

MEDICAL CONTESTED CASE HEARING NO. 14017

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 October 9, 2013 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to nine additional physical therapy sessions for her lumbar spine and left shoulder for her compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by BT, ombudsman.
Respondent/Self-insured appeared and was represented by SS, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable low back and left shoulder injury as a result of pushing and pulling a cart loaded with supplies. She underwent physical therapy while under the care of her former treating doctor, but stated that such therapy did not improve her condition. Claimant's current treating doctor has recommended additional therapy, and has expressed the expectation that the prescribed treatment will improve Claimant's symptoms and functionality.

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 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(s), "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."

With regard physical therapy for the shoulder and back, respectively, the ODG reads as follows:

Shoulder:

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) The latest UK Health Technology Assessment on management of frozen shoulder concludes that based on the best available evidence there may be benefit from stretching and from high-grade mobilization technique. (Maund, 2012)

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); Home exercise kits; 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

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

Medical treatment, partial tear: 20 visits over 10 weeks

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

Superior glenoid labrum lesion (ICD9 840.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (labral repair/SLAP lesion): 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 scapula (ICD9 811):

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

Back:

Recommended. 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. See also Exercise. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy (“sports medicine model”), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. (Zigenfus, 2000) (Linz, 2002) (Cherkin-NEJM, 1998) (Rainville, 2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (Skargren, 1998) A spinal stabilization program is more effective than standard physical therapy sessions, in which no exercises are prescribed. With regard to manual therapy, this approach may be the most

common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve quality of life. (Goldby-*Spine*, 2006) Better symptom relief is achieved with directional preference exercise. (Long, 2004) As compared with no therapy, physical therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of physical therapy relative to "sham" therapy (massage), it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007) In this RCT, exercise and stretching, regardless of whether it is achieved via yoga classes or conventional PT supervision, helps improve low back pain. (Sherman, 2011) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; Stretching; & Aquatic therapy. [Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2005) As for visits with any medical provider, physical therapy treatment does not preclude an employee from being at work when not visiting the medical provider, although time off may be required for the visit.]

Active Treatment versus Passive Modalities: The use of active treatment modalities instead of passive treatments 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)

Patient Selection Criteria: Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Riipinen, 2005) (Hicks, 2005) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (Frost, 2004) Patients exhibiting the centralization phenomenon during lumbar range of motion testing should be treated with the specific exercises (flexion or extension) that promote centralization of symptoms. When findings from the patient's history or physical examination are associated with clinical instability, they should be treated with a trunk strengthening and stabilization exercise program. (Fritz-Spine, 2003) Practitioners must be cautious when implementing the wait-and-see approach for LBP, and once medical clearance has been obtained, patients should be advised to keep as active as possible. Patients presenting with high fear avoidance characteristics should have these concerns addressed aggressively to prevent long-term disability, and they should be encouraged to promote the resumption of physical activity. (Hanney, 2009)

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. (Luijsterburg, 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 good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs. (Ostelo, 2009) There is inconclusive evidence for the effectiveness of outpatient physical therapy after first lumbar discectomy. Although evidence from two trials suggested that intervention might reduce disability short-term, and more intensive intervention may be more beneficial than less intensive therapy, pooled results did not show statistically significant benefit. (Rushton, 2011)

Post-surgical (fusion) rehab: Following lumbar spinal fusion, delayed start of rehabilitation results in better outcomes, and improvements in the group starting at 12-weeks were 4 times better than that in the 6-week group. (Oestergaard, 2012)

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. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

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 (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10-12 visits over 8 weeks

See 722.1 for post-surgical visits

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visits

Fracture of vertebral column without spinal cord injury (ICD9 805):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks

In order to prevail, Claimant must show one of three things: that her proposed treatment is consistent with the ODG, that evidence-based medicine exists that is more persuasive than the

ODG, or that the requested treatment is not addressed by the ODG. As the proposed therapy is addressed by the ODG, as set forth above, and as the IRO decision indicates that Claimant has already undergone the physical therapy endorsed by the ODG, Claimant can not meet her burden of proof through either the first or the last listed method for doing so, and must instead produce persuasive evidence-based medical evidence in order to prevail. The evidence she has presented, however, consists solely of a letter from her treating doctor, espousing the benefits of the proposed treatment, which is not considered evidence-based medical evidence, as that term is statutorily defined. Since Claimant has not succeeded in overcoming the decision of the IRO by any accepted route, a decision in favor of Carrier is appropriate as to the issue presented for resolution.

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 (Date of Injury), Claimant was the employee of the (Employer), Employer.
 - C. On (Date of Injury), Employer was self-insured for workers' compensation purposes.
2. Self-insured delivered to Claimant/Petitioner a single document stating the true corporate name of Self-insured, and the name and street address of Self-insured's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 1.
3. Nine additional physical therapy sessions for Claimant's lumbar spine and left shoulder is not health care reasonably required for Claimant's compensable injury (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) Field Office.
3. The preponderance of the evidence is not contrary to the decision of the IRO that nine additional physical therapy sessions for Claimant's lumbar spine and left shoulder is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to nine additional physical therapy sessions for her lumbar spine and left shoulder for her compensable injury of (Date of Injury).

ORDER

Self-insured 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 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 14th day of October, 2013.

Ellen Vannah
Hearing Officer