MEDICAL CONTESTED CASE HEARING NO. 09226
M6-09-19392-01

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.

ISSUE

A benefit contested case hearing was held on June 23, 2009, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to outpatient physical therapy 3 times a week for 4 weeks for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was represented by CS, attorney. Carrier appeared and was represented by attorney, JT.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained a compensable injury to her left wrist and hand. As a result of her injury, she underwent left wrist flexor tenosynovectomy and carpal tunnel release on December 8, 2008. Claimant underwent 12 post-surgical physical therapy sessions but has had continued symptoms. Dr. DP ordered additional outpatient physical therapy three times a week for four weeks for the left wrist.

The carrier's first utilization reviewer denied the requested physical therapy citing the *ODG* and noted that Claimant had received 12 post operative physical therapy visits following left wrist flexor tenosynovectomy and carpal tunnel release on December 8, 2008. The reviewer noted documented improvement with therapy, but continued deficits as of the date of the review; and, concluded that the current request for 12 additional visits exceeds the *ODG* recommendation of up to 14 post-operative physical therapy visits for tenosynovitis. The reviewer further noted that the *ODG* does not support more than 8 visits following carpal tunnel release, and does not recommend electrical stimulation (included in Dr. DP's request) for either of those conditions.

The second utilization reviewer also cited the *ODG* in recommending denial of the requested physical therapy. That reviewer noted the *ODG* recommendation for fading of treatment frequency and active self-directed home physical therapy.

An IRO reviewer (a physical medicine and rehabilitation specialist) reviewed the records and upheld the adverse determinations of the utilization review doctors. The IRO reviewer denied the requested physical therapy citing the *ODG*. The reviewer noted the diagnosis of carpal tunnel syndrome and noted Claimant's course of treatment including anti-inflammatory medication, physical medicine rehabilitation and night splinting without improvement. The reviewer noted that Claimant

underwent open carpal tunnel release and tenosynovectomy of the left wrist flexor tendon on December 8, 2008, and completed 12 post-operative therapy sessions. The IRO reviewer cited the *ODG* recommendations for 8 post-operative physical therapy sessions for open carpal tunnel release and 14 sessions for post-surgical treatment of synovitis/tenosynovitis; and, noted a caveat in the *ODG* regarding treatment beyond guideline recommendations. According to the reviewer, the *ODG* allows for more visits when grip strength is a problem, even if range of motion has improved. The reviewer cited the physical therapy notes of Claimant's treatment and noted improvement in grip strength and range of motion. The reviewer concluded that some additional therapy may be indicated, but 12 additional sessions was excessive.

Dr. DP requested additional post-surgical therapy for the flexor tendon synovectomy and carpal tunnel release. In a March 6, 2009 record, he stated that he believed that the carrier had denied the requested additional therapy based solely on the carpal tunnel release, but had ignored the synovectomy in considering the request. He stated that the latter surgery required a more extensive physical therapy program.

The records of Dr. S, a physical medicine and rehabilitation doctor treating Claimant, show that Claimant was diagnosed residual left trigger thumb as the result of her carpal tunnel release surgery. Dr. S recommended a repeat EMG and repeat carpal tunnel release by a hand specialist. Dr. S opined that further occupational therapy would benefit Claimant by strengthening and facilitating further range of motion after the trigger thumb was appropriately addressed.

Dr. C, a hand surgeon, on April 30, 2009, diagnosed status post left carpal tunnel decompression; stenosing tenosynovitis affecting the flexor pollicis longus tendon of the left arm; moderate entrapment neuropathy of the median nerve at the wrist; and, lateral epidcondylitis of the right elbow. He recommended referral back to physical therapy and possible surgical decompression for the thumb problem failing conservative measures.

DISCUSSION

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

"Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG),* and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. As the utilization review and IRO doctors in the instant case have stated, the *ODG* allows for physical therapy for treatment of neck injuries and sets out the recommended number of physical therapy sessions that are reasonable and necessary.

The *ODG* Treatment Guidelines for the forearm, wrist and hand discuss physical therapy as follows:

> 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

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

All of the doctors who reviewed the requested physical therapy and the IRO doctor denied the requested additional twelve sessions citing the relevant provisions of the *ODG*, specifically the fact Claimant had already undergone the recommended amount of physical therapy and there was no medical documentation that warranted a departure from the *ODG* standard of care. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome the *ODG* and the opinions of the doctors correctly applying the *ODG*.

Other Evidence Based Medicine

When weighing medical evidence, the hearing officer must first determine whether the doctor giving the expert opinion is qualified to offer it, but also, the hearing officer must determine whether the opinion is relevant to the issues in the case and whether the opinion is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* ***Black v. Food Lion, Inc.***, 171 F.3rd 308 (5th Cir. 1999); ***E.I. Du Pont De Nemours and Company, Inc. v. Robinson***, 923 S.W.2d 549 (Tex. 1995). When determining reliability, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. ***Kelly v. State***, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990).

Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. Drs. DP, S and C, Claimant's treating doctors, may well be qualified to render an opinion regarding treatment of her left wrist and hand problems. The treatment proposed by Dr. DP, however, is a departure from the *ODG*. Claimant argued that she has three separate conditions (post carpal tunnel release; post tenosynovectomy; and, trigger thumb) and should be allowed to have the recommended number of physical therapy sessions for each separate condition. It is clear that Dr. DP's request, however, was for the problems caused by the carpal tunnel release and tenosynovectomy. The IRO reviewer and the utilization reviewer had the benefit of the clinical records, including those of Drs. DP and S. Dr. C's opinion was generated after the date of the IRO review. As the IRO noted, Claimant may need some additional therapy, but the request in the instant case, exceeds the *ODG* recommendations. The Claimant did not present evidence-based medicine justifying departure from the *ODG* and has not, therefore, met the requisite evidentiary standard required to overcome the IRO. The preponderance of the evidence is not contrary to the IRO decision and the requested outpatient physical therapy 3 times a week for 4 weeks does not meet the criteria set out 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 (Self-Insured), when she sustained a compensable injury.

   C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and name and street address of Carrier's registered agent which was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant's treating doctor recommended outpatient physical therapy 3 times a week for 4 weeks for treatment of the compensable injury, specifically post-surgical therapy for open carpal tunnel release and tenosynovitis.

4. For treatment of the forearm, hand and wrist the *ODG* sets out a recommended number of physical therapy sessions for specific diagnoses and surgical procedures.

5. Claimant has undergone the recommended number of sessions of physical therapy for open carpal tunnel release and tenosynovectomy for treatment of her compensable injury.

6. The IRO decision upheld the Carrier's denial of the requested outpatient physical therapy 3 times a week for 4 weeks because the Claimant had already undergone the number of sessions of physical therapy recommended by the *ODG* and the medical evidence did not justify additional physical therapy.

7. The requested service is not consistent with the *ODG* criteria for physical therapy for the wrist and hand.

8. The requested outpatient physical therapy 3 times a week for 4 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO that outpatient physical therapy 3 times a week for 4 weeks is not health care reasonably required for the

compensable injury of _____.

DECISION

Claimant is not entitled to outpatient physical therapy 3 times a week for 4 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 Section 408.021.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

For service in person, the address is:

JB, EXECUTIVE DIRECTOR
(SELF-INSURED)
(STREET ADDRESS)
(OFFICE BUILDING, FLOOR)
(CITY), TEXAS (ZIP CODE)

For service by mail, the address is:

JB, EXECUTIVE DIRECTOR
(SELF-INSURED)
(P.O. BOX)
(CITY), TEXAS (ZIP CODE)

Signed this 6th day of August, 2009.

Erika Copeland
Hearing Officer