

MEDICAL CONTESTED CASE HEARING NO. 18027

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. For the reasons discussed herein, the Administrative Law Judge (ALJ) determines that Claimant is not entitled to chiropractic therapy to cervical, thoracic, and lumbar spine three times a week for four weeks for the compensable injury of (Date of Injury).

ISSUES

A contested case hearing was held on October 3, 2018 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to chiropractic therapy to cervical, thoracic, and lumbar spine three times a week for four weeks?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by CJ, ombudsman. Respondent/Carrier appeared and was represented by JC, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant.

For Carrier: None.

The following exhibits were admitted into evidence:

ALJ's Exhibits ALJ-1 and ALJ-2.

Claimant's Exhibits C-1 through C-7.

Carrier's Exhibits CR-1 through CR-D.

BACKGROUND INFORMATION

Claimant contested the determination of the IRO doctor who determined that he was not entitled to the requested chiropractic therapy. He relied on the medical records of Dr. RS, his treating doctor, and Dr. BS, the chiropractor referral. Carrier argued that Claimant offered insufficient evidence-based medicine to overcome the IRO decision, which is based on the Official Disability Guidelines (ODG).

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." The ODG addresses the necessity for chiropractic care:

Recommended as an option.

ODG Chiropractic Guidelines:

Therapeutic care –

Mild: up to 6 visits over 2 weeks

Severe*: Trial of 6 visits over 2 weeks

Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute (not chronic)

Elective/maintenance care – Not medically necessary

Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care

* Severe may include severe sprains/strains (Grade II-III) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders) (Hannafin, 2004)

Medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing. While not proven by multiple high-quality studies, a trial of manipulation for patients with radiculopathy may also be an option, when radiculopathy is not progressive, and studies support its safety. As with any conservative intervention in the absence of definitive high-quality evidence, careful attention to patient response to treatment is critical. Many passive and palliative interventions can provide relief in the short term but may risk treatment dependence without meaningful long-term benefit. Such interventions should be utilized to facilitate a return to normal functional activities, particularly work. Potential cautions or contraindications include coagulopathy, fracture, and progressive neurologic deficit. (Andersson-NEJM, 1999) (Cherkin-NEJM, 1998) (Mohseni-Bandpei, 1998) (Aure, 2003) (Pengel, 2002) (Assendelft, 2003) (Cherkin, 2003) (Licciardone, 2003) (Giles, 2003) (Ferreira, 2003) (Assendelft, 2004) (Grunnesjo, 2004) (Bronfort, 2004) (Hoiriis, 2004) (Oliphant, 2004) (Koes, 2004) (Legorreta, 2004) (UK BEAM, 2004) (Ianuzzi, 2005) (Muller, 2005) (Licciardone, 2005) (Airaksinen, 2006) (Ernst, 2006) (Hurwitz, 2006) (Santilli, 2006)

One high-quality clinical trial comparing chiropractic and physical therapy found both effective, but chiropractic was slightly more favorable for acute back pain and PT for chronic cases. (Skargren, 1998) A systematic review of 6 randomized controlled trials examined the use of spinal manipulation by physical therapists and found that it was an effective means to treat low back pain. (Kuczynski, 2012) An economic evaluation of four non-pharmaceutical treatments for low-back pain concluded that the mean costs per treatment group were \$369 for medical care only, \$560 for chiropractic care only, \$579 for chiropractic care with physical modalities, and \$760 for medical care with physical therapy. This study did not compare outcome success. (Kominski, 2005) Physician consultation is more cost-effective alone than when combined with manipulative treatment; outcomes show significant improvement in both groups, but the combination group had slightly more reduction in pain and clearly higher patient satisfaction. (Niemisto, 2005) Various techniques of manipulation are done by different providers. Manipulation, as used in the above studies, is defined as a process of physiological movement which goes beyond the passive range of motion into the paraphysiological zone, which may involve high velocity with or without recoil. This form of manipulation ("diversified") is the most commonly used by chiropractors; there is another form ("flexion-distraction"), but there are limited studies. The efficacy of distraction manipulation is not well established. (Gay, 2005) Spinal manipulation has been reviewed in 4 good-quality systematic reviews, and short-term, but not long-term, improvements have been reported. (Kinkade, 2007) Patients with acute low back pain receiving recommended first-line care did not recover more quickly with the addition of diclofenac or spinal manipulative therapy, according to the results of a randomized controlled trial in the November 8 issue of *The Lancet*. (Hancock, 2007) In this study of workers' comp patients, fewer chiropractic care visits was significantly associated with a lower likelihood of disability recurrence and 8.6% shorter disability duration. (Wasiak, 2007) A recent RCT found that reductions in pain were similar in both the experimental and control groups. Outcomes were assessed daily on days 1 to 14 by patient diary and at 6 months by mailed questionnaire. Limitations of the study included inability to closely monitor patient diaries, low recruitment rate, inability to blind clinicians and patients to treatment, and use of equivalence doses as the primary outcome measure. (Jüni, 2009)

Number of Visits: Several studies of manipulation have looked at duration of treatment, and they have generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Several studies question the need for extended treatment or at least encourage the need for reassessment after a few weeks of treatment. (Burton, 2000) (Hurwitz, 2002) (MDCConsult, 2003) (Stig, 2001) (Niemsto, 2003) (Haas, 2004) (Haas2, 2004) (Descarreux, 2004) One study

showed a success rate of 88% by six weeks with an average total of 8.2 visits and 3.8 more visits with a recurrence. (Triano, 1992) Another clinical trial found that only 4 sessions of manipulation and stabilizing exercises resulted in less pain and disability than physician consultation alone. (Niemisto, 2003) An RCT to determine the optimal number of visits for spinal manipulation found that either 12 or 18 are best, depending on time frame, with 18 best after a year. One hundred patients with cLBP were randomized to each of four dose levels of care: 0, 6, 12, or 18 sessions of spinal manipulation from a chiropractor, three times per week for up to 6 weeks. At 12 weeks, the greatest differences from the no-manipulation control were found for 12 visits, but at 24 weeks, differences were negligible; and at 52 weeks, the greatest group differences were seen for 18 visits. The researchers concluded that the number of spinal manipulation visits had modest effects on outcomes over those of 18 hands-on visits to a chiropractor, but overall, 12 visits yielded the best return, although that dose was not well distinguished from other dose levels. (Haas, 2013)

Patient Selection Criteria: The results of a recent study demonstrate that two factors - symptom duration of less than 16 days and no symptoms extending distal to the knee - were associated with a very good outcome from early referral for spinal manipulation. After only 1-2 sessions of spinal manipulation treatment and a range of motion exercise, the success rate when both criteria were present was 85%, and that when both criteria were absent was only 28%. (Fritz, 2005) Other studies support using the following patient selection criteria: (1) Duration of current LBP less than 16 days; (2) Not having symptoms below the knee; (3) FABQ score less than 19 points; (4) At least one hypomobile segment in the lumbar spine; and (5) Hip internal rotation range of motion >35 degrees. (Flynn, 2002) (Niemisto, 2004) (Fritz, 2004) (Childs, 2004) (Riipinen, 2005) Patients with signs and symptoms that suggest movement restrictions of the lumbar region should be treated with joint mobilization–manipulation techniques and range of motion exercises. (Fritz-Spine, 2003)

Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT) as well as Education and Exercise. The use of active treatments instead of passive modalities is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that fewer visits would be required in uncomplicated cases.

Current research: A recent comprehensive meta-analysis of all clinical trials of manipulation has concluded that there was good evidence for its use in acute, sub-acute, and chronic low back pain, while the evidence for use in radiculopathy was not as strong,

but still positive. (Lawrence, 2008) A Delphi consensus study based on this meta-analysis has made some recommendations regarding chiropractic treatment frequency and duration. They recommend an initial trial of 6-12 visits over a 2- to 4-week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2- to 4-week period. According to the study, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels despite residual pain, as well as to avoid catastrophizing and overdependence on physicians, including doctors of chiropractic." (Globe, 2008) These recommendations are consistent with the recommendations in ODG, which suggest a trial of 6 visits, and then 12 more visits (for a total of 18) based on the results of the trial, except that the Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24). Payers may want to consider this option for patients showing continuing improvement, based on documentation at two points during the course of therapy, allowing 24 visits in total, especially if the documentation of improvement has shown that the patient has achieved or maintained RTW. This systematic review concluded that there is moderate quality evidence that spinal manipulation is effective for the treatment of acute lumbar radiculopathy, but there is no evidence for the treatment of thoracic radiculopathy. (Leininger, 2011) Based on high-quality evidence in adults with chronic low back pain, SMT vs other interventions has a small statistically significant, but not clinically relevant, short-term effect on pain relief and functional status, and referral for SMT should be based on cost considerations and patient and provider preferences. (Rubinstein, 2011) A NASS systematic review suggested that 5 to 10 sessions of SMT administered over 2 to 4 weeks achieve equivalent or superior improvement in pain and function compared with other commonly used interventions. (Dagenais, 2010) All three interventions (manipulation, supervised exercise, and home exercise) had good outcomes in this RCT, but supervised exercise had a slight edge. (Bronfort, 2011) This RCT assessed the efficacy of spinal manipulation/mobilization (manual therapy) followed by specific active exercises and concluded that manual therapy accelerates reduced disability compared to exercise alone. (Balthazard, 2012) Osteopathic manual therapy (OMT) did well in this RCT. With 6 treatment sessions during a course of 8 weeks, 50% of the OMT group and 35% of the sham OMT group reported substantial improvement (relative risk [RR], 1.41).

(Licciardone, 2013) According to this systematic review, there is a paucity of quality clinical trials testing OMT in adult patients with chronic non-specific low back pain, and more data is required. (Orrock, 2013) In patients with back-related leg pain, spinal manipulative therapy (SMT) plus home exercise and advice (HEA) provided more short-term improvement in pain and function than HEA alone. SMT plus HEA demonstrated a clinically significant advantage over HEA after 12 weeks, but not at 52 weeks. At 12 weeks, 37% of patients receiving SMT plus HEA had at least a 75% reduction in leg pain, compared with 19% in the HEA group. (Bronfort, 2014) The AHRQ draft comparative effectiveness review of noninvasive treatments for low back pain concluded that spinal manipulation was no more effective than sham manipulation, but manipulation was as effective as other interventions thought to be effective. (Chou, 2016)

The IRO reviewer agreed with two utilization review doctors and opined that the requested treatment did not meet ODG criteria. Specifically, the IRO reviewer opined that there was no indication of a worsening of his original injury to justify further chiropractic care as medically necessary. The two Utilization Review doctors opined there was limited clinical and objective findings to justify additional chiropractic care. Claimant provided the medical records from Dr. S and Dr. S. However, these medical providers did not cite the ODG Guidelines or other evidence-based medical studies to support the necessity of the requested treatment.

Claimant has the burden of proof on this case to show by the preponderance of evidence-based medical evidence that the disputed procedure is health care that is clinically appropriate and considered effective for his injury. Evidence-based medical evidence entails the opinion of a qualified expert that is supported by evidence-based medicine. The evidence presented at the hearing cannot be construed to constitute evidence-based medical evidence sufficient to overcome the decision of the IRO reviewer. As Claimant did not overcome the IRO decision by a preponderance of the evidence-based medical evidence, he has accordingly failed to meet his burden of proof.

The Administrative Law Judge 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. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
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 ALJ's Exhibit Number 2.

3. On (Date of Injury), Claimant was the employee of (Employer), Employer.
4. On (Date of Injury), Employer provided workers compensation insurance through Transportation Insurance Company, Carrier.
5. On (Date of Injury), Claimant sustained a compensable injury.
6. Chiropractic therapy to cervical, thoracic, and lumbar spine three times a week for four weeks is not health care reasonably required 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 Claimant is not entitled to cervical, thoracic, and lumbar spine three times a week for four weeks.

DECISION

Claimant is not entitled to cervical, thoracic, and lumbar spine three times a week for four weeks 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 **TRANSPORTATION INSURANCE COMPANY**, and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEM
1999 BRYAN STREET, STE. 900
DALLAS, TX 75201-3136**

Signed this 4th day of October, 2018.

BRITT CLARK
Administrative Law Judge