MEDICAL CONTESTED CASE HEARING NO. 11024
M6-10-27545-01

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 contested case hearing was held on September 21, 2010 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to 12 sessions of physical therapy (aquatic therapy) for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by MM, ombudsman. Carrier appeared and was represented by PP, attorney.

BACKGROUND INFORMATION

Claimant is a 31-year-old former teacher who injured her right knee at work on _____. The injury was diagnosed as a strain/sprain, but she developed Complex Regional Pain Syndrome (CRPS) of the right lower extremity which is an accepted part of the injury. Claimant was treated with physical therapy of various kinds and has had over 50 sessions according to the case review. Claimant's physical therapist, Dr. P, P.T. who is with Petitioner therapy center, recommended 12 aquatic therapy treatments, consisting of 3 per week for 4 weeks, to be followed by a home exercise program. This recommendation is supported by Dr. G, M.D., the physician who is treating Claimant for her CRPS. Carrier denied the request for aquatic therapy and this proceeding ensued.

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. 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."

With regard to Complex Regional Pain Syndrome, the ODG provides as follows:

> CRPS, Treatment
>
> Recommended hierarchy of options as indicated below. The goal is to improve function. Multiple pathophysiological mechanisms are responsible including neuropathic (sympathetic and independently-maintained pain), and immunologic (regional inflammation and altered human leukocyte antigens). Both peripheral sensitization and central sensitization have been proposed. (Ribbers, 2003) (Stanton-Hicks, 2006) There are no evidence-based treatment guidelines but several groups have begun to organize treatment algorithms. Recommendations:
> 1. Rehabilitation: (a) *Early stages*: Build a therapeutic alliance. Analgesia, encouragement and education are key. Physical modalities include desensitization, isometric exercises, resisted range of motion, and stress loading. If not applied appropriately, PT can actually be detrimental. (b) *Next steps*: Increase flexibility with introduction of gentle active ROM and stretching (to treat accompanying myofascial pain syndrome). Other modalities may include muscle relaxants, trigger point injections and electrical stimulation (based on anecdotal evidence). Edema control may also be required (elevation, retrograde sympathetic blocks, diuretics and adrenoceptor blockers when sympathetically maintained pain-SMP is present). (c) *Continued steps*: Continue active ROM; stress loading; scrubbing techniques; isotonic strengthening; general aerobic conditioning; and postural normalization. (d) *Final steps*: Normalization of use; assessment of ergonomics, posture and modifications at home and work. In some cases increased requirements of analgesic medications, psychotherapy, invasive anesthetic techniques and SCS may be required. See CRPS, spinal cord stimulators.
> 2. Psychological treatment: Focused on improved quality of life, development of pain coping skills, cognitive-behavioral therapy, and improving facilitation of other modalities. (a) *Early stages*: education. (b) *Next steps*: clinical psychological assessment (after 6 to 8 weeks): identification of stressors; identification of comorbid Axis I psychiatric disorders (depression, anxiety, panic and post-traumatic stress).

3. Pain management: (a) *Pharmacological*: antidepressants (particularly amitriptyline); anticonvulsants (particularly gabapentin); steroids; NSAIDS; opioids; calcitonin; bisphosphonates; α1 adrenoceptor antagonists (terazosin or phenoxybenzamine). The latter class of drugs has been helpful in SMP. Clonidine has been given transdermally and epidurally. (See CRPS, medications.) Bisphosphonates have some literature support in the presence of osteopenia. (Rho, 2002) (b) *Minimally invasive*: depends on degree of SMP, stage of rehabilitation (passive or active movement), and response to blocks. (See CRPS, sympathetic blocks.) Responders to sympathetic blocks (3 to 6 blocks with concomitant PT) may be all that is required. For non-responders somatic block or epidural infusion may be required to optimize analgesia for PT. (c) *More invasive*: After failure of progression or partial relief, consider tunneled epidural catheters for prolonged sympathetic or somatic blocks or neurostimulation with SCS in CRPS-I and II. See CRPS, spinal cord stimulators. Also consider peripheral nerve stimulation in CRPS-II and intrathecal drug delivery in patients with dystonia, failed neurostimulation, long-standing disease, multi-limb involvement and requirement of palliative care. (d) *Surgical*: Sympathectomy is not generally recommended, but has been considered in patients that respond to sympathetic blocks. Pre-procedure the patient should have outcomes assessed with radiofrequency and neurolytic procedures. (See CRPS, sympathectomy.) Motor Cortex Stimulation has been considered.
Outcome measures for all treatments of CRPS: Objective measures such as the Beck Depression Inventory, the State Trait Anxiety Inventory, McGill Pain Questionnaire-Short Form, the Pain Disability Index, & the Treatment Outcomes in Pain Survey (the last three may not meet the APA standards for standardized test in clinical use). See Psychological evaluations. See also CRPS, diagnostic criteria; CRPS, medications; CRPS, prevention; CRPS, sympathetic blocks; & Sympathetically maintained pain (SMP). See also Spinal cord stimulators (SCS).

The IRO reviewer, a board certified physical medicine and rehabilitation specialist, pointed out that Claimant has had over 50 sessions of physical therapy and that the recommended 12 additional sessions of aquatic therapy exceed the ODG recommended frequency and duration for CRPS. The ODG only recommends physical therapy in early stages of treatment for CRPS. The reviewer further pointed out that Claimant has attained normal range of motion of her knee with only mild functional deficits on physical examination. While Claimant's therapist and treating physician feel that low impact aquatic therapy would be helpful, they have not shown that a preponderance of the evidence based medicine supports the requested 12 sessions of aquatic therapy.

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).

C. Claimant sustained a compensable injury on _____.

D. The Independent Review Organization determined that 12 sessions of physical therapy (aquatic therapy) is not health care reasonably required for the compensable injury of _____.

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. The requested 12 sessions of physical therapy (aquatic therapy) is not health care reasonably required for Claimant's 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 Independent Review Organization that 12 sessions of physical therapy (aquatic therapy) is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to 12 sessions of physical therapy (aquatic therapy) 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 §408.021.

The true corporate name of the insurance carrier is**, (SELF-INSURED)** and the name and address of its registered agent for service of process is:

DR. JR
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 22nd day of September, 2010.

Warren E. Hancock, Jr.
Hearing Officer