MEDICAL CONTESTED CASE HEARING NO. 09112
M6-09-17311-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on February 26, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that physical therapy three times a week for six weeks is not reasonably required health care for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by MF, ombudsman.
Respondent/Carrier appeared and was represented by JM, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable burst fracture at L2 and underwent spinal fusion at L1-L3 as part of the treatment for the injury. After surgery, he had 12 physical therapy sessions, beginning on December 18, 2007, and ending on January 15, 2008. An impairment rating report by Dr. GPF, MD indicates that Claimant was released from active care after completing the postoperative rehabilitation. Despite the surgery and physical therapy, Claimant has continued to have low back pain. An MRI on October 30, 2008, revealed an annular tear at L4-5 and mild disc degeneration at L4-5 and L5-S1. Upon seeing the results of the MRI, Claimant's treating doctor, Dr. EK, III, MD, recommended physical therapy, three times a week, for six weeks. Carrier refused to pre-authorize the request and its decision was upheld on reconsideration and appeal to an IRO. Claimant now appeals the IRO decision, asserting that the preponderance of the evidence is contrary to the IRO decision upholding Carrier's denial of his doctor's request for treatment.

The appeal was assigned to (Independent Review Organization), who in turn assigned it to a physician reviewer who was identified as a board certified orthopedic surgeon. In determining the necessity of the requested physical therapy visits, the physician reviewer considered the Official Disability Guidelines (ODG), office notes from Dr. EK from September 18, 2007, through October 30, 2008, x-rays of Claimant's lumbar spine taken on September 20, 2007, a December 2007 physical therapy evaluation, the MRI, and peer reviews from the doctors who had previously upheld Carrier's denial of the physical therapy request. In upholding Carrier's denial, the physician reviewer stated that the medical records document normal neurologic evaluations without evidence of loss of motion, protective muscle spasm, or progressive loss of function. The physician reviewer stated that Claimant's doctor had not documented objective abnormal findings or any specific reason that Claimant could not be involved in a home exercise program as directed by the ODG.

In response to the IRO recommendation that the denial be upheld, Dr. EK wrote to the ombudsman assisting Claimant in this matter, stating:

> (Claimant) underwent an L2 corpectomy with an L1 to L3 fusion on 9-20-07. The patient has healed from this surgery; however, he continues to have low back pain.
>
> We did perform an MRI on 10-30-08, which revealed that he has a hype-intense (sic) zone, and an annular tear at L4-L5 disc space. This can cause significant low back pain. (Claimant) is a very motivated individual, and I believe will perform well in physical therapy. I do feel that physical therapy will increase his low back strength to the heavy duty job that he had, and also will decrease his low back pain.

An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (Texas Labor Code §408.021). "Health care reasonably required" is defined as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, generally accepted standards of medical practice recognized in the medical community (Texas Labor Code §401.011(22-a)). "Evidence based medicine" means the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines (Texas Labor Code §401.011 (18-a)). In accordance with the above statutory guidance, Rule 137.100 directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be reasonably required.

With regard to physical therapy of back and neck injuries, the ODG provides as follows:

> **Physical Therapy (PT)**
>
> 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) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; & Stretching. [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.]

Active Treatment versus Passive Modalities: The use of active treatment modalities instead of passive treatments 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).

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)

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 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. (Luijesterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

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 (ICD9 847.2):
10 visits over 8 weeks
Sprains and strains of unspecified parts of back (ICD9 847):
10 visits over 5 weeks
Sprains and strains of sacroiliac region (ICD9 846):
Medical treatment: 10 visits over 8 weeks
Lumbago; Backache, unspecified (ICD9 724.2; 724.5):
9 visits over 8 weeks
Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):
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 (ICD9 722.7)
Medical treatment: 10 visits over 8 weeks
Post-surgical treatment: 48 visits over 18 weeks
Spinal stenosis (ICD9 724.0):
10 visits over 8 weeks
See 722.1 for post-surgical visits
Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):
10-12 visits over 8 weeks
See 722.1 for post-surgical visits
Curvature of spine (ICD9 737)

12 visits over 10 weeks
See 722.1 for post-surgical visits
Fracture of vertebral column without spinal cord injury (ICD9 805):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 34 visits over 16 weeks
Fracture of vertebral column with spinal cord injury (ICD9 806):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 48 visits over 18 weeks
Work conditioning (See also (See also Procedure Summary entry):
10 visits over 8 weeks

Dr. EK has inferred that physical therapy is medically necessary to address Claimant's ongoing low back pain and that the MRI results support the proposed therapy. He offered no evidence based medicine in support of his assertion that Claimant needs the six weeks of physical therapy. Claimant testified that Dr. EK said that the physical therapist could show him some new exercises that might help with his low back pain prior to attempting epidural steroid injection therapy. As noted by the physician reviewer, there is no evidence that Claimant could not perform these new exercises just as well in a home based setting.

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. As an orthopedic surgeon, Claimant's treating doctor is qualified to offer an opinion on his treatment. The trier of fact must then determine whether the opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See* Black vs. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999); E.I. Du Pont De Nemours and Company, Inc. v. Robinson, 923 S.W.2d 549 (Tex. 1995).

A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. Black v. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999). Health care providers are directed to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be reasonably required. (28 Tex. Admin. Code § 137.100 (Rule 137.100). The treatment proposed by Dr. EK is not consistent with the directives contained in the current edition of the ODG. Dr. EK failed to support his opinion with evidence based medicine. Although qualified to render an opinion on the best course of treatment for his patient, Dr. EK has failed to show that the proposed course of care is medically necessary in light of evidence based medicine and the preponderance of the evidence is not contrary to the IRO decision.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer).

C. Claimant sustained a compensable injury on _____.

D. The Texas Department of Insurance appointed (Independent Review Organization) to act as the Independent Review Organization (IRO) in this matter.

E. The IRO determined that Claimant is not entitled to physical therapy three times a week for six weeks.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant failed to offer evidence based medicine contrary to the IRO decision.

4. Physical therapy three times a week for six weeks is not reasonably required medical treatment for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO that physical therapy three times a week for six weeks is not reasonably required medical care for the compensable injury of _____.

DECISION

Claimant is not entitled to physical therapy three times a week for six weeks for treatment of the compensable injury of _____.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **INDEMNITY INSURANCE COMPANY OF NORTH AMERICA** and the name and address of its registered agent for service of process is

ROBIN M. MOUNTAIN
6600 CAMPUS CIRCLE DRIVE EAST, SUITE 300
IRVING, TEXAS 75063-2732

Signed this 26th day of February, 2009.

KENNETH A. HUCHTON
Hearing Officer