

**DECISION AND ORDER**

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence is not contrary to the decision of the IRO that Claimant is not entitled to outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session for the compensable injury of (Date of Injury).

**STATEMENT OF THE CASE**

On March 31, 2015, Jacqueline Harrison, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Petitioner/Claimant appeared and was assisted by LS, ombudsman. Respondent/Carrier appeared and was represented by KB, attorney.

**DISCUSSION**

Evidence presented in the hearing revealed that Claimant sustained a compensable injury on (Date of Injury). Claimant, a 14 year employee of a hospital, testified that she had injured her lumbar spine while attempting to keep a 400 pound patient from falling. Claimant indicated that she had undergone medical treatment which included but was not limited to medication, steroid injections and surgery to her cervical spine.

Carrier indicated that it had accepted a lumbar sprain/strain only and evidence in the record revealed that Claimant's (Date of Injury), compensable injury did not extend to and include lumbar HNP at L4-5 and L5-S1, lumbar radiculopathy, chronic pain syndrome, lumbar spinal stenosis at L5-S1, facet arthrosis syndrome, and bilateral facet joint arthropathy at L5-S1 for which Claimant had subsequently undergone additional medical treatment.

Claimant's treating physician, SJ, D.C., reported that Claimant had a diagnosis of lumbar disc bulge, thoracic pain, cervical pain, and S/P cervical repair. Evidence indicates that Dr. G recommended chiropractic care, physiotherapy, and chronic pain management. Dr. G also reported that she expected the treatment to alleviate pain, increase range of motion, improve function, and build coping skills to better manage Claimant's condition. Evidence reveals that Dr. G thereafter requested outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session for the compensable injury of (Date of Injury).

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 Official Disability Guidelines (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(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is 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 pertinent provisions of the ODG applicable to this case are as follows, to wit:

## 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) In this RCT, exercise and stretching, regardless of whether it is achieved via yoga classes or conventional PT supervision helps improve low back pain. (Sherman, 2011) 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 instead of passive modalities 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) In this RCT, two active interventions, multidisciplinary rehab (intensive, bio-psychosocial PT) and exercise (exercises targeted at trunk muscles together with stretching and relaxation), reduced the probability of sickness absence, and were more effective for pain than self-care advice at 12 months. (Rantonen, 2012)

*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. (Luijsterburg, 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) There is inconclusive evidence for the effectiveness of outpatient physical therapy after first lumbar discectomy. Although evidence from two trials suggested that intervention might reduce disability short-term, and more intensive intervention may be more beneficial than less intensive therapy, pooled results did not show statistically significant benefit. (Rushton, 2011) A systematic review yielded moderate to low quality evidence

for effectiveness of postoperative exercise programs starting 4-6 weeks after lumbar disc surgery. Exercise programs seem to be more beneficial than no treatment, and high intensity exercises may be more effective than low intensity exercises. (Oosterhuis, 2013)

*Post-surgical (fusion) rehab:* Following lumbar spinal fusion, delayed start of rehabilitation results in better outcomes, and improvements in the group starting at 12-weeks were 4 times better than that in the 6-week group. (Oestergaard, 2012)

*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.

The case was reviewed by a medical provider who is licensed by the Texas State Board of Chiropractic Examiners. The reviewer upheld the denial of the outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session for the compensable injury of (Date of Injury). The basis of the denial was that Claimant had little to no documentation provided regarding the efficacy of the previous therapy provided to her. There was no functional improvement in her condition in the past and it was determined that the requested treatment was not likely to provide clinical efficacy or improve Claimant's functional status in the future. Specifically, the reviewer indicated that the ODG does not endorse the request for electrical muscle stimulation and ultrasound for the chronic pain, as it noted that passive therapies are not indicated for addressing chronic pain.

Medical documentation and testimony were insufficient to establish that the medical treatment requested was health care reasonably required for the compensable injury of (Date of Injury). Therefore, the Petitioner has failed to meet her burden to overturn the decision of the IRO that she is not entitled to outpatient physical therapy for the lumbar/thoracic/cervical spine twice a

week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session for the compensable injury of (Date of Injury).

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

### **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 (Date of Injury), Claimant was the employee of (Employer), Employer.
  - C. On (Date of Injury), Employer provided workers' compensation insurance with Harris Health System as a self-insurer.
  - D. On (Date of Injury), Claimant sustained a compensable injury.
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.
  - E. Outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session is not health care reasonably required for treatment for the compensable injury of (Date of Injury).

### **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 Outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session is not health care reasonably required for treatment for the compensable injury of (Date of Injury).

**DECISION**

Claimant is not entitled to outpatient physical therapy for the lumbar/thoracic/cervical spine twice a week for three weeks to include therapeutic exercises, manual therapy, ultrasound, & electrical simulation at no more than four units per session is not health care reasonably required for treatment for the compensable injury of (Date of Injury).

**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:

**DSL  
ADDRESS  
CITY, STATE ZIP**

Signed this 15th day of April, 2015.

Jacqueline Harrison  
Hearing Officer