

MEDICAL CONTESTED CASE HEARING NO. 16050

**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 in (Docket #1) the claimant is entitled to left L3, L4, and L5 medial branch blocks for the compensable injury on (Date of Injury); that in (Docket #2) the claimant is not entitled to a back brace and TENS unit for the compensable injury on (Date of Injury); and that in (Docket #3) the claimant is not entitled to an additional 8 physical therapy sessions for the compensable injury on (Date of Injury).

**ISSUES**

On January 9, 2017, William M. Routon II, 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 left L3, L4, and L5 medial branch blocks are not reasonable and necessary medical care for the compensable injury of (Date of Injury)?
2. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a back brace and TENS unit are not reasonable and necessary medical care for the compensable injury of (Date of Injury)?
3. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that an additional 8 physical therapy sessions are not reasonable and necessary medical care for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

The petitioner/claimant appeared and was assisted by SA, ombudsman. The carrier/respondent appeared and was represented by PB, attorney.

**BACKGROUND INFORMATION**

The disputed treatments in this case are in connection with the lumbar spine injury sustained by the claimant in (Year of Injury). In 1998, the claimant had surgery to the L4-5 and L5-S1 levels of his lumbar spine. As explained by LR, M. D., the doctor who has requested each of the treatments, the surgery was an "anterior body fusion" and the claimant never had posterior surgery to fuse the posterior elements—the facet joints. That meant, according to Dr. R, that the

claimant “has not had fusion of his facet joints and there is still intact capsule and cartilage and sensory innervation”. Dr. R also asserted that the claimant's “fusion may be incomplete and there is still an intact joint at all lumbar levels.” Dr. R stated as recently as December, 2016 that the claimant's pain was facet mediated pain due to micromotion of the facet joints since they were never fused. The claimant also testified that Dr. R, with whom the claimant has treated for the last 20 years in connection with the compensable injury, confirmed to him that the fusion performed was “crooked.”

In reviewing Dr. R’s request for left L3, L4, and L5 medial branch blocks (Docket #1) the utilization review doctor, an orthopedic surgeon, based part of his opinion on the claimant having been diagnosed with lumbar radiculopathy. However, a review of Dr. R’s reports indicate that the “suggestion” of lumbar radicular pain was related to levels of the claimant's lumbar spine that are above the levels where the fusion surgery was performed and which are at issue in this case. The reviewer also apparently assumed a successful anterior and posterior fusion, and that the medial branch blocks were being requested for treatment rather than diagnostic purposes.

In reviewing Dr. R’s request for a back brace and TENS unit (Docket #2), three utilization review doctors all denied Dr. R’s requests. On initial review in May, 2016, the reviewing doctor, a pain management and physical medicine and rehabilitation doctor, opined that the TENS unit was not medically necessary but did not explain the basis for her opinion. She also opined that there was “strong and consistent evidence” that back braces/lumbar supports were not effective in preventing back pain. The reviewer on appeal of that denial, an orthopedic surgeon, in August, 2016 denied the TENS unit due to insufficient information that was presented to him on the claimant's treatment history, and because there was no specific duration that had been requested for a TENS unit trial. That reviewer also denied the back brace/lumbar support because they had not been shown to be effective in preventing back pain, and because there was no documentation of any recent lumbar surgery (because, of course, the surgery had been approximately eighteen years earlier). Finally, a second initial reviewer, an anesthesiologist, in September, 2016 also denied both the TENS unit and the back brace/lumbar support. As to the TENS unit, the reviewing doctor stated that guidelines did not recommend “sole use of a TENS unit for chronic musculoskeletal pain.” This utilization reviewer, like the others before him, was apparently not provided any medical records in regard to the compensable injury, or the earlier treatment, including surgery, because he indicated part of the basis for his denial was that the records provided for his review did not “identify any acute trauma to the spine.”

In reviewing Dr. R’s request for an additional 8 physical therapy sessions (Docket #3) the utilization review doctor, an anesthesiologist, denied the request on the basis that “the recent records” provided to him did not provide any goals to be obtained by physical therapy for an injury “now more than 14 [sic] years old.” The reviewer, in the appeal from the denial, stated generally that there was no indication for physical therapy beyond that allowed by the guidelines.

In (Docket #1), the IRO doctor, a Board Certified anesthesiologist, denied the request for the medial branch blocks on the assumption that they were being requested for pain relief despite the fact, the reviewer assumed, that the claimant had apparently had a complete and successful fusion surgery at L4-5 and L5-S1.

In (Docket #2), the IRO doctor, identified as an anesthesiologist and pain management doctor, opined in November, 2016 that the back support should not be authorized since the “literature also indicates supports are not effective in preventing neck and back pain.” The reviewer indicated that he believed insufficient information had been provided to determine whether a TENS unit was appropriate in this case. He stated that clarification was needed in regard to the claimant's previous treatment and whether all conservative measures, such as physical therapy had failed. It is noted that this doctor, who performed his review in November, 2016, only had medical records back to May, 2016, and some of those were only prescriptions and peer reviews.

In (Docket #3), the IRO doctor identified, as an anesthesiologist, denied the request for additional physical therapy because he was provided little or no information in regard to the claimant's treatment history, a history of his prior physical therapy, and because “there is no clear rationale provided to support a course of physical therapy at this time for this patient who sustained injuries over 24 years ago.”

## **DISCUSSION**

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 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."

On the date of this medical contested case hearing, the ODG provides the following with regard to medial branch blocks:

### **Facet joint diagnostic blocks (injections)**

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels.

*See Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); and Facet joint intra-articular injections (therapeutic blocks). See also Neck Chapter and Pain Chapter.*

### **Criteria for the use of diagnostic blocks for facet "mediated" pain:**

Clinical presentation should be consistent with *facet joint pain, signs & symptoms*.

1. One set of diagnostic medial branch blocks is required with a response of  $\geq 70\%$ . The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a "sedative" during the procedure.

8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (*Resnick, 2005*)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (*Franklin, 2008*)]

Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (*Cohen, 2007*) (*Bogduk, 2000*) (*Cohen2, 2007*) (*Manchukonda, 2007*) (*Dreyfuss, 2000*) (*Manchikanti2, 2003*) (*Datta, 2009*)

*Etiology of false positive blocks:* Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (*Cohen, 2007*) The use of sedation during diagnostic injections may increase the rate of false-positive blocks and lead to misdiagnoses and unnecessary procedures, but has no effect on satisfaction or outcomes at 1-month. (*Cohen, 2014*)

*MBB procedure:* The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. (*Clemans, 2005*) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as

increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumaticos, 2006) (Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. (Cohen, 2010)

The claimant has experienced chronic pain since the date of the compensable injury, even after conservative care and then surgery. At least beginning in 2010, the claimant received medial branch neurotomies by Dr. R to relieve the pain and reduce the claimant's need for narcotic medications, including OxyContin, Topamax, and Hydrocodone. The claimant testified, and the treatment records in evidence from Dr. R indicate, that the neurotomies have been very successful, for a year or more at a time, in relieving the claimant's pain, reducing his need for narcotic medications, and in allowing the claimant to work a full work week (after his injury, the claimant returned to school and retrained in IT so that he could return to the workforce).

The claimant testified that Dr. R wants the requested medial branch blocks not as a treatment but as a diagnostic tool for a new medial branch neurotomy. In his December, 2016 report, Dr. R confirmed that he is requesting the blocks “because the ODG guidelines state I am not allowed to proceed with a repeat neurotomy without the diagnostic block.” On the date of this medical contested case hearing, the ODG provides the following with regard to facet joint radiofrequency neurotomy:

**Criteria for use of facet joint radiofrequency neurotomy:**

- (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See *Facet joint diagnostic blocks* (injections).
- (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at  $\geq 50\%$  relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6

months duration). No more than 3 procedures should be performed over the course of a year.

- (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function.

An examination report from Dr. R in March, 2012 related that prior medial branch blocks achieved the level and duration of relief required by the ODG to support the medial branch neurotomy. The claimant's most recent neurotomy was in December, 2014. The relief and benefits lasted well over the recommended periods set out above. Finally, as the above portions of the ODG state, repeat neurotomies depend on variables like “evidence of adequate diagnostic blocks,” which is the basis of Dr. R’s request.

On the date of this medical contested case hearing, the ODG provides the following with regard to back braces and TENS units:

**Back braces (lumbar supports):**

Not recommended for prevention. Recommended as an option for treatment. See below for indications.

See also *Back brace, post operative (fusion); IntelliSkin posture garments; and SpineCor brace.*

**Prevention:** Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (*Jellema-Cochrane, 2001*) (*van Poppel, 1997*) (*Linton, 2001*) (*Assendelft-Cochrane, 2004*) (*van Poppel, 2004*) (*Resnick, 2005*) Lumbar supports do not prevent LBP. (*Kinkade, 2007*) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (*Bigos, 2009*) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (*van Duijvenbode, 2008*) A total of 23 studies involving 30,850 participants evaluated six different prevention strategies: exercise, education, exercise combined with education, back belts, shoe insoles, and other strategies. Exercise combined with education reduces the risk for a LBP episode at short-term ( $\leq 12$  months) follow-up (RR: 0.55). Exercise alone reduces the use of sick leave in the long term (RR: 0.22). Other interventions, including education alone (RR: 1.03), back belts (RR: 1.01), and shoe insoles (RR: 1.01), did not appear to be associated with the prevention of LBP. (*Steffens, 2016*)

**Treatment:** Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very

low-quality evidence, but may be a conservative option). Under study for post-operative use; see *Back brace, post operative* (fusion). Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. (Roelofs, 2007) Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration. (Kim, 2006) An RCT to evaluate the effects of an elastic lumbar belt on functional capacity and pain intensity in low back pain treatment, found an improvement in physical restoration compared to control and decreased pharmacologic consumption. (Calmels, 2009) This RCT concluded that lumbar supports to treat workers with recurrent low back pain seems to be cost-effective, with on average 54 fewer days per year with LBP and 5 fewer days per year sick leave. (Roelofs, 2010) This systematic review concluded that lumbar supports may or may not be more effective than other interventions for the treatment of low-back pain. (van Duijvenbode, 2008) For treatment of nonspecific LBP, compared with no lumbar support, an elastic lumbar belt may be more effective than no belt at improving pain (measured by visual analogue scale) and at improving functional capacity (measured by EIFEL score) at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, evidence was weak (very low-quality evidence). (McIntosh, 2011) Bracing is a low-risk, cost-effective method to treat certain thoracolumbar fractures, and it offers equivalent efficacy as surgical management in many cases. The evidence for bracing of osteoporotic-type fractures is less clear, and further investigation will be necessary to delineate its optimal role. (Chang, 2014)

**TENS (transcutaneous electrical nerve stimulation):**

Not recommended as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based *conservative care* to achieve *functional restoration*, including reductions in medication use.

**Acute:** Not recommended based on published literature and a consensus of current guidelines. No proven efficacy has been shown for the treatment of acute low back symptoms. (Herman, 1994) (Bigos, 1999) (van Tulder, 2006)

**Chronic:** Not generally recommended as there is strong evidence that TENS is not more effective than placebo or sham. (Airaksinen, 2006) There is minimal data on how efficacy is affected by type of application, site of application, treatment duration, and optimal frequency/intensity. (Brousseau, 2002) There are sparse randomized controlled trials that have investigated TENS for low back pain. One study of 30 subjects showed a significant decrease in pain intensity over a 60-minute treatment period and for 60 minutes after. (Cheing, 1999) A larger trial of 145 subjects showed no difference between placebo and TENS treatment. (Deyo, 1990) Single-dose studies may not be effective for evaluating long-term outcomes, or the standard type of use of this modality in a clinical setting.



(Milne-Cochrane, 2001) (Sherry, 2001) (Philadelphia Panel, 2001) (Glaser, 2001) (Maher, 2004) (Brousseau, 2002) (Khadikar, 2005) (Khadikar2, 2005) Although electrotherapeutic modalities are frequently used in the management of CLBP, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. TENS does not appear to have an impact on perceived disability or long-term pain. High-frequency TENS appears to be more effective on pain intensity when compared with low frequency, but this has to be confirmed in future comparative trials. It is also not known if adding TENS to an evidence-based intervention, such as exercise, improves even more outcomes, but studies assessing the interactions between exercise and TENS found no cumulative impact. (Poitras, 2008) For more information, see the *Pain Chapter*.

**Recent research:** A recent meta-analysis concluded that the evidence from the small number of placebo-controlled trials does not support the use of TENS in the routine management of chronic LBP. There was conflicting evidence about whether TENS was beneficial in reducing back pain intensity and consistent evidence that it did not improve back-specific functional status. There was moderate evidence that work status and the use of medical services did not change with treatment. Patients treated with acupuncture-like TENS responded similarly to those treated with conventional TENS. (Khadilkar-Cochrane, 2008) On June 8, 2012, the Centers for Medicare & Medicaid Services (CMS) issued an updated decision memo concluding that TENS is not reasonable and necessary for the treatment of chronic low back pain based on a lack of quality evidence for its effectiveness. Coverage is available only if the beneficiary is enrolled in an approved clinical study. (Jacques, 2012)

The requests for a back brace/lumbar support, and a TENS unit, while not extensively discussed in Dr. R's reports, were requested for the purpose of providing "nonnarcotic treatment options to reduce and control [the claimant's] pain." The first suggestion of these options does not appear in Dr. R's reports until 2015. There is little discussion or support in his reports to support a back brace providing pain relief, and there are little or no specific plans in Dr. R's report for a TENS unit trial.

On the date of this medical contested case hearing, the ODG provides the following with regard to physical therapy for the low back:

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*.

**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:**

10 visits over 8 weeks

**Sprains and strains of unspecified parts of back:**

10 visits over 5 weeks

**Sprains and strains of sacroiliac region:**

Medical treatment: 10 visits over 8 weeks

**Lumbago; Backache, unspecified:**

9 visits over 8 weeks

**Intervertebral disc disorders without myelopathy:**

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**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

**Spinal stenosis:**

10 visits over 8 weeks

**Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:**

10-12 visits over 8 weeks

**Curvature of spine:**

12 visits over 10 weeks

**Fracture of vertebral column without spinal cord injury:**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

**Fracture of vertebral column with spinal cord injury:**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

**Torticollis:**

12 visits over 10 weeks

**Other unspecified back disorders:**

12 visits over 10 weeks

**Work conditioning** (See also *Procedure Summary* entry):

10 visits over 8 weeks

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) Compared with usual care, treatment of new LBP with early PT resulted in a statistically significant improvement in disability in a RCT with 220 participants. The PT involved only four sessions over 3 weeks, consisting of manipulation and exercise, among patients being seen for LBP in a primary care setting, and the effects persisted for one year. The authors suggest that the potential benefits of early physical therapy should be evaluated in light of the time and effort required to participate in physical therapy. (Fritz, 2015) See also specific physical therapy modalities, as well as *Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; Stretching; Aquatic therapy; Group physical therapy*. [Physical therapy is the treatment of a disease or injury using 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-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)

**Timing of PT initiation:** Preliminary evidence suggests that early physical therapy may decrease cost without compromising outcomes. After initially screening 3855 articles, 14 studies were included in a systematic review. The majority of articles studied low back pain (only 2 articles studied cervical pain). For spinal pain, there was low-quality evidence that early versus delayed physical therapy was associated with decreased cost and decreased frequency of opioid prescriptions, advanced imaging, and surgeries. One subgroup analyzed showed improved function/disability with early physical therapy in an occupational health setting. These results suggest that it may be beneficial for physical therapist providers to be utilized early in an episode of care for a lumbar spinal disorder. (Ojha, 2016)

As with the requests for a back brace and TENS unit, the requests for physical therapy were for the purpose of providing “nonnarcotic treatment options to reduce and control [the claimant's] pain.” Dr. R did note in December, 2016 that his request for physical therapy was “a prerequisite to any interventional spine procedure.” He acknowledged that the denials were due to the age of the injury, but said he would “be happy to send [the claimant] to physical therapy” although he was “not optimistic” that it would be of much help to the claimant.

In regard to the requested medial branch blocks, they are being requested as the ODG-required diagnostic prerequisite for a new medial branch neurotomy. As discussed above, the neurotomy procedure has been shown, by actual experience with the claimant, to provide substantial and substantive relief from his chronic pain for in excess of the time required by the ODG for repeat neurotomies. The denials of this treatment by the utilization review and IRO doctors are based on incomplete records being provided to them, and on the difference between a peer review and the opinion of a doctor who has provided personal treatment to the claimant for 20 years and has seen the benefit of the neurotomies, which have a prerequisite of satisfactory medial branch blocks. Based on a careful review of the evidence presented in the hearing, the claimant has met his burden of overcoming the IRO decision in (Docket #1) by a preponderance of the evidence-based medicine, as well as documentation of the actual results of the treatment based on the requested diagnostic procedure. The preponderance of the evidence-based medicine is contrary to the decision of the IRO and, consequently, the claimant is entitled to left L3, L4, and L5 medial branch blocks.

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet his burden of overcoming the IRO decision in (Docket #2) by a preponderance of the evidence-

based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for a back brace and TENS unit. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, the claimant is not entitled to a back brace and TENS unit.

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet his burden of overcoming the IRO decision in (Docket #3) by a preponderance of the evidence-based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for an additional 8 physical therapy sessions. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, the claimant is not entitled to an additional 8 physical therapy sessions.

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 Workers' Compensation Division of the Texas Department of Insurance.
  - B. On (Date of Injury), the claimant was the employee of (Employer).
  - C. On (Date of Injury), the claimant sustained compensable injuries to his neck and lumbar spine.
  - D. On (Date of Injury), the employer provided workers' compensation insurance with, Carrier.
  - E. The IRO determined that the claimant is not entitled to left L3, L4, and L5 medial branch blocks.
  - F. The IRO determined that the claimant is not entitled to a back brace and TENS unit.
  - G. The IRO determined that the claimant is not entitled to an additional 8 physical therapy sessions.
2. The carrier delivered to the claimant a single document stating the true corporate name of the carrier, and the name and street address of the carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Left L3, L4, and L5 medial branch blocks are health care reasonably required for the compensable injury of (Date of Injury).
4. A back brace and TENS unit are not health care reasonably required for the compensable injury of (Date of Injury).
5. An additional 8 physical therapy sessions are not health care reasonably required for the compensable injury of (Date of Injury).

### **CONCLUSIONS OF LAW**

1. The Workers' Compensation Division of the Texas Department of Insurance has jurisdiction to hear this case.
2. Venue is proper in the (City) Field Office.
3. The preponderance of the evidence is contrary to the decision of the IRO that left L3, L4, and L5 medial branch blocks is not health care reasonably required for the compensable injury of (Date of Injury).
4. The preponderance of the evidence is not contrary to the decision of the IRO that a back brace and TENS unit is not health care reasonably required for the compensable injury of (Date of Injury).
5. The preponderance of the evidence is not contrary to the decision of the IRO that an additional 8 physical therapy sessions is not health care reasonably required for the compensable injury of (Date of Injury).

### **DECISION**

In (Docket #1), the claimant is entitled to left L3, L4, and L5 medial branch blocks for the compensable injury on (Date of Injury).

In (Docket #2), the claimant is not entitled to a back brace and TENS unit for the compensable injury on (Date of Injury).

In (Docket #3), the claimant is not entitled to an additional 8 physical therapy sessions for the compensable injury on (Date of Injury).

**ORDER**

The carrier is liable for the left L3, L4, and L5 medial branch blocks at issue in this hearing in (Docket #1). The carrier is not liable for the back brace, TENS unit, or additional 8 physical therapy sessions at issue in this hearing in (Docket #2) and (Docket #3), respectively. The claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **TEXAS PPROPERTY & CASUALTY INSURANCE GUARANTY ASSOCIATION for LUMBERMENS MUTUAL CAUSALTY COMPANY**, and the name and address of its registered agent for service of process is:

**MARVIN KELLY, EXECUTIVE DIRECTOR  
9120 BURNET ROAD  
AUSTIN, TX 78758**

Signed this 12th day of January, 2017.

William M. Routon II  
Hearing Officer