

# Hot Topics & Cases in Physical Therapy & Occupational Therapy

Chairperson: Maria DeIMuto, PT, CCM

Monday, March 23<sup>rd</sup>; 1:15 – 2:05 pm

Disclosures

None

# PT/OT Impact to Patient Recovery High vs low value therapy in Workers' Compensation

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No relevant financial disclosures

Disclosures

# Learning Objectives

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1. Distinguish high-value vs low-value PT/OT
2. Identify system drivers of low value therapy.
3. Challenge current referral and utilization patterns

# Why PT/OT Matters, With Value Framing

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## High Value Consults

Function > Pain

Job-specific Tasks

Graded Exposure

Planned discharge

## Low Value Consults

Passive Modalities

No RTW focus

Open-ended visits

Fear reinforcement

# Gaps in the Care Continuum

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Delayed referrals

“Eval & treat” referrals with no goals

No job demands shared

No RTW timeline

No outcome measures = pain only

Review focus on visit counts, not clinical value.

Fragmented communication

# Early vs Delayed Therapy

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Same injury, Same diagnosis.

Different timing. Different value. Different outcomes....

Was therapy early *and* high-value?

# Case 1: Acute Low Back Pain

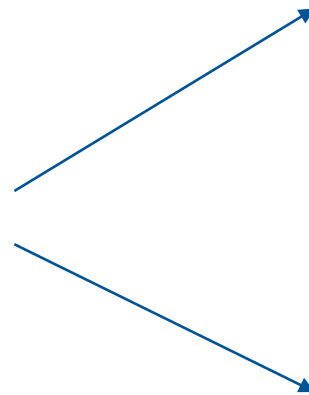
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**Acute nonspecific LBP  
(warehouse role)**

**Early PT: stay active + graded  
exposure**

**Work-focused goals + light  
duty**

**Outcome: faster function &  
RTW**



## **High Value PT**

- ✓ Education: pain vs. damage
- ✓ Stay active
- ✓ Lifting simulation
- ✓ RTW coordination

## **Low Value PT**

- × Passive Modalities
- × No loading
- × No work integration
- × Fear-based restrictions

# Case 2: Upper Extremity Overuse

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## High Value OT

Task Analysis

Work simulation

Micro ergonomic changes

Employer communication

## Low Value OT

Generic Exercises

Splint only

No worksite input

No RTW plan

# Red Flags for Low-Value Therapy

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Passive care dominates

No functional metrics

No work progression

Endless visits

Therapist unaware of full job demands

Patients becoming more fearful

# Green Flags for what High Value Therapy

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Functional Based goals

Job-specific tasks

Time limited plans

Early employer engagement

Planned discharge

# Stakeholder challenge

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Clinicians:

“Am I referring with intent, or outsourcing problem?”

Therapists:

“Am I building work capacity, or just delivering treatment?”

Case Managers/UR:

“Am I approving visits, or evaluating value?”

Lawyers:

“Is therapy clarifying recovery, or mudding causation?”

# Take-Home

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The question isn't:

“Did the patient get PT or OT?”

The question is:

“Did they get the right therapy, at the right time, with the right goals?”

Thank you!

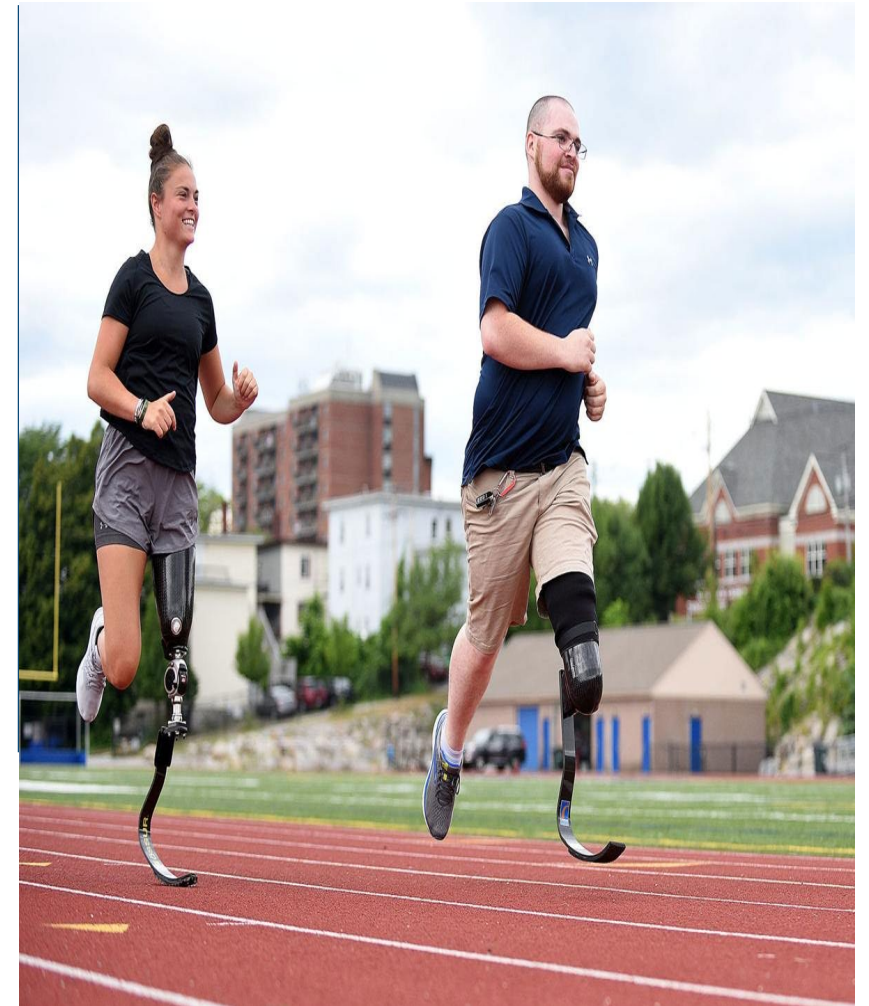
# Adaptive Resources and Services

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# Improving Function and Independence



No disclosures

Disclosures

# Activities of Daily Living

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Dressing Sticks, Sock aids

Shower rails, shower chairs, grab bars

Weighted utensils for hand tremors, plate guards

Multi Position Stenders, Chairs

Watches

Canes, walkers

# Home Environment

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Widen doors

Lower counter tops

Ramps

Chair Lifts

Stair Lifts

# Wheelchairs

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Manual

All-terrain

Beach

Sport (Bball, racing, tennis)

Powered

Folding

# Sports and Fitness

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Wheelchair accessible treadmills

Arm bikes

Custom orthotics

Running blades

Skis

# Transportation

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Wheelchair Accessible Vehicles

Swivil seats, Removable seats

Steering Aids [joysticks, hand controls]

Left foot accelerators

Wheelchair Accessible Boats



# Creativity and Adaptability

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Thank you!

# Hot Topics in Physical Therapy-Understanding PT Notes

Kirstin Lane, PT, DPT

Regional Manager of WorkStrategies

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# Disclosures

None.

# Subjective Findings-what patients say

- Pain 0=no pain, 10=worst
- PRO (Patient Reported Outcomes)
  - Ability index (want high score: Lower Extremity Functional Scale)
  - Disability index (want low score: Neck Disability Index, Oswestry Disability Index, QuickDASH)
  - Psychosocial measure (OREBRO, Pain Catastrophizing Scale, Tampa Scale of Kinesiophobia, Fear Avoidance Beliefs Questionnaire, PROMIS)
- Work status/work requirements
- Prior Level of Function



# Objective Findings-what PTs see

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- BMI, Vitals
- Impairments
  - ROM, strength, gait, balance, special tests
- Functional testing
  - Material handling, positional tolerances
- Look for test-re-test to monitor progress

# What might a PT test based on the injury verses a job description?

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## R Knee Sprain-

- walking, standing, bending, kneeling, pushing/pulling dollies, occ lift 55 and freq lift 40, ladder

## s/p Lumbar fusion:

- walking, standing, bending, stooping, kneeling, pushing/pulling dollies, occ lift 55 and freq lift 40, ladder

## s/p L rotator cuff repair:

- reaching and handling activities, ladder, occ lift 55 and freq lift 40

# Assessment-tying it up with a bow

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## TRADITIONAL COMMUNICATION

Pt presents s/p lumbar sprain with dec ROM, dec LE strength, and dec lifting ability. Pt to benefit from skilled PT to return to PLOF.

## ENHANCED COMMUNICATION

Pt presents s/p lumbar sprain with inability to reach below 24 inches, limited lifting at all levels to 15 lbs, and limited standing tol to 5 min, whereas work requires lifting up to 25 lbs at all levels and standing at workstation-currently no stool available. Of concern is high OREBRO of 82, will incorporate psychologically informed therapy techniques as appropriate.

# PLAN

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- Frequency (visits per week)-case velocity is important, if only 1-2 times per week, why?
- Duration (weeks or months expected for recovery)-may not be reflective of total need, rather of expectation of authorization or an effort not to lose visits already approved with a new POC.

# Goals

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- Short term goals-typically stepping stones for long term goals
- Long term goals-overall expected outcomes at end of care
  
- Are these functional?
- Is RTW realistic?

Thank you!

# Most Educational PT WC Case of the Year

Kirstin Lane, PT, DPT

Regional Manager of WorkStrategies

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# Disclosures

None.

# Injured Worker

- 28 yo female
- CNA on psych ward in acute care hospital
- Has worked on the same unit for 7 years
- No prior WC injuries

# The Incident

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- Was called to a patient restraint
- 4 employees worked together to calm a 320 lb agitated patient
- During the restraint, the injured worker believes her left arm was pulled
- After the incident, the injured worker noticed left sided neck pain

# Course of Events

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## DAY OF INCIDENT

- Reported the injury/sent to Occ Health
- Was diagnosed with a cervical strain, taken off work, given muscle relaxers and pain meds

## 3 DAY F/U

- Cont L sided neck pain/now pain down L shoulder.
- Guarded/unable to turn head/neck.

# Course of Events Cont

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- 3 week mark:
- Remained out of work due to pain
- Referred to Physical Therapy

# Physical Therapy Findings

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- Subjective: Constant pain L neck and into shoulder/down upper arm. Pain and difficulty moving L arm for upper body dressing. Reports some numbness in hand: non-specific
- Objective: Mildly dec ROM C-spine. Mild tightness L upper trap, otherwise (-) cervical screen. (-) special test findings L shoulder for ligamentous/capsular pathology. Additional testing (+ Brachial Plexus Tension Test, + Roos, + Adson's) indicates Brachial Plexus injury.

# Communication

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- 4 weeks post injury: PT IE sent to MD, including written assessment of potential for brachial plexus involvement.
- PT calls MD and leaves message. PT and MD connect, MD check in, in agreement with brachial plexus pathology-increased meds.
- 8 weeks post injury: PT re-eval full ROM, no further numbness, RTW light duty

# Could this case have gone sideways?

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YES!

# Moral of the Story

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- 3 week wait for PT-lost case velocity
- PT special test findings-potential to help guide without imaging
- Communication between practitioners- KEY

Thank you!

Q & A

Thank you!