Saskatchewan Workers' Compensation Board

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Primary Chiropractic and Physical Therapy

Soft Tissue Treatment Guidelines

Effective Date: 06 July 2018

Contents

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 of Saskatchewan and the Saskatchewan Physical Therapy Association.

These guidelines have been developed to address typical soft tissue injuries. The time frames identified here do not apply to post-surgical injuries or fractures.

When a worker will exceed soft tissue guidelines, the treating chiropractor or therapist will contact the WCB chiropractic or physiotherapist consultant by phone or email leaving a message with sufficient detail to explain why soft tissue guidelines will be exceeded.

Written documentation to support this explanation is to follow the telephone contact. This written documentation can be included in the regular WCB reporting template if this is timely and, if not, in a narrative report or email communication. The written documentation is to include the date of the initial telephone contact with the DC or PT consultant.

DEFINITIONS

Soft Tissue

Soft tissue includes muscle, tendons, fascia and ligaments, which includes articular capsule (i.e. mechanical back pain).

Soft Tissue Injury

Soft tissue injury is an injury to one or more soft tissue structures including muscle, tendons, fascia and ligaments (articular capsule or ligament) 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.

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Intervention

An intervention is an appropriate WCB coded service provided to the injured worker by the treating practitioner during the acute, sub-acute or chronic phase of the injury.

This intervention or service can include the following:

- Initial examination and treatment which may include patient history, physical examination, necessary treatment (biomechanical treatment, movement patterns, myofascial therapy, electrotherapy), advice and reassurance.
- Subsequent Visit (including review of history and examination as necessary) and treatment (biomechanical treatment, movement patterns, myofascial therapy, electrotherapy), advice and reassurance.
- Initial Conditioning Assessment.
- Individual Conditioning Instruction.
- Group Supervised Exercise Therapy.
- Functional Conditioning.
- Patient Education.
- Return to work planning.

BASIC SOFT TISSUE INJURY TREATMENT PROGRAM

A. Zero to Four Weeks Post-Injury

Interventions

1. After conducting an initial assessment of the injured worker, chiropractors and physical therapists may provide a maximum of 10 interventions* within the first four weeks that could include:
    a. Biomechanical intervention (Code 400 and 401 DC or Code 2000 and 2001 PT);
    b. Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC and Code 2008 – Individual Regional/Global Conditioning PT).

        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).

    c. 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:

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i. The stages of tissue healing.
ii. Self-management including self-directed reactivation strategies.
iii. The recovery and return-to-work process (Return-to-work during the early stages of recovery is safe when clinically appropriate).
iv. Pain management, where indicated.
v. Maintenance of normal activity such as walking, swimming and suitable employment is appropriate with safe clinical findings.

2. 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.

Return to Work

3. 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.

4. While an employer can accommodate the injured worker's current 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.

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

Reporting

6. The CHI/PTI, and or the CHP / PTP should include a paper measure score (Roland Morris, Quick DASH, Neck Disability, or Lower Extremity Spinal Function, as appropriate) estimate on work restrictions (if any) and, a firm date on return to work in any capacity. This return to work may not be at the usual job duties, however the worker should be able to enter the work place albeit in a reduced functional capacity, as soon as is possible.

Billing

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

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8. The WCB will fund, but does not count the following items as interventions:
    a. Initial assessment.
    b. Return-to-work planning.
    c. Telephone calls or consultations (Code 405C and Code 2015).

B. Five to Eight Weeks Post-Injury

Interventions

9. Chiropractors and physical therapists may provide a maximum of 23 interventions between five and eight weeks that could include:
    a. Biomechanical intervention (Code 401 DC and Code 2001 PT).
    b. Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC) and (Code 2008 – Individual Regional/Global Conditioning PT).
    c. Patient education session (Code 414 DC and Code 2011 PT).
    d. Global conditioning (Code 411 DC and Code 2007 PT). See below for situations that warrant global conditioning.
    e. Functional conditioning (Code 408 DC and Code 2004 PT) See below for situations that warrant functional conditioning.
    f. Return-to-work planning (Code 407 DC and Code 2002 PT).

Global and Functional Conditioning

10. Functional and global conditioning sessions are used only in situations where the customer 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.

11. Before you begin functional conditioning, you may need to conduct a functional assessment (Code 415 DC and Code 2012 PT.) Only one functional test is allowed during this period without approval.

12. However, you may not need to conduct functional testing if your physical examination findings and 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 a formal functional assessment.

File Review

13. 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 a Multi-Disciplinary Assessment Team Review (MATR) is needed.

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14. This review may involve the WCB asking you as the injured worker's practitioner regarding:
    a. The injured worker's timeframe for recovery.
    b. 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).

15. 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:
    a. Reasonable progression is occurring, or
    b. You feel a multidisciplinary assessment is required.

16. The WCB may ask the injured worker be sent to an Assessment Team Review at this time if:
    a. Objective clinical and functional progress is not being attained;
    b. There are yellow or red flags present with little progress in recovery;
    c. 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.

C. Nine to Twelve Weeks Post-Injury

Interventions

17. 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.

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

19. Where the injured worker is participating in a return-to-work plan and non-endurance progressions are required, functional conditioning is permitted 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, as per the Dictionary of Occupational Titles (DOT), and the worker is presenting with substantially reduced lifting levels.

20. If you anticipate that the treatment may exceed 12 weeks, please contact the consultant to discuss.

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Assessment Team Review (MATR)

21. A multidisciplinary assessment should be requested if you as the treating practitioner do not see improvement (or resolution) of the patient's condition including:
    a. Objective clinical findings,
    b. Clear change in self-reported functional outcome scores,
    c. An estimation of recovery approaching 10/10, and
    d. A clear plan for return to work including a clear plan to return to full duties at work.

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

23. NOTE: WCB's Case Management Staff and a Chiropractic or Physical Therapy Consultant may 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.

ENHANCED SOFT TISSUE INJURY PROGRAM

24. 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 telephone the Chiropractic / Physical Therapy consultant at the WCB offices.

25. Please contact the consultant by telephone or via email prior to the discussion, so that the consultant has a chance to review the file before you speak. During the call, you and the consultant will discuss your customer's needs, clinical findings, and your evidence-based rationale to request an enhanced treatment program.

26. The goal of this discussion ensures that:
    a. Injured workers receive the right treatment at the right time,
    b. Injured workers at risk of prolonged recovery are routed to an Assessment Team Review promptly to reduce the risks of chronic disability.

RECURRENT TREATMENT

27. If the worker has a permanent work injury related impairment and or permanent restrictions determined by WCB, the worker may be eligible for recurrent treatment. Recurrent treatment should be provided based on reported objective physical and functional findings.

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28. If the worker returns for recurring treatment, the WCB will pay for the initial evaluation and one intervention at the time of evaluation, but treatment will not be funded until the case manager has confirmed ongoing treatment is supported.

29. After approval is granted, the number of interventions per flare should not exceed six (6).

30. If you have not received approval with a decision regarding care within two (2) business days, please phone/email the WCB consultant to ask for clarification regarding ongoing care.

31. The goal of treatment for a recurring condition is to assist the worker to maintain their function and treat flare-ups (which results in reduced function). This can be accomplished by:
    a. A review and progression as appropriate, of any home based coping strategies,
    b. Provision of a few treatment interventions (typically not to exceed six (6)), and
    c. An expectation that the worker will be discharged again to manage on their own once the flare-up resolves.

CONCLUSION

32. The goal of the Soft Tissue Guidelines is to assist the worker to return to full function and to return to all work duties in a timely manner using interventions which are shown to be helpful in the literature. The nature of the interventions changes over time, moving from passive, protection strategies in the first few hours to active function-based interventions as is appropriate given the stage of healing.

RESOURCE LIST

A literature review was completed of 42 articles. Articles were excluded if they did not meet the time frames of treatment identified in the soft tissue injury care model.

The following resources were used to develop the Soft Tissue Guidelines:

Anema JR, Steenstra IA, Bongers PM, de Vet HC, Knol DL, Loisel P, van Mechelen W. 2007. Multidisciplinary rehabilitation for sub acute low back pain: graded activity or workplace intervention or both?: a randomized controlled trial. *Spine* (Phila Pa 1976). 32:291-8.

Fritz JM, Delitto A, Erhard RE. 2003. 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* (Phila Pa 1976). 28(13):1363-71; discussion 1372. PubMed PMID: 12838091.

Karjalainen, K; Malmivaara, A; van Tulder, M; Roine, R; Jauhiainen, M; Hurri, H; Koes, B. 2000. Multidisciplinary biopsychosocial rehabilitation for sub acute low-back pain among working age adults. *Cochrane Database of Systematic Reviews*. Issue 3.

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

Loisel, P; Lemaire, J; Poitras, S; Durand, MJ; Champagne, F; Stock, S; Diallo, B; Tremblay, C. 2002. Cost-benefit and cost-effectiveness analysis of a disability prevention model for back pain management: a six-year follow up study. *Occupational and Environmental Medicine*. 59(12): 807-815.

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

Rivero-Arias, MSc. Oliver; Gray, PhD, Alastair. 2006. Cost Utility Analysis of Physiotherapy Treatment Compared with Physiotherapy Advice in Low Back Pain. *Spine* (Phila Pa 1976). 31(12):1381-7.

Robb, G; Reid, D; Arroll, B; Jackson, R. 2007. General practitioner diagnosis and management of acute knee injuries: summary of an evidence-based guideline. *The New Zealand Medical Journal*. 120(1249).

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

Stenstra, Ivan; Anema, Johannes; van Tulder, Maurits; Bongers, Paulien; de Vet, Henrica; van Mechelen, Willem. 2006. Economic Evaluation of a Multi-Stage Return to work Program for Workers on Sick-Leave Due to Low Back Pain. *Journal of Occupational* Rehabilitation. 16(4):557-78.

Sinclair, S Dip P&OT; Msc. Hog-Johnson, S, PhD; Mondloch, M, PhD; Shields, Susanne A. Msc. 1997. The Effectiveness of an Early Active Intervention Program for the Worker with Soft-Tissue Injuries: The Early Claimant Cohort Study. *Spine* (Phila Pa 1976). 22(24): 2919-31.

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