MEDICAL CONTESTED CASE HEARING NO. 10189
M6-10-26070-01

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 June 2, 2010 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that Claimant is not entitled to physical therapy 3 times a week for 4 weeks for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by JT, ombudsman.
Respondent/Carrier was represented by RT, attorney.

BACKGROUND INFORMATION

On _____, Claimant sustained a compensable injury when she fell down stairs. She has a protrusion at L5-S1 and back pain. She has been treated with medications, physical therapy (12 weeks) work hardening (2 weeks), and epidural steroid injections.

Dr. T, treating doctor, recommended that Claimant have additional physical therapy 3 times a week for 4 weeks. Two utilization reviewers and an IRO reviewer determined that the requested sessions were not reasonable and necessary for Claimant's compensable injury. The first utilization reviewer said that Claimant had already participated in more than the number of sessions recommended by the *Official Disability Guidelines* (ODG). The second reviewer said that Claimant had undergone previous physical therapy without substantial benefit. The IRO reviewer, who is board certified in internal medicine, relied on (1) the reviewer's medical judgment, clinical experience and expertise in accordance with accepted medical standards and (2) the ODG. The reviewer wrote that the Claimant's request for additional physical therapy would not be supported by the ODG because the request was made for a 2 year old injury and Claimant's response to her initial physical therapy was poor.

Texas Labor Code Section 408.021 provides that 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. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) 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, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011

(18a) to be 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. The Commissioner of the Division of Workers' compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

The ODG provides the following for physical therapy:

> 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; & Aquatic therapy. [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). A recent RCT comparing active spinal stabilization exercises (using the GDS or Godelive Denys-Struyf method) with passive electrotherapy using TENS plus microwave treatment (considered conventional physical therapy in Spanish primary care), concluded that treatment of nonspecific LBP using the GDS method provides greater improvements in the midterm (6 months) in terms of pain, functional ability, and quality of life. (Arribas, 2009)

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) Practitioners must be cautious when implementing the wait-and-see approach for LBP, and once medical clearance has been obtained, patients should be advised to keep as active as possible. Patients presenting with high fear avoidance characteristics should have these concerns

addressed aggressively to prevent long-term disability, and they should be encouraged to promote the resumption of physical activity. (Hanney, 2009)

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)

Post-surgical (discectomy) rehab: A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs. (Ostelo, 2009)

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 Procedure Summary entry):
10 visits over 8 weeks

Physical Therapy Guidelines

Physical Therapy Guidelines, showing recommended frequency and duration of PT visits are next. Only appropriate conditions have physical therapy guidelines. These guidelines provide evidence-based benchmarks for the number of visits with a physical or occupational therapist and the period of time during which these visits take place. (Note: These guidelines do not include work hardening programs.) The physical therapy guidelines do not describe the type of therapy required, and the number of visits does not include physical therapy that the patient should perform in their own home or work site, after proper training from a clinician. Unless noted otherwise, the visits indicated are for outpatient physical therapy, and the physical therapist's judgment is always a consideration in the determination of the appropriate frequency and duration of treatment. Support for the physical therapy guidelines is relevant medical literature and actual experience data, combined with consensus review by experts. The most important data sources are the high quality medical studies that are referenced in the treatment guidelines, *ODG Treatment in Workers' Comp*, within the Procedure Summaries of each relevant chapter, summarized under the entry for "Physical Therapy." For clinical trials that show effectiveness for these therapies, the number of visits required to achieve this are isolated from each study and combined with the same information from other successful studies to arrive at the benchmark number of visits in ODG.

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

Generally there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/ procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, for example, in unusual cases where co-morbidities involve completely separate body domains, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker.

As described above, for more detail users should refer to *ODG Treatment in Workers' Comp*, within the Procedure Summaries of each relevant chapter, for recommendations about specific treatments and modalities, along with supporting links to the highest quality relevant medical studies, which have been summarized, rated, and highlighted. In these Procedure Summaries ODG covers many different types of treatments that can be supported by the medical evidence, and it also identifies the maximum number of visits that can be justified by the evidence; however, this does not mean that a provider should do every possible treatment that may be recommended (actually, this would be highly unlikely since different specialties would be required), or always deliver the maximum number of visits, without taking into account what was needed to cure the patient in a particular case. Furthermore, duplication of services is not considered medically necessary. While the recommendations for number of visits are guidelines and are not meant to be absolute caps for every case, they are also not meant to be a minimum requirement on each case (i.e., they are not an "entitlement"). Any provider doing this is not using the guidelines correctly, and provider profiling would flag these providers as outliers. This applies to all types of treatment, and not just physical therapy. Furthermore, flexibility is especially important in the time frame recommendations. Generally, the number of weeks recommended should fall within a relatively cohesive time period, between date of first and last

visit, but this time period should not restrict additional recommended treatments that come later, for example due to scheduling issues or necessary follow-up compliance with a home-based program. When there are co-morbidities, the same principles should apply as in the ODG guidelines for return-to-work. See Additional note on co-morbidities at the end of the description of the Return-To-Work "Best Practice" Guidelines. In estimating the maximum number of treatment visits for workers with multiple diagnoses, users should use the number from the diagnosis with the longest number of visits. This assumes that whatever separate therapy, if any, that the lesser diagnosis requires, it can be done during the same visits addressing the more serious problem. If there are reasons why these therapies cannot be concurrent, documentation should support medical necessity. For example, in unusual cases where co-morbidities involve completely separate body domains, requiring separate treatments that would be difficult to combine, either additional visits or additional time for a visit may be justified. [For the purpose of this discussion, we would assume there could be only three separate body domains: (1) spine and pelvis; (2) upper extremity and hands; & (3) lower extremity and feet.] Of course, each billed treatment should require one-on-one patient contact with the licensed therapist and not include modalities/exercises that the patient has learned to do on their own without supervision, and there should also be some economies of scale such that the involvement of two body domains should not require either a doubling of the number of visits or a doubling of the modalities (or time) per visit. Also see Multiple incidences of disability duration in the same section for recommendations regarding number of treatment visits, for example, physical therapy, in these situations. And physical therapy visits post surgery should be considered separately from visits used up in an attempt at conservative treatment that might have avoided surgery.

Physical medicine treatment (including PT, OT and chiropractic care) should be an option when there is evidence of a musculoskeletal or neurologic condition that is associated with functional limitations; the functional limitations are likely to respond to skilled physical medicine treatment (e.g., fusion of an ankle would result in loss of ROM but this loss would not respond to PT, though there may be PT needs for gait training, etc.); care is active and includes a home exercise program; & the patient is compliant with care and makes significant functional gains with treatment.

Claimant testified that when she participated in work hardening, the injury to her lower back became worse. She stated that she understands that the physical therapy recommended by Dr. T will help to strengthen her legs and to reduce the amount of pain medication that she needs.

Claimant's evidence included a letter written by Dr. T on May 25, 2010. He wrote that he had treated Claimant for chronic back pain for 15 months with little progress in relieving her discomfort. He stated that physical therapy was currently the best option for Claimant, noting that Claimant reported some benefit after each past episode of physical therapy. He also cited a review published in the Cochrane Database in July of 2000 that found exercise to be effective in the treatment of chronic pain as it resulted in decreased pain and improved function. He did not address reasons to justify exceeding the number of physical therapy sessions recommended in the ODG.

Claimant's evidence based medicine was not sufficient to overcome the opinion of the IRO reviewer. Based on the evidence presented, Claimant did not show that the requested treatment is health care reasonably required for the compensable injury of _____.

Even if 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, who was the employee of the (Self-Insured), sustained a compensable injury.

   C. The IRO determined that the requested treatment is not health care reasonably required for the compensable injury of _____.

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. The requested treatment is not health care reasonably required for the compensable injury of _____ as it would exceed the number of sessions recommended in the ODG without documentation of exceptional factors to justify the need to exceed the number of recommended sessions.

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 the IRO that physical therapy 3 times a week for 4 weeks is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to physical therapy 3 times a week for 4 weeks for 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 **(Self-Insured)** and the name and address of its registered agent for service of process is

For service in person, the address is:

JB, EXECUTIVE DIRECTOR
(SELF-INSURED)
(STREET ADDRESS)
(BUILDING, FLOOR)
(CITY), TEXAS (ZIP CODE)

For service by mail, the address is:

JB, EXECUTIVE DIRECTOR
(SELF-INSURED)
(P.O. BOX)
(CITY), TEXAS (ZIP CODE)

Signed this 22nd day of June, 2010.

CAROLYN F. MOORE
Hearing Officer