MEDICAL CONTESTED CASE HEARING NO. 15050

MEDICAL DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that: The preponderance of the evidence-based medical evidence is contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to physical therapy 3x4 left knee for the compensable injury of (Date of Injury), since the physical therapy 3x4 left knee has been shown to be health care reasonably required for the Claimant's compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A contested case hearing was held on June 30, 2015 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to physical therapy 3x4 left knee for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by LR, ombudsman. Respondent/Carrier appeared and was represented by BJ, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Petitioner/Claimant:

1. MR, Petitioner/Claimant

For Respondent/Carrier:

1. Dr. BS (by telephone)

The following exhibits were admitted into evidence:

> Hearing Officer's Exhibit HO-1
> Petitioner/Claimant's Exhibits C-1 through C-4
> Respondent/Carrier's Exhibits CR-1 through CR-9

DISCUSSION

It was undisputed that the Claimant sustained a compensable injury to at least his left knee on (Date of Injury) while working for the (Employer) He was diagnosed by Dr. GH with tears of the

anterior cruciate ligament (ACL) and medial meniscus of the left knee, and on March 10, 2014, Dr. H performed arthroscopic surgery, including an ACL reconstruction and a partial medial meniscectomy. After this first surgery, the Claimant underwent 12 sessions of physical therapy, although it is noted that the *Official Disability Guidelines* (ODG) recommends 24 physical therapy visits over a 16-week period after an ACL reconstruction surgery. Thereafter, the Claimant continued to have problems and pain in his left knee, and an MRI performed on August 7, 2014 showed a persistent or recurrent medial meniscus tear. Dr. H performed the second surgery on the Claimant's left knee on September 8, 2014, which included a repeat arthroscopic medial meniscectomy. After the second surgery, the Claimant underwent 16 sessions of physical therapy. The evidence shows that the Claimant apparently was not getting significant relief initially during this stint of physical therapy, and the provider/facility was changed. After the change, the Claimant's left knee condition improved, although there was apparently room for additional improvement at the conclusion of this physical therapy, which led to the request for the additional physical therapy that was denied and is the subject of this appeal. It should be noted here that after the second surgery, the Claimant was diagnosed with deep vein thrombosis (DVT) in his left leg, and while there has been no determination one way or the other on whether this condition is related to the compensable (Date of Injury) injury, this condition necessitated a cessation of the Claimant's physical therapy for a period of time.

The request herein for 12 additional sessions of physical therapy was denied by two of the Carrier's utilization review agents (URAs). The denials were upheld by an IRO. The IRO physician reviewer, who is board certified in Orthopedic Surgery, noted that the medical necessity for additional physical therapy has not been established since Dr. H has not outlined the specific expectations from this treatment. The physician reviewer based the decision on the ODG and medical judgment, clinical experience and expertise.

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 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(s), "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."

The ODG addresses the medical necessity of physical therapy for a knee injury under the heading "Physical medicine treatment" as follows:

> Recommended. Positive limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. See also specific modalities. (Philadelphia, 2001) Acute muscle strains often benefit from daily treatment over a short period, whereas chronic injuries are usually addressed less frequently over an extended period. It is important for the physical therapy provider to document the patient's progress so that the physician can modify the care plan, if needed. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions (eg, joint range-of-motion and weight-bearing limitations, and concurrent illnesses). **(Rand, 2007)** Controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) A randomised controlled trial of the effectiveness of water-based exercise concluded that group-based exercise in water over 1 year can produce significant reduction in pain and improvement in physical function in adults with lower limb arthritis, and may be a useful adjunct in the management of hip and/or knee arthritis. (Cochrane, 2005) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Lowe, 2007) **Supervised therapeutic exercise improves outcomes in patients who have osteoarthritis or claudication of the knee. Compared with**

home exercise, supervised therapeutic exercise has been shown to improve walking speed and distance. (Rand, 2007) A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion. The physical therapy visit may also include advice regarding assistive devices for ambulation. (Zhang, 2008) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In patients with ACL injury willing to moderate activity level to avoid reinjury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (Neuman, 2008) Limited gains for most patients with knee OA. (Bennell, 2005) More likely benefit for combined manual physical therapy and supervised exercise for OA. (Deyle, 2000) Many patients do not require PT after partial meniscectomy. (Morrissey, 2006) There are short-term gains for PT after TKR. (Minns Lowe, 2007) Physical therapy and patient education may be underused as treatments for knee pain, compared to the routine prescription of palliative medication. (Mitchell, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) This study sought to clarify which type of postoperative rehabilitation program patients should undergo after ACL reconstruction surgery, comparing a neuromuscular exercise rehabilitation program with a more traditional strength-training regimen, and it showed comparable long-term primary and secondary outcomes between the 2 groups at 12 and 24 months. On the basis of the study, the authors recommend a combined approach of strength exercises with neuromuscular training in postoperative ACL rehabilitation programs. (Risberg, 2009) This RCT concluded that, after primary total knee arthroplasty, an outpatient physical therapy group achieved a greater range of knee motion than those without, but this was not statistically significant. (Mockford, 2008) Knee bracing after ACL reconstruction appears to be largely useless, according to a systematic review. The most important rehab for ACL surgery patients is to start physical therapy early and rigorously. Accelerated rehabilitation (starting at 3 weeks postoperatively rather than the traditional 3 months and intended to reduce the usual 6-month time for return to activity) was considered to be safe according to this review. The authors

conclude that immediate postoperative weight-bearing, range of knee motion from 0° to 90° of flexion, and strengthening with closed-chain exercises are likely to be safe. They also suggest that starting eccentric quadriceps strengthening and isokinetic hamstring strengthening at week 3 after surgery may accelerate recovery. The reviewers found promising data for home-based rehabilitation for the motivated patient, but found doubtful support for neuromuscular training such as proprioceptive and balance training, perturbation training, and vibratory stimulation. (Kruse, 2012) In this systematic review, strength training, Tai Chi and aerobics exercises improved balance and falls risk in older individuals with knee OA, while water-based exercises and light treatment did not. (Mat, 2015) See specific physical therapy modalities by name, as well as Exercise. **See also Aerobic exercises; Activity restrictions; ACL injury rehabilitation; Aquatic therapy; Barefoot walking; Cold/heat packs; Compression garments; Computerized muscle testing; Continuous-flow cryotherapy; Continuous passive motion (CPM); Deep transverse friction massage (DTFM); Diathermy; Durable medical equipment (DME); Education; Electrical stimulators (E-stim); Electromyographic biofeedback treatment; Electrothermal shrinkage (for lax ACL); Flexionators (extensionators); Footwear, knee arthritis; Functional improvement measures; Functional restoration programs (FRPs); Gait training; Game Ready™ accelerated recovery system; Gym memberships; Heat; Home exercise kits; Immobilization;** Interferential current stimulation (ICS); **Iontophoresis; Joint active systems (JAS) splints; Joint mobilization; Kinesio tape (KT); Knee brace; Low level laser therapy (LLLT); Magnet therapy; Manipulation; Manual therapy; Massage therapy; Mechanical stretching devices (for contracture & joint stiffness); Mud pack therapy; Non-surgical intervention for PFPS (patellofemoral pain syndrome); Orthoses; Phonophoresis;** Power mobility devices (PMDs); **Proprioception exercises; Pulsed magnetic field therapy (PMFT/PEMF); Static progressive stretch (SPS) therapy; Strapping; Strengthening exercises; Stretching and flexibility; Tai Chi; Taping; Therapeutic knee splint (patellofemoral pain); Traction, knee (skeletal traction treatment); Ultrasound, therapeutic; U-Step walker; Walking aids (canes, crutches, braces, orthoses, & walkers); Work conditioning, work hardening.**

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).

This systematic review concluded that PT interventions that empower patients to actively self-manage knee OA (such as aerobic, strength, and proprioception exercise) improved outcomes the best. (Wang, 2012) The latest AAOS Guidelines for Treatment of Osteoarthritis of The Knee, include a strong recommendation that patients with symptomatic osteoarthritis of the knee participate in self-management programs, strengthening, low-impact aerobic exercises, and neuromuscular education; and engage in physical activity consistent with national guidelines. (AAOS, 2013)

ODG Physical Medicine 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.

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Medical treatment: 9 visits over 8 weeks

Post-surgical (Meniscectomy): 12 visits over 12 weeks

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):

Medical treatment: 12 visits over 8 weeks

Post-surgical (ACL repair): 24 visits over 16 weeks

Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):

Medical treatment: 9 visits over 8 weeks

Post-surgical: 12 visits over 12 weeks

Articular cartilage disorder - chondral defects (ICD9 718.0)

Medical treatment: 9 visits over 8 weeks

Post-surgical (Chondroplasty, Microfracture, OATS): 12 visits over 12 weeks

Pain in joint; Effusion of joint (ICD9 719.0; 719.4):

9 visits over 8 weeks

Arthritis (Arthropathy, unspecified) (ICD9 716.9):

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks

Abnormality of gait (ICD9 781.2):

16-52 visits over 8-16 weeks (Depends on source of problem)

Fracture of neck of femur (ICD9 820):

Post-surgical: 18 visits over 8 weeks

Fracture of other and unspecified parts of femur (ICD9 821):

Post-surgical: 30 visits over 12 weeks

Fracture of patella (ICD9 822):

Medical treatment: 10 visits over 8 weeks

Post-surgical (closed): 10 visits over 8 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

Fracture of tibia and fibula (ICD9 823)

Medical treatment: 12-18 visits over 8 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

Amputation of leg (ICD9 897):

Post-replantation surgery: 48 visits over 26 weeks

Quadriceps tendon rupture (ICD9 727.65)

Post-surgical treatment: 34 visits over 16 weeks

Patellar tendon rupture (ICD9 727.66)

Post-surgical treatment: 34 visits over 16 weeks

Work conditioning

See Work conditioning, work hardening

It is the opinion of both of the Carrier's URAs, the IRO physician reviewer, and Dr. BS, the latter of whom is a board-certified orthopedic surgeon who conducted a peer review at the Carrier's request, that since the Claimant has had at least 28 sessions of physical therapy for his compensable injury, no further physical therapy is warranted under the ODG. A review of the ODG guidelines, however, seems to indicate that 36 sessions of physical therapy would be within its guidelines in this case: 24 sessions after the first surgery and 12 sessions after the second surgery. Dr. H, who is also a board-certified orthopedic surgeon, has provided a letter dated May 5, 2015 that explains that the Claimant's slow recovery after the second surgery, the problems with the initial physical therapy facility, and the complication of DVT, set back his recovery and that he needs the additional physical therapy to regain range of motion and strength

in his leg. Appendix D of the ODG provides for exceptions to recommendations in the ODG treatment guidelines, and it is determined that under Appendix D, Dr. H's explanation is sufficient to support a finding that the additional 12 sessions of physical therapy is medically necessary in this case. After a careful review of the entire record, it is determined that the evidence establishes that the preponderance of the evidence-based medical evidence is contrary to the IRO decision. For the reasons stated, it is, therefore, determined that the record establishes that the requested physical therapy is health care reasonably required for the compensable (Date of Injury) injury.

The Hearing Officer 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. 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 (Employer), Employer.

   C. On (Date of Injury), Employer had workers' compensation insurance coverage with Texas Mutual Insurance Co., Carrier.

   D. On (Date of Injury), the Claimant sustained a compensable injury to at least his left knee while in the course and scope of his employment with (Employer)

   E. The IRO decision dated February 19, 2015 upheld the Carrier's denials of the treatment in question.

2. The physical therapy 3x4 left knee has been shown to be health care reasonably required for the Claimant's compensable (Date of Injury) injury.

3. The Carrier delivered to Claimant a single document stating the true corporate name of the Carrier, and the name and street address of the Carrier's registered agent, which was admitted into evidence as Hearing Officer's Exhibit Number 1.

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-based medical evidence is contrary to the decision of the IRO that the Claimant is not entitled to physical therapy 3x4 left knee for the compensable injury of (Date of Injury), since the physical therapy 3x4 left knee has been shown to be health care reasonably required for the Claimant's compensable (Date of Injury).

DECISION

The Claimant is entitled to physical therapy 3x4 left knee for the compensable injury of (Date of Injury).

ORDER

The Carrier is **ORDERED** to pay medical benefits in accordance with this decision, the Act and the implementing Rules.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY,** and the name and address of its registered agent for service of process is

RICHARD GERGASKO
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TX 78723

Signed this 20th day of July, 2015.

Patrice Fleming-Squirewell
Hearing Officer