MEDICAL CONTESTED CASE HEARING NO. 10005
M6-09-18405-01

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 benefit contested case hearing was held on August 3, 2009, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to occupational therapy three (3) times per week for four (4) weeks to bilateral elbows for the compensable injury of _____.

PARTIES PRESENT

The Claimant appeared and was assisted by Ms. RR, an ombudsman. The Carrier's representative, appearing telephonically, was Mr. RJ, an attorney.

BACKGROUND INFORMATION

The Claimant did not appear at a CCH that was scheduled for June 23, 2009. A ten-day letter was served on the Claimant and he called the (City) Field Office to request that his hearing be rescheduled. On August 3, 2009, a CCH was convened, at which time the Claimant appeared. He testified that he confused a medical appointment he had for June 23, 2009, and the CCH scheduled for that day. He stated he called the (City) Field Office on June 23, 2009, but was told he missed the Hearing time. He requested that the CCH be rescheduled. The undersigned finds good cause for the Claimant's failure to appear at the CCH originally scheduled for June 23, 2009.

The Claimant works for (Employer). He was cutting trees along power lines for a utility company at the time of the injury. He had problems with pain in the elbows and wrists, losing strength and grip in both arms and hands, and loss of feeling (his hands "falling asleep"). From initial treatment with Dr. J in November 2007, the Claimant was diagnosed with medial and lateral epicondylitis and carpal tunnel syndrome. An MRI of the left elbow and one of the right elbow were conducted on January 8, 2009. The findings reported chronic medial epicondylitis with edema. An EMG/nerve conduction study conducted on December 11, 2008, reported findings of bilateral carpal tunnel syndrome.

The Claimant participated in physical therapy under an order from Dr. R, M.D. Therapy provided some relief, but the problems persisted. The Claimant missed one scheduled therapy session during the regimen; however, that is not considered consequential. The therapy has included myofascial release therapy, electrical stimulation therapy, and massage therapy. From June through September, 2008, he received eleven (11) therapy sessions. In January 2009, Dr. D recommended additional physical therapy two (2) times a week for four (4) weeks. Dr. D seeks therapeutic exercises (97110), high volt galvanic stimulation for decrease in edema (G0283), Iontophoresis (97033), and

myofascial release, stretching, and strengthening (97014). The additional physical therapy to the bilateral elbows recommended by Dr. D have been variously reported as eight (8) or twelve (12) added sessions (either two times a week for four weeks or three times a week for four weeks). The recommendation for therapy by Dr. D was denied.

The carrier's first utilization review doctor, a Board Certified orthopedic surgeon medical doctor, found the additional requested physical therapy is not medically necessary, citing the Official Disability Guidelines (*ODG*). The Utilization Review denied the additional requested physical therapy on January 29, 2009. The Claimant requested that the denial be reconsidered, and this was done in February 2009. It also concluded that the additional requested therapy was not medically necessary. The physician who accomplished the Reconsideration was a Board Certified orthopedic surgeon. He also relied on the ODG. A peer review by another orthopedic surgeon resulted in the same conclusion and a recommendation that the additional therapy was not medically necessary due to an exhaustion of ODG recommended benefits. All reviewers noted that the Claimant has received physical therapy to both upper extremities up to or exceeding that authorized by the ODG.

An IRO reviewer and family practice medical doctor reviewed the records and upheld the previous adverse determinations of the utilization review doctors. The IRO reviewer denied the requested additional physical therapy sessions citing the *ODG* provisions. The Reviewer stated that further occupational therapy care will be extremely unlikely to offer further benefits. The reviewer stated that the modalities requested are of limited, short term benefit or are of unproven efficacy. The report states that Iontophoresis has short term, but no significant long term, benefit. Stimulation has insufficient evidence to support long term benefit. The utilization reviewers, the peer reviewer, and the IRO reviewer state that Claimant has completed the recommended number of sessions allowed by the *ODG*.

Claimant offered the reports of Dr. D and his testimony of continued problems in support of the recommendation for additional therapy. The original therapy he received for his upper extremities (associated with bilateral epicondylitis) was under the direction of Dr. R. Since January 2009, the Claimant has been under the care of Dr. D, under whose direction he has not received any physical therapy.

DISCUSSION

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." Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be 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 accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.208 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

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**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. As the utilization review and IRO doctors in the instant case have stated, the *ODG* allows for physical therapy for treatment of upper extremities for medial and lateral epicondylitis and sets out the recommended number of physical therapy sessions that are reasonable and necessary.

The *ODG* Treatment Guidelines for the elbow follows:

> Recommended. Limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. See also specific physical therapy modalities by name. (Piligian, 2000) (Handoll-Cochrane, 2003) (Boisaubert, 2004) (Boyer, 1999) (Sevier, 1999) (Foley, 1993) (Struijs, 2004) (Smidt, 2005) (Smidt, 2003) (Lund, 2006) Women and patients who report nerve symptoms are more likely to experience a poorer short-term outcome after PT management of lateral epicondylitis. Work-related onsets, repetitive keyboarding jobs, and cervical joint signs have a prognostic influence on women. (Waugh, 2004) A recent clinical trial found that, after 12 months, the success rate for physical therapy (91%) was significantly higher than injection (69%), but only slightly higher than in the wait-and-see group (83%). (Korthals-de Bos, 2004)
>
> *ODG* Physical Therapy Guidelines –
>
> General: Up to 3 visits contingent on objective improvement documented (ie. VAS improvement of greater than 4). Further trial visits with fading frequency up to 6 contingent on further objectification of long-term resolution of symptoms, plus active self-directed home PT.
>
> **Medial epicondylitis/Golfers' elbow** (ICD9 726.31):
> Medical treatment: 8 visits over 5 weeks
> Post-surgical treatment: 12 visits over 12 weeks

Regarding the specific modalities of therapy sought by Dr. D, the *ODG* Physical Therapy Guidelines states the following:

Electrical Stimulation: Not recommended. Despite the large number of studies, there is still insufficient evidence for most physiotherapy interventions for lateral epicondylitis due to contradicting results, insufficient power, and the low number of studies per intervention. (Smidt, 2003) (Bouter, 2000) In general, it would not be advisable to use these modalities beyond 2-3 visits if signs of objective progress towards functional restoration are not demonstrated. (California, 1997) (Piligian, 2000) (Boyer, 1999) (Sevier, 1999).

Exercise: Recommended. Lateral epicondylitis and other disorders of the elbow can be treated conservatively with activity modification and exercise, including gentle muscle stretching, range-of-motion exercises, flexibility and graduated strengthening. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. (Bisset, 2006) (Boisaubert, 2004) (Trudel, 2004) (Field, 1998) (California, 1997) (Pienimaki, 1998) (Solveborn, 1997) With regard to type of exercise, one trial concluded that stretching, concentric strengthening with stretching, and eccentric strengthening with stretching all show significant gains without significant differences with regard to pain-free grip strength, Patient-rated Forearm Evaluation Questionnaire, Disabilities of the Arm, Shoulder, and Hand questionnaire, Short Form 36, and visual analog pain scale. (Martinez, 2005) Only limited levels of evidence exist to suggest that eccentric exercise (EE) has a positive effect on clinical outcomes such as pain, function, and patient satisfaction/return to work when compared to various control interventions such as concentric exercise (CE), stretching, splinting, frictions and ultrasound. More studies need to be conducted with regard to EE. (Woodley, 2006) Eccentric exercises with a simple wrist-extending rubber cylinder in a simple, home-based program could help alleviate pain for people with chronic lateral epicondylitis. The exercises involved twisting the cylinder with concentric wrist flexion of the noninvolved arm, and releasing the twist with eccentric wrist extension of the involved arm. The exercise was performed in 3 sets of 15 repetitions daily, and the intensity increased over the treatment period. The eccentric group had a significant improvement in the amount of disability, compared to the standard-treatment group, and there was also a significant decrease in pain, compared to the standard-treatment group. (Tyler, 2009)

Iontophoresis: Recommended as a conservative option if there is evidence of objective functional improvement after trial use. Limited evidence suggests that iontophoresis treatment was well tolerated by most patients and was effective in reducing symptoms of epicondylitis at short-term follow-up, but little difference was noted long-term. (Nirschl, 2003) (Baskurt, 2003) (Runeson, 2002) (Demirtas, 1998) Some evidence suggests that iontophoresis and phonophoresis may show positive effects in the reduction of pain or improvement in function for patients with lateral epicondylitis but more studies need to be conducted. (Trudel, 2004) Some group health insurers have concluded that use of iontophoresis for treatment of inflammatory musculoskeletal disorders is experimental and investigational because of insufficient evidence of its effectiveness. (Aetna, 2006) Iontophoresis is a method of transdermal local drug delivery using electrical current. A charged, ionic drug is placed on the skin using an electrode of the same charge, allowing direct current to drive the drug into the skin. Iontophoresis may take advantage of sweat

ducts, sebaceous glands, hair follicles, and imperfections in the skin to achieve penetration. In the treatment of musculoskeletal disorders, iontophoresis is often offered in the physical medicine and rehabilitation setting.

Massage (Myofascial release, stretching, and strengthening) Under study. Insufficient evidence exists to evaluate many physical modalities used to treat disorders of the elbow, often employed based on anecdotal or case reports alone. In general, it would not be advisable to use these modalities beyond 2-3 visits if signs of objective progress towards functional restoration are not demonstrated. (California, 1997) (Piligian, 2000) (Boyer, 1999) (Sevier, 1999) Deep transverse friction massage (DTFM) combined with other physical therapy modalities did not show consistent benefit over the control of pain, or improvement of grip strength and functional status. (Brosseau-*Cochrane*, 2002) For the long term in treating tennis elbow, one meta-analysis determined that physiotherapy (pulsed ultrasound, deep friction massage and exercise program) was the best option but was not significantly different from the "wait-and-see" approach. (Boisaubert, 2004).

As noted previously herein, "health care reasonably required" means health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence-based medicine or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

All of the doctors who reviewed the requested additional physical therapy and the IRO doctor denied the requested additional eight sessions, citing the relevant provisions of the *ODG*. They specifically cited the fact that Claimant had already undergone the recommended amount of physical therapy and there is no medical documentation that warrants a departure from the *ODG* standard of care. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome the opinions of the doctors correctly applying the *ODG*.

The Petitioner/Claimant failed to present any evidence-based medical opinion from a competent source to overcome the IRO's decision. The fact that the Claimant has changed treating physicians to a hand specialist does not satisfy for an exception in the ODG. The Claimant did not present evidence-based medicine justifying departure from the *ODG* and has, therefore, not met the requisite evidentiary standard required to overcome the IRO decision. The preponderance of the evidence is not contrary to the IRO decision.

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 _____, the Claimant was the employee of (Employer), when he

sustained a compensable injury.

C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and name and street address of Carrier's registered agent which was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The Claimant's treating orthopedic surgeon recommended additional sessions of physical therapy to the upper extremities for treatment of the compensable injury to both elbows.

4. For treatment of the medial epicondylitis, the *ODG* sets out a recommended number of physical therapy sessions.

5. Claimant has previously undergone eleven sessions of physical therapy for the bilateral elbows [three in excess of the ODG recommended number of eight (8) sessions], as well as at-home therapy, other treatment modalities, and restricted work.

6. The IRO decision upheld the Carrier's denial of the requested additional sessions of physical therapy to the bilateral elbows because the Claimant has already undergone more than the number of sessions of physical therapy recommended by the *ODG*, and the medical evidence did not justify additional physical therapy.

7. The requested service is not consistent with the *ODG* criteria for physical therapy to medial epicondylitis to the bilateral elbows.

8. The requested additional sessions of physical therapy for the medial epicondylitis to the bilateral elbows is 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO that additional sessions of physical therapy for the bilateral elbows is not health care reasonably required for the compensable injury of _____.

DECISION

The Claimant is not entitled to occupational therapy three (3) times per week for four (4) weeks to bilateral elbows for the compensable injury of _____.

ORDER

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

The true corporate name of the insurance carrier is **LIBERTY INSURANCE CORPORATION** and the name and address of its registered agent for service of process is

CORPORATION SERVICES COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701

Signed this 10th day of August, 2009.

ROY H. LEONARD
Hearing Officer