MEDICAL CONTESTED CASE HEARING NO. 09176
M6-09-18987-01

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 June 11, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that occupational therapy, twice a week for four weeks, a total of eight sessions, is not reasonably required health care for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by MF, ombudsman. Respondent/Carrier appeared and was represented by PB, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable repetitive trauma injury to her right arm. The date of injury for the occupational disease is _____. On October 24, 2008, Claimant underwent an open carpal tunnel release, a release of the first dorsal compartment, removal of a ganglion mass in the right ulnar wrist, extensor synovectomy of multiple extensor tendons (4) on the right wrist, and an injection to her right lateral epicondyle. Claimant had 17 sessions of physical/occupational therapy between the date of surgery and December 31, 2008. Her former treating doctor, who has since moved from the (City) area, requested an additional eight sessions of occupational therapy. The sessions were to take place twice a week for four weeks. Carrier denied the request to preauthorize the additional sessions of occupational therapy and Claimant appealed the denial, requesting an IRO.

The IRO, (IRO), submitted the appeal to a board certified orthopedic physician reviewer who upheld Carrier's denial of the requested services. The physician reviewer determined that Claimant had exceeded the amount of occupational therapy recommended by the Official Disability Guidelines (ODG) and the request for the additional eight sessions of occupational therapy was unsupported by objective data of improvement.

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 (Texas Labor Code §408.021). "Health care reasonably required" is defined 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, generally accepted standards of medical practice recognized in the medical community (Texas Labor Code §401.011(22-a)). "Evidence based medicine" means 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 (Texas Labor Code §401.011 (18-a)). In accordance with the above statutory guidance, Rule 137.100 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 reasonably required.

As hereinabove noted, Claimant had a right carpal tunnel release, a right ganglion mass removed, synovectomy of multiple extensor tendons, and an injection to her right elbow. Of the foregoing, the ODG provides for physic al therapy for 3-8 visits over 3-5 weeks for an open carpal tunnel release, and up to 14 post-surgical visits over 12 weeks for tenosynovitis. Under the umbrella classification of Physical Medicine Treatment for carpal tunnel syndrome, the ODG states:

> Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple physical therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is an effective operation that also should not require extended multiple physical therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments. See also more specific physical therapy modalities.
> **ODG Physical Medicine Guidelines –**
> Allow for fading of treatment frequency, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
> **Carpal tunnel syndrome** (ICD9 354.0):
> Medical treatment: 1-3 visits over 3-5 weeks
> Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks
> Post-surgical treatment (open): 3-8 visits over 3-5 weeks

With regard to occupational therapy for the forearm, wrist and hand, the ODG provides as follows

> Physical/Occupational therapy:
>
> Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical

therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (Handoll-Cochrane, 2003) (Handoll2-Cochrane, 2003) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy ($p<0.05$). (Rapoliene, 2006)

ODG Physical/Occupational Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Fracture of carpal bone (wrist) (ICD9 814):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 16 visits over 10 weeks
Fracture of metacarpal bone (hand) (ICD9 815):
Medical treatment: 9 visits over 3 weeks
Post-surgical treatment: 16 visits over 10 weeks
Fracture of one or more phalanges of hand (fingers) (ICD9 816):
Minor, 8 visits over 5 weeks
Post-surgical treatment: Complicated, 16 visits over 10 weeks
Fracture of radius/ulna (forearm) (ICD9 813):
Medical treatment: 16 visits over 8 weeks
Post-surgical treatment: 16 visits over 8 weeks
Dislocation of wrist (ICD9 833):
Medical treatment: 9 visits over 8 weeks
Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks
Dislocation of finger (ICD9 834):
9 visits over 8 weeks
Post-surgical treatment: 16 visits over 10 weeks
Trigger finger (ICD9 727.03):
Post-surgical treatment: 9 visits over 8 weeks

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):
Medical treatment: 12 visits over 8 weeks
Post-surgical treatment: 14 visits over 12 weeks
Synovitis and tenosynovitis (ICD9 727.0):
Medical treatment: 9 visits over 8 weeks
Post-surgical treatment: 14 visits over 12 weeks
Mallet finger (ICD9 736.1)
16 visits over 8 weeks
Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):
Post-surgical treatment: 12 visits over 8 weeks
Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):
Post-surgical treatment: 18 visits over 6 weeks
Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):
Medical treatment: 14 visits over 6 weeks
Post-surgical treatment: 20 visits over 10 weeks
Sprains and strains of wrist and hand (ICD9 842):
9 visits over 8 weeks
Sprains and strains of elbow and forearm (ICD9 841):
Medical treatment: 9 visits over 8 weeks
Post-surgical treatment/ligament repair: 24 visits over 16 weeks
Open wound of finger or hand **(ICD9 883):**
9 visits over 8 weeks. See also Early mobilization (for tendon injuries).
Pain in joint (ICD9 719.4):
9 visits over 8 weeks
Arthropathy, unspecified (ICD9 716.9):
Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks
Amputation of thumb; finger **(ICD9 885; 886):**
Medical treatment: 18 visits over 6 weeks
Post-replantation surgery: 36 visits over 12 weeks
Amputation of hand (ICD9 887):
Post-replantation surgery: 48 visits over 26 weeks
Work conditioning (See also Procedure Summary entry):
12 visits over 8 weeks
Carpal tunnel syndrome (ICD9 354.0):
Medical treatment: 1-3 visits over 3-5 weeks
Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks
Post-surgical treatment (open): 3-8 visits over 3-5 weeks

Claimant's post-operative diagnoses included carpal tunnel syndrome, right; De Quervain's stenosing tenosynovitis; right wrist, extensor tendon synovitis; mass to ulnar wrist; and lateral epicondylitis, right elbow. The longest period of physical/occupational therapy provided for in the ODG for these diagnoses is 14 visits over 12 weeks for De Quervain's syndrome. Claimant offered no evidence based medical opinion to show that her condition is such that it requires additional and ongoing physical/occupational therapy in excess of that recommended in the ODG.

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 _____.

   D. The Texas Department of Insurance appointed (IRO) as the IRO in this matter.

   E. The IRO determined that the requested occupational therapy, two times a week for four weeks for a total of eight sessions, should be denied.

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, twice a week for four weeks for a total of eight sessions, in addition to the 17 sessions of occupational therapy already completed is not reasonably required medical treatment 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 occupational therapy twice a week for four weeks, for a total of eight sessions, is not reasonably required medical care for the compensable injury of _____.

DECISION

Claimant is not entitled to occupational therapy twice a week for four weeks, for a total of eight sessions.

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 **AMERICA FIRST LLOYD'S INSURANCECOMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701.

Signed this 12th day of June, 2009.

KENNETH A. HUCHTON
Hearing Officer