\_\_.
2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
3. The Claimant failed to provide evidence-based medical evidence contrary to the IRO's determination that physical therapy for 12 sessions and an EMG of the right upper extremity is not reasonable and necessary.
4. Physical therapy for 12 sessions and an EMG of the right upper extremity are not health care reasonably required for the compensable injury of \_\_\_\_\_.

## **CONCLUSIONS OF LAW**

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
2. Venue is proper in the (City) Field Office.
3. The preponderance of the evidence is not contrary to the decision of the IRO that physical therapy for 12 sessions and an EMG of the right upper extremity is not health care reasonably required for the compensable injury of \_\_\_\_\_.

## **DECISION**

The Claimant is not entitled to physical therapy for 12 sessions and an EMG for the right upper extremity for the compensable injury of \_\_\_\_\_.

## **ORDER**

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **HARTFORD UNDERWRITERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**CORPORATION SERVICE COMPANY  
701 BRAZOS STREET, SUITE 1050  
AUSTIN, TEXAS 78701**

Signed this 1<sup>st</sup> day of June, 2009.

David Paul Weston  
Hearing Officer