Physical Assessment and Low-Tech Rehabilitation

Mario Fucinari DC, CCSP, MCS-P
Certified Chiropractic Sports Physician
Certified Insurance Consultant
Certified Medical Compliance Specialist

The information contained in these notes is for educational purposes and is not intended to be and is not legal advice.

No AUDIO or VIDEOTAPING allowed.

Unauthorized Recoding or Distribution of any presentation materials is illegal.

LEGAL NOTICE: The information contained in this workbook is for educational purposes and is not intended to be and is not legal advice. Recording of any kind is strictly PROHIBITED during the presentations. The laws, rules and regulations regarding the establishment and operation of a healthcare facility vary greatly from state to state and are constantly changing. Mario Fucinari DC does not engage in providing legal services. If legal services are required, the services of a healthcare attorney should be attained. The information in this class workbook is for educational purposes only and should not be construed as written policy for any federal agency. No part of this workbook covered by the copyright herein may be reproduced, transmitted, transcribed, stored in a retrieval system or translated into any language in any form by any means (graphics, electronic, mechanical, including photocopying, recording, taping or otherwise) without the expressed written permission of Mario Fucinari DC. Making copies of this seminar workbook and distributing for profit or non-profit is ILLEGAL. Mario Fucinari DC assumes no liability for data contained or not contained in this workbook and assumes no responsibility for the consequences attributable to or related to any use or interpretation of any information or views contained in or not contained in this seminar workbook.

CPT® is a registered trademark of the AMA. The AMA does not directly or indirectly assume any liability for data contained or not contained in this seminar workbook. This seminar workbook provides information in regard to the subject matter covered. Every attempt has been made to make certain that the information in this seminar workbook is 100% accurate, however it is not guaranteed.

About Dr. Mario Fucinari, DC, CCSP, MCS-P
• Certified Chiropractic Sports Physician (CCSP)
• Certified Insurance Consultant
• Certified Medical Compliance Specialist – Physician
• National Speaker’s Bureau for NCMIC and Foot Levelers
• Member of ACA & ICS
• Past President of Illinois Chiropractic Society,
• Current Chairman of the ICS Medicare Committee
• Member of Medicare Chiropractic Carrier Advisory Committee

© Copyright 2015. Physical Diagnosis and Rehabilitation. Mario Fucinari DC, CCSP
What is the Purpose of Chiropractic Care?

Medicare’s Definition of Medical Necessity
1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services must have a direct therapeutic relationship to the patient’s condition. (Medicare does not pay for pain).

2. You must have a reasonable expectation of recovery or improvement of function.

3. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. A diagnosis of pain is not sufficient for medical necessity

**Acute subluxation** - treatment for a new injury, identified by x-ray or physical exam. The treatment is expected to improve, arrest, or retard the patient’s condition.

**Chronic subluxation** - A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), but where the continued therapy can be expected to result in some **functional improvement**. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered.

An **acute exacerbation** is a temporary but marked deterioration of the patient’s condition that is causing **significant interference with activities of daily living** due to an acute flare-up of the previously treated condition. The patient’s clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

Why Rehabilitation?
- Patients tend to “let pain be the guide.” therefore they tend to decondition over time.
- This then leads to chronic pain and co-dependency on medications and disability.

Patient Fears and Worries
- 2/3 believe a wrong movement will cause a serious problem
- ½ believe that avoiding certain movements is the best course of action

Fiber Typing:
Muscle fibers are recruited, depending on the amount of force needed.
Fibers are classified by the:
- Speed/twitch
- Force capacity
- Fatigue-resistance (endurance)

Type I fibers are for endurance. Type I are slow twitch. Endurance athletes, such as marathon runners, cross-country skiers and distance cyclists often possess up to 90% slow twitch fibers.
Type II are fast twitch.
Type IIb are high force fibers
Type IIa are intermediate force

These fibers generate an explosive burst of power for a short period of time. This makes them most suitable to stop and go activities such as basketball, soccer, and hockey, as well as max output activities such as weightlifting, and many track and field events.

As we age, Type II fibers decrease in size/volume. The Type II sacrifice makes way for more Type I.
Journals of Gerontology, Series A, Biological Sciences and Medical Sciences. 1995 Nov;50 Spec No:11-6.

Multifidus
Thus there is a correlation between the status of the type II fibers and the intervertebral disc. Exercise of the Type I and Type II fibers along with manipulation enhances the health of the IVD

Multifidus:
Thoracic sections contain 75% slow-twitch fibers.
Lumbar sections are evenly mixed

Anatomical changes following low back injury include asymmetric atrophy in the multifidus.

Even 5 years after surgery, fiber changes were seen in the multifidus

Research shows that musculoskeletal pain is more common now than it was 40 years ago.

Why Rehabilitation?
- Most back problems are not caused by structural pathology (arthritis, herniated disc) or serious disease (tumor, infection, fracture) and therefore benefit from reassurance and reactivation.
- Prevention of deconditioning is a fundamental goal of the modern management of spinal disorders.

Deconditioning Syndrome (728.2)
“Diminished ability or perceived ability to perform tasks involved in a person’s usual activities of daily living.”
Rehabilitation of the Spine by Craig Liebenson. Pg. 7
Rehabilitation Therapy
- Purpose is to identify the cause of the pain, reduce the cause and teach the patient how to keep the problem from returning.
- The goal of rehabilitation is to reduce the patient’s painful intolerances.

Rehabilitation Case Management

Risk Factors for Low Back Disorders
- Static work posture, especially prolonged trunk flexion
- Seated working postures
- Frequent lifting, pushing, and pulling
- Whole body vibration, especially seated
- Compressive forces

Positive Risk Factors
- Family History:
  - Myocardial infarction, coronary artery disease or sudden death before the age of 55 in father or other males in first-degree relative or before age 65 in mother or other female first-degree relative
- Cigarette smoking: Current or within the last 6 months
- Hypertension: >140 systolic or >90 diastolic

Red Flags and Yellow Flags
Red Flags – a clinical symptom or sign that may indicate sinister pathology as a source of the patient’s spinal pain.
- Physical Sign
Yellow Flags – a symptom or sign that should raise the index of suspicion regarding the development of chronicity in a patient with spinal pain.
- Psychosocial factor

Red Flags of Serious Disease
- AGE <20 or >50
- Trauma related to pain
- History of cancer
- Night pain
- Fever, chills, night sweats, nausea, vomiting, fatigue, diarrhea
- Weight loss
- Pain at rest
- Corticosteroid use
- Red Flags of Serious Disease
- Recent infection
- Generalized systemic disease (diabetes)
- Failure of 4 weeks of conservative care
- Cauda Equina
• Saddle anesthesia
• Sphincter disturbance
• Motor weakness lower limbs

Waddell Nonorganic Signs
• Superficial tenderness to light pinch
• Nonanatomic tenderness, which is not localized and often extends from the lumbar spine to thoracic or pelvis
• Axial loading pain, when low back pain is reported with vertical loading to the patient’s head
• Pain with whole body rotation, when shoulders and pelvis are rotated in the same plane
• Discrepancy between seated and lying SLR
• Give-way or cogwheel weakness that cannot be explained on a localized neurologic basis
• Sensory disturbances in a stocking rather than a dermatomal pattern of distribution
• Disproportionate verbalization and facial expressions during examination

The Physical Exam

On the initial examination or if significant, on subsequent visits, note the following:

Inspection
  Patient build
  Carriage and gait cycle
  Patient movement
  Examine the shoes
  Scoliosis
  Antalgia
  Skin appearance
  Biomechanical Inspection

Muscle Strength Testing

Rehabilitation
• Every rehabilitation program must start with an assessment of abnormal function (strength, endurance, coordination, balance and flexibility)
• The quantifiable functional deficit is the baseline from which to determine progress
• Why are you doing that particular exercises.
• Ask the patient, “What can you NOT do?”
• The type of rehabilitation program one administers, should isolate the “weak link” and provide the appropriate mode, intensity, frequency, intensity, and duration of exercise to improve function. Hence the need for physical capacity evaluation.
Evidence Based Outcomes Assessment Tools  “Functional Impairment”

Outcomes Assessment
Have patient complete on initial exam, on re-exam as clinically indicated and at any exacerbations.
These tests quantify the amount of patient deconditioning present.
A measure of the patient’s functional impairment of activities of daily living.

Outcome Assessment Tests:
Visual Analog Scale
Pain Drawings
Revised Oswestry Low Back Pain Disability Questionnaire
Roland-Morris Disability
Neck Pain Disability Index Questionnaire
Headache Disability Index
Bournemouth Questionnaire – Cervical and Lumbar. “Lifestyle illnesses”
Zung Psychological Assessment Questionnaire

Neck Pain Disability Index Score
0-8 = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled

Revised Oswestry Disability Index Score
0-5% = None
6-20% = Mild
20-40% = Moderate
40-60% = Severe
60-80% = Crippled
80%+ Bed Bound

To be significant, the assessment test must have a minimum of a 30% decrease in score between the exam and re-exam to be clinically significant.

Physical Activity Readiness Questionnaire (PAR-Q)
1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
2. Do you feel pain in your chest when you do physical activity?
3. In the past month, have you had chest pain when you were not doing physical activity?
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
7. Do you know of any other reason why you should not do physical activity?
Phases of Care

Inflammation Phase
- Initial reaction to injury necessary for healing.
- Area becomes red and swollen due to changes in vascularity.
- Tissue death leads to release of bradykinin and histamine
- Phase lasts two to three days following injury.
- If edema continues, rehabilitation of the tissue stops.

Inflammation Phase Treatment Goals:
- Prevent disruption of new tissue
- Rest, ice, compression and elevation (RICE)
- Maintain strength of the surrounding tissues, while protecting the injured tissue.

Repair Phase
- Replacement/regeneration of tissue occurs
- Collagen fibers are randomly laid down to serve as the framework for repair
- The haphazard positioning of the collagen fibers yields sub-optimal health.
- Requires longitudinal fibers, not transverse.
- This phase begins two days after the injury and may last for two months.

Repair Phase Treatment Goals
- Repair takes up to 8 weeks
- Prevent excessive muscle atrophy and joint deterioration
- Gradually low-load stresses are introduced to increase collagen synthesis and prevent loss of joint motion
- US, EMS and ice are used to support and hasten new tissue formation

Exercises:
- Isometric within the pain-free zone
- To increase function, do isometric exercises at various angles
- Light, controlled tubing or bands
- Proprioception concerns with wobble boards

Remodeling Phase
- Weakened tissue is now strengthened.
- Tissue has the opportunity to increase in structure, strength and function.
- Collagen fiber alignment must occur here along the lines of stress for success.
- Collagen fibers must become thicker and more properly aligned.
- This phase lasts up to two to four months after the injury.
Remodeling Phase Treatment Goals:
- Optimize tissue function
- Build upon the exercises from the repair phase
- Begin more sport-specific or ADL-specific functional exercises
- In training, progress from slow velocity to fast velocity to replicate functional needs

Treatment with Bed Rest
- Bed rest leads to a loss of muscle strength of 10% per week
- Reversible; however, reconditioning time is longer than deconditioning time.

**ACUTE STAGE (up to 3 weeks)**

**Physiotherapy**

Passive modalities imply that the patient is passive in the encounter. (Acute care)

Supervised Modalities
- Heat, ice
- Mech Traction
- Electric Stim
- Vasopneumatic Devices
- Paraffin Bath
- Whirlpool
- Diathermy
- Infrared

Constant Attendance Modalities (Acute to Sub-acute care)
- Electric Stim (attended)
- Contrast Baths
- Ultrasound
- Hubbard Tank

**SUB-ACUTE CARE**

Rehabilitation Therapy
The physician or therapist is required to have direct one-on-one patient contact.
The patient must perform the rehab exercises while the doctor instructs, oversees, and corrects the biomechanics.
The codes for rehab services are based on 15-minute intervals.

**97110 Therapeutic Exercises**

**97110** is used when the **treatment goals are to increase strength, endurance, functional capacity, range of motion, and flexibility**.

- Treadmill (endurance), Isokinetic exercises for ROM (weights or bands), Lumbar stabilization exercises (flexibility), Gymnic ball (stretching or strengthening)
- Documentation must show objective loss of range of motion, strength or mobility.
- Muscle strength cannot predict who will have future back troubles.

© Copyright 2015. Physical Diagnosis and Rehabilitation. Mario Fucinari DC, CCSP

**YOGA**

Yoga as therapeutic Exercises

- Dysfunction of the deep intrinsic muscles (diaphragm, intercostals, abdominals, pelvic floor, and deep spinal intrinsic muscles) can be seen in study of the breathing mechanics of yoga-based respiratory exercises.
- The goal of yoga is to increase strength, flexibility, to repair the altered CNS postural and respiratory programs and restore spinal stability.

**Core Stability**

- Multifidus
- Transverse abdominus
- Oblique muscles
- Diaphragm


**Reps vs. Sets**

- The repetition number (“reps”) means the number of times a patient performs an exercise consecutively, without stopping. In most programs, this number usually is somewhere between one and 20.
- “Sets” are a series of reps, defined by the rest period between (which varies from 30 seconds to several minutes). Set recommendations vary from one to three to five, and occasionally more.
- The “total reps” of an exercise can be determined by multiplying the number of reps times the number of sets performed.

**Documentation Requirements:**

- What was done
- Location (hip, knee, foot)
- Amount of time service performed
  - Units
  - Time in Minutes
  - Clock Time (5:15 pm – 5:30 pm)
The provider or qualified therapist must remain in contact with the patient via visual, verbal and/or manual contact with the patient during the provision of the service”

*AMA CPT Assistant, July 2004, Volume 14, Issue 7*

The 5 Ws of Therapy
1) What was done?
2) Where (Location)?
3) Why (Rationale)?
4) What are the settings/resistance?
5) Who oversaw/attended?

**Treatment Plan:**
A. Treatment Frequency

B. Treatment Goals
   a. Short Term (2 weeks)
      - Resolution of any radicular pain in the lower extremity
      - Low back pain consistently less than or equal to 6/10 with all activities
      - Resting low back pain with less than or equal to 2/10
      - Independent with basic self-care ADL without increased low back pain
   b. Long Term (4 weeks)
      - Low back pain at worst less than or equal to 4/10 with all activities
      - Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
      - Bilateral hip flexion, multifidus and gluteal strength to 4+ to 5/5
      - Independent self management
      - To prepare the patient for a home-based exercise program

C. Care Plan

Short – Term Goals Examples
1. Resolution of any radicular pain in the lower extremity
2. Low back pain consistently less than or equal to 6/10 with all activities
3. Resting low back pain with less than or equal to 2/10
4. Independent with basic self-care ADL without increased low back pain

Long – Term Goals Examples
1. Low back pain at worst less than or equal to 4/10 with all activities
2. Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
3. Bilateral hip flexion, multifidus and gluteal strength to 4+ to 5/5
4. Independent self management
5. To prepare the patient for a home-based exercise program
97110 Therapeutic Exercises used when the treatment goals are to increase strength, endurance, functional capacity, range of motion, and flexibility.

The Shoulder

The Rotator Cuff:
- Supraspinatus – Abducts the humerus to 30 degrees
- Infraspinatus – Extends and externally rotates the humerus
- Teres Minor – Extends and externally rotates the humerus
- Subscapularis - Extends and medially rotates the humerus

The Lumbar Spine:
- 80% of the population experiences low back pain
- 97% of the pain stems from mechanical injury
- Reduced flexibility
- Repeated stresses

Management
- Acute protocol is followed to control pain and hemorrhage
- Passive stretching
- Active stretching
- Strengthening
- Chiropractic care

Level One Exercise Cat Camel
- Used for mobility
- Work in the no pain range
- Slow and controlled 5 reps
- Postural awareness

The core muscles consist primarily of slow-twitch Type I muscle fibers, which respond best to time under tension.

They need sustained contractions of 6 to 20 seconds to improve intramuscular coordination.


Warm Up Exercises:
- Up to 10 minutes
- Increases circulation
- Increases core temperature
PELVIS

Anatomy

Biomechanics

Clinical considerations

Sacroiliac Joint
  • Anatomy
  • Biomechanics
  • Clinical considerations
  • Sciatic neuritis
  • Treatment

Piriformis Syndrome
  • Anatomy
  • Biomechanics
  • Clinical considerations
  • Sciatic neuritis
  • Treatment

Pelvic Rehabilitation
  • Stretching
  • Strengthening
  • Proprioception
  • Treatment

Lumbar Bridging I and II

Proprioception:

97112 Neuromuscular Re-education
  • Used when treatment goals are re-education/improvement of proprioception, balance, coordination, kinesthetic sense, and posture.
  • NOT TRIGGER POINT THERAPY
  • Separate from the manipulation and should be billed as such.
  • -59 modifier rules apply
  • Billed in 15-minute increments (units).
• One-on-one patient contact is required.
• Medically reasonable and necessary for impairments causing poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination and hypo/hypertonicity.
• Treatments include Proprioceptive Neuromuscular Facilitation (PNF) and BAP boards.

Three key areas of Proprioception
Cervical Spine
   Abrahams 1977
   Normalize head position

SI joints
   Hinoki 1975
   Facilitates kinetic chain

Sole of foot
   Freeman and Wyke 1964
   Normalize foot position
   Balance starts from the ground up!

Proprioception Testing
The person stands on one leg for as long as possible. Give the subject a minute to practice their balancing before starting the test. The timing stops when the elevated foot touches the ground or the person hops or otherwise loses their balance position. The best of three attempts is recorded. Repeat the test on the other leg.

Scoring: time the total length of time person can stay in the balance position.

Variations / modifications: to increase the degree of difficulty, the test can be conducted with the person having their arms either by their sides, held out horizontally, or on their head. You could also conduct the test with their eyes closed for each of these variations too.

One Leg Standing Balance Test
Someone should stand close by since you will be unsteady at first.

1. Knee Flexion
   Slowly bend knee as far as possible.
   Hold position as long as possible, up to 10 seconds.
   Repeat.
   Try with both hands at first.
   IF STEADY, then try with only one hand.
   IN TIME, as you progress, try with no hands. DO NOT ATTEMPT AT FIRST.
   When this becomes easy, repeat the above steps with the eyes closed.

   One Leg Standing Balance Test

2. Hip Flexion
   Slowly bend knee as far as possible.
   Hold position as long as possible, up to 10 seconds.
   Repeat.
   Try with both hands at first.
IF STEADY, then try with only one hand.
IN TIME, as you progress, try with no hands. DO NOT ATTEMPT AT FIRST.
When this becomes easy, repeat the above steps with the eyes closed.

1) Half Roll Balance

2) Airex Balance Pad

3) Stability Trainer/Dyna Disc

Do #1-3 in sequence

Eyes open, hold 10 - 20 seconds X 5 times
   • Single leg balance then,
   • Single leg reach then,
   • Single leg hip internal and external rotation.

Repeat sequence with eyes closed.

4) Rock and Roller
   Dual Exercise Board a unique combination of rocker and wobble boards to help develop
   balance and proprioception in patients with gait deficiencies or postural imbalances.

Proprioception of the head and cervical spine is associated with the muscle spindles in the upper
cervical spine.

97150 Group Therapeutic Procedures (2 or More People)
   • Used in a group setting such as with neuromuscular reeducation.
   • Documentation must identify:
     1. The specific treatment technique used in the group
     2. How the treatment technique will restore function
     3. The frequency and duration of the particular group setting
     4. The number of persons in the group
     5. Treatment goal in the individualized plan.
   • Time is not defined in this code.

Manipulation and Rehabilitation
   • Manipulation plus exercise out performed manipulation or exercise alone (Spine 2002;
     27:2383-2389).
   • CMT is a valid treatment for mechanical low back pain and CMT alone does not provide
     comprehensive care for chronic LBP or recurring back pain sufferers. (European Journal

Those with documented hypomobility may benefit from some initial manipulation or
mobilization with a transition into stabilization training.

Journal of Orthopedic & Sports Physical Therapy 2007; Vol 37, #10

Measured the multifidus at L4-5 and L5-S1 at rest

Results:
- 3.5% increased strength w/o manipulation
- 17.2% increase post manipulation
- 20.6% increase 24 hours post manipulation
- 30.4% increase post manipulation with exercise

Multifidus

There is sympathetic feedback in the multifidus. Thus there is a correlation between the multifidus status of the type II fibers and the intervertebral disc

Exercise of the Type I and Type II fibers along with manipulation enhances the health of the IVD

**Exercise Rx and the Child**

- Prevention of childhood obesity and Type 2 Diabetes
- Physiologically, children are not small adults
- Children are emotionally immature and need encouragement and support.
- Resting heart rate of young individuals is higher than adults.
- Only 50% age 12 to 21 are physically active

National Association for Sport and Physical Education

- Children should accumulate at least 60 minutes of age-appropriate physical activity on all or most days.
- Children should participate in several bouts of physical activity lasting 15 minutes or more each day.
- Children should participate in a variety of age-appropriate physical activities to achieve optimal health, wellness, fitness, and performance benefits.
- Extended periods (2 hours or more) of inactivity are discouraged, especially during the daytime hours.

**Exercise Prescription**

Centers for Disease control and American College of Sports Medicine recommends that all adults in the U.S. should accumulate 30 minutes or more of moderate-intensity physical activity on most, if not all, days of the week.

“Exercise a day, keeps _______ away”

**It’s a job.**
Rehabilitation of the Elderly

Effects of the Aging Process

- Initial workload should be low
- Cycle may be preferable to a treadmill, due to balance
- Treadmills should have handrails due to decreased balance, poor coordination or fear
- Adapt treadmill speed
- Initial stage of rehabilitation may be extended, due to adjustment time to the equipment
- Exercise-induced dysrhythmias are more frequent
- Prescribed medications may influence the electrocardiographic and hemodynamic responses to exercise

Cardiorespiratory Fitness

- Goal is to accumulate at least 30 minutes of moderate intensity of physical activity on all, or most, days of the week.
- Walking, aquatic exercises or stationary cycle are options
- Intensity should start low and progress according to tolerance.
- Duration is preferred over intensity
- Exercise performed at least 3 to 3 days per week.

Resistance Training

- Muscular strength declines partially due to decreased muscle mass
- Training will increase muscular strength, power and endurance.
- Decreased frailty, falls and fractures
- First 8 weeks with minimal resistance to allow for adaptation of connective tissue
- One set of 8 – 10 exercises to include the major muscle groups
- 10 to 15 reps of 12-13 out of 20 on exertion rating
- Increase reps before weight
- Avoid explosive weight thrusts
- Machines or bands are used as opposed to free weights
- Participation should not occur with acute arthritic flare-ups
Flexibility Training
• Flexibility enhances functional capacity and reduces injury
• Flexibility exercises should be prescribed for every muscle joint
• Yoga and tai chi help to increase flexibility and proprioception at the same time
• At first, an entire session may be used to address flexibility

If you have questions…
www.AskMario.com
E-mail: Doc@AskMario.com
**AFFIX YOUR OFFICE LABEL HERE**

Patient Name ______________________________

Date of Rehab Session ______________________

Attended by: ______________________________

Doctor Signature __________________________

Start Time _________________________________

Finish Time _________________________________

<table>
<thead>
<tr>
<th>Exercise</th>
<th># Reps X # Sets</th>
<th>Band Color or Weight</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>