MEDICAL CONTESTED CASE HEARING NO. 18022

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Administrative Law Judge determines that Claimant is entitled to outpatient physical therapy services, an additional five sessions, for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

On September 05, 2018, a medical contested case hearing was held 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 outpatient physical therapy services, an additional five sessions, for the compensable injury of (Date of Injury)? (As amended by agreement of the parties.)

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by DM, ombudsman. Respondent/Carrier appeared and was represented by KT, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant

For Carrier: No one

The following exhibits were admitted into evidence:

Administrative Law Judge's Exhibits ALJ-1 through ALJ-3

Claimant's Exhibits C-1 through C-7

Carrier's Exhibits CR-A through CR-F

BACKGROUND INFORMATION

Claimant testified that on (Date of Injury), he fell backward off a short wall and severely injured his left shoulder. Claimant has undergone four or five surgeries, including a total left shoulder arthroplasty with removal of surgical implants. Claimant underwent several sessions of physical therapy after that surgery, but his physical therapist and surgeon requested eight more sessions to increase his range of motion, strength, and function. The request for eight session was denied, but the URA doctor agreed to allow three additional sessions. Carrier apparently allowed Claimant to undergo those three sessions. Claimant requested an IRO review. The IRO doctor agreed Claimant should have an additional two sessions of physical therapy, to focus on home exercise program education. Claimant contends he should receive the remaining five sessions of physical therapy. Carrier agrees with the IRO doctor that there is a lack of evidence-based medicine to support Claimant receiving those additional five sessions of physical therapy Claimant is still requesting.

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(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."

On the date of this medical contested case hearing, the Official Disability Guidelines provides the following with regard to physical therapy:

> Recommended. Positive (limited evidence).
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> Also see specific physical therapy modalities by name. See the Low Back Chapter for more information. 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); Game Ready™ accelerated recovery system; 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.
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> ODG Physical Therapy Guidelines –
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> Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT.
> Rotator cuff syndrome/Impingement syndrome:
> 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
> Sprained shoulder; rotator cuff tear:
> Medical treatment, sprain: 10 visits over 8 weeks
> Medical treatment, tear: 20 visits over 10 weeks
> Post-surgical treatment, arthroscopic: 24 visits over 14 weeks
> Post-surgical treatment, open: 30 visits over 18 weeks
> Massive rupture of rotator cuff:

Post-surgical treatment, arthroscopic: 30 visits over 18 weeks
Post-surgical treatment, open: 40 visits over 18 weeks
Adhesive capsulitis:
Medical treatment: 16 visits over 8 weeks
Post-surgical treatment: 24 visits over 14 weeks
Dislocation of shoulder:
Medical treatment: 12 visits over 12 weeks
Post-surgical treatment (Bankart): 24 visits over 14 weeks
Acromioclavicular joint dislocation:
AC separation, type III+: 8 visits over 8 weeks
Post-surgical treatment: 24 visits over 14 weeks
Superior glenoid labrum lesion:
Medical treatment: 10 visits over 8 weeks
Post-surgical treatment (labral repair/SLAP lesion): 24 visits over 14 weeks
Arthritis (Osteoarthrosis; Rheumatoid arthritis; Arthropathy, unspecified):
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):
Medical treatment: 14 visits over 6 weeks
Post-surgical treatment: 20 visits over 10 weeks
Fracture of clavicle:
8 visits over 10 weeks
Fracture of scapula:
8 visits over 10 weeks
Fracture of humerus:
Medical treatment: 18 visits over 12 weeks
Post-surgical treatment: 24 visits over 14 weeks

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) Both physical therapy and corticosteroid injections significantly improve symptoms in patients with shoulder impingement syndrome (approximately 50% improvement in Shoulder Pain and Disability Index scores maintained through 1 year), but physical therapy may be more efficient. (Rhon, 2014)

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 over strengthened 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: 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.

The IRO doctor noted the ODG states "post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks". The IRO doctor added, "After review of the PT notes, the objective findings indicate that the patient has been performing the strength training therapeutic exercises. The patient should be transitioned to an Independent HEP (home exercise program) at this time. Therefore 2 additional sessions, not 8 are reasonable to instruct the patient safely. The patient has already completed 24 visits allowed per the ODG."

Within the ODG, there is Appendix D – Documenting Exceptions to the Guidelines. Appendix D states the following, "These publications are guidelines, not inflexible proscriptions, and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions and also help payors make reimbursement determinations, but they cannot take into account the uniqueness of each patient's clinical circumstances."

CB, M.D., Claimant's surgeon, wrote a supporting letter on June 26, 2018, but it lacks any detail. He requested an additional 8-10 physical therapy visits and stated, "Given (Claimant)'s history, condition and the published data supporting the use of this prescribed treatment, I believe that it is warranted, medically appropriate, and necessary." Dr. B did not discuss the ODG, the specific published data, or why Claimant's condition did not fit within the ODG.

In this case, LH, PT, DPT, wrote a letter dated June 24, 2018, to address the need for Claimant's additional physical therapy sessions. Dr. H documented Claimant had three rotator cuff repairs due to re-tearing of the tendon after each surgery, and finally a left shoulder reverse total shoulder arthropathy and removal for implants by Dr. B on December 18, 2017. He noted Dr. B gave very specific post-operative protocol that specifically stated Claimant's activities that could be safely completed. (That protocol is found in Claimant's Ex. 5, when Dr. H requested a redetermination of the additional physical therapy visits.) Dr. H noted Claimant was just beginning the strength building portion of the therapy. He noted Claimant's progress and his range of motion measurements as of May 03, 2018. Dr. H wrote:

> While I do not have any specific evidence based research on why (Claimant) would benefit from further physical therapy, I do have functional reasoning in that (Claimant) is severely hindered by his strength and motion deficiencies. While

> the ODG Guidelines (sic) only allow for 24 PT visits over 10 weeks, (Claimant) obviously does not fit the specific guidelines. His shoulder issues have been compounding over the last 3 years and his healing process has been slower than the guidelines account for. This reasoning obviously guided the surgeons (sic) timeframe for progression of his PT protocol to optimize his potential for success on this terminal procedure for the shoulder, decision making that I fully support.

Dr. H, while not using any specific magic terms, explained how the ODG did not fit Claimant's situation, specifically that he has had several surgeries over three years and so the ODG did not fit his situation. The IRO doctor only looked at the arthroplasty and did not take into consideration that Claimant has undergone three other rotator cuff repairs or that the arthroplasty included removal of surgical implants. Dr. H explained the uniqueness of Claimant's physical situation and why the specific therapeutic protocol Dr. B recommended for his unique situation needed to be followed. Claimant met his burden of proof.

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 (Employer), Employer.

   C. On (Date of Injury), Employer provided workers' compensation insurance with Great West Casualty Company, Carrier.

   D. On (Date of Injury), Claimant sustained a compensable injury.

   E. The Independent Review Organization doctor board certified in physical medicine and rehabilitation and pain medicine determined Claimant should not have outpatient physical therapy services, an additional eight sessions.

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 Administrative Law Judge's Exhibit Number 2.

3. Outpatient physical therapy services, an additional five sessions, is 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) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that outpatient physical therapy services, an additional five sessions, is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to outpatient physical therapy services, an additional five sessions, for the compensable injury of (Date of Injury).

ORDER

Carrier is 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 **GREAT WEST CASUALTY COMPANY** and the name and address of its registered agent for service of process is

DAVID SARGENT
1717 MAIN STREET, SUITE 4750
DALLAS, TEXAS 75201-7346.

Signed this 06th day of September, 2018.

KEN WROBEL
Administrative Law Judge