MEDICAL CONTESTED CASE HEARING NO. 15053

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the 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 is contrary to the decision of the Independent Review Organization (IRO) that Claimant is entitled to 12 sessions of physical therapy to the right knee.

STATEMENT OF THE CASE

A contested case hearing was held on July 28, 2015 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to 12 sessions of physical therapy to the right knee for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was represented by CS, attorney.

Respondent/Carrier was represented by RT, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant.

For Carrier: None.

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits: HO-1.

Claimant's Exhibits: C-1 through C-10.

Carrier's Exhibits: CR-A through CR-H.

DISCUSSION

On (Date of Injury), Claimant sustained a compensable injury when she slipped and fell on water injuring her right knee. As a result of the compensable injury, Claimant had surgery to her right

knee on February 4, 2015. It should be noted that prior to the right knee surgery, the medial and lateral meniscus tears were disputed. However, the parties eventually agreed, by signing a Benefit Dispute Agreement on December 11, 2014, that the medial and lateral meniscus tears were part of the compensable injury.

The requested procedure was denied by the Carrier's utilization review agents and referred to an IRO who upheld the Carrier's denial. The IRO opined that the "[d]ue to the lack of exceptional factors present in the right knee to support ongoing physical therapy as recommended by guidelines, it is this review's opinion that the request for 12 sessions of physical therapy, right knee is not medically necessary and the prior denial remain upheld.

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. 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(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."

In regards to physical therapy for the knees, the ODG states the following:

> 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

Claimant relies on the office notes and written opinion from her treating physician in order to establish that the ODG have been met. Claimant's treating physician provided a narrative report documenting the reasons as to why he disagrees with the IRO's determination against the requested physical therapy. The treating physician provided a persuasive and thorough report explaining why the additional 12 sessions of physical therapy to the right knee is medically necessary. In the July 1, 2015 narrative report, the treating physician opined, in part that the Claimant "falls outside of the standard ODG Guidelines because the patient underwent a right knee arthroscopy which was more extensive than the standard arthroscopy requiring a partial medial meniscectomy, partial lateral meniscectomy and removal of cartilaginous chondral fragment which had fractured off and subsided in the intercondylar notch region." He further noted that Claimant had a Functional Capacity Evaluation (FCE) on May 12, 2015, which revealed that Claimant continued to have "significant deficits observed with respect to her agility, gait, range of motion, balance bending, body mechanics, carrying, coordination, core strength, edema endurance flexibility, kneeling, lifting, pain, posture, prolonged ambulation, pulling, pushing stair climbing, standing strength, overall trunk mobility and work tolerance." Because of the continued problems, a work hardening program has been recommended.

On June 5, 2015, Claimant was examined by a designated doctor, who supported the treating physician's recommendation for the additional 12 sessions of physical therapy to the right knee. He also reviewed the FCE taken in May of 2015, and also noted that the "physical demand level demonstrated was medium with a lengthy caveat paragraph essentially outlining my thoughts regarding the clinical picture today. The Official Disability Guidelines references this type of exception to the guidelines (sic) in Appendix D."

The medical evidence presented in support of the necessity of the proposed treatment is sufficient and is supported by evidence-based medicine. Therefore, the preponderance of the evidence is contrary to the decision of the IRO that Claimant is not entitled to 12 sessions of physical therapy to the right knee for the compensable injury of (Date of 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 the (Employer), Employer.

C. On (Date of Injury), Employer provided workers' compensation insurance with the State Office of Risk Management, Carrier.

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

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 IRO determined that the requested service was not reasonable and necessary health care for the compensable injury of (Date of Injury).

4. Claimant did present sufficient evidence-based medical evidence contrary to the IRO decision.

5. The 12 sessions of physical therapy to the right knee is 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 contrary to the decision of the IRO that 12 sessions of physical therapy to the right knee is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to 12 sessions of physical therapy to the right knee for the compensable injury of (Date of Injury).

ORDER

Carrier is 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 **STATE OFFICE OF RISK MANAGEMENT (a self-insured governmental entity)** and the name and address of its registered agent for service of process is

For service in person, the address is:

STEPHEN S. VOLLBRECHT, EXECUTIVE DIRECTOR
STATE OFFICE OF RISK MANAGEMENT
300 W. 15th STREET
WILLIAM P. CLEMENTS, JR.
STATE OFFICE BUILDING, 6TH FLOOR
AUSTIN, TEXAS 78701

For service by mail, the address is:

STEPHEN S. VOLLBRECHT, EXECUTIVE DIRECTOR
STATE OFFICE OF RISK MANAGEMENT
P.O. BOX 13777
AUSTIN, TEXAS 78711-3777

Signed this 5th day of August, 2015.

Teresa G. Hartley
Hearing Officer