

**Primary Chiropractic  
and Physical Therapy  
Soft Tissue Treatment  
Guidelines**

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## **1.0 Preface**

The WCB Health/Medical Services Unit developed these guidelines for soft tissue injuries, with input from biomechanical health care consultants and the Chiropractors' Association and the Saskatchewan Physical Therapy Association.

These guidelines have been developed to address typical soft tissue injuries; however, the time frames identified here do not apply to post-surgical injuries or fractures. In some instances, more intensive treatment will be required at a primary level.

When enhanced services are required, the WCB physical therapy and chiropractic consultants would be contacted to help decide if enhanced services should occur at the primary level or if an assessment team review is required.

## 2.0 Definitions

### **Soft Tissue**

Soft tissue includes muscle, tendons, fascia and ligaments.

### **Soft Tissue Injury**

Soft tissue injury is an injury to one or more soft tissue structures including muscle, tendons, fascia and ligaments that connect the skeletal structure.

Soft tissue injuries generally include strains, sprains and contusions. Soft tissues also can be injured as a result of:

- direct trauma
- over-use
- over stretching
- whiplash-type injuries (i.e., caused by a motor vehicle accident)

Soft tissue injuries do not include:

- direct or indirect trauma to bones (i.e., fractures)
- nerves (i.e., carpal tunnel syndrome or neuropraxia)
- vascular (i.e., complex regional pain syndrome)
- post-surgical soft tissue recovery

## 3.0 BASIC SOFT TISSUE INJURY TREATMENT PROGRAM

### 3.1 Zero to Four Weeks Post-Injury

#### 3.1.1 Interventions

After conducting an initial assessment of the injured worker, chiropractors and physical therapists may provide a maximum of ten interventions\* within the first four weeks that could include:

- Biomechanical treatment (Code 400 and 401 DC or Code 2000 and subsequent 2001)
- Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC \$30.00) and (Code 2008 – Individual Regional/Global Conditioning PT \$60.00/hr)

In most cases, it is recommended that regional conditioning should be done at home during this period. If, as a health care practitioner, you feel an injured worker requires in-clinic regional conditioning, you should deliver the intervention using one-on-one individualized exercise instruction for a typical intervention period (i.e., 20 minutes.)

- At least one “one-on-one” educational session with the injured worker, lasting at least 20 minutes (Code 414 DC-Education and Code 2011 PT – Education.)

During an educational session, you should explain:

- the stages of tissue healing
  - self-management including self-directed reactivation strategies
  - the recovery process and return to work (Return to work during the early stages of recovery is safe when clinically appropriate.)
  - pain management, where indicated
- Current literature supports maintenance of normal activity such as walking, swimming, and suitable employment for injured workers.

At your discretion, you may use multiple interventions in a day; however, each intervention will be counted as part of the ten interventions allotted during this stage of tissue healing.

When an injured worker enters primary treatment later than the first week post-injury, the number of interventions should be prorated to the four-week mark. For example, where treatment commences at three weeks post-injury, five interventions can be provided.

*\*NOTE: An intervention is defined as a biomechanical treatment or one of the prorated interventions identified on the WCB fee schedule.*

### **3.1.2 Return to work**

Chiropractors and physical therapists should make at least one return-to-work planning contact with the employer (Code 407 DC RTW Plan and Development and Code 2002 RTW Planning and Monitoring.)

The contact should be a telephone conversation; a letter mailed to the employer will not fulfill this requirement.

When an employer can accommodate the injured worker's current functional abilities and restrictions, return-to-work planning and reporting should proceed, with the agreement of the primary care provider (if not you.) The return to work schedules should be communicated to all parties using WCB's Practitioner Return to Work (PRTW) form.

Return-to-work planning sessions with an injured worker are not counted as part of the ten interventions during this treatment period.

### **3.1.3 Billing**

During the first four weeks post-injury, the WCB will not fund group supervised, global and functional conditioning and functional testing.

WCB will fund, but does not count the following items as interventions:

- Initial assessment
- Return-to-work planning
- Telephone calls or consultations (Code 405C and Code 2015.)

## **3.2 Five to Eight Weeks Post-Injury**

### **3.2.1 Interventions**

Chiropractors and physical therapists may provide a maximum of 23 interventions between five and eight weeks that could include:

- Biomechanical treatment (Code 401 DC and Code 2001 PT)
- Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC \$30.00) and (Code 2008 – Individual Regional/Global Conditioning PT \$60.00/hr)
- Patient education session (Code 414 DC and Code 2011 PT)
- Global conditioning (Code 411 DC and Code 2007 PT) See 3.2.2. for situations that warrant global conditioning.
- Functional conditioning (Code 408 DC and Code 2004 PT) See 3.2.2. for situations that warrant functional conditioning.
- Return-to-work planning (Code 407 DC and Code 2002 PT)

### **3.2.2 Global and Functional Conditioning**

Functional and global conditioning sessions are used only in situations where the client is not progressing in treatment or on a return-to-work plan where conditioning allows for tolerance development that cannot be safely introduced in the workplace.

Before you begin functional conditioning, you need to conduct a functional assessment (Code 415 DC and Code 2012 PT.) Only one functional test is allowed during this period.

However, you may not need to conduct functional testing if your return to work discussions with the injured worker indicate he/she feels capable of performing his/her critical job demands. Return to work capacities can be determined from daily functional conditioning records and observations and does not always require an additional assessment.

### **3.2.3 File Review**

Following WCB guidelines, WCB Case Management staff will review the injured worker's file at seven weeks post-injury to evaluate the risk of prolonged recovery and determine if an Assessment Team Review is needed.

This review may involve the WCB asking you as the injured worker's practitioner or therapist regarding:

- The injured worker's timeframe for recovery
- The injured worker's timeframe for return to work, if a return-to-work plan has not been communicated to the WCB, employer, injured worker and primary care provider (if other than yourself.) As a practitioner or therapist, you should be prepared to discuss progress in recovery and return to work to help the WCB determine if either:
  - reasonable progression is occurring; or
  - you feel a multidisciplinary assessment is required.

WCB may ask the injured worker be sent to an Assessment Team Review at this time if:

- progress is not being attained
- there are yellow or red flags present with little progress in recovery
- a return-to-work plan is not in progress

*NOTE: Return-to-work planning/telephone calls would not be counted as part of the interventions delivered during this treatment period.*

### **3.3 Nine to 12 Weeks Post-Injury**

#### **3.3.1 Interventions**

After conducting an initial assessment of the injured worker, chiropractors and physical therapists can continue with a maximum of 16 interventions during this period as long as the worker is involved with a return-to-work program that is progressing.

Return-to-work planning/telephone calls would not be counted as part of the interventions delivered during this treatment period.

Where the injured worker is participating in a return-to-work plan and non-endurance progressions are required, you can use functional conditioning if the injured worker's material handling tasks are greater than what has been measured during the rehabilitation program. For example, you can use functional conditioning if the injured worker requires lifting to heavy industrial DOT and the worker is presenting with substantially reduced lifting levels.

#### **3.3.2 Assessment Team Review**

If, as the practitioner/therapist, you do not see any objective improvement, you should request an Assessment Team Review.

In situations where no functional improvement has occurred and/or the injured worker is not in the workplace and awaiting Assessment Team Review, the recommended treatment frequency is one to two times a week with biomechanical and regional conditioning.

*NOTE: Usually WCB's Case Management Staff and a Chiropractic or Physical Therapy Consultant will have reviewed the injured worker's file before nine weeks as part of their efforts to identify injured workers who would benefit from assessment team review. As part of this review, team members will ensure vocational (RTW) interventions have been occurring and that WCB's standards of care and treatment protocols have been implemented.*

## **4.0 ENHANCED SOFT TISSUE INJURY PROGRAM**

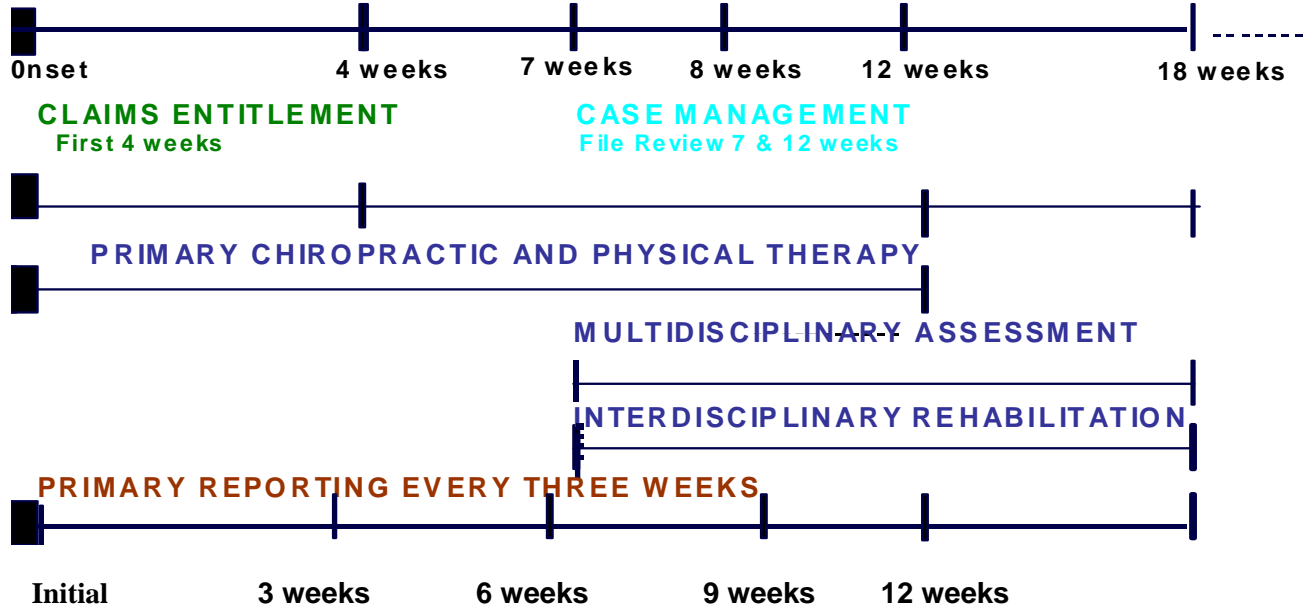
If, as a chiropractor or physical therapist, you feel that the injured worker's condition warrants more than the maximum number of interventions in any of the time frames discussed in this document, please phone the Chiropractic/Physical Therapy consultant at the WCB offices.

During the call, you and the consultant will discuss your client's needs, clinical findings, and your evidence-based rationale to request an enhanced treatment program. The goal of this discussion ensures that:

- injured workers receive the right treatment at the right time
- injured workers at risk of prolonged recovery are routed to an Assessment Team Review promptly to reduce the risks of chronic disability

# 5.0 Soft Tissue Injury Care Model

## WCB SOFT TISSUE INJURY GUIDELINES



## 6.0 LITERATURE REVIEW AND RESOURCE LIST

The literature review was undertaken in an effort to answer the following questions:

1. Does the literature support the theory/hypothesis that typical soft tissue injuries resolve within six to eight weeks without intervention or with minimal intervention?
2. Does it support treatment during this time frame?
3. Does it not support treatment during this time frame?
4. Is there evidence that supports a style of treatment during this time frame?

Key search terms used during this literature review:

1. Ligament injury
2. Soft tissue
3. Soft tissue rehabilitation
4. Insurance rehabilitation
5. WCB
6. Workers
7. Work hardening
8. Functional restoration
9. WCB Rehabilitation
10. Rehabilitation soft tissue injury
11. Treatment guidelines WCB
12. Treatment guidelines soft tissue
13. Treatment guidelines soft tissue injuries
14. Soft tissue injuries evidence based guidelines
15. Evidence based treatment soft tissue injuries
16. Excessive treatment soft tissue injuries
17. Cost effective treatment WCB soft tissue injuries
18. Cost effective treatment soft tissue injuries
19. Cost effective treatment work injuries
20. Soft tissue work injury management
21. Soft tissue rehabilitation best practice
22. Physiotherapy intervention work injury
23. Physiotherapy intervention soft tissue injury
24. Physiotherapy best practice work injury

The literature review found 42 articles. The resource list that was used as a reference appears on the following page. Articles were excluded if they did not meet the time frames of treatment identified in the soft tissue injury care model.

## Resource List

“Comparison of classification-based physical therapy with therapy based on clinical practice guidelines for patients with acute low back pain: a randomized clinical trial.” Spine 1 July 2003;28(13): pp 1363-71; discussion 1372.

Anema, Johannes R.; Steenstra, PhD, Ivan A; Bongers, PM; de Vet, HC; Knol, DL; Loisel, P; van Mechelen, W. “Multidisciplinary Rehabilitation for Sub acute Low Back Pain: Graded Activity or Workplace Intervention or Both?” An RCT Spine 1 Feb 2007 32(3): pp 291-8; discussion 299-300.

Karjalainen, K; Malmivaara, A; van Tulder, M; Roine, R; Jauhiainen, M; Hurri, H; Koes, B. “Multidisciplinary biopsychosocial rehabilitation for sub acute low back pain among working age adults” SO: Cochrane Database of Systematic Reviews 2007, Issue 4.

Lemstra, M; Olszynski WP. “The effectiveness of standard care, early intervention, and occupational management in Workers' Compensation claims: part 2.” Spine 15 July 2004 29(14): pp 1573-9.

Loisel, P; Lemaire, J; Poitras, S; Durand, MJ; Champagne, F; Stock, S; Diallo, B; Tremblay, C. “Cost-benefit and cost-effectiveness analysis of a disability prevention model for back pain management: a six-year follow up study.” SO: Occupational and Environmental Medicine

Ostelo, RWJG; de Vet, HcW; Waddell, G; Kerckhoffs, MR; Leffers, P; van Tulder, MW. “Rehabilitation after lumbar disc surgery (Review)” Cochrane Review 2007, Issue 4.

Rivero-Arias, MSc. Oliver; Gray, PhD, Alastair. “Cost Utility Analysis of Physiotherapy Treatment Compared with Physiotherapy Advice in Low Back Pain” Spine Volume 31, Number 12: pp 1381-1387

Robb, G; Reid, D; Arroll, B; Jackson, R. “General practitioner diagnosis and management of acute knee injuries: summary of an evidence-based guideline.” The New Zealand Medical Journal Vol. 120, No. 1249

Schonstein E, Kenny DT; Keating J, Koes BW. “Work conditioning, work hardening and functional restoration for workers with back and neck pain” Cochrane Database of Systematic Reviews Reviews 2003 Issue 3: John Wiley & Sons, Ltd Chichester, UK.

Stenstra, Ivan; Anema, Johannes; van Tulder, Maurits; Bongers, Paulien; de Vet, Henrica; van Mechelen, Willem. “Economic Evaluation of a Multi-Stage Return to work Program for Workers on Sick-Leave Due to Low Back Pain” J. Occup Rehabil (2006) 16: pp 557-578

Sinclair, S Dip P&OT; Msc. Hog-Johnson, S, PhD; Mondloch, M, PhD; Shields, Susanne A. Msc. "The Effectiveness of an Early Active Intervention Program for the Worker with Soft-Tissue Injuries: The Early Claimant Cohort Study" Spine Volume 22(24) 15 December 1997: pp 2919-2931

Zigenfus, GC; Yin, J; Giang, GM; Fogarty, WT. "Effectiveness of early physical therapy in the treatment of acute low back musculoskeletal disorders." Journal of Occupational Environmental Medicine 2002 Jun 44(6): pp 490; author reply 490-1.