MEDICAL CONTESTED CASE HEARING NO. 14003

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 September 16, 2013, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to outpatient physical therapy – 12 sessions of up to 4 units per session, for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by CM, ombudsman. Respondent/Carrier appeared and was represented by JRT, attorney.

BACKGROUND INFORMATION

Claimant sustained an injury to his right shoulder and had right shoulder surgery on (Date of Injury). HSE, MD performed the surgery. After surgery, Dr. E recommended physical therapy and Claimant attended 24 sessions of physical therapy. In early March of 2013, Dr. E recommended that Claimant continue physical therapy "per rotator cuff protocol" and to increase strengthening.

On March 12, 2013, (Agent), Carrier's utilization review agent, gave the physical therapist notice of its refusal to authorize an additional 12 sessions of physical therapy. The utilization review agent's physician reviewer, DKM, MD, MPH, recommended that the requested physical therapy be denied because Claimant had received 24 sessions of physical therapy and he found no documentation in the medical records to show why Claimant would need additional skilled therapy care. Dr. M stated that he was not saying that additional therapy was not needed, only that there was no need for it to be administered through a skilled therapist. Claimant requested reconsideration of Dr. M's opinion and the request was reviewed by GS, DO, a certified orthopedic surgeon. Dr. S recommended that preauthorization for the additional skilled physical therapy be denied. The utilization review agents' decisions were appealed through the Independent Review Organization (IRO) process.

The Texas Department of Insurance appointed Pure Resolutions LLC as the Independent Review Organization. Pure Resolutions chose a board certified orthopedic surgeon as its physician reviewer. The IRO physician reviewer listed the medical records that he examined, including the daily progress notes from the post-surgery physical therapy and the surgeon's office notes. The physician reviewer concluded that the additional 12 sessions of physical therapy requested was not medically necessary because there was no clear rationale provided to support exceeding the 24 sessions recommended in the Official Disability Guidelines (ODG) and there were no exceptional factors of delayed recovery documented. The IRO physician reviewer opined that Claimant had completed sufficient formal therapy and should be capable of continuing to improve his strength and range of motion with independent, self-directed home exercise. The IRO physician reviewer cited his medical judgment, clinical experience, expertise in accordance with accepted medical standards, and the ODG in making his decision.

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 regarding the treatment 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 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 neither the Department nor the Division is considered a party to the 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. (Division Rule 133.308 (s).)

In regard to physical therapy for shoulder injuries, the ODG provides as follows:

> Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. 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 orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist 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)
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> *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)
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> *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 overstrengthened 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: See the Low Back Chapter for more information. 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.

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); 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.

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 (ICD9 726.1; 726.12):
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
Complete rupture of rotator cuff (ICD9 727.61; 727.6)
Post-surgical treatment: 40 visits over 16 weeks
Adhesive capsulitis (IC9 726.0):
Medical treatment: 16 visits over 8 weeks
Post-surgical treatment: 24 visits over 14 weeks
Dislocation of shoulder (ICD9 831):
Medical treatment: 12 visits over 12 weeks
Post-surgical treatment (Bankart): 24 visits over 14 weeks
Acromioclavicular joint dislocation (ICD9 831.04):
AC separation, type III+: 8 visits over 8 weeks
Sprained shoulder; rotator cuff (ICD9 840; 840.4):
Medical treatment: 10 visits over 8 weeks
Medical treatment, partial tear: 20 visits over 10 weeks
Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks
Superior glenoid labrum lesion (ICD9 840.7)
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) (ICD9 714.0; 715; 715.9; 716.9)
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) (ICD9 353.0):
Medical treatment: 14 visits over 6 weeks
Post-surgical treatment: 20 visits over 10 weeks
Fracture of clavicle (ICD9 810):
8 visits over 10 weeks
Fracture of scapula (ICD9 811):
8 visits over 10 weeks
Fracture of humerus (ICD9 812):
Medical treatment: 18 visits over 12 weeks
Post-surgical treatment: 24 visits over 14 weeks

On June 22, 2012, Claimant underwent an MRI of the right shoulder that revealed the presence of tendinopathy of the supraspinatus tendon with irregularity along the bursal surface beneath the

acromioclavicular joint. On December 6, 2012, Dr. E performed a right shoulder arthroscopic rotator cuff repair, tenodisis of the long head of the biceps and subacromial decompression. The applicable physical therapy guideline in the ODG for Claimant's situation calls for 24 physical therapy visits over 14 weeks. (**Rotator cuff syndrome/Impingement syndrome** (ICD9 726.1; 726.12) - Post-surgical treatment, arthroscopic.)

Dr. E ordered 24 sessions of physical therapy. Claimant attended the physical therapy at (Healthcare Provider) in January and February of 2013. Dr. E ordered additional physical therapy in March of 2013, but Claimant offered no expert medical evidence to explain why Claimant's situation is outside of the norm contemplated by the ODG and to show that the additional physical therapy is reasonably necessary and is consistent with evidence-based medicine. Under the facts presented, Claimant has failed to overcome the determination of the IRO physician reviewer that additional physical therapy visits after the completion of the 24 visits in January and February is not reasonably required health care for the compensable injury of (Date of Injury).

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 the (Employer), Employer.

   C. The State Office of Risk Management is the statutorily designated carrier for Employer.

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

   E. The compensable injury of (Date of Injury), extends to a full thickness tear of supraspinatus tendon (rotator cuff tear), Type 2 acromion with spurring of AC joint, rotator cuff impingement syndrome, adhesive capsulitis, tendinopathy of the supraspinatus tendon, and fraying beneath the acromioclavicular joint.

   F. Pure Resolutions LLC was appointed by the Texas Department of Insurance as the Independent Review Organization in this matter.

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. Outpatient physical therapy, consisting of 12 sessions of up to 4 units per session, in addition to the 24 sessions of physical therapy completed by Claimant in January and February of 2013, is not 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 not contrary to the decision of the IRO that Claimant is not entitled to outpatient physical therapy 12 sessions of up to 4 units per session for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to outpatient physical therapy – 12 sessions of up to 4 units per session for the compensable injury of (Date of Injury).

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

For service in person, the address is:

SELF-INSURED
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

For service by mail, the address is:

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

Signed this 17th day of September, 2013.

KENNETH A. HUCHTON
Hearing Officer