MEDICAL CONTESTED CASE HEARING NO 12063
M6-12-37714-01

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 January 23, 2012 decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to Occupational Therapy (OT) for the right shoulder, 3 times per week for 4 weeks under CPT Code 97110 and Manual Therapy for the right shoulder, 3 times per week for 4 weeks under CPT Code 97140 for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by MV, a ombudsman. Respondent/Carrier appeared and was represented by PM, attorney.

BACKGROUND INFORMATION

The evidence presented in the hearing revealed that, on (Date of Injury), Claimant sustained an injury to include her right shoulder as a result of lifting an air conditioner in the course and scope of her employment as a customer service employee/cashier for Employer, (Employer). The evidence indicated that Claimant has received conservative treatment for her compensable injury, including medications, therapy, and injections. Claimant initially treated with MR, M.D., whom the evidence indicated requested 12 sessions of therapy for Claimant's compensable injury. The evidence strongly indicated that Carrier approved these sessions, but that Claimant only attended 6 of the 12 sessions at the direction of Dr. R . It appears from the evidence that Claimant did not complete the full course of approved sessions because she began to treat with MF, M.D. After a right shoulder MRI in September 2011, Dr. F diagnosed Claimant with right shoulder subacromial impingement. The records in evidence also indicate that Claimant underwent two occupational therapy (OT) evaluations with CF, OTR at Dr. F's practice (Healthcare Provider) – on July 21, 2011 and October 5, 2011. Dr. F writes in a treatment record dated November 23, 2011 that Claimant had 6 sessions of therapy with Dr. R . Though Dr. F further noted in this record that these sessions "did not help" Claimant, he requested the additional therapy sessions made the basis of this dispute. Claimant indicated in her testimony that Dr. F's notation indicating that the previous therapy had not helped was not accurate.

The additional physical medicine sessions at issue in this case were initially and upon reconsideration denied by Carrier's Utilization Review Agent (URA), DG, M.D. Dr. F then requested review by an Independent Review Organization (IRO). The IRO reviewer, identified as an M.D. Board Certified in Physical Medicine and Rehabilitation, upheld Carrier's denial of the proposed treatment. Noting that there were "discrepant statements in the records" pertaining to how many therapy sessions Claimant actually attended, the IRO reviewer noted that there was "no supporting documentation demonstrating the need or medical necessity for additional physical medicine treatment sessions" beyond the 12 sessions that had been previously authorized.

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 in making decisions about the care of individual patients. 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 chapter pertaining to the shoulder includes a section on physical therapy that considers the occupational and manual therapy at issue and provides as follows, in part:

> "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)
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> *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)
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> *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.

See also more specific listings: Activity restrictions; Acupuncture; Bipolar interferential electrotherapy; Biofeedback; Biopsychosocial rehab; Cold lasers; Cold packs; Continuous-flow cryotherapy; Continuous passive motion (CPM); Cutaneous laser treatment; Deep friction massage; Diathermy; Dynasplint system; Electrical stimulation; Ergonomic interventions; ERMI Flexionater®/ Extensionater®; Exercises; Flexionators (extensionators); Graston instrument assisted technique (manual therapy); Ice packs; Interferential current stimulation (ICS); Iontophoresis; Kinesio tape (KT); Low level laser therapy (LLLT); Manipulation; Massage; Mechanical traction; Neuromuscular electrical stimulation (NMES devices); Occupational therapy; Polar care (cold therapy unit); Range of motion; Return to work; Static progressive stretch (SPS) therapy; TENS (transcutaneous electrical nerve stimulation); Thermotherapy; Ultrasound, therapeutic; Work; Work conditioning, work hardening.

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."

Pursuant to Rule 133.308(t), Claimant, as the party challenging the decision of the IRO, had the burden of proof to overcome that decision by a preponderance of evidence-based medical evidence. The IRO decision in this case was based largely on the ODG, which does not support the necessity of the additional therapeutic sessions at issue.

Claimant offered her lay testimony and a number of medical records in support of her position. Claimant's lay testimony is not probative on questions, such as those posed in this case, that require expert evidence. *See* MCCH 01120. Claimant did not produce an opinion from a qualified expert with some basis in evidence-based medicine in support of the necessity of the proposed treatment to overcome the decision of the IRO.

Based on a review of the evidence presented in the hearing, Claimant did not meet her burden of proof to overcome the decision of the IRO by a preponderance of evidence-based medical evidence. Consequently, a preponderance of the evidence is found not to be contrary to the IRO decision and Claimant is thus not entitled to OT for the right shoulder, 3 times per week for 4 weeks under CPT Code 97110 and Manual Therapy for the right shoulder, 3 times per week for 4 weeks under CPT Code 97140 for the compensable injury of (Date of Injury).

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) Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On (Date of Injury), Claimant was the employee of (Employer), Employer, and sustained a compensable injury.

C. On (Date of Injury), Employer provided workers' compensation insurance coverage to its employees as a self-insured.

D. The Independent Review Organization (IRO) determined that the health care at issue in this hearing was not health care reasonably required for Claimant's compensable injury of (Date of Injury).

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. Occupational Therapy (OT) for the right shoulder, 3 times per week for 4 weeks under CPT Code 97110 and Manual Therapy for the right shoulder, 3 times per week for 4 weeks under CPT Code 97140 is not health care reasonably required for the compensable injury of (Date of Injury).

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) Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that OT for the right shoulder, 3 times per week for 4 weeks under CPT Code 97110 and Manual Therapy for the right shoulder, 3 times per week for 4 weeks under CPT Code 97140 is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to OT for the right shoulder, 3 times per week for 4 weeks under CPT Code 97110 and Manual Therapy for the right shoulder, 3 times per week for 4 weeks under CPT Code 97140 for the compensable injury of (Date of Injury).

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 self-insured insurance carrier is **(SELF-INSURED)** and the name and address of its registered agent for service of process is

(SELF INSURED)
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 25th day of January, 2012.

Jennifer Hopens
Hearing Officer