

MMI and the Official Disability Guidelines (ODG)



Material Disclaimer

The material presented in this presentation is made available by the Texas Department of Insurance/Division of Workers' Compensation (TDI-DWC) for educational purposes only. The material is not intended to represent the sole approach, method, procedure or opinion appropriate for the medical situations discussed.

Please . . .



- ✓ Sign in for this morning
- ✓ Silence your cell phones

How to Determine Maximum Medical Improvement (MMI)

- Understand definition of MMI
- Review *Request for DD Examination*
- Review the medical records
- Prepare a checklist of information to obtain from medical history and physical exam
- Perform DD exam
- Make referrals, if necessary, to answer question

How to Determine Maximum Medical Improvement (MMI)

- Based on records reviewed and exam findings, define compensable injury for certification of MMI and IR and explain in report
- Consider *Official Disability Guidelines* (ODG), including Appendix D, to determine if based on reasonable medical probability additional treatment can be anticipated to result in further material recovery or lasting improvement
- If not at MMI, why not?
 - What is needed to reach MMI?

How to Determine Maximum Medical Improvement (*MMI*)

- If at MMI, why *is* IE at MMI?
- If at MMI, what is date and why that date?
- Answer question from DWC Form-032
 - Has MMI been reached?
 - If so, on what date?
- Answer yes or no with sufficient explanation as to **why or why not**
 - Do not answer with just a conclusion

Definition of MMI

The earlier of

- **Clinical MMI** - The *earliest* date, after which based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated or
- **Statutory MMI** (listed on DWC Form-032) - 104 weeks from date on which income benefits begin to accrue

Statutory MMI

- DD does **NOT** determine statutory MMI date
- Statutory MMI date should be provided on DWC Form-032 or Presiding Officer Directive, if applicable
 - 104 weeks from date on which income benefits begin to accrue
 - not applicable for claims without initiation of income benefits (i.e., temporary income benefits (TIBS))
- MMI **cannot** be later than statutory MMI date, but IE may reach clinical MMI prior to statutory MMI
- If statutory MMI, explain why IE was not at clinical MMI prior to reaching statutory MMI

Practical Considerations

- MMI must be certified before impairment rating is assigned
- Date of MMI may not be prospective or conditional
- Assign IR for current compensable injury based on IE's condition on MMI date considering medical record and certifying examination

Practical Considerations

- Consider whether additional treatment (per ODG, including Appendix D) may reasonably be anticipated to result in further material recovery or lasting improvement
 - Expected disability duration does not equate to MMI
- Consider whether passage of time, resumption of activities of daily living, participation in home exercise, etc. may reasonably be anticipated to result in further material recovery or lasting improvement

Practical Considerations

- Expected disability duration
 - Does *not* equate to MMI
- ***Do not use MDGuidelines for MMI***



**MDGuidelines
For MMI**

Case 1 - MMI

- 28-year-old paramedic sustained fracture of right lateral tibial plateau 08/11/2015
 - Statutory MMI 08/19/2017
- Treated with ORIF
- 28 post-op PT sessions through 12/15/2015
 - Improvement in knee ROM, strength and ADLs
 - Walking/standing limited to 30-60 minute intervals
 - 2.0 cm right thigh atrophy
 - Knee flexion 100°
 - Knee extension minus 10°

Case 1 - MMI

FCE 12/15/2015

- Deficits in ability to squat, lift from floor level, ascend and descend stairs and climb ladder, and push/pull
- Unable to complete treadmill test of cardiovascular fitness due to knee pain and weakness
- Multiple parameters for validity showed maximal and consistent effort
- Medium physical demand category (lifting, push/pull)

Case 1 - MMI

- Ortho Follow-up Visit 12/20/2015
 - Working with restrictions with 911/dispatch (sedentary work)
 - Continued home/gym exercise program concurrent and post-PT
 - Difficulty walking, standing, stairs due to right knee pain and limited ROM
 - Slight limp
 - Fracture healed, good alignment
 - Recommended 6 additional visits PT over next 6-8 weeks for progression of gym and home exercise program
- Additional 6 visits PT denied 1/4/2016 by insurance carrier/utilization review – “request exceeds ODG recommended PT”

Case 1 - MMI

DD Medical History 2/15/2016

- Continued restricted duty 911/dispatch
- Continued home/gym program – “getting a little stronger, slow progress”
- Difficulty with standing/walking greater than 30-60 minute intervals, stairs
- PT Preauthorization denial appealed

Case 1 - MMI

DD Physical Exam 2/15/2016

- Right knee ROM
 - Flexion 100°
 - Extension minus 10°
- Antalgic gait w/shortened stance and push-off
- 1.5 cm right thigh atrophy
- 4+/5 strength right knee extension

Case 1 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

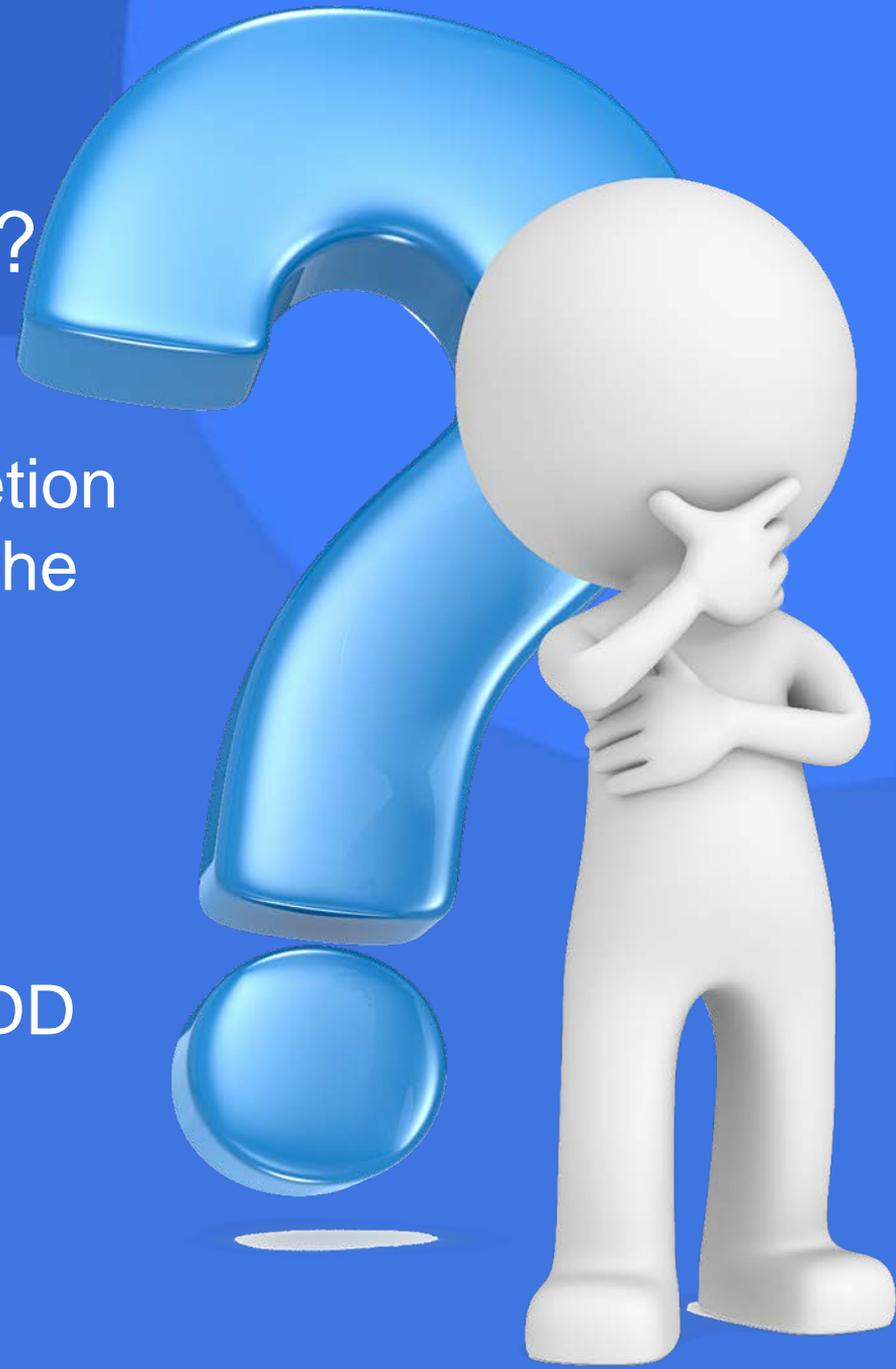
(May not be greater than statutory MMI date shown on DWC Form-032)



Case 1 - MMI

Has MMI been reached?
If so, on what date?

- A. MMI 12/15/2015 – completion of post-operative PT and the FCE date
- B. MMI 12/20/2015 – date of follow-up with orthopedic surgeon
- C. MMI 2/15/2016 – date of DD exam
- D. Not at MMI

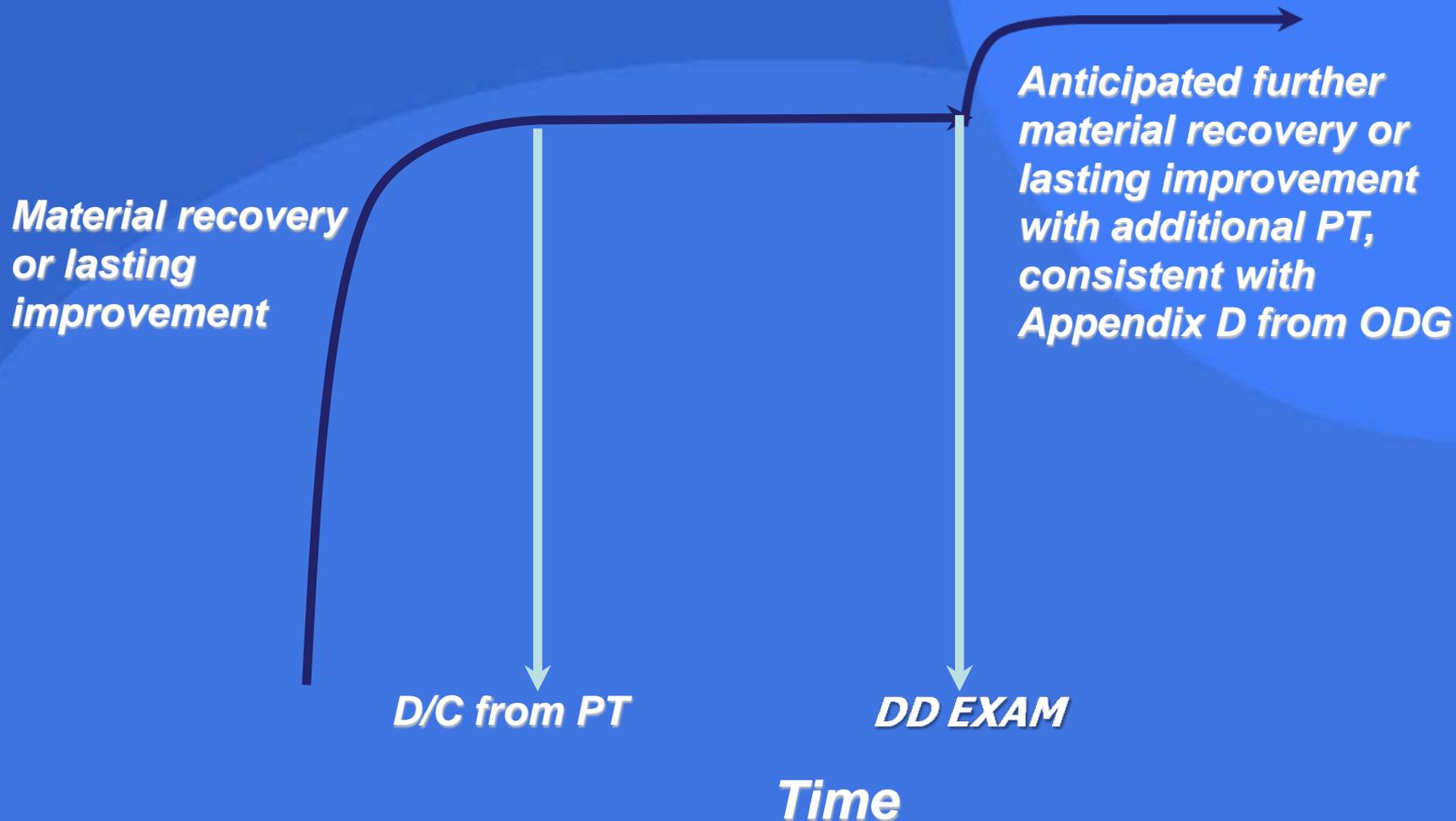


Case 1 - MMI

- IE not at MMI
- Additional treatment (PT) in all reasonable medical probability is anticipated to result in further material recovery or lasting improvement
- Supported by ODG (including Appendix D)



Not at MMI



Case 2 - MMI

- 28-year-old male restaurant manager began acute low back and left posterior thigh pain after slip and fall on wet floor, landing on buttocks on 6/15/2015
- Occupational medicine treatment
 - NSAIDs, muscle relaxant medication
 - 6 PT visits
 - No improvement in symptoms or activity tolerance
 - RTW with restrictions
 - Employer unable to accommodate restricted duty work

Case 2 - MMI

- Lumbar MRI scan showed 7 mm posterolateral left L5/S1 herniated nucleus pulposus (HNP) displacing left S1 nerve root
- Translaminar lumbar epidural steroid injection (ESI) x2 at L5/S1 with short term improvement

Case 2 - MMI

- Left L5/S1 hemi-laminotomy/discectomy 1/15/2016
 - Partial relief of lower extremity symptoms
- Completed 18 PT visits 3/15/2016
 - RTW without restrictions 3/8/2016
 - Handwritten PT discharge summary largely illegible

Case 2 - MMI

Surgeon Follow-up Exam 4/1/2016

- Working without restrictions since 3/8/2016
- Taking OTC analgesics as needed
- Intermittent low back pain
- SLR produced LBP without neural tension signs
- Lumbar flexion fingertips to mid shin, slightly decreased lumbar extension, both with increased LBP

Case 2 - MMI

Surgeon Follow-up Exam 4/1/2016 (cont'd)

- Left Achilles DTR decreased
- Decreased sensation left lateral foot
- Lower extremity strength 5/5
- “Patient is concerned about continued low back pain”
- Recommends MRI scan without contrast to “rule out recurrent disc herniation”

Case 2 - MMI

Repeat Lumbar MRI Scan With Contrast
4/5/2016

- Post-operative changes without any evidence of recurrent or residual disk herniation

Case 2 - MMI

Surgeon Follow-up 4/12/2016

- IE taking OTC analgesics as needed
- Performing home exercise program per PT
- Working without restrictions
- Exam unchanged from 4/1/2016
- Discussed MRI results, no additional surgery recommended and possible referral for additional interventional pain management
 - IE does not want to pursue
- Continue home exercises, OTC medication, return as needed

Case 2 - MMI

DD Exam 7/15/2016

- Chief complaint low back pain
- Normal gait
- Lumbar range of motion as follows
 - flexion to 50° degrees (sacral value of 40°)
 - lumbar extension 20°
 - both with increased left lower back pain

Case 2 - MMI

DD Exam 7/15/2016

- Left straight leg raise limited to 54° where it produces left low back pain, without dorsiflexion aggravation
- Right SLR 65° limited by hamstring tightness
- Left Achilles DTR decreased and numbness to pinprick over left lateral foot
- Lower extremity strength 5/5 bilaterally

Case 2 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

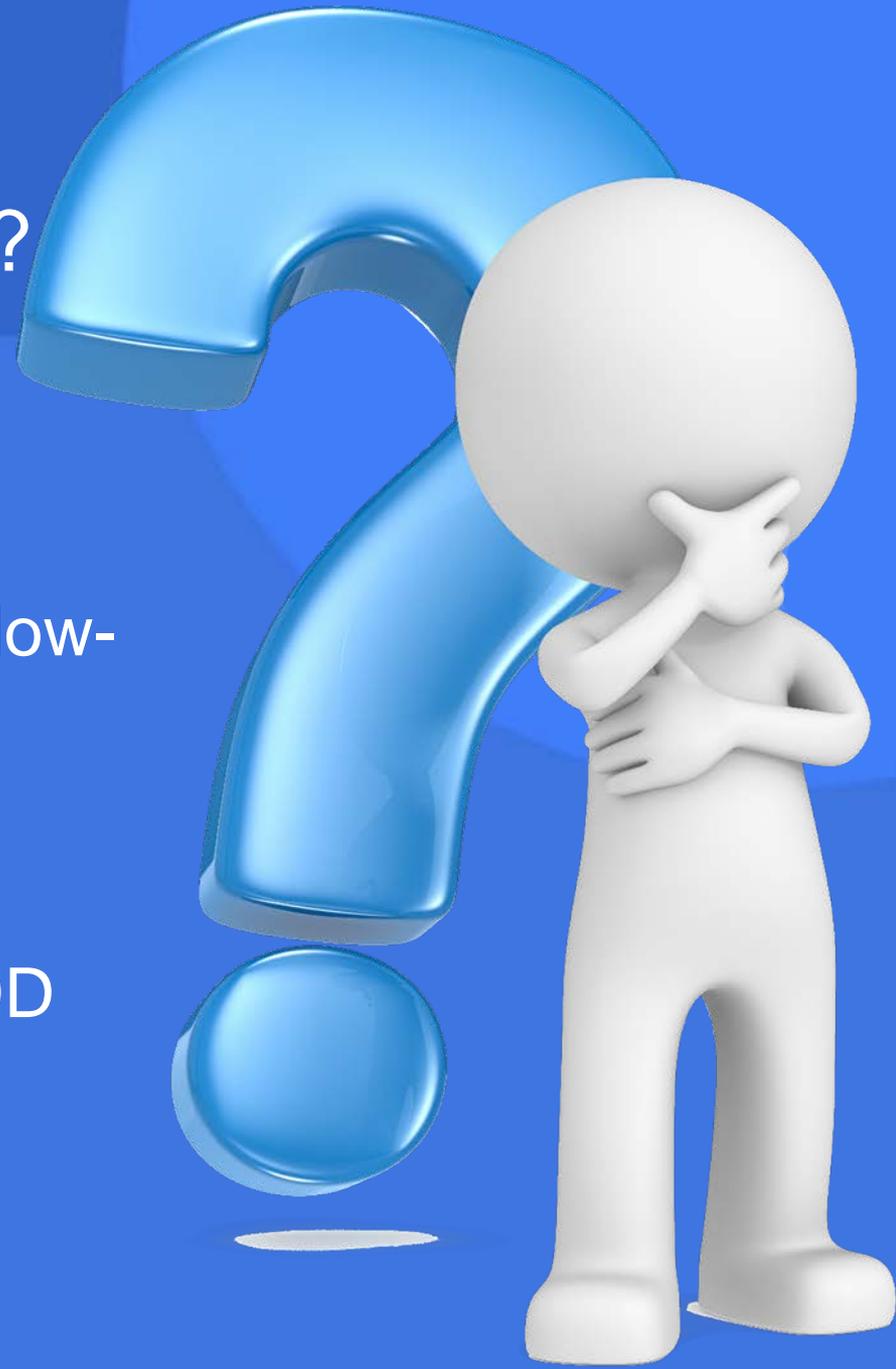
(May not be greater than statutory MMI date shown on DWC Form-032)



Case 2 - MMI

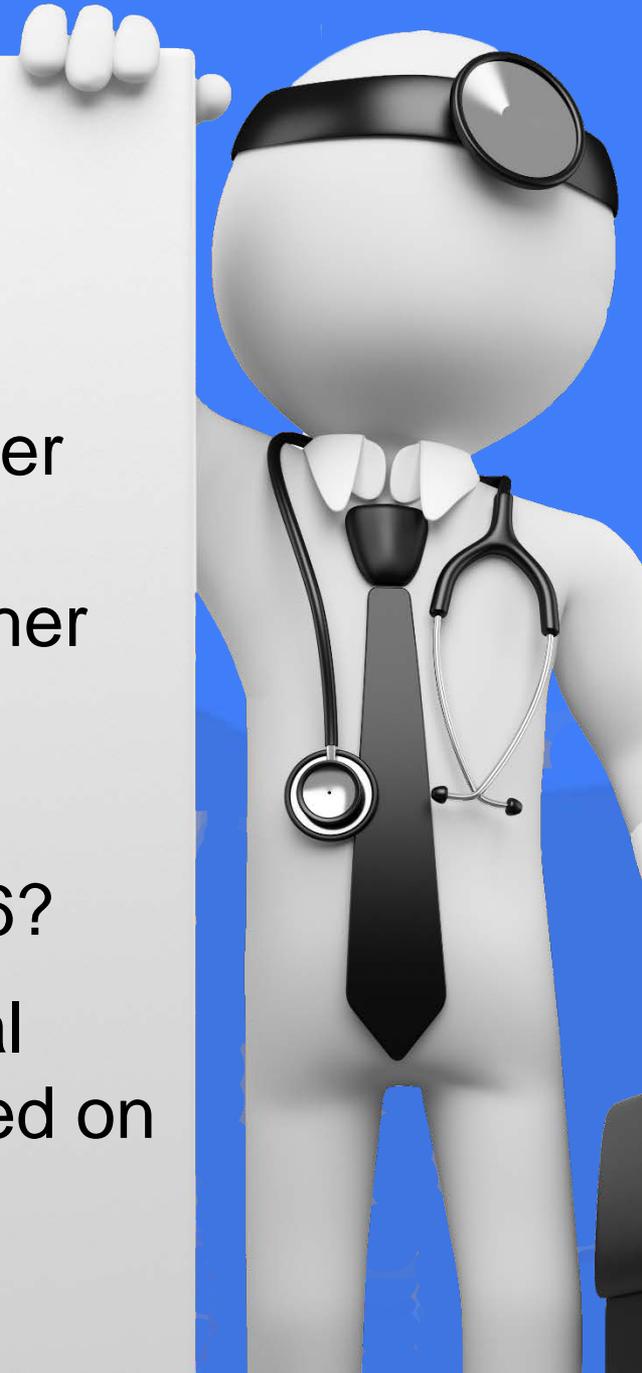
Has MMI been reached?
If so, on what date?

- A. MMI 3/15/16 – date of PT discharge
- B. MMI 4/1/2016 - date of follow-up with surgeon
- C. MMI 4/12/2016 - date of follow-up with surgeon
- D. MMI 7/15/2016 - date of DD exam
- E. Not at MMI



Case 2 - MMI

- IE at MMI 4/1/2016
- Additional treatment and/or time after 4/1/16 in all reasonable medical probability not likely to result in further material recovery from or lasting improvement
- What about repeat MRI scan 4/5/16?
- What about additional interventional pain management discussed/refused on 4/12/16?



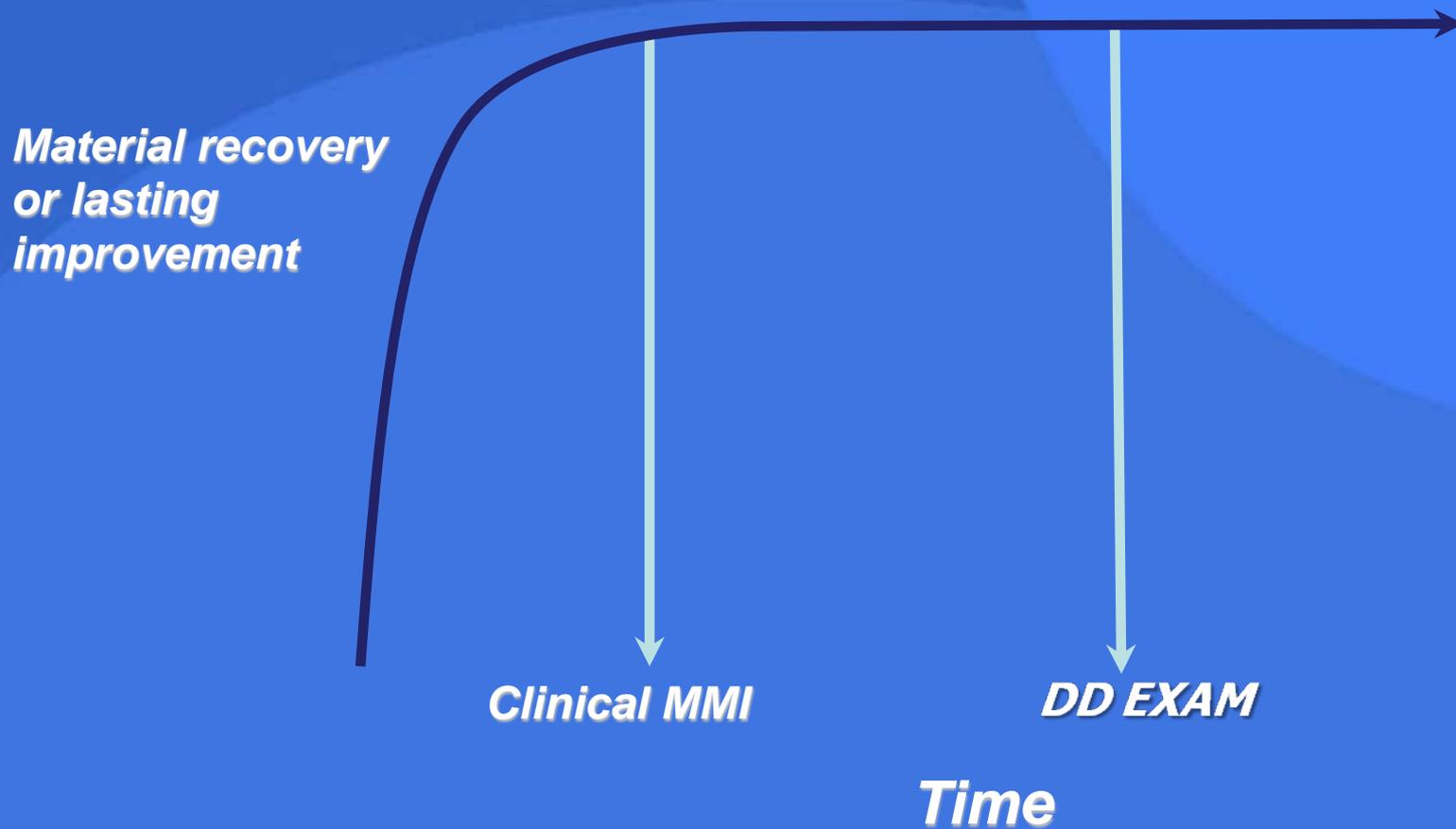
Some MMI Considerations

- What if IE refuses treatment even though it is recommended by ODG?
- What if IE does not need treatment, even though it is recommended by ODG?
- What if treatment not otherwise recommended by ODG would result in further material recovery or lasting improvement? – see Appendix D

MMI Before DD Exam

- IE reaches clinical plateau (MMI) prior to DD exam with no intervening change in condition or reasonable expectation of improvement
- If medical condition is unchanged may use physical exam findings at DDE for IR on MMI prior
- ***Explain this in your report!***

MMI Before DD Exam



Case 3 - MMI

- 26-year-old laborer sustained tears of right medial meniscus and ACL on 4/28/14
- Statutory MMI 5/8/16
- Initial dispute about compensability of injury, resolved in IE's favor at CCH 12/15/14

Case 3 - MMI

Extensive Treatment

- Medication
 - NSAIDs, muscle relaxants, acetaminophen
- 24 visits pre-op PT 2/1/15-7/1/15
- Arthroscopic meniscectomy, ACL repair surgery 11/15/15
- 30 visits post-op PT 12/1/15-5/5/16

Case 3 - MMI

Post-op PT on 5/5/16 Documents

- Right knee ROM
 - Flexion 100°
 - Extension -10°
- 2 cm right thigh atrophy
- 4/5 strength right knee extension
- Work hardening recommended

Case 3 - MMI

- Sustained recurrent medial meniscus tear in work hardening 5/15/16
- Under went arthroscopic medial meniscectomy 6/30/16
- Completes additional 12 post-op PT 8/15/16

Case 3 - MMI

DD Exam 9/1/16

- Right knee ROM
 - Flexion 100°
 - Extension 0°
- 1 cm right thigh atrophy
- 5/5 strength bilateral lower extremity
- Normal gait

Case 3 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

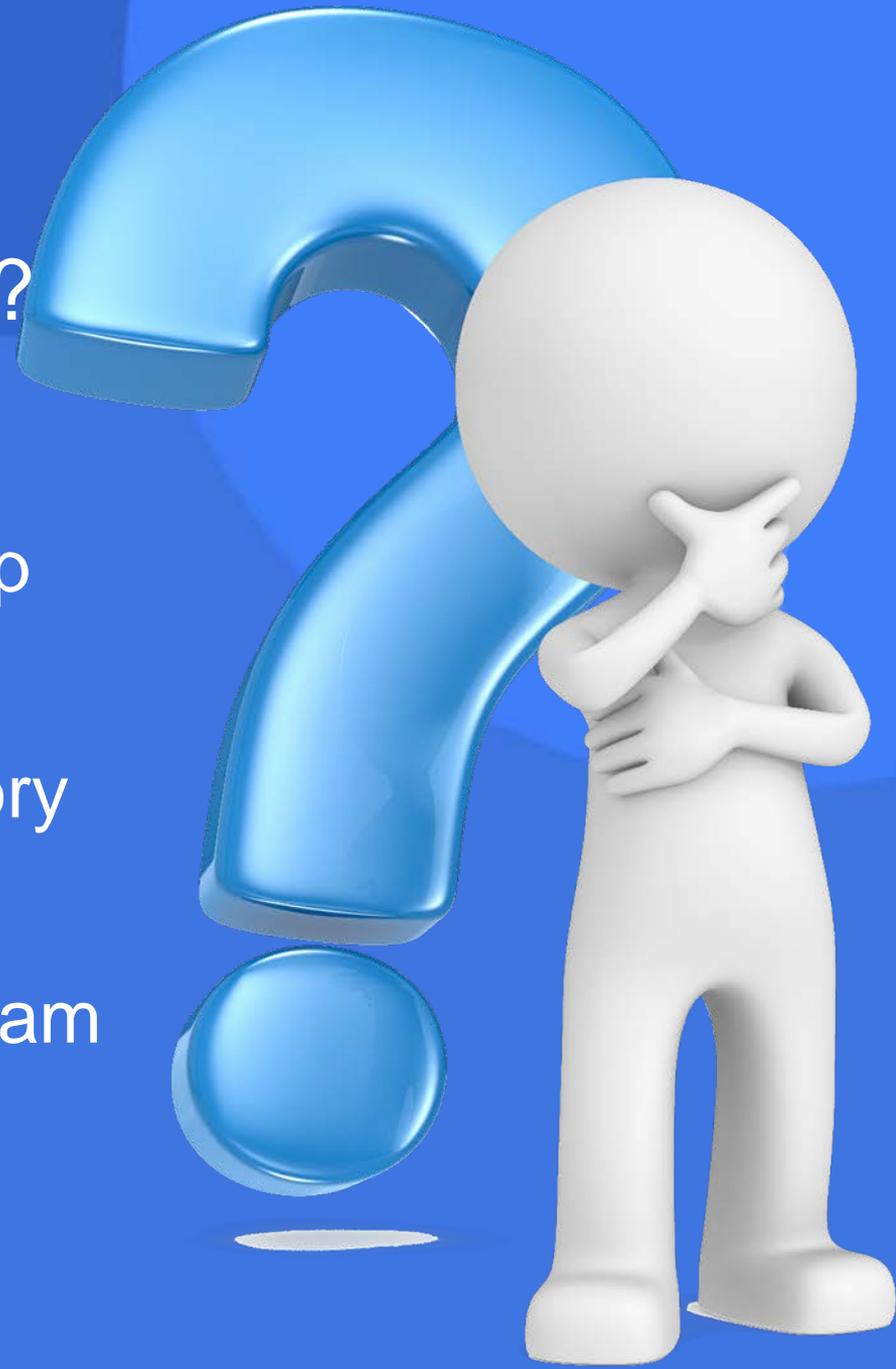
(May not be greater than statutory MMI date shown on DWC Form-032)



Case 3 - MMI

Has MMI been reached?
If so, on what date?

- A. 5/5/2016, date of post-op PT visit
- B. 5/8/2016, date of statutory MMI
- C. 9/1/2016, date of DD Exam
- D. Not at MMI

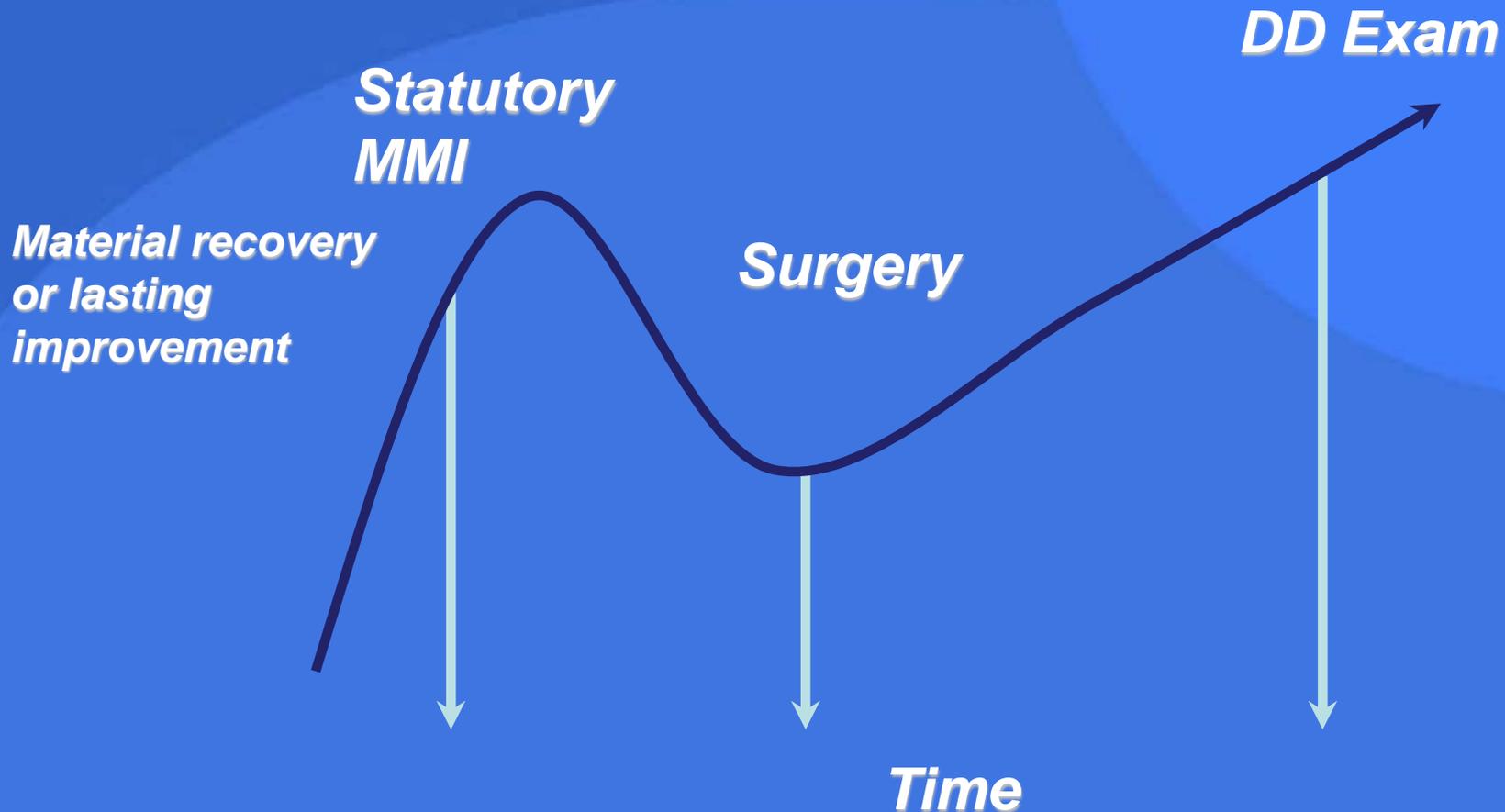


Case 3 - MMI

- IE at MMI, statutory MMI 5/8/16
- What is IR based on?
 - ROM at PT discharge 5/5/16
 - Not 9/1/16 DD exam findings which occurred after statutory MMI and do not reflect IE's condition at MMI



DD Exam After Statutory MMI With Surgery After Statutory MMI



Case 4 - MMI

- 29-year-old retail stock clerk injured right shoulder lifting box above shoulder height 7/30/2015
- Statutory MMI 8/8/2017
- Treated with NSAIDs and “Codman exercises”
- Returned to restricted duty work 8/04/2015
- Symptoms worsened with RTW
- MRI scan 9/12/2015 partial tear right supraspinatus, increased signal in subacromial bursa consistent with inflammation and Type II acromion

Case 4 - MMI

- Subacromial corticosteroid injection
9/15/15
- 9 visits of PT 9/18/2015 – 10/15/2015 with
some improvement in ROM, strength,
activity tolerance

Case 4 - MMI

- PT Discharge 10/15/2015
 - Flexion 160°
 - Extension 30°
 - Abduction 140°
 - Adduction 20°
 - External rotation 40°
 - Internal rotation 40°
 - 4+/5 strength of right supraspinatus and infraspinatus
- Ortho Follow-up 10/22/15
 - “Continue home exercise program, follow-up 1 month”

Case 4 - MMI

DD Exam 12/5/15

- Reports continued home exercise program and RTW with improvement
- Right shoulder ROM
 - Flexion 180⁰ Extension 50⁰
 - Abduction 170⁰ Adduction 40⁰
 - External rotation 80⁰ Internal rotation 80⁰
- 5/5 strength of supraspinatus, infraspinatus and subscapularis bilaterally
- Normal sensation

Case 4 - MMI

Question for DD to consider in the exam:

Has MMI been reached?

If so, on what date?

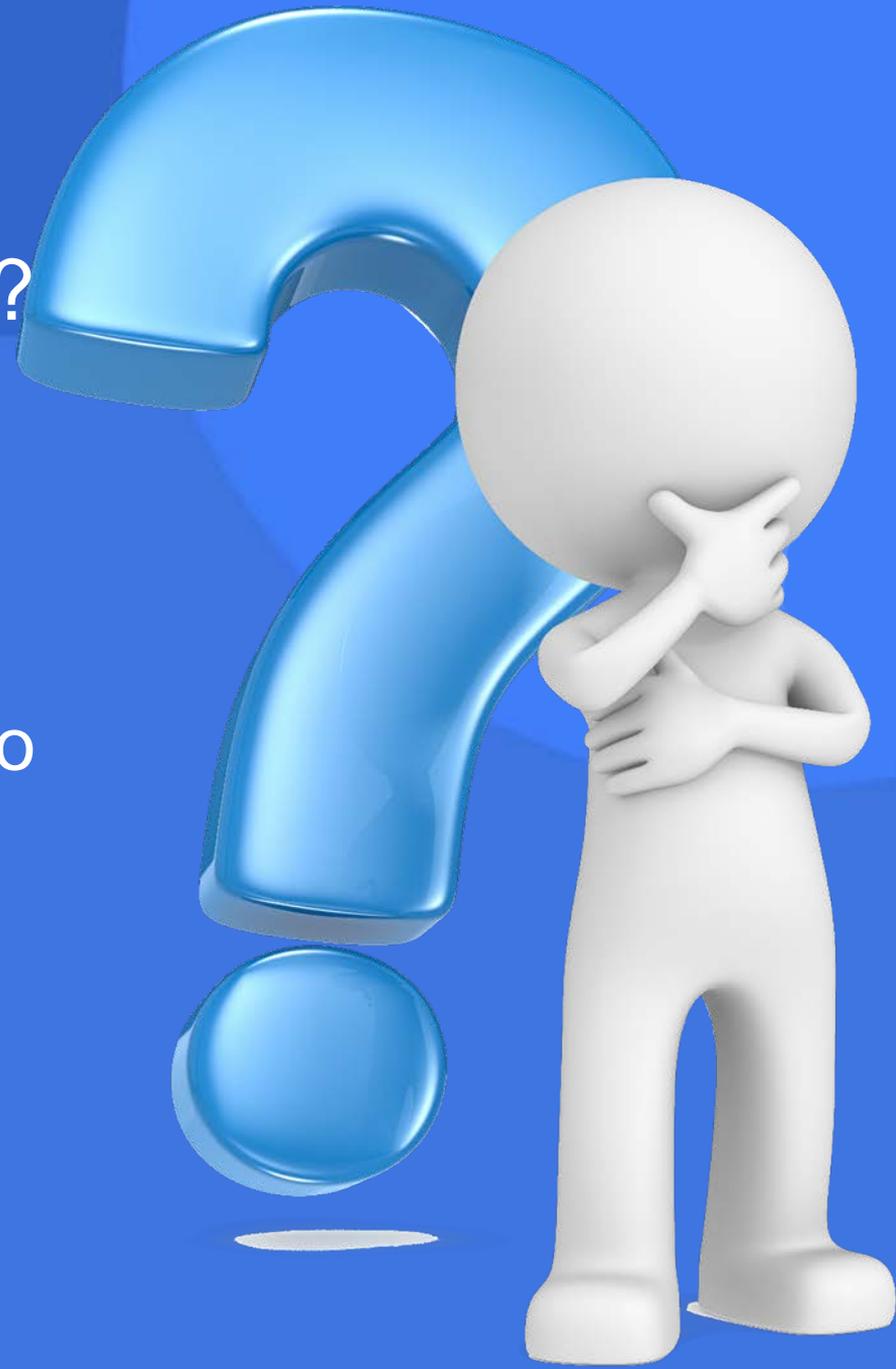
(May not be greater than statutory MMI date shown on DWC Form-032)



Case 4 - MMI

Has MMI been reached?
If so, on what date?

- A. 10/15/2015, date of PT discharge
- B. 10/22/2015, date of ortho follow-up
- C. 12/5/2015, date of DD exam
- D. Not at MMI



Case 4 - MMI

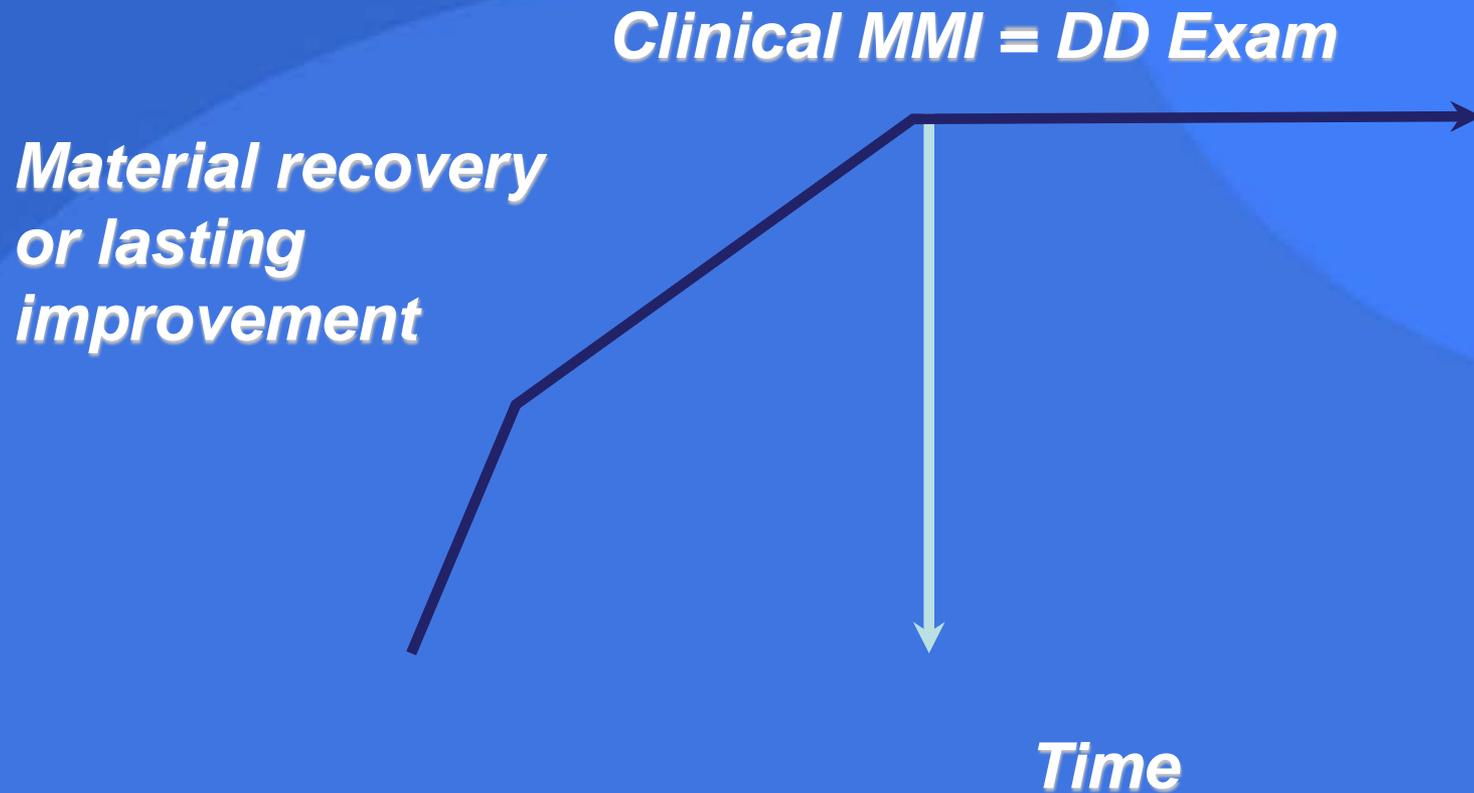
- IE at MMI, DD exam 12/5/15
 - Additional treatment, time, etc. not reasonably anticipated to result in further material recovery or lasting improvement
- PT discharge 10/15/2015
- Restricted ROM, mild weakness and activity intolerance that reasonably is anticipated to improve with continued HEP and RTW as retail stock clerk
- Ortho follow-up 10/22/2015
- No documentation of medical condition



MMI on Date of DD Exam

- Clinical findings from prior records show reasonable anticipation of further material recovery or lasting improvement but that anticipation is no longer present at DD exam
- Poor records, do not document medical condition
- Reached clinical plateau on date of DD exam and no additional lasting material recovery or improvement expected

MMI on Date of DD Exam



Questions About MMI?



MMI and ODG

- Based on medical records, medical history, and physical exam, is there evidence IE has reached MMI?
 - *Explain*
- Can additional treatment/testing per ODG including Appendix D, be reasonably anticipated to result in further material recovery or lasting improvement? If so, IE is not at MMI.
 - *Explain*
- If not at MMI, what is needed to reach MMI?
 - *Explain*

Using ODG

- Overview
- Procedure Summaries
 - Low back, physical therapy example
- Appendix D

[Search](#)

[Main Menu](#)

[ICD Index](#)

[CPT Index](#)

[Help](#)

ODG Evidence-Based Decision Support

ODG: Good to Go! (complimentary self-training module)

ODG® 2016

Official Disability Guidelines® (21st annual edition)
ODG® Treatment in Workers' Comp (14th annual edition)

I. Treatment Guidelines

- a. [Treatment Index](#)
- b. [UR Advisor™](#) (ICD-CPT)
- c. [Drug Formulary](#) (Appendix A)

II. Duration Guidelines

- a. [ICD Index](#)
- b. [CPT® Index](#)
- c. [Comorbidity Calculator™](#)
- d. [RTW Prescription™](#)

III. Cost Modeling

- [Reserve Calculator™](#)

Quick Links: [User Guide](#) [Suggest ODG Updates](#)

to open
tutorial

to open
treatment
index page

to open
user guide

to suggest
ODG updates

[Explanation of Medical Literature Ratings](#) (updated 02/20/15)

**click on body area
to open procedure
summary**

- [Ankle & Foot](#) (updated 03/01/16)
- [Burns](#) (updated 03/10/16)
- [Carpal Tunnel Syndrome](#) (updated 01/19/16)
- [Diabetes](#) (updated 01/21/16)
- [Elbow](#) (updated 04/01/16)
- [Eye](#) (updated 01/22/16)
- [Fitness for Duty](#) (updated 12/02/15)
- [Forearm, Wrist, & Hand](#) (updated 02/29/16)
- [Head](#) (updated 03/15/16)
- [Hernia](#) (updated 04/01/16)
- [Hip & Pelvis](#) (updated 02/12/16)
- [Infectious Diseases](#) (updated 03/22/16)
- [Knee & Leg](#) (updated 02/26/16)
- [Low Back](#) (updated 03/08/16)
- [Mental Illness & Stress](#) (updated 03/21/16)
- [Neck & Upper Back](#) (updated 02/15/16)
- [Pain](#) (updated 03/09/16)
- [Pulmonary](#) (updated 09/11/15)
- [Shoulder](#) (updated 03/02/16)

**to open
Appendix D**

- [Appendix A, ODG Workers' Compensation Drug Formulary](#) (updated 03/31/16)
- [Appendix B, Methodology Description using the AGREE Instrument](#)
- [Appendix C, Patient Information Resources](#)
- [Appendix D, Documenting Exceptions to the Guidelines](#)

Procedure Summaries

[Explanation of Medical Literature Ratings](#) (updated 02/20/15)

[Ankle & Foot](#) (updated 03/01/16)

[Burns](#) (updated 03/10/16)

[Carpal Tunnel Syndrome](#) (updated 01/19/16)

[Diabetes](#) (updated 01/21/16)

[Elbow](#) (updated 04/01/16)

[Eye](#) (updated 01/22/16)

[Fitness for Duty](#) (updated 12/02/15)

[Forearm, Wrist, & Hand](#) (updated 02/29/16)

[Head](#) (updated 03/15/16)

[Hernia](#) (updated 04/01/16)

[Hip & Pelvis](#) (updated 02/12/16)

[Infectious Diseases](#) (updated 03/22/16)

[Knee & Leg](#) (updated 02/26/16)

[Low Back](#) (updated 03/08/16)

[Mental Illness & Stress](#) (updated 03/21/16)

[Neck & Upper Back](#) (updated 02/15/16)

[Pain](#) (updated 03/09/16)

[Pulmonary](#) (updated 09/11/15)

[Shoulder](#) (updated 03/02/16)

[Appendix A, ODG Workers' Compensation Drug Formulary](#) (updated 03/31/16)

[Appendix B, Methodology Description using the AGREE Instrument](#)

[Appendix C, Patient Information Resources](#)

[Appendix D, Documenting Exceptions to the Guidelines](#)

*to open Low Back
procedure
summary*



ODG -TWC

ODG Treatment

Integrated Treatment/Disability D

Low Back - Lumbar & Thoracic

[Back to ODG - TWC In](#)

(updated 03/08/1

**to open Low Back
procedure
summary**

CONTENTS

| | |
|--|---|
| (1) Treatment Planning | 2 |
| (2) Codes for Automated Approval | 6 |
| (3) Procedure Summary | 9 |

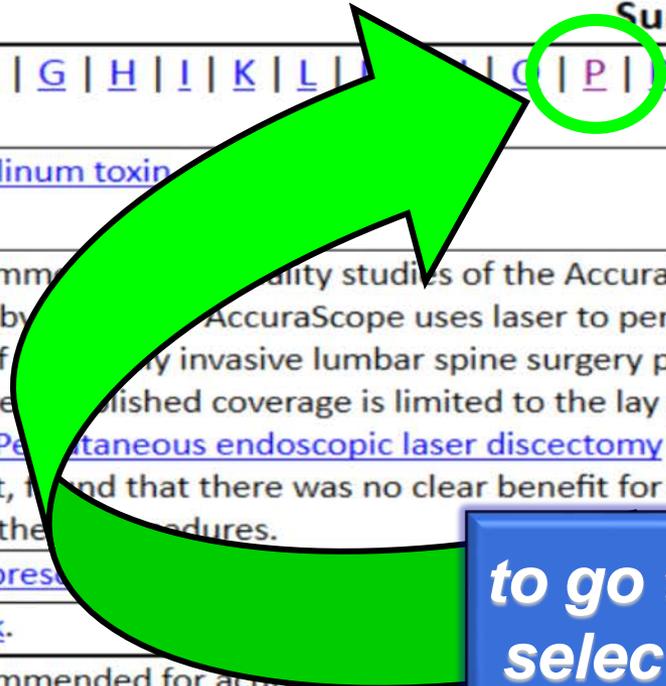


ODG Evidence-Based Decision

ODG: Good to Go! (complimentary self-training module)

Procedure Summary – Low Back

| Procedure/topic | Summary of medical evidence |
|--|--|
| Click to jump ahead: A B C D E F G H I K L M N O P R S T U V W X Y | |
| Abobotulinum toxinA (Dysport) | See Botulinum toxin |
| AccuraScope procedure (North American Spine) | Not recommended. Quality studies of the AccuraScope procedure are not required by the Agency. AccuraScope uses laser to perform anterior endoscopic studies of minimally invasive lumbar spine surgery procedures generally have not been published. Published coverage is limited to the lay press, along with similar procedures. See also Percutaneous endoscopic laser discectomy (PELD) , where comparative studies exist, and that there was no clear benefit for minimally invasive procedures. |
| Acetaminophen | See Nonprescription |
| Activity restrictions | See Work . |
| Acupuncture | Not recommended for acute low back pain using a short course of treatment. Acupuncture was found to be more effective than no treatment for chronic low back pain. Evidence does not support its use. (Furlan-Cochrane, 2006) (Haake, 2007) (Santaguida, 2009) These authors have reported that acupuncture is more effective than no treatment while others have reported non-significant differences between the two modalities. |



to go to "P" and select Physical Therapy

ODG Evidence-Based Dec

ODG: Good to Go! (complimentary self-

Pharmaceuticals

See [Medications](#).

Phototherapy

See [Low level laser therapy](#) (LLLT).

Physical therapy (PT)

Recommended. There is strong evidence that physical methods, including exercise and rest. Direction from physical and occupational therapy providers can play a role in this, with the best being delivering individually designed exercise programs in a supervised format (for example, group exercise and muscle-strengthening exercises seem to be the most effective types of exercises for treatment of low back pain in the "sports medicine model"), training in exercises for home use, and a functional restoration program (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) Successful outcomes depend on several factors (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) One clinical trial found that a spinal stabilization program is more effective than standard physical therapy (Skargren, 1998) A spinal stabilization program is more effective than standard physical therapy for chronic low back disorder, and it may be able to significantly reduce disability, handicap, or improve quality of life. (Goldby-Spine, 2006)

Compared with no therapy, physical therapy (up to 20 sessions over 12 weeks) following low back pain (massage), it is open to question whether this treatment acts primarily physiologic or psychologic. Exercise and stretching, regardless of whether it is achieved via yoga classes or conventional physical therapy, resulted in a statistically significant improvement in disability. The PT involved a primary care setting. The authors suggest that the potential benefits of early physical therapy are due to a combination of early physical therapy and specific physical therapy modalities, as well as [Exercise](#); [Work conditioning](#); [Lumbar exercise](#).

therapy is the treatment of a disease or injury by the use of therapeutic exercise and other modalities to improve mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2006)

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 for low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatment had success rates were 64.7% among those adhering to the active treatment recommendation (Therapeutic exercises (97110), but other active therapies may be recommended as well, in addition to passive modalities (97530). A recent RCT comparing active spinal stabilization exercises (using the GDS or GDS)

scroll through "P"
to Physical
Therapy

| | |
|-----------------------|--|
| Phototherapy | See Low level laser therapy (LLLT) . |
| Physical therapy (PT) | <p>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. 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)</p> |

See [Low level laser therapy \(LLLT\)](#).

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](#). 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. 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. 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 by the use of 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.]

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

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. ([Hannev, 2009](#))

Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based

Progression or rehabilitation to a more advanced program or stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. ([Luijsterburg, 2007](#)) ([Luijsterburg2, 2007](#)) ([Price, 2005](#)) ([Vad, 2002](#)) ([Smeal, 2004](#))

Post-surgical (discectomy) rehab: A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs. ([Ostelo, 2009](#)) There is inconclusive evidence for the effectiveness of outpatient physical therapy after first lumbar discectomy. Although evidence from two trials suggested that intervention might reduce

rehabilitation programs. ([Ostelo, 2009](#)) There is inconclusive evidence for the effectiveness of outpatient physical therapy after first lumbar discectomy. Although evidence from two trials suggested that intervention might reduce disability short-term, and more intensive intervention may be more beneficial than less intensive therapy, pooled results did not show statistically significant benefit. ([Rushton, 2011](#)) A systematic review yielded moderate to low quality evidence for effectiveness of postoperative exercise programs starting 4-6 weeks after lumbar disc surgery. Exercise programs seem to be more beneficial than no treatment, and high intensity exercises may be more effective than low intensity exercises. ([Oosterhuis, 2013](#))

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](#))

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:

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 8 weeks

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:

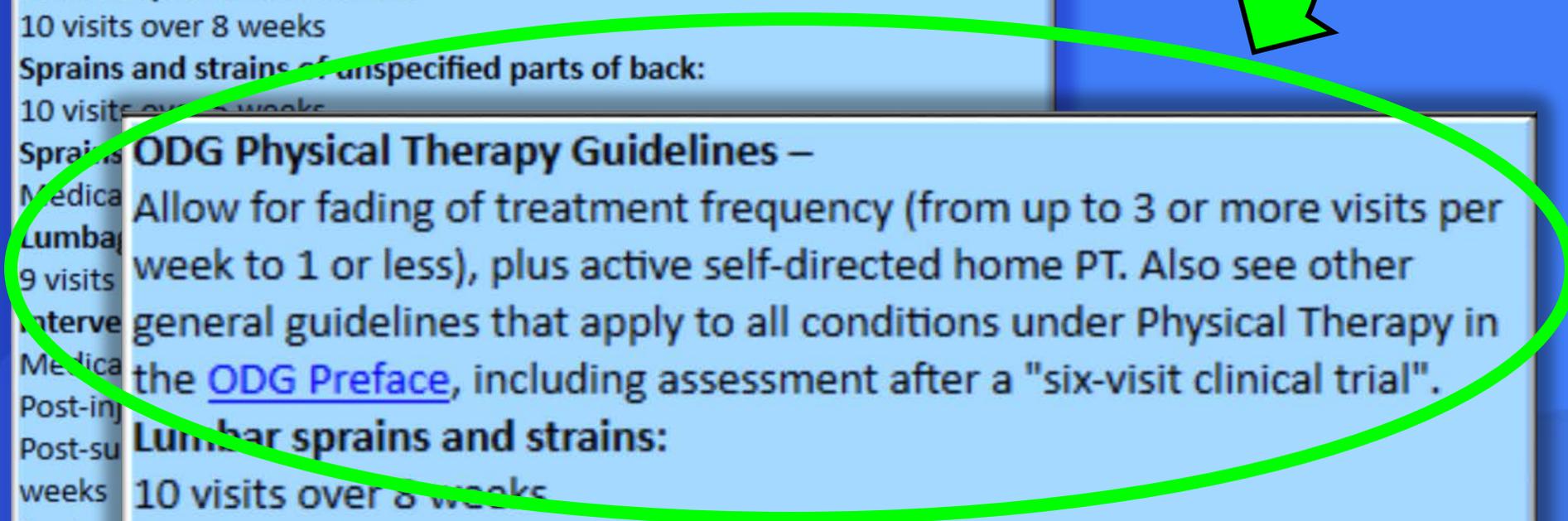
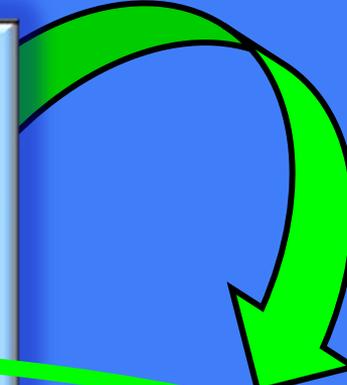
Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:



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

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

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:

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

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

Appendix D of ODG

Hip & Pelvis (updated 02/12/16)

Infectious Diseases (updated 03/22/16)

Knee & Leg (updated 02/26/16)

Low Back (updated 03/08/16)

Mental Illness & Stress (updated 03/21/16)

Neck & Upper Back (updated 02/15/16)

Pain (updated 03/09/16)

Prosthetic (updated 09/11/15)

Shoulder (updated 03/02/16)

Transdermal Compensation Drug Formulary (updated 03/31/16)

Appendix B, Metabolism Description using the AGREE Instrument

Appendix C, Patient Information Resources

Appendix D, Documenting Exceptions to the Guidelines

*to open
Appendix D*



ODG and Exceptions

Appendix D, Documenting Exceptions to the Guidelines defines a process for health care providers and insurance carriers to follow to help ensure appropriate medical treatment is provided in light of consideration of exceptional factors in individual cases

Situations Not Addressed in ODG

Non-occupational Conditions

- Dental implants for patient with broken teeth from work compensable injury
- Renal ultrasound study for hydronephrosis for patient with work compensable upper cervical spinal cord injury
- Cosmetic surgery for patient with work compensable burn injury

Situations Not Addressed in ODG

Unusual Presentations

- Severely comminuted femoral condyle fracture in 30-year-old as result of compensable motor vehicle accident
- Orthopedic surgeon recommends total knee replacement (TKR) due to severity of fracture
- While TKR is not typically indicated in 30-year-old patient, it is reasonable in this circumstance given inability to reduce severely comminuted femoral condyle fracture

Treatments That are Covered in ODG but Not Recommended

Co-morbid Conditions Supporting Performance of Treatment Not Recommended by ODG

- 45-year-old chronic diabetic patient complains of low back and leg pain following work related lifting injury
- On exam pain in non-dermatomal distribution
- Lower extremity nerve conduction velocity study may be indicated to assess for peripheral neuropathy

Treatments That are Covered in ODG but Not Recommended

Functional Improvement Supporting Treatment Exceeding ODG

- 36-year-old fireman sustains medial meniscal tear while working and undergoes arthroscopic meniscectomy
- Completes ODG recommended level of post operative PT with documented and specific objective functional improvement, but still has objective functional deficits
- Additional course of physical rehabilitation to address functional deficit is reasonable

The Five Factors of Appendix D - *Documenting / Considering ODG Exceptions*

1. Extenuating circumstances
2. Patient co-morbidities
3. Objective signs of functional improvement for treatment conducted
 - ***Work and/or Activities of Daily Living Functions***
 - ***Physical Impairments***, i.e. ROM, muscle flexibility, strength, or endurance deficits, exercise capacity
 - ***Approach to Self-Care and Education***

The Five Factors of Appendix D - *Documenting / Considering ODG Exceptions*

4. Measurable goals and progress points expected from additional treatment
5. Any additional evidence to support medical necessity of medical care at issue, including available evidence from literature that is relevant to medical service at issue

Questions About MMI and ODG?



Questions?





Thank you

Text LEAVE to 22333