

MEDICAL CONTESTED CASE HEARING NO. 18012

DECISION AND ORDER

This case is decided pursuant to 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 not entitled to a lumbar MRI without contrast, physical therapy, bilateral shoulder MRI, and lumbar MRI.

STATEMENT OF THE CASE

A contested case hearing was held on April 18, 2018, to decide the following disputed issue in Docket No. (Docket No. 1); IRO CASE NO. (IRO Case No. 1):

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a lumbar MRI without contrast is not health care reasonably required for the compensable injury of (Date of Injury)?

A contested case hearing was held on April 18, 2018, to decide the following disputed issue in Docket No. (Docket No. 2); IRO CASE NO. (IRO Case No. 2):

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that physical therapy, bilateral shoulder MRI, and lumbar MRI is not health care reasonably required for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by LM, ombudsman.

Respondent/Carrier appeared and was represented by RL, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: WJ

For Carrier: None

The following exhibits were admitted into evidence for (Docket No. 1)

Administrative Law Judge's Exhibits ALJ-1 and ALJ-2.

Claimant's Exhibits C-1 through C-17.

Carrier's Exhibits CR-A and CR-H.

The following exhibits were admitted into evidence for (Docket No. 2):

Administrative Law Judge's Exhibits ALJ-1 and ALJ-2.

Claimant's Exhibits C-1 through C-17.

Carrier's Exhibits CR-A and CR-G.

DISCUSSION

Claimant sustained a compensable injury on (Date of Injury), when he slipped and fell while carrying a heavy bag. Claimant stated he heard a pop in his right shoulder. The compensable injury of (Date of Injury) extends to and includes bilateral shoulder sprains/strains, cervical sprain/strain, lumbar sprain/strain, right shoulder rotator cuff tendon tear, right shoulder impingement of the rotator cuff at the AC joint. The Decision and Order in (Docket No.) found that the compensable injury does not extend to or include a left shoulder rotator cuff tear, cervical radiculopathy, and lumbar radiculopathy.

Claimant had a lumbar MRI on August 3, 2011. A right shoulder MRI was performed on October 5, 2011 and a left shoulder MRI was completed on November 1, 2012. Claimant treated conservatively with physical therapy for the compensable injury until 2014 when he discovered that he had unrelated cancer.

In 2017, with his cancer in remission, Claimant came under the care of CR, D.O., for the work related injury. In September 2017 Dr. R requested an MRI of the lumbar without contrast. Carrier reviewed the necessity for an MRI of the lumbar without contrast in light of the Official Disability Guidelines (ODG) and denied authorization. Claimant appealed the denial and an Independent Review Organization (IRO) was appointed by the Texas Department of Insurance in accordance with Rule 133.308. After consideration of the information provided, in IRO Case # (IRO Case No. 1), the IRO upheld Carrier's denial of the requested an MRI of the lumbar without contrast as not reasonably necessary for treatment of the compensable injury. Claimant thereafter filed a request for a contested case hearing as provided for by Rule 133.308(s). The contested case hearing was held on April 18, 2018, Docket No. (Docket No. 1).

Dr. R also filed a second request for the lumbar MRI and added a request for bilateral shoulder MRIs, and physical therapy for the lumbar, cervical, and bilateral shoulders. The Carrier's denial of this request was appealed, and in IRO Case # (IRO Case No. 2) the IRO reviewer upheld Carrier's denial. Claimant requested a contested heard that was held on April 18, 2018, Docket No. (Docket No. 2).

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 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 adopted treatment guidelines by Division Rule 137.100. The 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. A decision issued by an IRO is not considered an agency decision and the Department and the Division are not considered parties to an appeal. In a contested case hearing, the party appealing the IRO decision has the burden of overcoming the decision issued by the IRO by a preponderance of the evidence-based medical evidence. (Rule 133.308 (s).)

With regard to an MRI of the lumbar spine without contrast, the ODG lists the following criteria:

Indications for imaging -- Magnetic resonance imaging:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other “red flags”
- Uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit.
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome

- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient
- Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)

Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (*Carragee, 2004*) Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disc is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging discs, in 20% to 81%; and degenerative discs, in 46% to 93%. (*Kinkade, 2007*) Baseline MRI findings do not predict future low back pain. (*Borenstein, 2001*) MRI findings may be preexisting. Many MRI findings (loss of disc signal, facet arthrosis, and end plate signal changes) may represent progressive age changes not associated with acute events. (*Carragee, 2006*) MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. (*Kleinstück, 2006*) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as magnetic resonance imaging (MRI) without a clear rationale for doing so. (*Shekelle, 2008*)

A meta-analysis of randomized trials found no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and the researchers recommended that clinicians should refrain from routine, immediate lumbar imaging in these patients. (*Chou-Lancet, 2009*) Despite guidelines recommending parsimonious imaging, use of lumbar MRI increased by 307% during a recent 12-year interval. When judged against guidelines, one-third to two-thirds of spinal computed tomography imaging and MRI may be inappropriate. (*Deyo, 2009*) As an alternative to MRI, a pain assessment tool named Standardized Evaluation of Pain (StEP), with six interview questions and ten physical tests, identified patients with radicular pain with high

sensitivity (92%) and specificity (97%). The diagnostic accuracy of StEP exceeded that of a dedicated screening tool for neuropathic pain and spinal magnetic resonance imaging. (Scholz, 2009) Clinical quality-based incentives are associated with less advanced imaging, whereas satisfaction measures are associated with more rapid and advanced imaging, leading to competing demands for physicians. (Pham, 2009) Primary care physicians are making a significant number of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. (Lehnert, 2010) Degenerative changes in the thoracic spine on MRI were observed in approximately half of the subjects with no symptoms in this study. (Matsumoto, 2010) This large case series concluded that iatrogenic effects of early MRI are worse disability and increased medical costs and surgery, unrelated to severity. (Webster, 2010)

Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition are present, or if the patient is a candidate for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. (Chou, 2011) The National Physicians Alliance compiled a "top 5" list of procedures in primary care that do little if anything to improve outcomes but excel at wasting limited healthcare dollars, and the list included routinely ordering diagnostic imaging for patients with low back pain, but with no warning flags, such as severe or progressive neurologic deficits, within the first 6 weeks. (Aguilar, 2011) Owning MRI equipment is a strongly correlated with patients receiving MRI scans, and having an MRI scan increases the probability of having surgery by 34%. (Shreibati, 2011) A considerable proportion of patients may be classified incorrectly by MRI for lumbar disc herniation, or for spinal stenosis. Pooled analysis resulted in a summary estimate of sensitivity of 75% and specificity of 77% for disc herniation. (Wassenaar, 2011) (Sigmundsson, 2011) Accurate terms are particularly important for classification of lumbar disc pathology from imaging. (Fardon, 2001) (Fardon, 2014) Among workers with LBP, early MRI is not associated with better health outcomes and is associated with increased likelihood of disability and its duration.

(Graves, 2012) There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery. (Roudsari, 2010) For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) MRI with and without contrast is best test for prior back surgery. (Davis, 2011).

With regard to the use of MRIs for shoulder injuries, the ODG provides as follows:

Magnetic resonance imaging (MRI)

Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchar, 1999) Subtle tears that are full thickness are best imaged by MR arthrography, whereas larger tears and partial-thickness tears are best defined by MRI, or possibly arthrography, performed with admixed gadolinium, which if negative, is followed by MRI. (Oh, 1999) The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. (Dinnes, 2003) Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique is difficult to learn, so it is not always recommended. Magnetic resonance of the shoulder and specifically of the rotator cuff is most commonly used, where many manifestations of a normal and an abnormal cuff can be demonstrated. The question we need to ask is: Do we need all this information? If only full-thickness cuff tears require an operative procedure and all other abnormalities of the soft tissues require arthroscopy, then would shoulder arthrography suffice? (Newberg, 2000) Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. The choice of which imaging test to perform should be based on the patient's clinical information, cost, and imaging experience of the radiology department. (Ardic, 2006) MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears. However, the overall prevalence of tears of the

rotator cuff on MRI is 34% among symptom-free patients of all age groups, being 15% for full-thickness tears and 20% for partial-thickness tears. The results of this study support the use of MRI of the shoulder before injection both to confirm the diagnosis and to triage affected patients to those likely to benefit (those without a cuff tear) and those not likely to benefit (those with a cuff tear). (*Hambly, 2007*) The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (*Burbank, 2008*) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for shoulder MRI (37%), in patients with no histories of trauma and documented osteoarthritis on plain-film radiography. (*Lehnert, 2010*) See also *MR arthrogram*.

Indications for imaging -- Magnetic resonance imaging (MRI):

- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs
- Subacute shoulder pain, suspect instability/labral tear
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (*Mays, 2008*) (Emphasis added.)

On the date of this medical contested case hearing, the ODG provides the following with regard to physical therapy for the low 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*.

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:

10 visits over 8 weeks

Sprains and strains of unspecified parts of back:

10 visits over 5 weeks

Sprains and strains of sacroiliac region:

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified:

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy:

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

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:

10-12 visits over 8 weeks

Curvature of spine:

12 visits over 10 weeks

Fracture of vertebral column without spinal cord injury:

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury:

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Torticollis:

12 visits over 10 weeks

Other unspecified back disorders:

12 visits over 10 weeks

Work conditioning (See also *Procedure Summary* entry):

10 visits over 8 weeks

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*) Compared with usual care, treatment of new LBP with early PT resulted in a statistically significant improvement in disability in a RCT with 220 participants. The PT involved only four sessions over 3 weeks, consisting of manipulation and exercise, among patients being seen for LBP in a primary care setting, and the effects persisted for one year. The authors suggest that the potential benefits of early physical therapy should be evaluated in light of the time and effort required to participate in physical therapy. (*Fritz, 2015*) See also specific physical therapy modalities, as well as *Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; Stretching; Aquatic therapy; Group physical therapy*. [Physical therapy is the treatment of a disease or injury using 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 instead of passive modalities 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-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)

Timing of PT initiation: Preliminary evidence suggests that early physical therapy may decrease cost without compromising outcomes. After initially screening 3855 articles, 14 studies were included in a systematic review. The majority of articles studied low back pain (only 2 articles studied cervical pain). For spinal pain, there was low-quality evidence that early versus delayed physical therapy was associated with decreased cost and decreased frequency of opioid prescriptions, advanced imaging, and surgeries. One subgroup analyzed showed improved function/disability with early physical therapy in an occupational health setting. These results suggest that it may be beneficial for physical therapist providers to be utilized early in an episode of care for a lumbar spinal disorder. (*Ojha, 2016*)

On the date of this medical contested case hearing, the ODG provides the following with regard to physical therapy for the cervical spine:

Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. (*Rosenfeld, 2000*) (*Bigos, 1999*)

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, including assessment after a "six-visit clinical trial".

Cervicalgia (neck pain); Cervical spondylosis:

9 visits over 8 weeks

Sprains and strains of neck:

10 visits over 8 weeks

Displacement of cervical intervertebral disc:

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 (fusion, after graft maturity): 24 visits over 16 weeks

Degeneration of cervical intervertebral disc:

10-12 visits over 8 weeks

See 722.0 for post-surgical visits

Brachia neuritis or radiculitis NOS:

12 visits over 10 weeks

See 722.0 for post-surgical visits

Post Laminectomy Syndrome:

10 visits over 6 weeks

Fracture of vertebral column without spinal cord injury:

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury:

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Torticollis:

12 visits over 10 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 4 weeks

For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. (*Philadelphia, 2001*) (*Colorado, 2001*) (*Kjellman, 1999*) (*Seferiadis, 2004*) Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. (*Scholten-Peeters, 2006*) In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. (*Conlin, 2005*) A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for 3 weeks. (*Kongsted, 2007*) See also specific physical therapy modalities, as well as *Exercise*.

Whiplash: Therapies for whiplash-related disorders seem to have effects that are modest or marginal, and studies have yet to identify effective treatments for acute or chronic symptoms from whiplash injuries. This RCT found that simple advice is equally as effective as a more intense comprehensive physical therapy exercise program for chronic whiplash. (*Michaleff, 2014*) In this RCT, adding active management consultations to the usual emergency department (ED) care for acute whiplash does not improve patient outcomes and is not cost effective. (*Lamb, 2013*) It was suggested that whiplash symptoms themselves are not the fundamental problem, but the environment in which they are experienced may be the problem, with the interaction between whiplash victims and insurance/legal practitioners, whereas the symptoms that follow whiplash accidents should have a positive natural history. (*Ferrari, 2013*) (*Sterling, 2014*)

Active Treatment versus Passive Modalities: The use of active treatment instead of passive modalities is associated with substantially better clinical outcomes. See the *Low Back Chapter*. 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).

The ODG provides the following with regard to physical therapy for the shoulder:

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:

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

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 orthopedic referral. Patients with small tears of the rotator cuff may be referred to an orthopedist 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) 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.

Claimant appealed the denial of the physical therapy, bilateral shoulder MRIs, and lumbar MRI. MW, M.D., with the Utilization Review Agent (URA) upheld the denial of the lumbar MRI and bilateral shoulder MRIs. Dr. W opined that subjective complaints and objective examination

findings are nearly identical to the findings at the time of the last MRI of bilateral shoulders. According to Dr. W, there is no documentation of significant change in symptoms, nor are there findings suggestive of pathology to warrant the request for a repeat MRI. Dr. W offered basically the same rationale in her discussion of the requested lumbar MRI. She stated that there was limited evidence of significant objective findings to support the need for another lumbar MRI. As to the requested physical therapy, it was opined that given that age of the injury and lack of documentation of the number of physical therapy sessions, the request was not recommended.

Claimant requested that an IRO be appointed to review Carrier's denial of preauthorization of the requested health care. The Division appointed C-IRO Inc., as the IRO. C-IRO submitted the review of the request to a physician specializing in Anesthesiology. In IRO Case No. (IRO Case No. 2), the physician reviewer upheld the denial of the request for physical therapy, lumbar MRI, and bilateral shoulder MRIs. According to the physician reviewer, there were no recent objective findings of significant change in symptoms suggestive of significant pathology. Additionally, the physician reviewer with RYCO MedReview, LLC, in IRO Case No. (IRO Case No. 2) opined that the requested lumbar MRI without contrast was not medically indicated for the same reasons as stated in IRO Case No. (IRO Case No. 2).

Claimant argues that the recommendations of the ODG regarding the MRIs and physical therapy that was requested by Dr. R should not be followed. According to Claimant, his initial treating doctor, LT, M.D., has explained the necessity for Dr. R's requested healthcare. Claimant asserted that he has pain from his compensable injury and he would benefit from the requested treatment. There is, however, no persuasive expert medical evidence that would tend to show that the recommendations contained in the ODG do not apply to Claimant or that the treatment and testing requested by Dr. R are reasonably required for the compensable injury of (Date of Injury). No doctor provided medical evidence to establish that Claimant is an outlier and that health care other than that recommended by the ODG would be reasonably necessary.

Based on a careful review of the evidence presented in the hearing, Claimant failed to meet his burden of overcoming the IRO decision in (Docket No. 1) by a preponderance of the evidence-based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for a MRI of the lumbar spine without contrast. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, the claimant is not entitled to the MRI of the lumbar spine without contrast.

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet his burden of overcoming the IRO decision in (Docket No. 2) by a preponderance of the evidence-based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for physical therapy, bilateral shoulder MRIs or lumbar MRI. The preponderance of the evidence-based medicine is

not contrary to the decision of the IRO and, consequently, the claimant is not entitled to physical therapy, bilateral shoulder MRIs or lumbar MRI.

The Administrative Law Judge considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:
 - A. The Texas Department of Insurance, Division of Workers Compensation has jurisdiction over this matter.
 - B. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
 - C. The compensable injury of (Date of Injury) extends to and includes bilateral shoulder sprains/strains, cervical sprain/strain, lumbar sprain/strain, right shoulder rotator cuff tendon tear, right shoulder impingement of the rotator cuff at the AC joint.
 - D. On (Date of Injury), Claimant was the employee of (Employer), Employer
 - E. On (Date of Injury) Employer provided workers compensation insurance coverage through Ace American Insurance Company
 - F. The IRO determined that the lumbar MRI without contrast, physical therapy, bilateral shoulder MRI, and lumbar MRI for the compensable injury of (Date of Injury) are not medically necessary.
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. Physical therapy, bilateral shoulder MRI, and lumbar MRI are not health care reasonably required for the compensable injury of (Date of Injury).
4. A lumbar MRI without contrast is not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Workers' Compensation Division of the Texas Department of Insurance 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 physical therapy, bilateral shoulder MRI, and lumbar MRI are not health care reasonably required for the compensable injury of (Date of Injury).
4. The preponderance of the evidence is not contrary to the decision of the IRO that a lumbar MRI without contrast is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

In (Docket No. 1), the claimant is not entitled to a lumbar MRI without contrast for the compensable injury on (Date of Injury).

In (Docket No. 2), the claimant is not entitled to physical therapy, bilateral shoulder MRI, and lumbar MRI for the compensable injury on (Date of Injury).

ORDER

In (Docket No. 1), the claimant is not entitled to a lumbar MRI without contrast for the compensable injury on (Date of Injury). In (Docket No. 2), the claimant is not entitled to physical therapy, bilateral shoulder MRI, and lumbar MRI for the compensable injury on (Date of Injury). 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 **ACE AMERICAN INSURANCE COMPANY**, and the name and address of its registered agent for service of process is

**C T CORPORATION SYSTEM
1999 BRYAN STREET, SUITE 900
DALLAS, TEXAS 75201-3136**

Signed this 19th day of April, 2018.

Early Moyer
Administrative Law Judge