MEDICAL CONTESTED CASE HEARING NO. 10162
M6-10-23964-01

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.

ISSUES

A contested case hearing was held on March 12, 2010 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to additional physical therapy for the left shoulder for three times per week for four weeks for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by KF, ombudsman.

Respondent/Carrier appeared and was represented by SB, attorney.
Petitioner, Dr. S, M.D. did not appear at the hearing, so the record was held open. A letter dated March 15, 2010 was sent to the absent Petitioner allowing him ten days from the date of the letter to request that the hearing be reconvened to allow him to present evidence on the disputed issue. After no response was received from Petitioner Dr. S, the record was then closed on March 28, 2010.

BACKGROUND INFORMATION

On _____, Claimant sustained a left shoulder injury when he grabbed a heavy falling wire while working as a lineman. An April 20, 2009 MR/arthrogram revealed a large labral tear, a labral cyst and subluxation of the humeral head of his left shoulder. On June 1, 2009, Dr. S arthroscopically repaired the labral tear, as well as a microfracture chondroplasty of the grade 4 glenoid chondral injury. On or about July 13, 2009, Claimant began post-operative physical therapy to rehabilitate his shoulder. Claimant began to improve through six therapy sessions, but the next ten sessions and concurrent home exercises failed to improve the strength and range of motion of his injured shoulder. A second MR/arthrogram on September 29, 2009 showed a normal rotator cuff, sclerosis of the glenoid margin suggesting a labral repair and no sign of a recurrent labral tear. Carrier had originally approved 24 physical therapy sessions to be completed by October 30, 2009, but, at the doctor's direction, Claimant only completed 15 or 16 of those sessions, and the doctor did not attempt to obtain approval for extension of the completion date for the balance of those sessions. Instead, on October 22, 2009, the doctor requested pre-authorization for an additional 12 weeks of physical therapy (three times per week for four weeks). The request was denied by Carrier's pre-authorization reviewers on October 27, 2009 and the denial was referred to an IRO. Claimant now appeals the IRO's Notice of Decision dated December 8, 2009, that upheld the previous adverse decision of Carrier's pre-authorization reviewers.

The IRO reviewer, a board certified orthopedic surgeon, determined that the medical records do not adequately demonstrate the efficacy of the surgery or of the post-operative therapy received to date and that more physical therapy will probably not be helpful. He concluded that Claimant may require additional treatment, but physical therapy is not medically necessary. The reviewer's comments stated that the request for additional physical therapy failed to include serial progress notes that objectively depict improvement with continuing therapy and the possibility of continuing benefits from further supervised therapy; that there were no updated therapy goals and a treatment plan for the requested additional therapy, which should contain objective progress measures that are correlated with functional recovery; and that further information is needed to substantiate the medical necessity of the request for additional physical therapy. The IRO reviewer noted that his opinion was based on his medical judgment, clinical experience and expertise in accordance with accepted medical standards and the ODG – Official Disability Guidelines and Treatment Guidelines.

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. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) 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 evidence based medicine or, if evidence based medicine is not available, then 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. The Commissioner of the Division of Workers' compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

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 133.308 (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 ODG addresses physical therapy for shoulder injures as follows:

> 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 favoring 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) External rotator cuff strengthening is recommended because an imbalance between the relatively overstrengthened internal rotators and relatively weakened external rotators could cause damage to the shoulder and elbow, resulting in injury. (Byram, 2009)

Adhesive capsulitis: For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. (Carette, 2003) Physical therapy following arthrographic joint distension for adhesive capsulitis provided no additional benefits in terms of pain, function, or quality of life but resulted in sustained greater active range of shoulder movement and participant-perceived improvement up to 6 months. (Buchbinder, 2007) Use of the Shoulder Dynasplint System (Dynasplint Systems, Inc., Severna Park, MD) may be an effective adjunct "home therapy" for adhesive capsulitis, combined with PT. (Gaspar, 2009)

Active Treatment versus Passive Modalities: See the Low Back Chapter for more information. The use of active treatment modalities instead of passive treatments

is associated with substantially better clinical outcomes. 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). Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral.

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 (Osteoarthrosis; 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

Claimant's medical records reflect a left shoulder labral tear and a subluxation of the humeral head, which has been surgically repaired. He has also been diagnosed as having persistent post-operative shoulder instability.

The ODG Physical Therapy Guidelines provide for post-surgical treatments of 24 physical therapy treatments over a 14 week period.

Claimant's treating doctor only states disagreement with the IRO surgeon's decision upholding the adverse pre-authorization denials and states that Claimant's persistent subluxation-type symptoms are a manifestation of inadequate recovery and therapy post-operatively, rather than the manifestation of failure of the surgery. He concludes that therapy is the required and prescribed method of treatment at the current time. As such, the treating doctor failed to support his request for additional physical therapy with evidence based medicine.

Based on the evidence presented, the Claimant failed to meet his burden of overcoming the decision of the IRO by a preponderance of the evidence-based medicine. Claimant is not entitled to additional physical therapy for the left shoulder for three times per week for four weeks for the compensable injury of _____.

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. Claimant sustained a compensable injury on _____.

2. Carrier delivered to Claimant and Subclaimant 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 IRO decision was based on the ODG and it concluded that additional physical therapy for the left shoulder for three times per week for four weeks is not medically reasonable and necessary for the compensable injury of _____.

4. Additional physical therapy for the left shoulder for three times per week for four weeks 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that the Claimant is not entitled to additional physical therapy for the left shoulder for three times per week for four weeks for the compensable injury of _____.

DECISION

Claimant is not entitled to additional physical therapy for the left shoulder for three times per week for four weeks 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 **ARCH INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TEXAS 75201

Signed this 28th day of April, 2010.

David Wagner
Hearing Officer