

ADOPTED AMENDMENTS TO §134.1001

Spine Treatment Guideline

PREAMBLE FOR ADOPTION OF AMENDMENTS TO §134.1001

INTRODUCTION

The Texas Workers' Compensation Commission (the Commission) adopts an amendment to §134.1001, Spine Treatment Guideline with changes to the proposed text as published in the June 25, 1999, issue of the Texas Register (24 TexReg 4723) and Correction of Error published in the September 3, 1999, issue of the Texas Register (24 TexReg 7070).

As required by the Government Code, §2001.033(1), the Commission's reasoned justification for this rule is set out in this order which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the Commission disagrees with some of the comments and proposals.

This amendment to the Spine Treatment Guideline (STG) clarifies those services that are reasonable and medically necessary for care of the spine for the injured employees of Texas. The guideline is not to be used as a fixed treatment protocol, but rather identifies a normal course of treatment and reflects typical courses of intervention, while recognizing that there will be injured employees who will require less or more treatment than is outlined. The guideline also acknowledges that in atypical cases, treatment falling outside the guideline will occasionally be necessary. However, those cases that exceed the guideline level of treatment are subject to more careful scrutiny and review and require documentation of the special circumstances that justify the treatment. The guideline does not prescribe the type and frequency of treatment; treatment must be based on patient need and the health care provider's professional judgment. The rule is designed to function as a guideline and is not to be used as the sole reason for denial of treatments and services.

Changes made to the proposed rule are in response to public comment received in writing and at a public hearing held on August 4, 1999, and are described in the summary of comments and responses section of this preamble. Other changes were made based upon further review by staff and, in part, upon recommendations received from the Spine Treatment Guideline Revision Workgroup, to simplify and clarify the rules, ensure consistency, and to correct typographical, syntax or grammatical errors. Language changes were made specifically to subsections: (d)(2)(F); (e)(2)(D); (e)(2)(F); (e)(2)(L); (e)(2)(P); (e)(2)(R); (e)(2)(S); (e)(2)(T); (e)(2)(U); (e)(3)(C); (e)(3)(F); (e)(4); (f)(2)(B); (f)(2)(K); (f)(2)(L); (f)(3)(C); (f)(3)(D); (g)(3); (g)(4); (g)(6); (g)(7); (h)(1)(B); (h)(2)(A); (i)(2); (i)(3); (i)(5) and (i)(6). Changes were made to subsection (g)(7)(A),(B), (C) and (D). Subsection (e)(3)(G) and (e)(3)(H) were deleted. In subsection (j), additional definitions of terms were added. Subsections (k) and (l), the bibliography and revision bibliography, were deleted from the guideline and listed in the preamble. New language was added to subsection (e)(3)(B) and (e)(3)(G) and new subsections (b)(5) and (k) were created to respectively clarify effective dates of guideline usage and to include a severability clause.

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Amendments to §134.1001 contain deletion of 1999 Current Procedural Terminology (CPT) codes as published in the *Physician's Current Procedural Terminology 1999*, American Medical Association (AMA) copyright 1998. Staff reconsidered the use of 1999 CPT codes in the proposed STG. To prevent potential conflicts with the TWCC *Medical Fee Guideline (MFG)* and to ensure consistency among the Commission's guidelines, staff has amended subsection (i)(6), Surgical Treatment Charts 5A, 5B, and 5C, to reflect general procedural terminology instead of the 1999 CPT codes. Additionally, this amendment to subsection (i)(6) negated the need for subsection (i)(1), Surgical Treatment Code Legend; therefore, subsection (i)(1) has been deleted.

The guideline promotes quality health care, injury specific treatment and appropriateness of care, by identifying clinically acceptable courses of care for spine injuries, and by facilitating communication between all parties in order to achieve rapid recovery from the effects of an injury. This communication will also promote a timely return to modified or full duty work that takes into account the job demands and the functional capabilities of the injured employee.

The Commission considered all relevant statutory and policy mandates and objectives and designed this rule to achieve those mandates and objectives, including the following:

- (1) the establishment of medical policies and guidelines relating to use of medical services by employees who suffer compensable injuries;
- (2) the establishment of medical policies relating to necessary treatments for injuries which are designed to ensure the quality of medical care and designed to achieve effective medical cost control;
- (3) the establishment of a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatment and services; and
- (4) the establishment of a program for systematic monitoring of the necessity of treatments administered, for detection of practices and patterns by insurance carriers in unreasonably denying authorization of payment, and for increasing the intensity of review for compliance with medical policies or fee guidelines.

Section §134.1001 as proposed for amendment will achieve these objectives by:

- (1) identifying services that are reasonable and medically necessary for treatment of spine injuries;
- (2) assisting all parties with regard to the appropriate treatment and management of spine disorders as it relates to healthcare for the injured employee;

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- (3) establishing a guideline against which aspects of care can be compared;
- (4) identifying clinically acceptable courses of care for spine injuries;
- (5) establishing documentation standards which support the appropriateness of the level of service for assessment/evaluation and on-going treatment;
- (6) providing a mechanism for prospective, concurrent, and retrospective review to ensure efficient and effective health care utilization; and
- (7) establishing normal courses of treatment based on clinical indicators at different levels of healing.

In accordance with the statutory objectives and Commission policy, the Spine Treatment Guideline seeks to balance the need for cost control and review with the need for access to quality medical care by establishing typical courses of treatment, but allowing treatment outside the set parameters with additional documentation of the need for the treatment.

Quality of medical care is ensured by reliance upon input from medical experts and research of recognized studies in the field of spine treatment. The guideline ensures access to health care and that quality care will be available in each individual case by its ground rules that allow for treatment outside the stated parameters.

Effective medical cost control is achieved by establishing parameters for eligibility and termination of treatment, by setting documentation standards which support the appropriateness of the treatment; by requiring additional documentation for treatment falling outside the guideline's parameter; and by providing that treatments for the spine are subject to the Commission's separate rule requiring insurance carrier preauthorization for certain treatments as a prerequisite to payment for the services.

The guideline allows for prospective, concurrent, and retrospective review of treatment by setting standards for eligibility and treatment and setting documentation standards. These standards are to be used by health care providers as a basis for prospective review of possible treatment. The guideline and the documentation requirements should also provide the health care provider with a means to justify treatments when questioned concurrently or retrospectively by an insurance carrier.

The guideline and documentation also provide a starting point for insurance carriers in conducting prospective, concurrent, or retrospective review of treatment. The Medical Review Division (MRD) and the Compliance and Practices Division will use the guideline and documentation as a tool for prospective, concurrent, and retrospective review of treatment, including use in: conducting audits of health care providers and insurance carriers, the establishment of a program for systematic monitoring of the necessity of treatments administered, and providing medical

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dispute resolution. The guideline also serves as part of the screening criteria required by the Texas Department of Insurance (TDI) for use by insurance carriers and agents performing utilization review of medical care for injured employees under the Texas Labor Code.

The rule will provide a mechanism to monitor the necessity of treatment administered and establish treatment parameters, thus providing greater efficiency in the provision of treatment to the injured employee for spine injuries.

The clinical and diagnostic treatment guidelines contained in this proposed amendment have been developed in conjunction with health care providers and other parties in the workers' compensation system. The Commission's Medical Review Division (MRD) began its review of the STG by conducting a focus group with insurance carriers in 1997. The Commission invited eight different insurance carriers/agents to participate in this focus group. The purpose of the meeting was to collect feedback on the STG from the insurance carriers' perspective. The following insurance carriers/agents were represented at this focus group, Forte, Intracorp, Cigna, CorVel Corporation, Kemper National Services, Liberty Mutual, Texas Association of School Boards and the Texas Workers' Compensation Insurance Fund.

The MRD also contacted members of the original Spine Treatment Guideline Workgroup, who assisted in drafting the guideline in 1994, composed of members from the following areas of medical practice and business: chiropractic, neurosurgery, orthopaedic surgery, physical medicine and rehabilitation, family practice, physical therapy, occupational therapy, osteopathic medicine and insurance. Workgroup members were asked to review the guideline, recommend changes, and give feedback on the guideline's use and effectiveness since its adoption. The MRD also conducted separate focus groups with medical doctors and chiropractors in Austin, Dallas, El Paso, Houston and San Antonio. These focus groups provided feedback on the guidelines' use and recommended changes.

The MRD staff considered recommendations made by the Texas Workers' Compensation Commission's Medical Advisory Committee (MAC). By statute, the MAC advises the division in developing and administering the medical policies, fee guidelines, and utilization guidelines established under the Texas Labor Code, §413.011. The MAC is composed of members who are appointed by the Commission and include representation from: public health care facility, private health care facility, doctor of medicine, doctor of osteopathic medicine, doctor of chiropractic, dentist, physical therapist, pharmacist, podiatrist, occupational therapist, medical equipment supplier, registered nurse, employers, employees, and two representatives of the general public. The MAC formed a subgroup of the MAC members called the Guideline Standardization Subcommittee (GSS) to review all treatment guidelines and recommend changes that make all treatment guidelines consistent. The GSS recommended changes based on their research and expertise, that would make all treatment guidelines consistent with each other and consistent with terminology that is recognized and accepted by the medical community. Staff considered recommendations made by the GSS, the focus groups and the original workgroup.

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With the suggestion from staff, and agreement from the MAC, the Commission formed a Spine Treatment Guideline Revision Workgroup (STGRW) to review the recommendations from all these different groups and consider new treatments for inclusion in the STG. The MAC further suggested the disciplines to be considered in the composition of such a revision workgroup and suggested the names of potential participants. As a result, the STGRW was composed of members from the areas of medical practice and business, which included the following: chiropractic, neurosurgery, orthopaedic surgery, physical medicine and rehabilitation, occupational medicine, physical therapy, occupational therapy, osteopathic medicine, psychology, and insurance. Three of the members of the STGRW were also members of the MAC. Additionally, during the meeting process the STGRW recommended the section on interventional pain procedures-spinal injections also be reviewed by an anesthesiologist and/or a physiatrist. Based on this recommendation two additional medical doctors were added to the STGRW to provide pain management expertise. These two doctors were an anesthesiologist and a physical medicine and rehabilitation specialist. Several STGRW members participated in the development of the following: North American Spine Society (NASS), Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists; International Spinal Injection Society (ISIS), Guidelines for the Performance of Spinal Injection Procedures; Agency for Health Care Policy and Research (AHCPR), Acute Low Back Problems in Adults - Clinical Practice Guideline; and standards for the Physiatric Association of Spinal, Sports and Occupational Rehabilitation (PASSOR), a branch of the American Academy of Physical Medicine and Rehabilitation.

The STGRW have brought to the MRD staff a combination of multidisciplinary medical expertise, sound clinical judgement, extensive scientific research, faculty affiliations with universities and hospitals, and experience in the development of other spinal guidelines.

The revision of the STG included a review, conducted by the staff and STGRW members and their associates, of literature that focused on salient topics in the guideline. Literature submitted by commenters was reviewed and evaluated. Criteria were used to determine if the materials submitted by public commenters met the general definition of scientific research. The same criteria was used in the *Upper Extremities Treatment Guideline* and are standard in the industry. Therefore, a relevant study based on scientific research was determined to: a) seek to test a hypothesis; b) involve multiple subjects, including control groups, since single subject case studies rank low as an accepted method for establishing the efficacy of treatments; and c) address the spine and/or involvement of the central or peripheral nervous systems. Much of the literature submitted did not meet these criteria because publications failed to document results of multiple subject studies, use of control groups, or did not relate to treatment for spinal injuries, rather it provided many anecdotal accounts of the use of a particular treatment. Staff recognizes that in the proposed STG there was an incomplete indication of the amount of studies and scientific research reviewed by staff and the STGRW. The proposed STG did not provide a complete bibliography as the literature cited was for those treatments and services included in the guideline, and did not reflect all the material reviewed. The proposal preamble invited submission of public comment, and based on the number of comments that staff received regarding research literature reviewed, the resources used in the evaluation of treatments and/or key elements in the STG

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revision will be included at the end of this preamble.

In general, a new diagnostic or therapeutic intervention may be incorporated into the STG if the technology was supported by published scientific literature as a relevant study and received the endorsement of the STGRW as normative care for the spine. Parameters on treatment and documentation standards were added or amended based on a review of the literature by staff or the STGRW members, the professional expertise of the STGRW members, and recommendations received from public comment.

The STGRW first met in January 1999 to review the recommendations received and consider new diagnostic and treatment interventions for inclusion in the STG. They were instructed to assist staff in defining the normative treatment for injuries affecting the spine and also balance timely delivery and appropriate medical care with cost containment. The STGRW was requested to recommend a frame work for acceptable treatment and to advise staff in setting parameters for utilization of services and appropriate approaches to treatment. The STGRW was also tasked to develop general treatment parameters in the area of chronic pain management to be used until a specific pain management treatment guideline is developed. The STGRW continued to meet monthly through April 1999 and reviewed treatments incorporated in the previous STG to determine if they continued to be considered reasonable and medically necessary treatments for particular diagnoses. The STGRW recommended adding usage and documentation parameters to several of the diagnostic and treatment interventions to clarify when these services or treatments are appropriate.

The STGRW and staff reviewed literature submitted by the previously identified groups regarding new technology and new treatments. Of the treatments reviewed, only acupuncture was recommended for addition to the STG. The STGRW relied upon reports of scientific research as well as their own professional experience in developing their recommendations. The STGRW and staff reviewed the following new treatments: Intra Discal Electro Thermal treatment (IDET), magnet therapy, vitamin therapy, prolo therapy, spinoscopy, vertebral axial decompression (VAX-D) and the injection of Botox. Although several of these technologies were considered to have value, the STGRW concluded that they were relatively new treatments and that there were insufficient scientific studies and trials to warrant inclusion in the STG at this time. The review of the literature regarding Botox injections, though not a new treatment, did not support its usage for treatment of injuries to the spine.

Concurrent updates were presented to the MAC during the months that the STG was under revision. These updates occurred in January, March and April 1999. The MAC reviewed and supported recommendations made by the GSS and the STGRW, as well as making additional recommendations.

Following the proposal of the STG, public comments were received and summarized. The STGRW reconvened for a meeting in September 1999 to review issues of concern raised by public comment. The STGRW members were sent excerpts from the public comments indicating

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the major issues and copies of bibliography lists that staff compiled from the literature and studies submitted by commenters in writing and at the public hearing. STGRW members were asked to review the information prior to the meeting. Those in attendance included five physicians and one psychologist. Several of the STGRW members who were unable to attend the meeting submitted information and recommendations in writing.

After a review of the major issues submitted by the commenters, the STGRW made recommendations to the MRD staff. These recommendations were reviewed by MRD staff and based upon that review some changes to the proposed STG were deemed appropriate.

The STGRW recommended VAX-D treatment and Botox injections should not be included in the STG treatment tables. The medical literature and comments submitted by commenters regarding these treatments was reviewed. The STGRW found that this information did not support the inclusion of these technologies in the STG at this time. The STGRW noted that although Botox injections are valid in other medical treatments, the usage of Botox injections for injuries to the spine has not been supported through scientific trials.

The STGRW reviewed nerve conduction studies (NCS), current perception threshold (CPT), and somatosensory evoked potentials (SEP). The STGRW and staff concluded that nerve conduction studies were deemed to be an appropriate diagnostic tool and have been included in the List of Diagnostic Interventions, subsection (f)(2)(K) of the STG, as EMG/nerve conduction studies. The STGRW's review of CPT, a type of sensory conductive test, indicated that there was supporting literature for its effectiveness in some medical conditions but that there was little evidence to warrant its use for musculoskeletal conditions. However, staff's review of the literature supplied by commenters supported the efficacy of CPT testing for peripheral neuropathy that is not clinically detectable through sensory nerve conduction velocity (NCV) studies. Staff's review of the literature also supported the efficacy of CPT testing for the evaluation of radiculopathies and as an appropriate diagnostic tool for the quantitative measure of the functional integrity of sensory nerve fibers. CPT is considered a NCS and is therefore included in the STG. The STGRW recommended that the use of SEPs was appropriate only for intraoperative monitoring and that repeated studies indicated extremely limited application. Based on the literature and recommendation by the STGRW, staff has excluded SEP as a diagnostic intervention, although it may be appropriate for intraoperative monitoring.

Changes in the proposed text are as follows:

Table of Contents (a)(8)(A)-(I) - Inappropriate reference made to (A) Introduction to Algorithms was deleted. Additionally, Surgical Code Treatment Legend that referenced (i)(1) was deleted and subsequent section references were renumbered accordingly.

Table of Contents (a)(10) and (11) - The bibliography and revision bibliography sections have been deleted from the guideline and placed in the preamble. This was done in order to document a list of resources used in the evaluation of treatments and/or key elements in the STG revision.

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Subsection (b)(5) - Language was added to include and clarify the effective dates for usage of the STG.

Subsection (c)(1)(A)(ii) - "And" was replaced with "or" in order to correct inaccurate quotation from the Texas Labor Code, §408.021 (a).

Subsections (d)(1)(E), (d)(5), and (e)(2)(C) - "Educating" was replaced with "providing education to." Health care providers are required to provide education; the incorporation of the education is the responsibility of the injured employee. Also, inappropriate reference to (1)(E) in subsection (d)(1)(E) was corrected to (d)(5).

Subsection (d)(2)(F) - Language was changed to ensure that a focus review is consistent with rules developed by the Texas Department of Insurance (TDI) for utilization review of workers' compensation injuries, because the utilization review rules address both prospective and retrospective review. The inclusion of the term, "case management" was confusing in this application, therefore, it was deleted. "Proposed treatment" was replaced with "treatment being provided" to ensure prospective utilization is not a component of a focus review. The transposition of the phrase "as early as possible" to the beginning of the sentence instead of at the end of the sentence was made in order to improve syntax. Language was deleted to provide consistency in this subsection. Language was added to (d)(2)(F)(iv) of this subsection to direct that medical necessity is addressed through retrospective review according to TDI utilization review rules. Additionally, language was deleted in (ix) of this subsection for consistency with TDI rules.

Subsection (e)(2)(C) - Inappropriate reference (d)(1)(A)(v) was corrected to (d)(1)(E) and (e)(2)(C) was corrected to (d)(5).

Subsection (e)(2)(D) - Language was changed by replacing "outpatient evaluation and therapy" with "physical medicine treatment" to be consistent with the TWCC *Medical Fee Guideline*. Additionally, the language "over time of treatment" was deleted to improve syntax.

Subsection (e)(2)(F) - Three language changes were incorporated. Language was changed to establish when it is appropriate for an injured employee to enter a chronic pain management (CPM) program. The term "all conventional" was removed to clarify that CPM is considered to be a conventional treatment for injured employees who meet established program entry parameters. Another language change addressed the coincidental endpoint of CPM with attainment of maximum medical improvement (MMI) as one of the components of a CPM program, this clarified that an identified endpoint should "typically" coincide with the last step(s) in treatment prior to achievement of MMI, if not already determined. Further, the language allows notification to the injured employee that non-compliance "may" result in the certification of MMI and the required evaluation for assigning an impairment rating. Additional language was added to explain that a re-enrollment in or repetition of a subsequent CPM program would not be medically warranted "for the same condition or injury." Due to renumbering, reference paragraph

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(2)(R) was changed to paragraph (2)(T).

Subsection (e)(2)(L) - New language was added at the end of the subsection to establish that upon completion of a rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) neither re-enrollment in nor repetition of the same rehabilitation program is medically warranted for the same condition or injury.

Subsection (e)(2)(M) - Subsection (e)(2)(Y), regarding mental health evaluations, was moved for consistency purposes and is now subsection (e)(2)(M). As a result, subsections (e)(2)(N)-(X) have been renumbered.

Subsection (e)(2)(P) - Language "alternative or experimental" was added to avoid the exclusion of any treatments for review by the Commission.

Subsection (e)(2)(R) - Due to the STGRW's recommendation, staff restored language in the previous STG's list of indications, (v), spondylolisthesis. And a typographical error in the word "pseudarthrosis" was corrected in (vi).

Subsection (e)(2)(S) - For clarification purposes (iv) was included as an additional objective to interventional pain procedures.

Subsection (e)(2)(T) - Language additions and deletions were made to provide clarification in treatment parameters regarding diagnostic and therapeutic injections. And to provide consistency with language used throughout this guideline. Reference (e)(3)(G) was added to provide additional direction regarding documentation requirements.

Subsection (e)(2)(U) - Term "paraspinal" was deleted in order to avoid limiting the injection to a particular area.

Subsection (e)(2)(V) - Reference (e)(3)(G) was added to provide additional direction regarding documentation requirements.

Subsection (e)(2)(Y) - The term "should" was replaced with "shall" to provide consistency with the *TWCC Medical Fee Guideline*. And, irrelevant language was deleted.

Subsection (e)(3)(B) - In (v) the term "education" was replaced with "educational" for grammatical correction. In (vi) added the term "objective" to provide consistency with documentation requirements.

Subsection (e)(3)(C) - Deleted term "acceptable" for language clarification. The term "outpatient evaluation and therapy" was changed to "physical medicine treatment" to provide consistency with other treatment and fee guidelines. Added term "clinical" in (ii) and added clause (xii), regarding documentation requirement, in response to public comment. The term "and" was replaced with "or" in (xi) in order to provide consistency with documentation requirements.

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Subsection (e)(3)(F) - The term "and" was replaced with "or" in order to provide consistency in documentation requirements.

Subsection (e)(3)(F) - Language "return to work" was changed to "enhances the ability of the employee to return to or retain employment" to provide consistency with Texas Labor Code, §408.021.

Subsection (e)(3)(G) - Language was deleted and replaced with documentation criteria for acupuncture and spinal injections.

Subsection (e)(3)(H) - This subsection was deleted because emergency treatment is more appropriately addressed in other TWCC rules.

Subsection (e)(4) - Language was added for clarification purposes.

Subsection (f)(2)(B) - The term "or" was replaced with "and/or" to expand the list of diagnostic interventions for x-rays.

Subsection (f)(2)(K) - "EMG/evoked potential" was replaced with "EMG/nerve conduction studies (excluding Somatosensory Evoked Potential (SEPs))." The term "nerve conduction studies" more appropriately encompasses nerve studies, which include interpretation of evoked potentials, sensory and motor nerve conduction velocities, response amplitudes, and latencies studies. Current perception threshold studies are also included. Somatosensory evoked potentials are excluded as a diagnostic intervention.

Subsection (f)(2)(L) - Language was amended to be consistent with subsection (e)(2)(T), spinal injection techniques.

Subsections (f)(2)(L)&(M) - Amended references due to renumbering of subsections.

Subsection (f)(2)(N) - Reference (f)(3)(D) was added to provide additional direction regarding time recommendations.

Subsections (f)(3)(A)-(C)&(E) - The term "paragraph" was deleted for grammatical correction.

Subsection (f)(3)(C) - The term "months" was replaced with "weeks" for consistency with language clarifications made to subsection (e)(2)(T), spinal injections.

Subsection (f)(3)(D) - Language was changed to provide clarification and amend restrictive language to better reflect intent of the application of the guideline. Language "suspect degenerated" was changed to "suspected painful" in clause (iii) to allow subjective indications for discography. This was done because a discography is performed to identify pain generator(s) and in some cases degenerated discs are not painful.

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Subsections (g)(2),(3), and (4) - Language was added to include duration of care time frames, which provides consistency with the phases of care treatment tables.

Subsections (g)(3) and (4) - "Current or expected job requirements" replaced "job requirements for heavy physical labor" in order to include individuals whose job requirements would not require heavy physical labor.

Subsection (g)(6) - "As with all medical services," was added to remind health care providers of their responsibilities in providing medical services.

Subsections (g)(7)(A),(B), and (C) - Diagnostic testing was moved from the treatment interventions section to the assessments section because diagnostic testing is not a treatment intervention, it is a form of assessment. These subsections were also amended to include cross referencing to the appropriate section in the ground rules and to include examples of Behavioral Pain Management.

The term "outpatient evaluation and therapy" was replaced with "physical medicine treatment" which provides consistency with language changes in ground rules.

Subsections (g)(7)(A) and (B) - Injection examples were deleted because reference to ground rules was added.

Subsection (g)(7)(B) - The term "active" was deleted from "exercise" in order to ensure consistency throughout the guideline. Added TENS as a treatment intervention to provide consistency with the ground rules. Added language regarding post-medical vocational rehabilitation to return to work issues.

Subsection (g)(7)(C) - Added "injections" to treatment interventions to provide consistency with (e)(2)(T), spinal injections. Subsection was also amended to include cross-referencing to the appropriate ground rule.

Subsection (g)(7)(D) - The heading "Clinical or Behavioral Indicators" has been changed to "Clinical Indicators" to make the STG consistent with the Upper Extremities Treatment Guideline and the Lower Extremities Treatment Guideline.

Subsection (h)(1)(B) - Language regarding stabilizing treatment and services for the injured employee was added to provide consistency with other Commission rules.

Subsection (h)(2)(A) - The term and definition of "Human Performance Measurement" was replaced with the term and definition of "Functional Abilities Tests." This provides consistency with the TWCC *Medical Fee Guideline*.

Subsection (i) - The word "paragraphs" was replaced with the word "charts" because charts more

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accurately describe treatment algorithms. Also, inappropriate reference to subsection (e)(4), Documentation Requirements for Unrelated or Intercurrent Illness, was deleted.

Subsection (i)(1) - The Surgical Treatment Code Legend, was deleted and subsection (i) was re-numbered accordingly. This was done to provide consistency with the current TWCC Medical Fee Guideline. In renumbered subsection (i)(1) Initial Approach to Treatment of Spinal Injury Chart 1, and (i)(2) Fracture and/or Dislocation Chart 2, the term "primary" was replaced with "initial."

Subsection (i)(5) - Surgical Treatment Charts 5A, 5B, and 5C were amended to include general procedural terminology instead of the 1999 AMA CPT codes. This was done to prevent potential conflicts with the TWCC *Medical Fee Guideline* and to ensure consistency among the guidelines.

Subsection (i)(6) - "Levels of care" was changed to "phases of care" because the term "phase" more accurately captured the medical process.

Subsection (j) - Definitions of terms referred to in the ground rules were added and numbering was appropriately revised.

Subsections (k) and (l) - Deleted bibliography and revision bibliography from the guideline and added to the preamble a list of resources reviewed for the revision of this guideline. The bibliography and revision bibliography included references to materials which were used when the STG was originally drafted and some of these sources were no longer applicable. Instead of including these references in the STG itself, the materials used in revising the guideline have been included in the preamble to this rule.

Subsection (k) - New subsection (k) was created to include a severability clause.

Comments regarding the proposed amendment to the Spine Treatment Guideline were received from fourteen injured employees and from the following groups: Healthwatch, Inc.; Fort Worth Orthopedic Surgery and Sports Medicine; Sports Medicine Clinic of Southeast Texas, Houston Center for Pain Medicine, P.A.; Texas Back Institute; Empi; Texas Chiropractic Association; TCA Committee on Worker's Compensation; Dallas Institute of Acupuncture & Oriental Medicine; Capital Orthopaedics; Rehabicare; Texas Acupuncture Association; Community Medical Clinic; Innovative Rehabilitation; American Institute of Orthopaedic & Sports Medicine; EBI Medical Systems; MediQuip International; Mid Cities Orthopedic and Sports Medicine Clinic, P.A.; Behavioral Healthcare Associates; East Texas Neurology, LLC; CorVel Corporation; South Texas Spinal Clinic, P.A.; Neurosurgical Associates; AmeriMed International; Orthopedic Clinic, P.A.; Alamo HealthCare Systems; Research and Oversight Council on Workers' Compensation; Steven Callahan, Ph.D. and Associates; Spine Diagnostics & Therapeutics; Texas Osteopathic Medical Association; Texas Physical Therapy Association; Neurotron, Inc.; Central Texas Spine Institute, LLP; Texas Spine Society; Texas Orthopedic Association; Orthofix, Inc.; Alamo Bone & Joint Clinic; Neurological Services, Inc.; Texas

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Workers' Compensation Insurance Fund; Neurodyne Inc.; Texas Acupuncture Society; Oratec; Acupuncture Medical & Research Centre; KSF Orthopaedic Center; Injured Workers Assistance Center; Pain Institute of Texas.

Those groups expressing overall support and specific support regarding the proposed provisions on: acupuncture, manipulation, documentation requirement, limitation of TENS use, CPM program, spinal injection techniques, discography, allograft, and fluoroscopy were received from: Steven Callahan, Ph.D. and Associates; CorVel Corporation; Texas Osteopathic Medical Association ; Texas Acupuncture Association; Empi; Texas Chiropractic Association; TCA Committee on Worker's Compensation; Healthwatch, Inc.; Innovative Rehabilitation; EBI Medical Systems; Pain Institute of Texas; Texas Acupuncture Society; and Texas Workers' Compensation Insurance Fund.

Comments received after the comment deadline have not been included in comment summaries and responses.

Staff reminds workers' compensation system participants that there may be injured employees who require more or less treatment than is recommended in this guideline. Therefore any treatment(s) not included in this guideline are not precluded from being performed with the appropriate documentation to substantiate the need for the treatment(s)/service(s). This concept has not been explicitly stated in all the responses to comments, but it is applicable to them and should be used as a frame of reference for each. Summaries of the comments and Commission responses are as follows:

VAX-D

COMMENT: Many commenters expressed concern that vertebral axial decompression (VAX-D) is not included in the Spine Treatment Guideline (STG). Commenters recommended that VAX-D be included as an optional treatment for low back pain because the commenters felt the procedure affords an alternative to back surgery, decreases pain and is cost effective, as well. Many of the comments were anecdotal accounts from patients who had been treated with VAX-D. A commenter recommended that the use of VAX-D be mandatory.

RESPONSE: Commission disagrees. The STG Revision Workgroup (STGRW) reviewed additional information and testimonials submitted by commenters. The STGRW and staff concluded that the information received regarding VAX-D treatment did not meet the scientific research criteria as previously identified in this preamble because the information submitted was anecdotal and not based on trial studies. Therefore, VAX-D treatment has not been included.

IDET

COMMENT: Some commenters recommended the inclusion of Intra Discal Electro Thermal treatment (IDET) in the STG. Another commenter felt that the language in the proposed

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preamble regarding IDET was ambiguous and requested further clarification; however, the commenter requested that IDET not be included in the STG, allowing for case by case review.

RESPONSE: The Commission disagrees with the inclusion of IDET as a normative course of treatment in the STG. The STGRW reviewed literature submitted by commenters and recommended to staff that IDET may be a reasonable alternative to surgery. However, the Commission determined that IDET will not be included in the STG at this time because there are no existing scientific studies to support the use of IDET as a normal course of treatment.

BOTOX

COMMENT: The use of Botox injections was recommended by some commenters to be included in the STG for treatment of pain in certain circumstances.

RESPONSE: The Commission disagrees. After considering and reviewing literature received from commenters, the STGRW recommended that Botox injections not be included in the STG. The STGRW noted that although Botox injections are valid in other medical treatments, the usage of Botox injections for injuries to the spine has not been supported through scientific trials. Therefore, Botox injections have not been included in the STG at this time.

CPT and sNCT

COMMENT: Commenters recommended the inclusion of current perception threshold testing (CPT) in the STG. Commenters objected to the preamble language that excluded CPT testing in the evaluation of musculoskeletal conditions.

RESPONSE: The Commission agrees that CPT should be included in the STG. Staff reviewed the literature supplied by commenters and determined the literature supported the efficacy of CPT testing for peripheral neuropathy that is not clinically detectable through sensory nerve conduction velocity (NCV) studies. The literature also indicated the usage of CPT, including sensory nerve conduction threshold (sNCT), testing to be reliable for the evaluation of radiculopathies and as an appropriate diagnostic tool for the quantitative measure of the functional integrity of sensory nerve fibers. Therefore, current perception threshold (CPT) testing has been included as a nerve conduction study (NCS) in the List of Diagnostic Interventions (f)(2)(K). The diagnostic interpretation of the potentials evoked in standard NCS includes the analysis of changes in sensory and motor nerve conduction velocities (NCVs), response amplitudes, and latencies.

SEPs

COMMENT: The inclusion of somatosensory evoked potentials (SEPs) as a diagnostic tool was recommended by a number of commenters. Commenters opposed the limitation of SEP use to intraoperative monitoring only, and requested striking that language from the preamble. One commenter also requested the inclusion of dermatomal sensory evoked potentials (DSEPs) in the STG, as well. A commenter provided reference materials supporting inclusion of SEPs stating

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that there were no such materials cited in the bibliography.

RESPONSE: The Commission disagrees. Staff and the STGRW reviewed additional literature submitted by commenters and concluded the literature supported the efficacy of this treatment only for intraoperative monitoring. The literature indicated somatosensory evoked potential (SEP), including DSEP, testing to be very sensitive to important biologic variables, such as age and height, and has limited value in diagnosing radiculopathies. Consequently, the Commission did not include SEP testing in subsection (f)(2), List of Diagnostic Interventions.

OPPOSED TO CHANGES

COMMENT: Many commenters strongly opposed changes to the current STG language and recommend that the current STG remain in effect.

RESPONSE: The Commission disagrees. The review and revision of the STG includes the evaluation of current medical treatment parameters and protocols. Due to advances in technology (e.g., alternative treatments to surgery and treatment protocols) changes to the previous STG are warranted.

INTRODUCTION

COMMENT: Commenter requested additional language, or language clarification regarding treatment being "based on patient need and the healthcare provider's professional judgment."

RESPONSE: The Commission disagrees that any additional language is needed. The idea that treatment is based on patient need and determined by the health care provider's professional judgement is incorporated in the text of the introduction through its explanation that some injured employees will require more or less treatment than recommended in the STG. These differences in treatment are due to the patient's needs and the health care provider's professional judgement.

PURPOSE (b)(1)

COMMENT: Commenter agreed with the language in the Purpose, that the guideline does not prescribe the type and frequency of treatment and must be "based on patient need and the health care provider's professional judgement." Other commenters questioned why the guideline states the purpose of the STG is to clarify those services that are reasonable and medically necessary and then states treatment will not automatically be deemed reasonable and necessary simply because treatment is listed in the guideline. Commenter expressed concern that the language in the Purpose section concerning prospective and concurrent review is in direct conflict with TWCC/TDI rules regarding utilization review and recommended re-wording and requested clarification regarding prospective application of guidelines.

RESPONSE: The Commission disagrees. The STG identifies services that are reasonable and

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medically necessary for care of the spine in a normal course of treatment. The guideline points out that there are injured employees who will require more or less treatment than is outlined. The STG is a guideline and not a fixed treatment protocol. Therefore, inclusion in the STG doesn't mean a particular treatment is reasonable and medically necessary for every patient. The Commission further disagrees with commenter's concern that language in the Purpose section puts the STG in direct conflict with the TDI utilization review (UR) rules. The STG is not to be used as the sole reason for denying a request for proposed treatment as designated in Chapter 144 Subchapter G (relating to Treatments and Services Requiring Preauthorization). Additionally, the STG may not be used as the sole reason for approving or denying reimbursement for treatment already provided (retrospective review.) TDI UR rules do not address concurrent review; however, TWCC treatment guidelines comprise part of the screening criteria required by TDI for use in determining approvals for preauthorization (prospective review) and reviewing for medical necessity (retrospective review), and as such, this guideline is not in conflict with the existing TDI rules.

DEVELOPMENT PROCESS (b)(3)

COMMENT: Commenters requested clarification regarding the manner and process used by TWCC for sorting and weighting evidence in the development process, as well as the manner and process used to determine which procedures and services would be recommended, not recommended for inclusion in the STG or seen as contradictory.

RESPONSE: The revision of the STG included a review, conducted by staff and STGRW members and their associates, of literature that focused on salient topics in the guideline. Literature submitted by commenters was reviewed and evaluated. To evaluate the materials submitted by public commenters and establish whether the materials met the general definition of scientific research the following criteria were established. These criteria were previously articulated by TWCC in a previous treatment guideline and are standard criteria used in the industry. A relevant study based on scientific research: a) seeks to test a hypothesis; b) involves multiple subjects, since single subject case studies rank low as an accepted method for establishing the efficacy of treatment methods; and c) addresses the spine and/or involvement of the central or peripheral nervous systems. Much of the literature submitted did not meet these criteria because it did not document results of multiple subject studies, rather it provided many anecdotal accounts of the use of a particular treatment. Staff recognizes that in the proposed STG there was incomplete indication of the amount of studies and scientific research reviewed by staff and the STGRW. The proposed STG did not provide a complete bibliography as the literature cited was for those treatments and services included in the guideline, and did not reflect all the material reviewed. The proposed preamble invited submission of public comment and based on the number of comments that staff received regarding research literature reviewed, the resources used in the evaluation of treatments and/or key elements in the STG revision have been included at the end of this preamble.

ROLE OF TREATING DOCTOR (c)

*Adopted amendments to §134.1001 (Spine Treatment Guideline). Adopted at the December 2, 1999 public meeting and scheduled to be published in the December 17, 1999 issue of the Texas Register.
Effective Date: February 1, 2000*

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COMMENT: Commenter advised of a misquote from Texas Labor Code, §408.021 (a) which should read, "The employee is specifically entitled to health care that: (i) cures or relieves the effects naturally resulting from the compensable injury; (ii) promotes recovery; OR (iii) enhances the ability of the employee to return to or retain employment."

RESPONSE: The Commission agrees. Subsection (c)(1)(A) has been corrected to reflect language in Texas Labor Code, §408.021 (a).

COMMENT: Commenter requested better delineation of the role of the treating doctor in order for all parties to be able to follow the rules, stating that treating doctors are refusing to participate in on-going care of an injured employee once a referral has been made. Commenter further questioned if the definition of "doctor" includes a Ph.D. who might be requesting authorization for treatment.

RESPONSE: The Commission disagrees that the role or the description of the role of a treating doctor should be changed. Subsection (c)(2) requires that the treating doctor monitor all healthcare services and sets out what the monitoring should include. A referral to another doctor does not relieve the treating doctor of his/her primary responsibility for the employee's health care for a compensable injury. The definition of "doctor" in Texas Labor Code, §401.011(42), does not include a Ph.D.; however, a Ph.D., who is a licensed health care practitioner as defined in §401.011(42), may provide services to an injured employee who has been referred and may bill according to the rules.

APPLICATION INSTRUCTIONS FOR INVOLVED PARTIES (d)(1)(A)

COMMENT: Commenter suggested changing subsection (d)(1)(A) to read: "...based on normal tissue healing responses or dysfunctions for the average injured employees" to be consistent with ground rule (e)(2)(E).

RESPONSE: The Commission disagrees that there is inconsistency because each subsection serves a different purpose. Subsection (d)(1)(A), Application Instructions for the Health care provider, establishes that the STG identifies typical treatment based on normal tissue healing responses for the average injured employee. The language in subsection (e)(2)(E) establishes that the frequency of a specific treatment is based on the injured employee's disease or dysfunctional recovery phase.

EDUCATING (d)(1)(E), (d)(5) and (e)(2)(C)

COMMENT: Commenter suggested amending the language in these areas to indicate that the health care provider is responsible for "providing education to the injured employee" instead of "educating the injured employee."

RESPONSE: The Commission agrees and has amended the language in subsections (d)(1)(E)

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and (d)(5) as suggested. The language has been changed for both consistency and improved syntax.

FOCUS REVIEW (d)(2)(F)

COMMENT: Commenter expressed concern that the items listed for an insurance carrier's focus review are in conflict with the TWCC/TDI rules and the recommendations for changes in treatment could well constitute the practice of medicine without a license if recommendations are not from a licensed doctor.

RESPONSE: The Commission disagrees. Staff reviewed the issue with TDI staff and confirmed that there is no conflict between the STG and TDI rules. However, language has been amended to clarify that a focus review is not meant to address prospective treatment(s) and/or service(s). The TWCC preauthorization rule, Chapter 134, Subchapter G, identifies the specific treatment(s) and/or service(s) that require prospective utilization review, and it is only for those specific treatment(s) and/or service(s) that prospective review applies. The language "proposed treatment" has been replaced with "treatment being provided" to clarify that prospective utilization is not a component of a focus review. Additionally, language has been added to advise that medical necessity is addressed through retrospective review according to TDI utilization review rules.

OUT PATIENT EVALUATION AND THERAPY / PHYSICAL MEDICINE TREATMENT (e)(2)(D)

COMMENT: Commenters requested that language be added that directs acute care providers to assess for psychosocial "Yellow Flags" on or before 8 weeks of care per management strategies developed by New Zealand guideline team. Commenter also recommended that "Yellow Flag" assessment language be added to Assessments section in Table I - Initial Phase of Care Table. Another commenter suggested addition to sentence regarding early activation to include "...bicycling, neuromuscular relaxation/re-education."

RESPONSE: The Commission disagrees. A mental health evaluation for the assessment of psychosocial issues is already addressed in subsection (e)(2)(Y) of the STG and in the Initial Phase of Care Table. Additionally, psychosocial issues are more specifically addressed in the TWCC *Mental Health Treatment Guideline*. Staff further disagrees with the recommendation to include neuromuscular relaxation/re-education in the early activation language in the outpatient evaluation and therapy section [now Physical Medicine Treatment section] because this is a treatment intervention already identified in the Initial Phase of Care Table.

MANIPULATION (e)(2)(E)

COMMENT: Commenter recommended substitution of the word "treatment" for the word "manipulation." Another commenter recommended language addition, "...performed during the

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acute phase of care for ..."

RESPONSE: The Commission disagrees. Language contained in subsection (e)(2)(E) applies to manipulative treatment (manipulations) only. There are other subsections within (e)(2) that specifically address criteria for other treatments, such as physical medicine treatments, chronic pain management, etc. Additionally, staff disagrees with the recommended language addition to address the "acute phase of care" because such a phase has not been identified or used in the STG. However, the STG identifies and defines an initial, intermediate and tertiary phase of care, and manipulations are an appropriate treatment intervention in each phase.

CHRONIC PAIN MANAGEMENT (CPM) PROGRAMS (e)(2)(F)

COMMENT: Numerous commenters expressed concern regarding chronic pain management (CPM) programs. A commenter suggested that the following language be added: "The purpose of pain management programs is to teach the injured employee to manage, not necessarily eliminate, a chronic condition."

RESPONSE: The Commission disagrees with the suggested language addition because the STG already contains sufficient descriptive language in the CPM program section. Furthermore, the TWCC *Medical Fee Guideline* provides additional CPM program criteria.

COMMENT: Commenter recommended that TWCC develop a specific CPM treatment guideline; commenter further recommended that TWCC delete the expansive definition of CPM program from the subsection.

RESPONSE: The Commission disagrees with the deletion of the CPM definition. Although it is likely that the Commission will develop a pain management treatment guideline, there is a need for descriptive language in the CPM section of the STG because some spine pain management guidance is needed.

COMMENT: Commenter recommended the development of a fourth level (quaternary) phase of care to include only CPM, only after six months of unabated pain as the absolute last step in care.

RESPONSE: The Commission disagrees with the need to develop a fourth phase of care for CPM. Post tertiary treatment already included in the STG appropriately addresses services and treatments, including CPM, that an injured employee may require after the phases of care.

COMMENT: Several commenters agreed with the six month timeframe in selection criteria to enter the CPM program.

RESPONSE: The Commission agrees.

COMMENT: Commenters requested the deletion of the selection criteria for CPM programs from the STG stating that they belong in the TWCC *Medical Fee Guideline* or in a separate CPM

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treatment guideline, and that they are inconsistent with other treatment and fee guidelines.

RESPONSE: The Commission disagrees with the recommendation to delete the selection criteria in the STG. It would not be appropriate to include selection criteria in the *TWCC Medical Fee Guideline* because the *TWCC Medical Fee Guideline* outlines only CPM program standards. The *TWCC Medical Fee Guideline* is not a treatment guideline and is not meant to identify the treatment parameters that have been developed in the CPM subsection of the STG. There is, therefore, no inconsistency with other guidelines. Although it is likely that the Commission will develop a pain management treatment guideline, there is a need for selection criteria in the CPM subsection of the STG because some spine pain management guidance is needed.

COMMENT: A commenter expressed concern that the difference between chronic and acute pain is not sufficiently addressed in the guideline, and that treatment for injured employees with chronic pain flare-ups are not addressed. Another commenter recommended algorithms be developed for pain management's Interventional and rehabilitation procedures.

RESPONSE: The Commission disagrees. Definitions for the terms "chronic" and "acute" are contained in subsection (j), Glossary. The STG incorporated the development of post-tertiary care for treatment provided for the duration of the injury which includes pain management or other symptomology experienced after the tertiary phase of care for injured employees including those with chronic pain. Additionally, pain management programs are developed to meet specific patient need and it would be improbable to capture all the treatments interventions with algorithms.

COMMENT: Several commenters expressed concern that the language implies that CPM is not a conventional medical treatment and requested a language change to reflect failure of "most conventional treatments," not "all conventional treatments." Other commenters suggested deletion of the entire phrase, "who are not immediately returning to any conventional treatment" or deletion of the terms "immediately" and "conventional" from the selection criteria.

RESPONSE: The Commission agrees. The STGRW and staff revisited subsection (e)(2)(F), CPM programs, and recommended amendments to the language in the section. As a result, subsection (e)(2)(F) has been amended to read "CPM programs may be appropriate for injured employees with chronic pain for which surgical and non-surgical treatments have failed and who are not imminent candidates for other treatments."

COMMENT: Commenter suggested that injured employees who have documented narcotic addiction due to pain associated with the injury, and who have not had six months of pain, be allowed to enter a CPM program.

RESPONSE: The Commission agrees. The STG addresses normative care for injuries to the spine and with proper documentation does not prohibit injured employees who have narcotic addiction due to pain associated with the injury, and who have not had six months of pain, to

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enter a CPM program. Furthermore, the issue of addictions is addressed in the TWCC *Mental Health Treatment Guideline*, subsection (i)(3)(B)(iii)(VII) Criteria for Referral to Chronic Pain Management Programs.

COMMENT: Several commenters objected to the proposed endpoint of CPM programs to coincide with the determination of Maximum Medical Improvement (MMI) and several commenters requested the modification or deletion of that language.

RESPONSE: The Commission agrees. The endpoint of a CPM program may not always coincide with the determination of MMI. Thus, the CPM components have been amended to state the following, "...an identified endpoint, which typically coincides with the last step(s) in treatment prior to achievement of MMI, if not already determined..."

COMMENT: Several commenters recommended that CPM programs be re-incorporated into the Intermediate Phase of Care Table. Some commenters offered suggested replacement paragraphs.

RESPONSE: The Commission disagrees. The STGRW reviewed the possible inclusion of CPM in the Intermediate Phase of Care Table and concluded that six months of unabated pain would preclude inclusion in the Intermediate Phase of Care Table. Staff agreed with the STGRW's recommendation and some of the commenters' suggested language. Subsection (g)(6), Post-tertiary treatment, was incorporated in the STG to allow treatment(s) and/or service(s) be provided to control pain or other symptomology experienced after the Tertiary Phase of Care.

COMMENT: Commenter suggested adding "severe" to the pain description, and that "significantly alters the injured employee's ability to perform activities of daily living expected for a person with the same or similar injury..." be added to the description of chronic pain management programs.

RESPONSE: The Commission disagrees. The STG addresses chronic pain as "pain that has lasted without abatement for six months." The term chronic appropriately refers to long duration not severity and is not defined with the term "severe." In addition, unabated pain for six months would not necessarily encompass the alteration of the injured employee's ability to perform activities of daily living. "Acute" pain is defined separately from "chronic" pain.

COMMENT: Regarding the re-enrollment or repetition of another CPM program, commenter suggested adding that it would "generally" not be medically warranted. Another commenter requested clarification on how the re-enrollment limitation might affect a subsequent and separate injury.

RESPONSE: The Commission disagrees with the proposed inclusion of the word "generally" before "not be medically warranted" in subsection (e)(2)(F). The STGRW revisited the concept and concluded that a second or subsequent CPM program for the same injury would not be medically warranted. The Commission agrees with this conclusion because of the intensity of the

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CPM program. CPM is intended to typically coincide with the last step(s) of treatment prior to achievement of MMI. Consequently, a repetition of the CPM program would not be of medical benefit to the injured employee. Language has been added to subsection (e)(2)(F) to clarify that re-enrollment or repetition of a CPM program for the same condition or injury would not be medically warranted. As discussed previously, if re-enrollment or repetition of a CPM program is medically warranted for a particular injured employee, it should be substantiated with documentation of procedure (DOP).

COMMENT: Commenter recommended both work conditioning and work hardening be prohibited after the completion of a CPM program while another commenter recommended that both of these treatments be available after a CPM program is completed.

RESPONSE: The Commission disagrees. The CPM program is intended to typically coincide with the last step(s) of treatment prior to achievement of MMI. Completion of the CPM program does not prevent the injured employee from access to additional treatment after completion of the program because the injured employee is entitled to reasonable and medically necessary treatments for the duration of the injury. The Commission agrees that work hardening and work conditioning may be appropriate after completion of a CPM program.

COMMENT: Commenter recommended the combination of sections (F) CPM and (L) Rehabilitation Programs into a new Interdisciplinary Program ground rule, containing language in both (F) and (L) and the addition that the severity of the injured employee's medical condition be matched with the most appropriate program. Commenter also recommended that the new ground rule should state that participation in more than one program is inappropriate.

RESPONSE: The Commission disagrees. The programs are intended to complement each other, and are not mutually exclusive. The CPM program is intended for the management of chronic pain by the injured employee. Other rehabilitation programs (i.e., work conditioning, work hardening, and outpatient medical rehabilitation) are intended to physically rehabilitate the injured employee. These differences make it appropriate for more than one of these types of programs to be used on a particular injured employee.

TENS (e)(2)(G)

COMMENT: Commenter stated that TENS units have uses other than "acute pain" and suggested that "relief of muscle spasms and to re-educate muscles" be added to the TENS section. Other commenters expressed opposition to the limitations placed on usage of the TENS unit and another commenter recommended changing the duration limits from "four to eight weeks" instead of "four to six weeks." A commenter recommended allowing the physician to determine the duration for use of the TENS unit. One commenter recommended deletion of the word "objective" from the documentation that should be provided for continued use of TENS, both in this and in subsection (e)(3)(F), General Documentation Requirements.

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RESPONSE: The Commission disagrees. The TENS subsection addresses the use of TENS units for treatment of acute pain. Relief of muscle spasms is a subset of acute pain, as are many other symptoms of acute pain. A literature search did not produce any scientific studies to support the effectiveness of TENS in re-educating muscles. The suggested language changes regarding symptoms and TENS applications are not necessary because the use of TENS beyond four to six weeks, as determined by the health care practitioner, is allowed with appropriate documentation. The STGRW and staff again discussed and the STGRW agreed that for TENS usage, four to six weeks is an appropriate time duration for acute pain. Staff utilized the knowledge and medical expertise provided by members of the STGRW, several of whom participated in the development of these national guidelines, which provided the basis for the time duration. The term "objective" is a necessary component for justifying treatments and/or services as described in the General Documentation Requirements subsection, (e)(3).

COMMENT: Several commenters recommended the deletion of "other transcutaneous stimulators" or the separation of TENS from "other transcutaneous stimulators."

RESPONSE: The Commission disagrees with the recommendation to separate TENS from other transcutaneous stimulators because all TENS and other transcutaneous are similar. Even though the products may vary, the purpose remains the same.

COMMENT: Several commenters recommended that the insurance carrier determine if TENS unit should be rented or purchased for short term usage.

RESPONSE: The Commission disagrees. The *TWCC Medical Fee Guideline* more appropriately addresses the rental or purchase of TENS units.

COMMENT: Commenter requested greater flexibility in TENS usage in acute pain situations and the inclusion of language to allow for use of TENS in treatment of acute exacerbations and in the post tertiary phase of care. In addition, another commenter suggested the inclusion of TENS for chronic pain and offered language: "Trial TENS for 1 month, if successful in pain relief, increased mobility and decrease use of analgesics, then purchase of device should be authorized."

RESPONSE: The Commission disagrees there is a need for additional language. The use of TENS beyond four to six weeks, as determined by the health care practitioner, is allowed with appropriate documentation as described in the General Documentation Requirements subsection, (e)(3)(F). The Commission disagrees with the proposed language regarding trial TENS for chronic pain because medical literature did not support the efficacy of TENS units and other transcutaneous stimulators in chronic pain situations.

COMMENT: Commenter expressed concern that there is a negative inference regarding electrotherapy as being "non-typical" and an "abnormal" course of treatment.

RESPONSE: The Commission disagrees. The STGRW and staff reviewed treatments that are currently in the STG to determine if they were reasonable and medically necessary. Based on

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recommendations from the STGRW, staff added parameters to some of the treatments to clarify when these treatments are reasonable and medically necessary. The language regarding the use of TENS units and other transcutaneous stimulators is intended to add clarity regarding the appropriateness and purpose of the treatment, and not to give negative inference.

RETURN TO WORK PLANNING (e)(2)(H)

COMMENT: Commenter recommended revision of language in the last sentence by inserting "immediately" in place of ". . . as early as possible" in cases where the injury is severe and the provider expects obstacles in returning the injured employee to the work place."

RESPONSE: The Commission disagrees. Timely return to work planning efforts are a statutory requirement; however, "as early as possible" and "at the earliest medically appropriate time" is more reflective of the return to work goals. It is inappropriate and unreasonable to "immediately" address return to work planning efforts regardless of the severity of the injury.

SUBSECTION (e)(2)(I), referencing an Initial Mental Health Evaluation, HAS BEEN DELETED

COMMENT: Commenter suggested that the deleted paragraph remain a part of the STG. Further recommendation was that the section be amended to include: "(i.e., one-to-one psychotherapeutic counseling or biofeedback training with a Qualified Mental Health Provider)."

RESPONSE: The Commission disagrees. The information deleted in previous subsection (e)(2)(I) is included in the TWCC *Mental Health Treatment Guideline*. Subsection (e)(2)(M) of the STG references the TWCC *Mental Health Treatment Guideline*.

WORK HARDENING/WORK CONDITIONING/OUT PATIENT REHABILITATION (e)(2)(L)

COMMENT: Commenter recommended that work hardening and work conditioning be identified as two distinct programs. A commenter further requested clarification on what TWCC considers appropriate treatment parameters.

RESPONSE: The Commission disagrees that language changes are needed. In the STG, work hardening and work conditioning are two distinct programs contained within the "rehabilitation programs" subsection. Reference is made in subsection (e)(2)(L) to the TWCC *Medical Fee Guideline*, for definitions, program standards and program criteria. There is no need to restate information contained in the TWCC *Medical Fee Guideline*.

COMMENT: Another commenter recommended deletion of language concerning program goals for injured employees who have no specific job to return to, and offered optional language to incorporate time limitations, an identified endpoint, and the requirement of a specific job to return

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to or participation in a retraining program as criteria for admittance to either program. The commenter also recommended that language be added to ensure that intensity and duration of interdisciplinary programs are not intended for: sedentary or light positions, or those for whom an "increase in aerobic capacity is not present." The commenter further recommended language to limit participation in more than one work hardening or work conditioning program.

RESPONSE: The Commission disagrees. The goals established in this subsection are the result of STGRW's and staff's cooperative efforts and reflect the medical expertise offered by the STGRW. A goal of rehabilitation programs is to restore a reasonable level of physical functioning regardless of the injured employee's job status. Additionally, the TWCC *Medical Fee Guideline* more appropriately addresses the specific language pertaining to these programs. The language recommended by the commenters did not add to or clarify the already established goals. The Commission agrees with the commenter's recommended language to limit participation in more than one program. Language has been amended to subsection (e)(2)(L) to clarify that re-enrollment or repetition in the same rehabilitation program for the same condition or injury would not be medically warranted.

COMMENT: Commenter asked who will monitor a work conditioning program at the job site.

RESPONSE: The health care provider who is recommending the treatment, and the employer who is offering the on site progressive return to work program are jointly responsible. A coordinated effort on the part of the health care provider and the insurance carrier/employer is necessary to meet the goals of any work conditioning/work hardening program prescribed. A work conditioning program offered by the employer must meet the definition/criteria as set forth in the TWCC *Medical Fee Guideline*.

COMMENT: Commenter requested that TWCC clarify how to determine self-referral and conflict of interest elements.

RESPONSE: The requirements outlined in the proposed STG, subsection (e)(2)(N) have been in place since March 1995 with the adoption of the previous *Spine Treatment Guideline*. In accordance with the requirements of §413.041 of the TWCA, TWCC §134.100 and §134.101 provide guidance regarding self-referral and conflict of interests. In each calendar year during which a health care provider refers an injured employee to another (facility) in which the referring health care provider has a greater than 5.0% financial interest, the referring provider must file a disclosure with the Commission within 30 days of the first referral and to the insurance carrier within 7 days of the referral.

COMMENT: Previous subsection (e)(2)(O) [now (e)(2)(P)] states: Any new treatment must meet acceptable standards of care..... Commenter recommended that this be changed to read, "Any new alternative or experimental treatment must..."

RESPONSE: The Commission agrees. The language will be amended to read, "Any new,

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alternative, or experimental treatment must...." This language addition will not be in conflict with the glossary definition for "Acceptable Standards of Care."

BONE GROWTH STIMULATOR (BGS) previous subsection (e)(2)(Q) [now (e)(2)(R)]

COMMENT: Support for current usage indicators for the Bone Growth Stimulators (BGS) was submitted by numerous commenters. Many of these commenters additionally requested the inclusion of pseudarthrosis as an appropriate indicator for BGS.

RESPONSE: The Commission agrees. Pseudarthrosis is included as an indicator for the use of bone growth stimulators.

ALLOGRAFT previous subsection (e)(2)(Q)(iv) [now (e)(2)(R)(iv)]

COMMENT: Commenters questioned the exclusion of the use of allograft as an indicator for BGS.

RESPONSE: The Commission agrees. Allograft remains as an indicator for the use of bone growth stimulators because this was struck through in error, and a correction of error was published.

INTERVENTIONAL PAIN PROCEDURES previous subsection (e)(2)(R) [now (e)(2)(S)]

COMMENT: Commenter requested language change from "potential sources of pain" to "the site of effect of the medication." One commenter recommended the addition of interventional pain procedures to treatment tables and the statement that, "These procedures are not appropriate to release entrapped nerve roots from scars." Another commenter suggested the deletion of peripheral nerve stimulation as an Interventional pain procedure.

RESPONSE: The Commission disagrees with recommendations for language changes and deletion to subsection (e)(2)(S) and to the treatment tables. The STGRW and staff reviewed the issues in question and determined that no modifications/deletions to the language were indicated because the language recommended by the commenters did not add to or clarify the already stated objectives.

COMMENT: Commenter requested the incorporation of an additional objective to subsection (e)(2)(S)(iv), to include stimulation, as none of the objectives describe stimulation (i.e., delivering electrical energy to interrupt painful nerve impulses.)

RESPONSE: The Commission agrees. For clarification purposes, the inclusion of stimulation as an additional objective to interventional pain procedures was added to subsection (e)(2)(S)(iv).

SPINAL INJECTIONS previous subsection (e)(2)(S) [now (e)(2)(T)]

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COMMENT: Commenter requested that language be added to include the requirement of fluoroscopic control for needle placement for injections of large joints.

RESPONSE: The Commission disagrees. TWCC *Upper Extremities Treatment Guideline and/or Lower Extremity Treatment Guideline* are the more appropriate venues for inclusion of injection procedures for large joints.

COMMENT: Commenter recommended that procedural steps for injections that might be developed into a pain management algorithm. Another commenter requested language relative to all spinal injection techniques be changed from "appropriate active rehabilitation" to "outpatient evaluation and therapy." Another commenter recommended an overall language change to replace the term "joints" with "levels" and "injections" with "sessions."

RESPONSE: The Commission disagrees with the need for a pain management algorithm, because this issue will be more appropriately considered when a pain management treatment guideline is developed. The Commission agrees with the need for use of consistent language; therefore, "outpatient evaluation and therapy" and "appropriate active rehabilitation" have been changed to "physical medicine treatment" to be consistent with other treatment and/or fee guidelines. This change has been made throughout this guideline. The Commission also agrees with the recommendation to replace the term "joints" with "levels" in subsection (e)(2)(T)(ii) and (vi); and to replace the term "injections" with "sessions" in subsection (e)(2)(T)(ii) and (v). The STGRW reviewed the recommended language and agreed that these substitutions are more appropriate terms.

COMMENT: Several commenters recommended the deletion of the last sentence regarding the destructive properties of corticosteroids, as these injections are rarely destructive.

RESPONSE: The Commission agrees. The reference is not necessary in the STG and has been deleted.

COMMENT: Commenter recommended deletion of identification of treatment options "rehabilitation or manipulation" from the first sentence.

RESPONSE: The Commission agrees. The STGRW and staff reviewed the recommendation to delete the following phrase "... such as rehabilitation or manipulation." In an effort to avoid limiting options, staff deleted the phrase from subsection (e)(2)(T).

COMMENT: Commenter requested appropriate language be added to all sections to clarify injection limitations.

RESPONSE: The Commission agrees. Staff and the STGRW re-evaluated the spinal injection section. Changes were made to subsection (e)(2)(T) to clarify the use of injections.

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COMMENT: Commenters took exception to the 7-10 day relief requirement under spinal injections as unreasonable. A commenter stated that relief could not be expected for at least 7-10 days. Another commenter also suggested replacing the language "precludes the need" with "requires documentation of medical necessity and preauthorization" wherever this language appears. Another commenter recommended the addition of language to read "partial (at least 50%) relief for less than 7-10..."

RESPONSE: The Commission disagrees. The STGRW evaluated the commenters suggestions to the spinal injections subsection, but did not recommend the changes suggested by the commenters because of the STGRW's thorough review of national standards, literature and the experience of the STGRW members. Suggested language for preauthorization stipulations, "requires documentation of medical necessity and preauthorization" can not be added to a guideline when it is not in the preauthorization rule. The STGRW did, however, recommend changes which further clarify the use of injections. Amendments to the STG injection section are the result of the extensive research already conducted in the development of the following nationally recognized standards: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures*; and, Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*. Additionally, staff utilized the knowledge and medical expertise provided by members of the STGRW, several of whom participated in the development of these national guidelines, and incorporated their recommendation into the STG.

COMMENT: Commenter recommended deletion of the requirement for injections to be performed under fluoroscopic control or language changed to read, "may be performed. . ." instead of "should be performed. . ."

RESPONSE: The Commission disagrees. The STGRW reviewed NASS *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists* and literature provided by one of the members for spinal injections. These indicate the necessity for the use of fluoroscopy in conjunction with spinal injections. Based on these sources and the recommendation by the STGRW, staff has changed the language to read: "must be performed. . ." instead of "should be performed under fluoroscopic control."

COMMENT: A commenter requested clarification as to the usage of each type of injection regarding frequency and appropriate use, either diagnostic or therapeutic.

RESPONSE: The Commission disagrees with the need to further clarify the frequency and indications for therapeutic spinal injections because these are already appropriately defined in each subsection of the spinal injections. The Commission agrees with the suggestion to designate spinal injections as diagnostic or therapeutic. The STGRW re-evaluated the spinal injection subsection and recommended clarifications. Subsections (e)(2)(T)(i), Epidural Steroid Injections, and subsection (e)(2)(T)(iv), Diagnostic Selective Spinal Nerve Blocks, have been amended to

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designate the injections as therapeutic and diagnostic, respectively.

EPIDURAL STEROID INJECTION (ESIs) previous (e)(2)(S)(i) [now (e)(2)(T)(i)]

COMMENT: Commenter stated that the indications for ESIs are too restrictive and recommended the inclusion of "axial pain" in addition to radicular symptoms. Another commenter recommended the deletion of the last sentence regarding repeat series of injections, stating that rehabilitation usually follows the initial injection and a second injection is not administered until at least a month after the initial injection.

RESPONSE: The Commission disagrees with the commenter, that the indications for ESIs are too restrictive. The STGRW, based on their medical expertise and research, determined that the indications for ESIs are appropriate and should not include "axial pain." Therefore, axial pain was not included as an indication for ESIs. The Commission disagrees with the commenter's suggestion to delete the entire sentence regarding repeat series of ESIs. Based on recommendation from the STGRW, and to be consistent with the goals of the STG as delineated in subsection (b)(2), the last sentence of subsection (e)(2)(T)(i) has been amended to read: ". . . would not be indicated if the initial injection did not provide significant and long-term documented relief."

FACET INJECTIONS previous subsection (e)(2)(S)(ii) [now (e)(2)(T)(ii)]

COMMENT: Commenter recommended adding "For diagnostic injection, refer to subsection (f)(2)(M) and (3)(C)." Commenter further requested clarification so that facet injections would not be performed until at least 6 weeks post injury or 4 weeks conservative treatment, whichever is later. Several commenters objected to the language "who are neurologically intact" and recommended its deletion. Other commenters recommended that to determine the need for additional injections, the language be revised to reflect specific or different pain relief intervals based on whether the initial injection was diagnostic or therapeutic. Commenters further suggested diagnostic intervals of greater than 2-3 days and therapeutic intervals greater than 7-10 days.

RESPONSE: The Commission disagrees. The STGRW evaluated the commenters suggested changes to the spinal injections subsection. The STGRW did not recommend these referenced changes because of thorough review of other national standards, literature, and the experience of the STGRW members, but did recommend changes which more appropriately delineate the use of injections. The STG injection section is the result of the extensive research already conducted in the development of the following nationally recognized standards: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures* ; and, Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*. Additionally, staff utilized the knowledge and medical expertise provided by members of the STGRW, several of whom participated in the

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development of these national guidelines, and incorporated their recommendation into the STG.
COMMENT: Commenter requested clarification regarding how the three injection limit was determined and if the three injection limit in a 12-month period pertains to the same joint.

RESPONSE: The Commission agrees that the three injection limit could be clarified. The section on spinal injections was reviewed by the STGRW and staff, and as a result language clarifications have been made to reflect the substitution of "levels" for "joints" to clarify that the three injection limit in a 12-month period pertains to the same levels. The three injection limit was established by the combined medical expertise of members of the STGRW who thoroughly reviewed literature and national standards.

SACROILIAC JOINT INJECTIONS previous subsection (e)(2)(S)(iii) [now (e)(2)(T)(iii)]

COMMENT: Commenters recommended that to determine the need for additional injections, the language be revised to reflect specific or different pain relief intervals based on whether the initial injection was diagnostic or therapeutic. Commenters further suggested diagnostic intervals of greater than 2-3 days and therapeutic interval greater than 7-10 days.

RESPONSE: The Commission disagrees. The STGRW evaluated the commenters suggested changes to the spinal injections subsection. The STGRW did not recommend these changes, but did recommend changes which more appropriately delineate the use of injections because of thorough review of other national standards, literature, and the experience of the STGRW members. The STG injection section is the result of the extensive research already conducted in the development of the following nationally recognized standards: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists* ; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures* ; and, Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*. Additionally, staff utilized the knowledge and medical expertise provided by members of the STGRW, several of whom participated in the development of these national guidelines, and incorporated their recommendation into the STG.

DIAGNOSTIC SELECTIVE SPINAL NERVE BLOCKS previous subsection (e)(2)(S)(iv)
[now (e)(2)(T)(iv)]

COMMENT: Commenter recommended the section be subdivided into two sections, one to address "Selective Therapeutic Nerve Root Blocks" and the other "Selective Diagnostic Nerve Root Blocks." Another commenter suggested deletion of the word "diagnostic" from the title because the injections may be therapeutic. Commenter recommended deletion of the words "with negative or equivocal imaging studies and..." from the first sentence. Another commenter took exception to "negative or equivocal" because selective nerve root blocks are also used therapeutically for patients with positive imaging studies. Another commenter recommended deletion of the final sentence in this section regarding the limitations on the number of injections per level, "levels injected should not exceed...thoracic or lumbar."

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RESPONSE: The Commission agrees with separating therapeutic from diagnostic nerve blocks. This section of the STG subsection (e)(2)(T)(iv) regarding Diagnostic Selective Spinal Nerve Blocks was reviewed by the STGRW and staff. As a result of the combined medical expertise and input from members of the STGRW who served in the development of the following nationally recognized standards: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures*; and, Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*, the Commission has included language clarification to reflect many of the recommendations provided by commenters. Subsection (e)(2)(T)(iv) has been amended to address Diagnostic Selective Spinal Nerve Blocks only. The therapeutic nerve blocks are addressed in subsection (e)(2)(T)(i), Epidural Steroid Injections (ESIs). The Commission does not agree with deletion of the language "negative or equivocal." Based on the STGRW's thorough review of national guidelines, literature, and their medical expertise this language is appropriate for diagnostic testing. The Commission disagrees with the deletion of the final sentence regarding limitations on the number of injections per level. The language has been amended and the limitations on numbers of injections are no longer based on "per level."

MEDIAL BRANCH BLOCKS previous subsection (e)(2)(S)(v) [now (e)(2)(T)(v)]

COMMENT: Commenter requested that TWCC clarify whether the restrictive "two additional injections" language means two additional sessions.

RESPONSE: The Commission agrees with commenters recommendation for clarification. The STG language in subsection (e)(2)(T)(v) has been amended to read, "Repeat blockade should only be performed for confirmation of equivocal results in patients for whom ablative block is to be considered and should not exceed two additional sessions injections in a 12 month period."

ABLATIVE DORSAL MEDIAN BRANCH BLOCKS previous subsection (e)(2)(S)(vi) [now (e)(2)(T)(vi)]

COMMENT: Commenter recommended changing the facet pain source limit of "two joints" to "three levels," and to replace the word "times" with "sessions." Another commenter stated language was inappropriately restrictive in limiting blocks to no more than two joints.

RESPONSE: The Commission agrees with the recommendation to replace the terms "joints" with "levels," and to replace "times" with "sessions" in subsection (e)(2)(T)(vi) of the STG. The Commission disagrees with the commenter's opinion that the language was inappropriately restrictive in limiting blocks to no more than two joints because the STGRW reviewed the limitations, deemed them appropriate and did not recommend any changes. This was based on the combined medical expertise and input from the STGRW members who served in the development of the following nationally recognized standards: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection

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Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures*; and, Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*.

LYSIS OF ADHESIONS (e)(2)(S)

COMMENT: Commenter requested new addition, subsection (e)(2)(S)(vii), proposed for treatment parameters for Lysis of Adhesions to include placement of catheter and placement of epiduroscope.

RESPONSE: The Commission disagrees with the need for treatment parameters for Lysis of Adhesions. The STGRW, based on their medical expertise and research, determined these techniques are not supported by scientific studies and the inclusion would be inappropriate.

TRIGGER POINT INJECTIONS previous subsections (e)(2)(T) [now (e)(2)(U)]

COMMENT: Commenter recommended the inclusions of "to any one region" to clarify that the limit of four injections at any session pertains to one region. Commenters felt the limitations on trigger point injections were too restrictive. Commenter recommended the amendment of the third sentence to read "Frequency of injections....should not exceed six injections per anatomical site in a twelve month period."

RESPONSE: The Commission disagrees. Staff and the STGRW re-evaluated the Trigger Point Injections subsection of the STG and determined that sufficient and appropriate language clarifications and limits have been included in this subsection. This subsection is based on the extensive research conducted by several members of the STGRW who served in the development of the following nationally recognized standards: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures*; and, Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*.

COMMENT: Another commenter recommended deleting "paraspinal" as an indication for use.

RESPONSE: The Commission agrees with commenters recommendation. The STG language in subsection (e)(2)(U) has been amended to reflect the deletion of the word "paraspinal."

ACUPUNCTURE previous (e)(2)(U) [now (e)(2)(V)]

COMMENT: Several commenters requested the removal of the word "acute" from the indications for use and one commenter further requested deletion of the phrase "acute musculoskeletal pain." Commenters further took exception to the four to six weeks duration of treatment as too limiting. Several commenters requested that acupuncture be included in the Intermediate and Tertiary Phases of Care Tables as a treatment intervention. Commenters

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requested the deletion of the documentation requirement for the continued use of acupuncture beyond the acute phase. Another commenter suggested that improvement should be noted after six weeks to merit continuation of treatment. A commenter recommended that only those certified/licensed as acupuncturists be allowed to provide acupuncture services.

RESPONSE: The Commission disagrees with recommended changes. The medical literature reviewed by the STGRW and staff supported the use of acupuncture only in the acute phase of an injury. Therefore, it is not included in the Intermediate or Tertiary Phase of Care Tables. The literature also indicated acute musculoskeletal pain is an appropriate indicator for acupuncture and has not been deleted. The Commission disagrees with the deletion of documentation requirement because language was provided for clarification purposes and to be consistent with other subsections. The STG allows for those circumstances when the health care provider determines that the injured employee requires acupuncture beyond the acute phase, by allowing the health care provider to provide objective documentation to support the continued treatment. The TWCC *Medical Fee Guideline* requires a health care provider to operate within the scope of their professional license, therefore inclusion of licensure requirements in the STG is unnecessary.

CPT CODES previous (e)(2)(X) [now (e)(2)(Y)]

COMMENT: Several commenters suggested amendment of the language regarding the use of CPT codes in the STG. One commenter suggested that subsection (e)(2)(X) [Staff note: (e)(2)(X) is now (e)(2)(Y)] read, "The CPT codes in the current TWCC *Medical Fee Guideline* shall be used." Another commenter took exception to the use of 1999 CPT codes, because the current TWCC *Medical Fee Guideline* uses the 1994 CPT codes. Commenter requested that the preamble state that the CPT codes currently utilized by the system are 1994 CPT codes. Commenter requested the deletion of CPT codes from the STG because they do not add any substance to the document. Commenter further recommended general procedural terminology be used in Charts 5A, 5B, and 5C in lieu of CPT codes.

RESPONSE: The Commission agrees. The Commission has amended the Surgical Treatment Charts 5A, 5B, and 5C to reflect general procedural terminology instead of the CPT codes. This amendment was done to prevent potential conflicts with the TWCC *Medical Fee Guideline* and to ensure consistency among the guidelines. Additionally, the amended charts negated the need for subsection (i)(1), Surgical Treatment Code Legend; therefore, this subsection has been deleted. The Commission also agrees with commenter's suggestion to change "should" to "shall" in subsection (e)(2)(Y), the language has been amended to be provide consistency with TWCC rules and guidelines.

GENERAL DOCUMENTATION REQUIREMENTS (e)(3)

COMMENT: Commenter recommended replacing "the elements of that documentation may include" with " shall include" in the second sentence.

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RESPONSE: The Commission disagrees. The production of documentation is mandatory, but the elements of that documentation may vary on a case by case basis. Therefore, the elements are not all inclusive and language reflects "may" instead of "shall" appropriately.

COMMENT: Commenter recommended that subsection (e)(3)(B)(v) be amended to read, "Educational information" instead of "education information."

RESPONSE: The Commission agrees. Language has been amended to reflect the adjective form rather than the noun.

COMMENT: Commenter recommended that subsection (e)(3)(B)(vi) be amend to read, "objective documentation substantiating the need...."

RESPONSE: The Commission agrees. Language has been amended to provide consistency in documentation requirements and subsection (e)(3)(B)(vi) now reads "objective documentation...", as do other sections of (e)(3).

COMMENT: Commenter suggested language changes to replace "acceptable outpatient evaluations and therapies" with "successful outpatient therapies." A commenter suggested an additional example of documentation to be incorporated as new clause (xii) which would read, "demonstration by the provider of palpatory range-of-motion increase or pain decrease." Commenter further inquired as to what happens when conservative measures fail to provide substantial improvement.

RESPONSE: The Commission agrees in part. To be consistent with other treatment and/or fee guidelines "outpatient evaluation and therapy" has been changed to "physical medicine treatment" throughout this guideline. The term "acceptable" has been deleted. The STGRW reviewed the commenter's suggested addition to subsection (e)(3)(C) and concluded that the suggested language was confusing and did not provide an objective measurement of the program in the injured employee's recovery. However, the injured employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury and treatment should be based on the health care provider's professional judgement. When the health care provider's treatment deviates from the guideline, including failure of conservative measures to provide substantial improvement, documentation would be required to delineate the need for the treatment.

COMMENT: Commenter suggested that subsection (e)(3)(C)(ii) be amended to read, "description of patient's capabilities and clinical progress".

RESPONSE: The Commission agrees. Language has been amended to read, "clinical progress."

COMMENT: Commenter suggested adding new clause (xii) to read, "notes indicating reduction or decrease in pharmacological usage."

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RESPONSE: The Commission agrees, and language has been amended to reflect the additional clause (xii).

Documentation of pharmacological usage is an appropriate indication of the progress in the injured employee's recovery.

COMMENT: Commenter objected strongly to the inclusion of the manipulation definition in the documentation section and recommended that the specific documentation requirements for manipulation be applied to all treatments.

RESPONSE: The Commission disagrees. Staff and STGRW re-assessed the concern regarding documentation requirements for manipulation as well as all of the general requirements for documentation, and concluded the documentation requirements for all treatments were consistent.

COMMENT: Commenter recommended the addition of clause (iv) to Documentation of Continued Use of TENS to state "avoiding continued regression or worsening of symptoms or signs." Several commenters recommended deletion of the word "objective" from the documentation that should be provided for continued use of TENS as it is both unreasonable and impossible to impose "objective/quantified measures" for pain. The commenter further requested that the "return to work" measure to document continued usage, be replaced with, "enhances the ability of the employee to return to or retain employment." Another commenter recommended the deletion of the entire paragraph based on the commenter's belief that the continuation of certain medication in conjunction with electric stimulators may be appropriate, that reduction in pain cannot be objectively quantified and that the four to six week time frame for return to work may be impractical and/or impossible. Another commenter recommended changing "and" to "or" for continued use of TENS in clause (ii).

RESPONSE: The Commission disagrees with the recommendation to add a clause (iv) because "avoiding continued regression or worsening of symptoms or signs" indicates the maintenance of the status quo. The language used in subsection (e)(3)(F) (i)-(iii) indicate progress in the patient's condition which promotes recovery. The Commission disagrees with the recommendation to delete the word "objective" from the continued use of TENS measures in order to be consistent throughout the guideline. The term applies to measures of improvement, rather than level of pain. Improvement can be shown by objective documentation of procedure such as decreased use of medication, increased function due to reduction in pain, return to work, etc. The Commission agrees with the recommended language regarding "return to work" and has amended the sentence to provide consistency with statutory language in Texas Labor Code, §408.021. Also, as in all instances, the list is not all inclusive, other documentation may be accepted, where appropriate to the particular injured employee. The Commission also disagrees with the deletion of the paragraph because the language is appropriate based on the literature reviewed. The Commission agrees with the recommended change in language from "and" to "or" and the language has been amended in subsection (e)(3)(F) regarding the documentation requirements for the continued use of TENS units; therefore, any one of the documentation measure is appropriate for the continued use of TENS beyond four to six weeks.

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COMMENT: Commenter recommended that the entire section regarding permanent impairment for compensable injuries be deleted as it is inappropriate in its' context within the STG. Another commenter recommended the addition of language that would allow pain to be considered when assessing an impairment rating.

RESPONSE: The Commission agrees with the deletion of the permanent impairment section, and subparagraph (G) has been deleted. Other TWCC Rules address permanent impairment for compensable injuries and required documentation. The Commission disagrees with the inclusion of pain in assessing an impairment rating because the issue of pain for the assessment of an impairment rating is inappropriate in this guideline and are addressed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*.

DOCUMENTATION REQUIREMENTS FOR UNRELATED OR INTERCURRENT ILLNESS (e)(4)

COMMENT: Several commenters requested inclusion of language in subsection (e)(4) to allow the stabilizing treatment for intercurrent illnesses in treating the compensable injury as delineated in subsection (h)(1)(B).

RESPONSE: The Commission agrees. Language has been amended to read "... relation of this treatment to the treatment provided to the injured employee for the compensable injury must be documented by the health care provider. If this treatment appears not to be related to the treatment provided to the injured employee for the compensable injury, then the health care provider should inform the injured employee that this treatment may not be covered by the workers' compensation insurance carrier. The health care provider should clearly document the rationale for such treatment, its relation to the compensable injury and its relation to the treatment provided to the injured employee for the compensable injury."

LIST OF DIAGNOSTIC INTERVENTIONS (f)(2)

COMMENT: Several commenters recommended that in the list of diagnostic interventions, subparagraph (B) "plain x-ray" be amended to change "or" to "and/or."

RESPONSE: The Commission agrees, and the language in subsection (f)(2)(B) has been amended to read "and/or."

COMMENT: Commenter recommended adding "as indicated in subsection (f)(3)(D) to clarify the select situations that discography is appropriate."

RESPONSE: The Commission agrees with the concept of referencing the corresponding subsection. The language change has been added to reference the corresponding subsection, and reads, "(refer to subsection (f)(3)(D) of this section)."

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COMMENT: Several commenters requested the reinstatement of "physical capacity evaluation" in the List of Diagnostic Interventions and in the Phases of Care Tables.

RESPONSE: The Commission disagrees. Physical capacity evaluations are a component of functional capacity evaluations and are not required to be listed separately in the List of Diagnostic Interventions nor in the Phases of Care Tables. Functional Capacity Evaluations are already listed in the List of Diagnostic Interventions, subsection (f)(2)(O).

TIME RECOMMENDATIONS FOR LISTED DIAGNOSTIC INTERVENTIONS (f)(3)

COMMENT: Commenter requested that TWCC clarify parameters of medical necessity for diagnostic imaging.

RESPONSE: The Commission disagrees. The time recommendations outlined under subsection (f)(3)(B) are applicable to imaging studies at six weeks to four months after the date of injury and allow the health care provider to exercise professional judgment in the use of diagnostic interventions based on the medical necessity of the injured employee's individual condition. It is not the intent of the STG, a treatment guideline for normative care, to address specific medical necessity issues.

COMMENT: Commenter stated that the language in subsection (f)(3)(D) is restrictive and not consistent with the intent of a guideline and suggests the following language changes: change the words "should not be performed before" to "should usually be performed after"; change "must occur" to "usually occur"; and "suspect degenerated discs" to "suspected painful discs."

RESPONSE: The Commission agrees with recommended language changes to subsection (f)(3)(D), and the STG has been amended to include the commenter's suggested substitutions to eliminate restrictive terms.

COMMENT: Several commenters referenced the six month time limit for the performance of discography; one recommendation was that performance of discography be allowed before six months and another recommendation was to delete the time limit. A commenter expressed concerns regarding the limitations placed on discography.

RESPONSE: The Commission disagrees with the deletion of the time limit. The STGRW, including a member of the North American Spine Society (NASS) Task Force, researched this issue extensively. The combined medical expertise of the STGRW and a review of applicable medical literature, including the pre-publication copy of the *NASS Phase III Clinical Guideline for Multidisciplinary Spine Care Specialists: Herniated Disc*, supported the six month time limit. This timeframe was deemed appropriate because it allows ample time for the use of conservative care prior to use of this invasive procedure. However, prohibitive language was changed to "usually be performed."

PHASES OF NONOPERATIVE CARE, INITIAL, INTERMEDIATE, TERTIARY

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(g)(2),(3),(4)

COMMENT: Commenter recommended the inclusion of the duration of care for each of the three phases of nonoperative care for consistency with the phases of care treatment tables.

RESPONSE: The Commission agrees. The inclusion of the recommended duration of care per phase of care has been added to subsections (g)(2),(3) and (4) for consistency purposes.

COMMENT: Commenter recommended that "heavy physical labor" be replaced with "current or expected job requirements" in subsection (g)(4) and the same language be replaced in corresponding Phases of Care Tables. Another commenter requested clarification regarding what TWCC considers tertiary care.

RESPONSE: The Commission agrees. Language has been substituted as recommended in both the Intermediate and Tertiary Phases of Care. The Commission disagrees that further clarification of tertiary care is needed. Tertiary care is adequately defined in the STG. The development of tertiary care was carefully constructed by staff and the Guideline Standardization Subcommittee (GSS), which is a sub-committee of the Medical Advisory Committee (MAC) and is consistent with national guidelines and accepted medical standards..

COMMENT: Commenter suggested that post-tertiary treatment and post-MMI treatment be addressed in depth through a policy statement in the guideline. Other commenters suggested the development of a post-tertiary treatment table to compliment and integrate with other algorithms.

RESPONSE: The Commission disagrees. Post-tertiary treatment and post-MMI treatment are adequately defined in the STG. The development of this was carefully constructed by staff and the GSS, which is a sub-committee of the MAC. The Commission disagrees with the need to develop a specific post-tertiary treatment table at this time because treatment for the injured employee at this phase is at a lower frequency and receiving periodic medical care. The post-tertiary treatment is not comparable to nor consistent with language in the three active phases of care. Consequently, a treatment table is not indicated.

COMMENT: Commenter requested clarification of removal of doctors from Approved Doctor List (ADL) for overutilization. Several commenters expressed concern regarding the compliance language included in this section, regarding sanctions and removal of health care providers from the Approved Doctors List for overutilization of health care services, and regarding the regulatory sanctions and/or criminal charges against insurance carriers for operating outside the parameters of these rules. Another commenter requested that the compliance language be moved to subsection (d) "Application Instructions for Involved Parties" (1) Health care providers and (2) Insurance Carriers.

RESPONSE: The Commission disagrees with the need to provide further clarification of removal of doctors from the ADL. All issues pertaining to the removal of doctors from the ADL, and

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regulatory sanctions and/or criminal charges against insurance carriers are addressed in other Commission rules. Post-tertiary treatment is a new addition to the guideline and as with all medical services, health care providers are cautioned that there are ramifications for overutilization.

COMMENT: Commenter suggested the addition of language to the third sentence to read "Treatment should be provided...maintain function, or correct dysfunction and/or to help...."

RESPONSE: The Commission disagrees. Post-tertiary treatment is for an injured employee who is receiving interventions at a lower frequency, and receiving periodic medical care. It is the intent of post-tertiary treatment to control pain or other symptomology, including pain management, for the duration of the injury. Furthermore, post-tertiary treatment was developed to enable the injured employee to maintain function and/or to help the injured employee remain at work. Treatment for the correction of a specific dysfunction would more appropriately occur in either the Initial, Intermediate, or Tertiary Phases of Care. When treatment deviates from the guideline, documentation would be required to support the need for the treatment.

PHASE OF CARE TABLES (g)(7)(A)-(C)

COMMENT: Commenter indicated that the heading "Goal of Initial Intervention" had been omitted because the word "goals" had been deleted.

RESPONSE: The Commission disagrees. The Texas Register publication did contain the word "goal" under heading, "Goal of Initial Intervention," and the language describing the "goals" was stated as, "To prevent progression of disease, alleviate or minimize the effects of the illness and to maintain function."

COMMENT: Commenter recommended the inclusion of cross-referencing to the appropriate section in the STG ground rules for manipulations. Commenter requested that "exercise and active exercise" be included under "outpatient treatment interventions."

RESPONSE: The Commission agrees with the recommendation to cross-reference the appropriate sections in the STG ground rules for manipulations and the tables have been amended to reflect this cross-reference. The STGRW and staff discussed and agreed that for consistency, "active exercise" would be replaced with "exercise." As a result, "exercise" has been listed as a treatment intervention in subsection (g)(7)(B), Table II: Intermediate Phase of Care. The Commission and the STGRW disagree with commenter's request that "exercise and active exercise" be included under "outpatient treatment interventions" (now physical medicine treatment) because exercise may be a separate treatment intervention.

COMMENT: Another commenter recommended the inclusion of biofeedback and relaxation training in behavioral pain management.

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RESPONSE: The Commission agrees. Language changes have been made to Phases of Care Tables I, II and III, (g)(7)(A)-(C), under Treatment Interventions, Behavioral Pain Management, to add "(examples include, but not limited to: cognitive-behavioral psychotherapy, relaxation training, instrumental biofeedback, coping skills training.)" These examples were derived from medical literature included in the resource list.

COMMENT: Commenters further recommended the following language change in the Phases of Care Tables (A)-(C), move the "Diagnostic Testing" from the Treatment Intervention section to the Assessments section, because diagnostic treatment is not a treatment intervention but an assessment.

RESPONSE: The Commission agrees. "Diagnostic Testing" has been moved to the Assessments section in Tables I, II, and III, subsection (g)(7)(A)-(C).

COMMENT: Commenters also recommended language changes in the Phases of Care Tables (A) and (B): list the classes of appropriate medications for each Phase of Care.

RESPONSE: The Commission disagrees. The medications prescribed for an injured employee should be based on a physician's medical decision, which involves a case by case patient assessment and therefore a listing was not included in the STG.

COMMENT: Commenters recommended a language change in the Phases of Care Table (B): the proposed new language in Table (C), regarding return to work issues be incorporated into Table (B).

RESPONSE: The Commission agrees. It is appropriate to consider post-medical vocational rehabilitation services during the Intermediate Phase of Care, and the STG has been amended to reflect this in the Intermediate and Tertiary Phases of Care Tables.

COMMENT: Commenter recommended the reinstatement of the treatment intervention, "chronic pain management," into Table (B).

RESPONSE: The Commission disagrees. It is not an appropriate time within the Intermediate Phase to refer an injured employee to a chronic pain management program (CPMP) as the indications for a CPMP are "pain that has lasted without abatement for six months". The Intermediate Phase is before the onset of a chronic condition, and therefore too soon for a CPMP.

COMMENT: Commenters recommended language changes in the Phases of Care Tables (B) and (C), add acupuncture as a behavioral pain management treatment intervention to the Intermediate Phase of Care Table and as a chronic pain management treatment intervention to the Tertiary Phase of Care Table; clarify the frequency and number of manipulations under anesthesia, as well as the appropriateness and inappropriateness of that treatment; delete "unattended modalities" from treatment interventions section or state that no additional reimbursement will be allowed.

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RESPONSE: The Commission disagrees with the request that acupuncture be added as a Behavioral Pain Management treatment intervention to the Intermediate Phase of Care Table and as a Chronic Pain Management treatment intervention to the Tertiary Phase of Care Table. The literature reviewed by staff and the STGRW supported the use of acupuncture only in the acute phase of an injury and therefore is not included in the Intermediate or Tertiary Phase of Care Tables. The Commission disagrees that there is a need to establish the frequency and appropriateness of Manipulations Under Anesthesia. The STG allows the health care provider to exercise professional judgment in the use of treatment interventions based on the medical necessity of the injured employee's individual condition. It is not the intent of the STG, a treatment guideline for normative care, to address specific medical necessity issues for a particular situation. The Commission disagrees with the deletion of "unattended modalities" due to the STGRW's recommendation that "unattended modalities" are appropriate interventions and well recognized components of physical medicine. The TWCC *Medical Fee Guideline* addresses reimbursement issues.

COMMENT: Commenter recommended language change in the Phases of Care Table (C), replace the term "Tertiary" with "Chronic". Commenter requested the addition of the phrase "initial phase of the normal healing process" to "documented history of persistent failure" in the Clinical Indicators section of Table III.

RESPONSE: The Commission disagrees with the recommendations to change the titles and descriptors of the Phases of Care Tables. The Phases of Care and the Treatment Tables in the STG were carefully reviewed and amended by staff and the GSS of the MAC. The GSS recommended changes, based on their research and expertise, that would make all treatment guidelines consistent with each other and consistent with terminology that is recognized and accepted by the medical community. The Commission also disagrees with commenter's request to add language to the Clinical Indicators section of Table III, because the suggested language, "initial phase of the normal healing process" does not add any additional explanation or clarity to the existing language.

ASSESSMENTS/EVALUATIONS - subsection (h)

COMMENT: Commenter recommended that the first sentence be changed to read, "injury may produce ...due to deconditioning, and/or compensatory musculoskeletal dysfunction, chronic or progressive...."

RESPONSE: The Commission disagrees with commenter's recommended language addition because subsection (h)(1)(A), Sequelae of Injury, is adequately defined and described in the STG. The indications of musculoskeletal dysfunction are already encompassed in the subsection and the additional language does not further expand the existing language.

COMMENT: Several commenters requested inclusion of language to allow the stabilizing treatment for intercurrent illnesses in treating the compensable injury. A commenter requested clarification regarding the responsibility of determining treatment options relating to the

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intercurrent illness.

RESPONSE: The Commission agrees with the need to clarify the language in subsection (h)(1)(B), Intercurrent Illness. The language has been changed to read, "If an injured employee is suffering from a variety of intercurrent illnesses (such as hypertension, cardiac disease, diabetes, etc.), an interdisciplinary assessment may be needed to determine the treatment options required to bring the injured employee to the highest functional level. The intercurrent illnesses may require medical management and services necessary to stabilize the injured employee, and recommendations should be forwarded to the treating doctor for decision. When stabilizing treatments and services are performed, the health care provider should clearly document the rationale for such treatment as referenced in subsection (e)(4). Treatment for the intercurrent illnesses may/may not be related to the compensable injury and therefore, may/may not be the responsibility of the workers' compensation insurance carrier."

COMMENT: Commenter requested clarification regarding the responsibility of determining risk factors that necessitate additional evaluations and modification to the treatment plan.

RESPONSE: The Commission disagrees. The risk factors for complications should be evaluated by the health care provider and the insurance carrier and no further clarification in the STG is necessary. Such an occurrence should be evaluated by the health care provider and the workers' compensation insurance carrier on a case by case basis.

COMMENT: Commenter recommended replacing the term "Human Performance Measurement" with "Functional Capacity Examination" in subsection (h)(2)(A) for consistency with terminology in other various guidelines. The commenter further suggested moving "Appropriate and Inappropriate Testing," subsection (h)(3), from Assessments/Evaluations subsection (h), to Diagnostic Procedures subsection (f), because discussion on diagnostic testing is included in subsection (f).

RESPONSE: The Commission agrees in part with replacing the term "Human Performance Measurement." Instead of the suggested substitution, the term "Functional Abilities Testing" is the more appropriate term because it is consistent with the language contained in the TWCC *Medical Fee Guideline*. The STG has been amended in subsection (h)(2)(A) to read "Physical Examinations and Functional Abilities Testing." The Commission disagrees with the request to move "Appropriate and Inappropriate Testing" into the "Diagnostic Procedures" section. The placement of the subsection on Testing (Appropriate and Inappropriate Testing) is more suited to subsection (h) which addresses assessments, evaluations and testing than to subsection (f), Diagnostic Procedures.

GLOSSARY - subsection (j)

COMMENT: Several commenters requested the inclusion of various definitions in the glossary. The addition of definitions for the following was requested: "Behavioral Pain Management" or

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examples to include biofeedback, relaxation training or pain symptom control (subsection (g)(7)(A) Initial Phase of Care Table); a commenter provided a suggested definition;

RESPONSE: The Commission and the STGRW agree with the need to define and give examples of "Behavioral Pain Management." Rather than the commenter's suggested definitions, language was adapted from *Psychological Approaches to Pain Management: A Practitioner's Handbook*. Guilford Press, New York, 1996 and examples and placed into the Phases of Care Tables and Glossary sections of the STG.

COMMENT: The addition of definitions for the following was requested: "Outpatient Evaluation and Therapy" or a clarification statement to ground rule subsection (e)(2)(D);

RESPONSE: The Commission agrees with the recommendation to clarify the ground rule subsection (e)(2)(D). "Outpatient Evaluation and Therapy" was replaced with "Physical Medicine Treatment" for consistency with the TWCC *Medical Fee Guideline*.

COMMENT: The addition of definitions for the following was requested: "Axial pain"; "referred pain"; "radiculopathy"; in subsection (e)(2)(S) Spinal Injection Techniques and "Neck disability index" and "back disability index" in subsection (e)(3)(C)(x) and (xi);

RESPONSE: The Commission and the STGRW agree. Definitions of the recommended terms have been added to the Glossary section of the STG. Definitions were based on Dorland's Illustrated Medical Dictionary, 27th Edition with added clarification provided by the STGRW.

COMMENT: The addition of definitions for the following was requested: "nerve root irritation"; "radicular symptoms"; "exercise and active exercise" from Phase of Care Tables I and II, (g)(7)(A) and (B); "spine injury" as contemplated in the STG;

RESPONSE: The Commission disagrees. Staff and the STGRW re-assessed the glossary terms and determined the addition of these terms to the glossary was not necessary. The terms recommended for addition to the glossary are commonly used medical terms and there is no differentiation in the application of these terms between the STG and their customary use in the medical community. Also, only the term "exercise" will be used in all of the applicable Phases of Care Tables so that all the tables are consistent with each other.

COMMENT: Amendments to the following definitions: "Phases of Care" in subsection (j)(40) to include post-tertiary; tertiary phase of care subsection (j)(55) to include the language "duration of 0 to 6 weeks" for consistency with the Tertiary Phase of Care Table.

RESPONSE: The Commission disagrees with the recommendation to add the post-tertiary treatment to the phases of care definition in subsection (j)(40). The development of the Phases of Care and the subsequent Tables in the STG was carefully constructed by the staff and the GSS of the MAC. Post-Tertiary treatment is not considered a phase of care in the STG. It is

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treatment(s) that may be provided to the injured employee after the phases of care, for the duration of the injury. Post-Tertiary treatment is not limited to any particular treatment(s)/service(s) or to a specific time duration. The Commission agrees with commenter's recommendation to add the language "0-6 weeks duration" for consistency in subsection (j)(55). COMMENT: Commenter requested a rewording in the definition of "medical necessity" and recommended to change "signs and symptoms" to "signs or symptoms."

RESPONSE: The Commission agrees. The definition of "medical necessity" has been changed to include "signs or symptoms."

GENERAL COMMENTS

COMMENT: Several commenters expressed concern that the industry was not notified of the STG revision and was denied input on the revision development.

RESPONSE: The Commission disagrees that the industry was denied input in the STG development. The Commission began its initial review of the STG by conducting a focus group with insurance carriers in 1997. At that time, the Commission invited different insurance carriers and utilization review agents to participate in this focus group. Additionally, workgroup members who assisted in drafting the 1995 STG were contacted for input regarding the STG revision. Subsequently, the MAC recommended the formation of a new workgroup (STGRW) and made suggestions for the composition of that group. The STGRW was comprised of health care providers representing both active practices and business interests.

MAC meetings are opened to the public and are posted in the Texas Register. The Commission encourages the members of the MAC to stay in touch with their constituents or professional associations, because MAC members are representatives of the various system participants and should be sharing information. During the revision of the STG, there were periodic STG updates presented to the MAC beginning in the summer of 1998 and through the spring of 1999.

In addition, system participants are encouraged to provide feedback and comments regarding proposed rules during public comment periods and at public hearings.

COMMENT: Commenter questioned the qualifications, knowledge and motives of the staff and STGRW involved in the development of the STG. Commenter also expressed concern regarding the selection method of the STGRW.

RESPONSE: The MAC gave suggestions for the composition of the STGRW. The MAC recommended that specialists and all disciplines in the treatment of spine injuries plus insurance carrier representatives be included. Staff requested the MAC to submit names for consideration, and to include a minimum of 3 MAC members to serve on the STGRW. The STGRW was comprised of health care providers representing both active practices and business interests, and included the following disciplines: chiropractic, occupational medicine, neurosurgery,

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orthopaedic surgery, physical medicine and rehabilitation, physical therapy, occupational therapy, osteopathic medicine, psychology, anesthesiology and insurance. Several STGRW members participated in the development of the following: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Spinal Injection Procedures*; Agency for Health Care Policy and Research (AHCPR), *Acute Low Back Problems in Adults - Clinical Practice Guideline*; and standards for the Physiatric Association of Spinal, Sports and Occupational Rehabilitation (PASSOR), a branch of the American Academy of Physical Medicine and Rehabilitation.

COMMENT: Commenter stated the STG contained discerning, elusive language and no definitions of terms.

RESPONSE: The Commission disagrees. The purpose of the STG is to describe normative care and clarify those services that are reasonable and medically necessary for operative and nonoperative care of the spine for the injured employees of Texas. Many recommendations to add, substitute, clarify, define and/or add new terms, were incorporated into the STG.

COMMENT: A few commenters indicated no clinical documentation or research was cited and publications cited were outdated.

RESPONSE: The Commission agrees that the documentation citations in the STG were unclear and may have been confusing. To more clearly indicate the studies and research that were reviewed by the Commission staff and STGRW, and to remove older references previously included in the STG, subsections (k) and (l) were removed from the proposed guideline and all the materials reviewed and evaluated in revising the STG are listed in the preamble. This will more accurately inform the public of the references used to determine which procedures and services were recommended or not recommended for inclusion in the STG.

COMMENT: Commenter felt the STG contains unclear and threatening language for non-compliance.

RESPONSE: The Commission disagrees. The language in the STG is intended to fulfill many statutory and policy objectives. The objectives include assisting all parties with regard to the appropriate treatment and management of disorders of the spine, and providing a mechanism for the prospective, concurrent, retrospective review for efficient and effective health care utilization.

COMMENT: Commenter stated "guidelines such as this takes the concept of managed care too far."

RESPONSE: The Commission disagrees. The STG identifies a normal course of treatment but also allows for providing more or less health care to the injured employee than is recommended in this guideline. The treating doctor is allowed to determine what is medically necessary with

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objective documentation.

COMMENT: Commenters expressed concern that the make-up of the STGRW did not contain pain management specialists. Commenter was also concerned that the STGRW did not include an anesthesiologist, an occupational medicine doctor, or a neurologist.

RESPONSE: The Commission disagrees. The STGRW was comprised of health care providers representing both active practices and business interests, and included the following disciplines: chiropractic, occupational medicine, neurosurgery, orthopaedic surgery, physical medicine and rehabilitation, physical therapy, occupational therapy, osteopathic medicine, psychology, anesthesiology and insurance.

COMMENT: Some commenters suggested rejection of the proposed guideline in favor of continued study or the postponement of the proposed guideline until revisions include specific guidance to health care providers and insurance carriers on appropriate treatment parameters. A suggestion was made for the development process to be research-based rather than consensus-based.

RESPONSE: The Commission disagrees with the suggested rejection of the proposed guideline in favor of continued study or the postponement of the proposed guideline. The revised STG is a significant improvement over the previous guideline in that it clearly delineates treatment parameters, includes additional treatments, and incorporates the medical expertise of an expanded number of specialties. The revised STG more clearly defines standards and is more consistent and correlates with other TWCC guidelines. The revision was in fact based on research. The revision of the STG included a review, conducted by the staff and STGRW members and their associates, of literature that focused on salient topics in the guideline. Literature submitted by commenters was reviewed and evaluated. Criteria were used to determine if the materials used in the development of the STG met the general definition of scientific research. Therefore, a relevant study based on scientific research was determined to: a) seek to test a hypothesis; b) involve multiple subjects, including control groups, since single subject case studies rank low as an accepted method for establishing the efficacy of treatments; and c) address the spine and/or involvement of the central or peripheral nervous systems. Much of the literature submitted did not meet these criteria because publications failed to document results of multiple subject studies, use of control groups, or did not relate to treatment for spinal injuries, rather it provided many anecdotal accounts of the use of a particular treatment. The commission recognizes that in the proposed STG there was incomplete indication of the amount of studies and scientific research reviewed by staff and the STGRW. In the proposed STG there was an incomplete indication of the amount of studies and scientific research reviewed by staff and the STGRW. Based on the number of comments that staff received regarding research literature reviewed, the resources used in the evaluation of treatments and/or key elements in the STG revision have been included at the end of this preamble.

COMMENT: A commenter expressed general complaints about the TWCC's Compliance and

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Practices Division's inability to enforce insurance carrier compliance.

RESPONSE: The Commission will forward the commenter's complaints to the appropriate division, Compliance and Practices.

COMMENT: Several commenters expressed concern about the "multiple versions" of the proposed guideline.

RESPONSE: There is only one proposed STG which was published in the June 25, 1999, issue of the Texas Register. For the convenience of the public TWCC has recently begun placing a copy of proposed rules on its Internet website. In the initial stages of adding proposed rules to the website it was discovered that translations of the proposal from the word processing program to the language necessary for placement on the Internet resulted in some formatting irregularities. In addition, there was a mistake published in the Texas Register which was corrected in a correction of error notice published in the September 3, 1999, issue of the Texas Register (24 Texas Register 7070). Because of the concern that those differences could cause confusion, the comment period was extended to September 27, 1999, for submission of comments on the few areas of the guideline where differences were noted. The corrections were also placed on the TWCC website.

COMMENT: Commenter suggested grammatical revisions.

RESPONSE: Steps have been taken at the suggestion of many commenters and grammatical revisions have been made.

COMMENT: Another commenter opposed any fixed guideline for spinal surgery.

RESPONSE: The Commission disagrees. The Commission is mandated to establish medical policies relating to necessary treatments for injuries. As such there is a need for the STG. The STG, however, is a guideline and not a fixed treatment protocol. The STG allows treatment outside the set parameters with additional objective documentation of the medical necessity for the treatment.

COMMENT: A commenter opined that preauthorization companies have played a valuable role in the increase of a higher level of care for the injured worker and recommended expansion of the preauthorization rule.

RESPONSE: The Commission disagrees that the STG revisions relate to expansion of the preauthorization rule. The TWCC preauthorization rule (§134.600) identifies the specific treatment(s) and/or service(s) that require prospective Utilization Review, and it is only for those specific treatment(s) and/or service(s) that prospective review applies.

COMMENT: Commenter recommended that the term "injured employees" be changed to

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"injured workers" throughout the TWCC guidelines.

RESPONSE: The Commission disagrees. The Commission has chosen to use the term "injured employee" and is attempting to utilize this term consistently throughout TWCC rules.

COMMENT: Commenter recommended that in every instance where "appropriate" treatments, diagnostics, and testing were indicated by inclusion in the STG, all "inappropriate" treatments, diagnostics and testing should also be listed.

RESPONSE: The Commission disagrees with the recommendation to list all "inappropriate" treatments, diagnostics and testing. The purpose of the STG is to identify services that are reasonable and medically necessary for treatment of spine injuries. The STG allows treatment outside the set parameters with additional objective documentation of the medical necessity for the treatment. Therefore, the fact that a particular treatment, diagnostic or test is not listed in the STG does not necessarily make it "inappropriate" to a specific case.

COMMENT: Several commenters expressed concern with the overriding reliance on "objective" findings without addressing the subjective issues as well. It was recommended that "subjective" be included wherever the STG states "objective" evaluations or measures.

RESPONSE: The Commission disagrees that the STG erroneously contains an overriding reliance on "objective" findings without addressing the subjective issues as well. Because the intent of the STG is to describe normative care and to establish documentation standards which support the appropriateness of the level of service, objective documentation is most appropriate for establishing medical necessity. When a health care provider determines that subjective evaluations or measures are appropriate, such documentation may also be provided.

COMMENT: Several commenters were opposed to the preauthorization of treatments and services that are included in the STG, stating that as long as treatment is included in the STG, then further preauthorization should not be required. Another commenter further stated that if the guideline is followed, then an audit of the physician should not occur. Conversely, the commenter contended that if the treatment is outside the guideline, then an audit of the physician would be appropriate.

RESPONSE: The Commission disagrees. Guidelines do not replace the preauthorization process. The STG is not to be used as a fixed treatment protocol or the sole reason for approving or denying a proposed treatment. The STG identifies a normal course of treatment and establishes that there are injured employees who will require more or less treatment than is outlined. The STG allows the health care provider to exercise professional judgment in providing treatments based on the medical necessity of the injured employee's individual condition. It is neither the intent of the STG to address specific medical necessity issues nor to prescribe the type and frequency of treatment. The Commission also disagrees with commenter's contention that an audit of the physician should not occur if the guideline is followed. TWCC has no way to determine

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which health care providers adhere to the medical treatment and fee guidelines, unless an audit is performed. Also, treatment that uses the upper limits listed for normative treatment in the STG, may not "adhere," as some need more and some need less.

COMMENT: Commenter expressed concern about information presented in medical review seminars regarding the roles of doctors in the system.

RESPONSE: The Commission acknowledges commenter's concern. However, medical review seminars present the most up-to-date and accurate TWCC information.

COMMENT: Commenter stated that the proposed STG contained no discussion of the relative weight of a designated doctor's input and another commenter suggested that the treating doctor be given presumptive weight as long as the treating doctor remains fully compliant with the statute and rules.

RESPONSE: The Commission disagrees that discussion of the relative weight of a designated doctor's decision should be included in the STG. Designated doctor issues are addressed in Texas Labor Code §408.122. The Commission disagrees that the weight of the treating doctor's decision should be addressed in the STG because issues relating to treating doctors are addressed in §133.3 of the TWCC Act. Other rules address these issues in depth.

COMMENT: Some commenters requested that TWCC develop a mailing list of all health care providers to advise of all proposed rule and guideline developments and revisions. Commenters further stated that TWCC is not using its resources well and needs to solve problems of inefficiency and duplication of efforts. Some commenters suggested that TWCC utilize guidelines already developed by the North American Spine Society (NASS), or that professional societies revise the TWCC STG.

RESPONSE: The Commission disagrees with suggestion that TWCC develop a mailing list of all health care providers for purposes of advising of all proposed rule and guideline development and revisions. Lists like these have been attempted, but such a list is not possible to maintain due to large numbers of health care providers in Texas changing health care practices. In an effort to expand delivery of the information regarding proposed rules effectively and efficiently, TWCC has initiated the provision of information related to proposed rules and guidelines via the TWCC Internet website. The Commission encourages the members of the MAC to stay in touch with their constituents or professional associations, as MAC members are representatives of the various system participants and should be sharing information. The Commission disagrees that guidelines, such as those developed by NASS, were not utilized in the revision of the STG. Much of the information that was added in the revision of the STG was based on the input of several STGRW members who participated in the development of the following national guidelines: North American Spine Society (NASS), *Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists*; International Spinal Injection Society (ISIS), *Guidelines for the Performance of Lumbar Spinal Injection Procedures*; and, Agency for Health Care Policy and

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Research (AHCPR), *cute Low Back Problems in Adults - Clinical Practice Guideline*.

Guidelines already established by professional societies provide excellent guidance for the revision of the STG. However, these guidelines do not specifically address workers' compensation issues and injuries and it could be inappropriate to adopt one of these guidelines in lieu of the revised STG.

COMMENT: Several commenters expressed concern regarding communication problems existing between TWCC and health care providers, stating that health care providers were allowed little or no involvement in the development of the STG. A commenter expressed concern that members of the prior STG workgroup were not contacted.

RESPONSE: The Commission disagrees that health care providers were left out of the development of the STG. The workgroup members who assisted in drafting the 1995 STG were contacted, and given the opportunity to comment on the revised STG draft. The MAC reviewed available options and recommended the formation of a workgroup (STGRW) and made suggestions for the composition of the STGRW. The MAC further suggested the disciplines to be considered in the composition of such a revision workgroup and suggested the names of potential participants. As a result, the STGRW was composed of members from the areas of medical practice and business, which included the following: chiropractic, neurosurgery, orthopaedic surgery, physical medicine and rehabilitation, occupational medicine, physical therapy, occupational therapy, osteopathic medicine, psychology, and insurance. The Commission makes an effort to share information with the public. The MAC meetings are opened to the public and are posted in the Texas Register. During the revision of the STG, there were periodic STG updates presented to the MAC beginning in the summer of 1998 and through the spring of 1999. The Commission encourages the members of the MAC to stay in touch with their constituents or professional associations, because MAC members are representatives of the various system participants and should be sharing information.

COMMENT: Commenter stated TWCC should take advantage of the assistance of professionals, associations and medical societies who offer help. Commenter also stated TWCC's definition of health care practitioner regarding the practice of medicine by non-licensed individuals is in conflict with Texas BME position paper. Commenter also referred to a report from the Committee on Business and Industry, December 1998, and suggested that the study showed carriers' delays and denials were not helping the system.

RESPONSE: The Commission agrees that TWCC should take advantage of professionals, associations and medical societies who offer help. TWCC utilizes such a system with the assistance of the MAC, focus groups, and workgroups. The Commission disagrees that the position paper on the unauthorized practice of medicine issued by the Texas Board of Medical Examiners (BME) conflicts with the STG because amendments to the BME position paper removed the requirement that utilization review be done by a physician licensed to practice medicine in Texas.

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The following resources were among those used in the evaluation of treatments or key elements in the Spine Treatment Guideline (STG) revision.

- AAEM Somatosensory Evoked Potentials Subcommittee: Kraft, G.H., M.D., et. al. (1998) "Somatosensory Evoked Potentials: Clinical Uses." *Muscle Nerve*, 21 pp. 252-258.
- American Osteopathic Association, (1998) *Protocols For Osteopathic Manipulative Treatment*, Chicago.
- American College of Occupational and Environmental Medicine, Practice Guidelines Committee, (1997) *Occupational Medicine Practice Guidelines*, Chapter 14, Low Back Pain Complaints, OEM Press.
- An, H.S., et. al. "Prospective Comparison of Autograft vs. Allograft for Adult Posterolateral Lumbar Spine Fusion: Differences Among Freeze-Dried, Frozen, and Mixed Grafts." *Journal of Spinal Disorders*, Vol. 8, No. 2, pp. 131-135.
- BenElياهو, D.J., et. al. (1996) "Current Perception Threshold (CPT) Quantitative Sensory Testing in patients with symptomatic and MRI documented disc herniations. The neurosensory diagnosis of discogenic pain." 11th Annual Meeting of the American Academy of clinical Neurophysiology Presentation.
- Block, A.R., Kramer, E.F., Fernandez, E. Eds. *Handbook of Pain Syndromes*, Chapter 5, Clinical Outcome and Economic Evaluation of Multidisciplinary Pain Centers by Okifui, A., Turk, D.C. and Kalauokalani, D.; Lawrence Earlbaum & Associates Publishers, Mahwah, NJ 1999
- Block, A.R., et. al., eds. (1999) Okifuji, A., et. al. "Clinical Outcomes and Cost-Effectiveness of Multidisciplinary Pain Centers" *Handbook of Pain Syndromes: Biopsychosocial Perspectives* pp. 77-97.
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STATUTORY AUTHORITY

The amendment is adopted pursuant to the Texas Labor Code, §402.061 which requires the Commission to adopt rules necessary for the implementation and enforcement of the Texas Workers Compensation Act, and the Texas Labor Code, §413.011, which requires the Commission to establish by rule medical policies and guidelines relating to necessary treatments for injuries, and the Texas Labor Code, §413.013, which requires the Commission to establish by rule a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services; and to establish by rule a program for the systematic monitoring of the necessity of treatments administered and fees charged and paid for

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medical treatments or services, including the authorization of prospective, concurrent, or retrospective review under the medical policies of the Commission to ensure that the medical policies or guidelines are not exceeded. These statutory provisions clearly authorize the Commission to adopt a rule such as §134.1001 which includes guidelines relating to necessary treatments.

§134.1001. Spine Treatment Guideline.

- (a) Table of Contents. The following headings and their corresponding subdivisions comprise a table of contents for this section.
 - (1) Introduction - subsection (b).
 - (A) Purpose - subsection (b)(1).
 - (B) Goals - subsection (b)(2).
 - (C) Development Process - subsection (b)(3).
 - (D) Philosophy of Care - subsection (b)(4).
 - (E) Effective date - subsection (b)(5).
 - (2) Role of Treating Doctor - subsection (c).
 - (A) Statutory Requirements - subsection (c)(1).
 - (B) Treating Doctor Responsibilities - subsection (c)(2).
 - (C) Referrals - subsection (c)(3).
 - (D) Diagnostics - subsection (c)(4).
 - (E) Expectation and Compliance - subsection (c)(5).
 - (3) Application Instructions for Involved Parties - subsection (d).
 - (A) Health Care Provider - subsection (d)(1).
 - (B) Insurance Carriers - subsection (d)(2).
 - (C) Medical Review Division - subsection (d)(3).
 - (D) Consulting or Peer Review Health Care Provider - subsection (d)(4).
 - (E) Injured Employee - subsection (d)(5).
 - (F) Employer - subsection (d)(6).
 - (4) Ground Rules - subsection (e).
 - (A) Introduction - subsection (e)(1).
 - (B) Ground Rules - subsection (e)(2).
 - (C) General Documentation Requirements - subsection (e)(3).
 - (D) Documentation Requirements for Unrelated or Intercurrent Illness - subsection (e)(4)

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- (5) Diagnostic Procedures - subsection (f).
 - (A) Introduction - subsection (f)(1).
 - (B) List of Diagnostic Interventions - subsection (f)(2).
 - (C) Time Recommendations for Listed Diagnostic Interventions - subsection (f)(3).

- (6) Phases of Nonoperative Care - subsection (g).
 - (A) Introduction to Nonoperative Treatment Tables - subsection (g)(1).
 - (B) Initial Phase of Care - subsection(g)(2).
 - (C) Intermediate Phase of Care - subsection (g)(3).
 - (D) Tertiary Phase of Care - subsection (g)(4).
 - (E) Criteria to Distinguish between Intermediate and Tertiary Phases of Care - subsection (g)(5).
 - (F) Post-tertiary Treatment - subsection (g)(6).
 - (G) Phase of Care Tables - subsection (g)(7).

- (7) Assessments/Evaluations - subsection (h).
 - (A) Interdisciplinary Assessment - subsection (h)(1).
 - (B) Functional Capacity Evaluations - subsection (h)(2).
 - (C) Appropriate and Inappropriate Testing - subsection (h)(3).

- (8) Treatment Algorithms - subsection (i).
 - (A) Initial Approach to Treatment of Spinal Injury Chart 1 - subsection (i)(1).
 - (B) Fracture and/or Dislocation Chart 2 - subsection (i)(2).
 - (C) Soft Tissue Injury Chart 3 - subsection (i)(3).
 - (D) Peri-Operative Algorithm Chart 4 - subsection (i)(4).
 - (E) Surgical Treatment Chart 5 - subsection (i)(5).
 - (F) Surgical Treatment Subchart Chart 5A - subsection (i)(5)(A).
 - (G) Surgical Treatment Subchart Chart 5B - subsection (i)(5)(B).
 - (H) Surgical Treatment Subchart Chart 5C - subsection (i)(5)(C).
 - (I) Treatment Continuation Chart 6 - subsection (i)(6).

- (9) Glossary - subsection (j).

- (10) Severability - subsection (k).

- (b) Introduction
 - (1) Purpose. The purpose of this guideline is to clarify those services that are

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reasonable and medically necessary for operative and nonoperative care of the spine for the injured employees of Texas. This guideline identifies a normal course of treatment. There may be injured employees who will require more or less treatment than is recommended in this guideline. This is a guideline and shall not be used as the sole reason for denial when a treatment or service is not listed in the guideline. Similarly the guideline shall not be used as the sole reason for accepting the treatment or service as reasonable and medically necessary simply because the treatment or service is listed in the guideline.

- (2) Goals. The primary goals of this guideline are:
 - (A) to assist all parties with regard to the appropriate treatment and management of disorders of the spine;
 - (B) to establish elements against which aspects of care can be compared;
 - (C) to establish a guideline to identify services that are reasonable and medically necessary for treatment of the compensable injury;
 - (D) to establish documentation standards which support the appropriateness of the level of service; and
 - (E) to provide a mechanism of prospective, concurrent, retrospective review for efficient and effective health care utilization.

- (3) Development Process. The Texas Workers' Compensation Commission (TWCC), in conjunction with health care providers and other parties in the system, have developed clinical and diagnostic treatment guidelines. Following are three major components in the guideline development process.
 - (A) Design and Methodology. A search of all 50 workers' compensation state agencies revealed that only a few had developed treatment guidelines. The format and design of these guidelines were mainly in narrative presentation. Research revealed an algorithmic approach to be the most understandable. Therefore, the focus of this treatment guideline is toward an algorithmic approach versus straight text.
 - (B) Provider Work Group. Research into successful guidelines developed in the private sector identified that involvement from provider work groups achieves the best outcome regarding clinical policy development.
 - (C) Public Evaluation. The evaluation of the developed guideline should be broad and include comments from employees, employers, health care providers and insurance carriers.

- (4) Philosophy of Care. The health care of the injured employee is a coordinated team effort. All parties including employees, employers, health care providers,

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insurance carriers and the Texas Workers' Compensation Commission should promote quality health care, injury specific treatment and appropriateness of care. Communication between all parties must remain open in order to achieve rapid recovery from the effects of the injury. This communication should promote a timely return to modified or full duty work that takes into account the job demands and the functional capabilities of the injured employee.

- (5) Effective date. The Spine Treatment Guideline is effective for treatments and services provided on or after February 1, 2000. Treatments and services provided on or before January 31, 2000 are governed by the Spine Treatment Guideline in effect on the date that the treatment or service was provided, and the previous Spine Treatment Guideline is continued in effect for that purpose.
- (c) Role of Treating Doctor (Primary Doctor/Gatekeeper).
- (1) Statutory Requirements. The following sections of the Texas Labor Code and specific Commission rules address key areas pertaining to those services that are reasonable and necessary for treatment of the spine.
 - (A) Section 408.021(a). 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. The employee is specifically entitled to health care that:
 - (i) cures or relieves the effects naturally resulting from the compensable injury;
 - (ii) promotes recovery; or
 - (iii) enhances the ability of the employee to return to or retain employment.
 - (B) Section 408.021(b). Medical benefits are payable from the date of the compensable injury.
 - (C) Section 408.021(c). Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.
 - (D) Section 408.025(b). The commission by rule shall adopt reasonable requirements for reports and records to be made available to other health care providers to prevent unnecessary duplication of tests and examinations.
 - (E) Section 408.025(c). The treating doctor shall be responsible for maintaining efficient utilization of health care.

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- (2) Treating Doctor Responsibilities.
- (A) The role of the treating doctor is an important role which requires the treating doctor to monitor all health care services being provided for the injured employee. These responsibilities of the treating doctor are vital aspects of the goal to ensure that the injured employee receives quality health care. This monitoring extends to ensure:
- (i) the identification of the extent and severity of the injury initially;
 - (ii) the appropriateness of all services;
 - (iii) the relatedness of all services to the workers' compensation injury;
 - (iv) separation and referral of nonrelated health care services for management by other health plans;
 - (v) whether the treatment is duplicative, necessary and/or effective;
 - (vi) the appropriate cost of the services;
 - (vii) the quality of the treatment; and
 - (viii) enhancement and promotion of effective communication among all involved parties.
- (B) Refer to §126.9 of this title (relating to Choice of Treating Doctor and Liability) for Payment; and §133.3 of this title (relating to Responsibilities of Treating Doctor) for responsibilities of the treating doctor.
- (3) Referrals. The treating doctor is responsible for recommending timely and appropriate referrals. The treating doctor must clearly delineate the clinical rationale for all referrals. The documentation contained in the TWCC required reports should clearly outline whether the purpose of the referral is to corroborate the diagnosis and/or proposed course of treatment or to initiate ongoing treatment. Once a consultation or referral has occurred, the consulting or referral doctor should submit a summary report or initiate a case management phone call back to the treating doctor.
- (4) Diagnostics. Diagnostic work should be performed in accordance with the recommended testing and timeframes contained in this guideline. If the need arises to deviate from the guideline, then a clinical rationale must be provided which adequately substantiates the need for this deviation. The need to repeat previously completed diagnostic procedures due to the quality of the study may trigger a review. All health care providers involved in the treatment of an injured employee must share copies of all diagnostic studies, film and reports in order to avoid unnecessary duplication of procedures. Section 133.2 of this title (relating to Sharing Medical Reports and Test Results) addresses the need to share medical records, including diagnostic studies, to avoid duplication. Section 133.106 of this title (relating to Fair and Reasonable Fees for Required Reports and Records)

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addresses reimbursement for copies of records.

- (5) Expectation and Compliance.
 - (A) All health care providers must encourage injured employees to be active participants in their health care treatment regimens and must communicate to the injured employee realistic expectations regarding the potential outcome of this treatment regimen as it relates to his/her physical functioning and/or ability to return to work. Therefore, documenting the injured employees' compliance with his/her treatment regimen is important when reporting the progress of his/her recovery.
 - (B) Health care providers must explain to the injured employee in clear terms the extent and severity of the injury and the treatment needed. Health care providers must define the symptomatology that is directly and/or indirectly related to the injury and specify treatment not covered under workers' compensation.
- (d) Application Instructions for Involved Parties.
 - (1) Health Care Provider. This guideline shall be used as a tool by the health care provider to establish the required elements to initiate and continue treatment. If, for example, a health care provider's treatment deviates from this guideline, documentation of the medical condition that specifically requires treatment outside the guideline parameters would be required to clearly delineate the need for the treatment.
 - (A) This guideline identifies typical treatment based on normal tissue healing responses for the average injured employee.
 - (B) This guideline recognizes that a subset of injured employees will be found to be outside the parameters of this guideline. If a health care provider's treatment deviates from this guideline, documentation would be required to clearly delineate the need for the treatment.
 - (C) This guideline should be used as a tool which identifies the recommended treatment parameters for treatment of injured employees within the workers' compensation system.
 - (D) This guideline identifies the need to provide documentation which clearly explains the reason for the treatment, the relatedness to the workers' compensation injury and alternative treatment.

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- (E) The health care provider is responsible for providing education to the injured employee about health care treatment appropriate for the workers' compensation injury (refer to subsections (d)(5) and (e)(2)(C)).
 - (F) This guideline recommends timely return to work of either full or modified job duties based upon the injured employee's functional capacity which includes ability, clinical status, and either full or modified job requirements.
- (2) Insurance Carriers. The insurance carrier shall use this guideline to compare treatment prospectively, concurrently and retrospectively with the predetermined elements contained in this guideline.
- (A) This document and its parameters serve only as a guideline and shall not be used as the sole reason for denial of treatments and services.
 - (B) This guideline provides a tool by which to monitor the injured employee's recovery process.
 - (C) This guideline serves as a tool to assist the insurance carrier in the medical audit process.
 - (D) This guideline is not to be used to direct care toward a specific health care discipline or to a specific type of treatment. The insurance carrier is responsible for providing their specific documentation and rationale if treatment is denied. This rationale may include elements of the guideline. Additional information regarding the rationale for denial of treatment may also be derived from the injured employee's medical records and from the professional opinion of a peer review, if utilized. In addition, this treatment guideline is a part of the screening criteria required by the Texas Department of Insurance to be used by Utilization Review Agents to determine preauthorization and retrospective review for medical necessity. Please refer to Title 28 of the Texas Administrative Code, Subchapter U, 28 TAC §§19.2000 - 19.2021, relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage.
 - (E) A subset of injured employees will be found to be outside the parameters of this guideline. If a health care provider's treatment deviates from this guideline, documentation would be required to clearly delineate the need for the treatment.
 - (F) The insurance carrier is responsible for performing a focus review of the injury. The focus review must clarify as early as possible and attempt to reach agreement that the treatment being provided is appropriate.

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Concurrent review activities should address and focus on:

- (i) adherence to treatment plans;
 - (ii) clinical progress;
 - (iii) return to work issues;
 - (iv) medical necessity through retrospective review in accordance with TDI rules;
 - (v) injured employee compliance with the treatment;
 - (vi) services provided consistent with treatment plan;
 - (vii) response to treatment;
 - (viii) improvement in injured employees' progress;
 - (ix) situations where there is no compliance, plateau, and/or there is minimal or no progress; and
 - (x) achievement of goals, improvement sooner than treatment plan indicated.
- (3) Medical Review Division. The Medical Review Division shall use the guideline as a tool for the basis of their administrative review of prospective, concurrent and retrospective treatment. This guideline shall also be used as a tool in conducting on-site audits and desk audits for both health care providers and insurance carriers.
- (4) Consulting or Peer Review Health Care Provider. This guideline should be used as a reference in advising the Medical Review Division and to determine when the need for an unbiased medical opinion is indicated. The peer reviewer should use his/her clinical expertise in conjunction with the clinical intent of the guideline to address issues.
- (5) Injured Employee. The injured employee should understand his/her role in complying with recommended treatment. The recovery process requires active cooperation of the injured employee. The health care provider is responsible for providing education to the injured employee about health care treatment appropriate to the workers' compensation injury (refer to subsections (d)(1)(E) and (e)(2)(C)).
- (6) Employer. The employer shall be responsible for reporting the compensable injury in a timely fashion to ensure that there is no delay in the treatment of the compensable injury. The employer should, when appropriate, be responsible for working with the insurance carrier and health care providers to ensure that the injured employee is afforded the opportunity to return to work in either a modified or full employment capacity as rapidly as possible within the medical limitations of his/her injury.
- (e) Ground Rules.

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- (1) Introduction. The Texas Workers' Compensation Commission treatment guidelines are not to be used as fixed treatment protocols. The guidelines reflect services that are reasonable and medically necessary for treatment of spine injuries. The guidelines recognize that a subset of injured employees will be found to be outside the guidelines' parameters. However, cases exceeding the guidelines' level of treatment shall be subject to more careful scrutiny and review and shall require documentation of the special circumstances justifying that treatment. The guideline should not be seen as prescribing the type, frequency or duration of treatment. Treatment must be based on the injured employee's need and the doctor's professional judgment.
- (2) Ground Rules.
 - (A) Notwithstanding any other provision of this section, treatment of a work related injury must be:
 - (i) adequately documented;
 - (ii) evaluated for effectiveness and modified based on clinical changes;
 - (iii) provided in the most appropriate, least intensive setting;
 - (iv) cost effective;
 - (v) consistent with this guideline which may include providing a documented clinical rationale for deviation from this guideline;
 - (vi) objectively measured and demonstrated functional gains; and
 - (vii) consistent in demonstrating ongoing progress in the recovery process by appropriate re-evaluation of the treatment.
 - (B) Communication between all health care providers involved in treating the injured employee must ensure that all previous treatment and diagnostic tests are considered when developing a treatment plan. All reports and records shall be made available to all health care providers to prevent unnecessary duplication of tests and examinations (refer to subsection (c)(2) and (3) of this section).
 - (C) Education is an essential component in ensuring the injured employees' compliance to all treatment. Education is essential for the active cooperation of the injured employee in all aspects of health care and as a means to prevent re-injury. The injured employee should understand his/her role in the recovery and return to work processes. The health care provider is responsible for providing education to the injured employee about health care treatment appropriate to the workers' compensation injury (refer to subsections (d)(1)(E) and (d)(5) of this section).
 - (D) Physical medicine treatment is required to meet the definitions/criteria set

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forth in the current Medical Fee Guideline. Treatment in this area should include activation as early as possible but no later than two weeks after treatment begins unless there is medical justification for delay. Early activation may include but is not limited to bilaterally symmetrical activities such as walking, swimming, bicycling and self-stretching. The activities should be goal directed - either timed intervals or numbered repetitions and may be performed at home or under supervision. Documentation of the injured employee's compliance and substantive and continued improvement should be included in reports already being submitted. This documentation should justify the continuation of therapy. For examples of types of documentation refer to paragraph (3)(C) of this subsection.

- (E) Manipulation should be performed for the minimum appropriate duration. Minimum appropriate duration can be defined as that duration of time from the initiation of treatment which will result in continued improvement, and where additional treatment will not further benefit the injured employee. The frequency of such treatment should be consistent with the phase of the injured employee's disease or dysfunctional process as determined by on-going evaluation and management of the injured employee's conditioning. Substantive and continued improvement over time from the treatment should be objectively documented. For examples of objective documentation refer to paragraph (3)(E) of this subsection. Additional treatment or further evaluation may be necessary if repeated efforts to withdraw from treatment results in documented significant deterioration of clinical status and the doctor has taken steps to determine that the patient is not physician/system dependent (i.e. behavioral consultation).

- (F) Although preoperative educational programs and chronic pain management programs are not specifically outlined, the intent of this guideline is not to eliminate or prohibit their use. When deemed medically necessary, these programs may be considered appropriate types of intervention to be utilized. Chronic pain management programs may be appropriate for injured employees with chronic pain for which surgical and non-surgical treatments have failed and who are not imminent candidates for other treatments. Chronic pain is pain that has lasted without abatement for six months. A primary goal of the chronic pain management program should be the independent self-directed management of chronic pain by the injured employee. Chronic pain management programs should include the following components: usual duration of four to six weeks; an identified endpoint which typically coincides with the last step(s) in treatment prior to achievement of Maximum Medical Improvement (MMI), if not already determined; and notification to the injured employee that non-compliance may result in the certification of MMI, and the required evaluation for the

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assignment of an impairment rating. The chronic pain management program should also provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain syndrome. After completion of a full chronic pain management program, re-enrollment or repetition of another full chronic pain management program for the same condition or injury, would not be medically warranted. For additional ground rules on the use of interventional measures for pain, refer to paragraph (2)(T) of this subsection.

- (G) TENS (transcutaneous electric nerve stimulation) units and other transcutaneous stimulators should be used for acute pain and usually for no longer than four to six weeks. If stimulators are needed beyond the acute phase, objective documentation should be provided for the continued rental/purchase. For examples of objective documentation refer to paragraph (3)(F) of this subsection.
- (H) All parties in the workers' compensation system should work together to ensure that the injured employee returns to work at the earliest medically appropriate time. Return-to-work is an important therapeutic approach which benefits the injured employee. The health care provider shall communicate with the injured employee, employer and the insurance carrier to coordinate a successful return to work. Return to work planning efforts should commence as early as possible in cases where the injury is severe and the provider expects obstacles in returning the injured employee to the workplace.
- (I) The level of service should be the same as the health care provider's usual and customary level of service regardless of the payor system.
- (J) Although not the typical course of treatment, there may be circumstances in which the injured employee may move between phases of care or utilize interventions in more than one phase of care simultaneously, depending on clinical indicators.
- (K) Treatment durations are cumulative; it may not always be necessary to use full durations for any given phase of care.
- (L) Rehabilitation programs such as work hardening, work conditioning and outpatient medical rehabilitation are required to meet the definitions/criteria set forth in the current Medical Fee Guideline. Work conditioning and work hardening program goals should be tailored to physical demands required by job specificity. When the injured employee does not have a

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specific job that he/she is returning to, the goal of these programs should be to restore a reasonable level of physical functioning. Work conditioning programs at the job site or a combination of work conditioning/work hardening and modified duty as part of a progressive return to work program can also be utilized to meet these goals when the employer has these programs in place. After completion of a rehabilitation program, re-enrollment or repetition in the same rehabilitation program for the same condition or injury would not be medically warranted.

- (M) When the injured employee displays signs and symptoms which may require further evaluation by a Qualified Mental Health Provider, refer to §134.1000 of this title (relating to the Mental Health Treatment Guideline) for parameters regarding documentation, evaluation and treatment.
- (N) The highest quality of patient care and clinical outcomes should be the standards by which referrals to intermediate and tertiary care programs are determined. Documentation should be provided by the treating doctor which demonstrates the clinical progress of the injured employee's condition and evidence of the doctor's supervision. With this documentation present, both intermediate and tertiary nonoperative care may be provided sequentially within the same facility or in facilities with linked ownership if self-referral or conflict of interest elements do not exist.
- (O) All health care providers treating an injured employee are responsible for substantiating in their documentation the level of service for which they request reimbursement. All payors have the responsibility to review all documentation submitted as the basis for the treatment and services provided.
- (P) Any new alternative or experimental treatment must meet acceptable standards of care (as defined in the Glossary) and may be subject to review by the Texas Workers' Compensation Commission.
- (Q) Documentation of significant neurological deficit may support early intervention (0 - 6 weeks) of MRI's and CT scans, which would better direct the course of treatment.
- (R) Indications for bone growth stimulators include:
 - (i) revision spinal fusion;
 - (ii) history of spinal fusion with prior delayed union at different level;
 - (iii) multiple level spinal fusion;
 - (iv) use of allograft;

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- (v) spondylolisthesis;
 - (vi) nonassociated high risk problems: e.g. smokers, and pseudarthrosis.
- (S) Interventional pain procedures may include spinal cord or peripheral nerve stimulation and/or implantable infusion pumps and are performed to achieve one or more of the following objectives:
- (i) to establish a diagnosis by identifying an anatomical source of pain (e.g., nerve sleeve injections and facet injections);
 - (ii) to complete therapeutic neurodestructive procedures to an anatomic source of pain identified by an appropriate response to diagnostic injections (e.g., injection of neurolytic substances, cryoneurolysis, and radiofrequency thermocoagulation);
 - (iii) to deliver specific medications (e.g. steroids and narcotics) to potential sources of pain;
 - (iv) to deliver electrical energy interrupting painful nerve impulses (e.g., stimulation).
- (T) Spinal injection techniques are interventional pain procedures that can be diagnostic as well as therapeutic. Interventional pain procedures should be performed methodically based on reproducible clinical examination findings. (refer to (e)(3)(G) for general documentation requirements).
- (i) Epidural Steroid (ESI) Injections (Translaminar and Transforaminal) - A therapeutic procedure performed by injecting corticosteroid and/or anesthetic along the affected spinal nerve and into the epidural space at the site of inflammation. This differs from a diagnostic selective spinal nerve block in that the ESI is primarily therapeutic. The ESI has low specificity due to epidural flow of anesthetic but has high sensitivity. Indications for ESIs include radicular extremity pain that proves unresponsive to noninvasive treatments including non-steroidal anti-inflammatories (NSAIDs), appropriate active rehabilitation or manipulation, and/or oral corticosteroids. If severe limitations of functions exist, ESIs may be performed prior to the initiation of more conservative options to facilitate those options. ESIs must be performed under fluoroscopic control. The frequency of injections should be limited to one to three injections spaced minimally seven to 14 days apart, as determined by clinical response and not to exceed six injections in a 12 month period. Repeat injections after the initial injection and/or series would not be indicated if the initial injection did not provide significant and long-term documented relief.

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- (ii) Zygapophyseal (Facet) and Costovertebral Joint Injections - Indications for intra-articular injections are limited to axial and referred pain in patients who are neurologically intact with pain for at least four weeks unresponsive to noninvasive treatments including NSAIDS, physical medicine treatment or manipulation and/or oral corticosteroids. These injections must be performed under fluoroscopic control. Relief for less than seven to 10 days to the initial session precludes the need for additional injections. Furthermore, injections should be limited to three levels not to exceed three sessions in a 12 month period. Repeat injections after the initial injection and/or series would not be indicated if the initial injection did not provide significant and long-term documented relief.

- (iii) Sacroiliac Joint (SI) Injections - Indications for SI injections are a strong clinical suspicion of SI joint dysfunction in a patient who has experienced pain for at least four weeks and failed to improve with noninvasive treatments including NSAIDS, physical medicine treatment or manipulation and/or oral corticosteroids. SI injections must be performed under fluoroscopic control. Relief for less than seven to 10 days from the initial injection(s) precludes the need for additional injection(s). The frequency of injection(s) should be limited to one to three injections spaced minimally seven to 14 days apart as determined by clinical response and not to exceed four injections in a 12 month period. Repeat injections after the initial injection and/or series would not be indicated if the initial injection did not provide significant and long-term documented relief.

- (iv) Diagnostic Selective Spinal Nerve Blocks (often called Spinal Nerve Root Blocks) - A diagnostic test performed to test the hypothesis that the spinal nerve transmits or is the pain source. This is done by injecting anesthetic along a spinal nerve and not onto adjacent structures or the epidural space to maintain diagnostic specificity. This diagnostic test is often called spinal nerve root blocks, however, because anesthetic is placed directly on the spinal nerve and not directly on the nerve root, correct anatomical nomenclature dictates that the procedure be called a selective spinal nerve block. Indications for this diagnostic test is to identify a segmental level when negative or equivocal imaging studies are associated with the clinical findings of nerve root irritation. The radicular symptoms remain unresponsive to conservative interventions. The test results should direct the surgical treatment plan. The test replaces EMG testing which has

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poor diagnostic specificity for root level.

- (v) Medial Branch and Dorsal Ramus Blocks - Indications for medial branch and dorsal ramus blocks exists in those patients with at least four weeks of axial or referred pain that has persisted in spite of appropriate treatment including NSAIDS, physical medicine treatment or manipulation, and/or oral corticosteroids. These diagnostic blocks must be performed under fluoroscopic control. Repeat blockade should only be performed for confirmation of equivocal results in patients for whom ablative block is to be considered and should not exceed two additional sessions in a 12 month period.
- (vi) Ablative Dorsal Median Branch Blocks (radiofrequency thermocoagulation, cryoneurolysis, chemical neurolysis) - Indications for these techniques exist in that patient with at least eight weeks of axial or referred pain that has a confirmed facet pain source limited to no more than three levels by prior diagnostic facet or select dorsal median branch blockade. Repeat ablation may be performed for recurrent pain not sooner than four months after initial ablative blockade and should not exceed two sessions in a 12 month period.
- (U) Trigger point injections - Indications include reproducible and palpable muscle spasticity of at least two weeks duration nonresponsive to appropriate treatment including NSAIDS and rehabilitation or manipulation. Less than five days of relief with initial injection would preclude additional injections. Frequency of injections should be limited to three injection sessions spaced minimally seven days apart and should not exceed four injection sessions in a 12 month period. No more than four injections should be given at any session. Failure to obtain at least three months of improvement with a set of three injection sessions would preclude additional injections.
- (V) Acupuncture - Acupuncture when indicated may be used for acute musculoskeletal pain and usually for no longer than four to six weeks. If treatment is needed beyond the acute phase, objective documentation should be provided for the continued treatment. (refer to (e)(3)(G) for general documentation requirements).
- (W) Preauthorization of any treatments or services will be as required in the Commission's preauthorization rule.

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- (X) When it becomes necessary for an injured employee to travel in order to obtain appropriate and necessary medical care for a compensable injury, reimbursement for travel expenses is governed by §134.6 of this title.
- (Y) The CPT codes in the current Medical Fee Guideline shall be used.
- (3) General Documentation Requirements.
 - (A) The health care provider's documentation is vital as an information source regarding the injured employee's injury and treatment and also provides information which impacts income benefits. For these reasons, many of the Commission's rules have set time requirements for submission of required reports. For more information, refer to Chapter 133, Subchapter B of this title (relating to Required Reports).
 - (B) Documentation shall be provided by the health care provider to determine the phase of care to be provided and the necessity for that care. The elements of that documentation may include:
 - (i) a description of the injury, including the events surrounding that injury and the extent and severity of that injury;
 - (ii) a description of any pre-existing condition(s), complicating conditions, and/or any non-related conditions;
 - (iii) a treatment plan, including proposed methods of treatment, expected outcomes, and probable duration of treatment;
 - (iv) updates to the treatment plan as needed, including the clinical progress of the injured employee and any revisions needed to the treatment plan based on the injured employee's response to treatment;
 - (v) educational information provided to the injured employee regarding his or her injury and treatment plan, and the injured employee's compliance with this treatment plan; and
 - (vi) objective documentation substantiating the need for deviation from the guideline, if necessary.
 - (C) Documentation for physical medicine treatment should be objective and illustrate compliance and substantive and continued improvement over time. Examples of this documentation may include but are not limited to:

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- (i) patient diaries documenting home program;
 - (ii) description of patient's capabilities and clinical progress made;
 - (iii) notes describing quantified changes in pain behavior using tools such as pain drawings;
 - (iv) notes describing the patient's demonstrated independent performance of provider instructed exercise;
 - (v) notes describing patient's exercise such as "patient is walking 45 minutes";
 - (vi) notes indicating increased ability in activities of daily living;
 - (vii) notes indicating increase in walking distance;
 - (viii) notes indicating increase in sitting time tolerance;
 - (ix) notes indicating increase in standing time tolerance;
 - (x) neck disability index results;
 - (xi) back disability index results; or
 - (xii) notes indicating reduction or decrease in pharmacological usage.
- (D) Documentation for rehabilitation programs such as work conditioning, work hardening or outpatient medical rehabilitation should show objective substantive and continued improvement over time that correlates to the job description the injured employee will most likely enter upon completion of the program. The examples listed in paragraph (3)(C) of this subsection may also be used to appropriately document progress made in rehabilitation programs.
- (E) Documentation for manipulation should show objective/quantified substantive and continued measures of improvement over time. The examples listed in paragraph (3)(C) of this subsection may be used to appropriately document progress.
- (F) Documentation for the continued use of TENS units and other transcutaneous stimulators beyond four to six weeks should show objective/quantified measures of substantive and continued improvement over time which may include but are not limited to:
- (i) decreased use of medication;
 - (ii) increased function due to reduction in pain; or
 - (iii) enhances the ability of the employee to return to or retain employment.
- (G) Documentation for acupuncture and spinal injections should show objective/quantified measures of substantive and continued improvement over time which may include but are not limited to:

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- (i) decreased use of medication;
 - (ii) increased function due to reduction in pain; or
 - (iii) enhances the ability of the employee to return to or retain employment.

- (4) Documentation Requirements for Unrelated or Intercurrent Illness. Situations may arise where certain medical conditions need to be delineated or clarified prior to intervention. Treatment administered to other body areas (not a part of the original injury) or for a pre-existing medical condition(s) must be identified and the relation of this treatment to the treatment provided to the injured employee for the compensable injury must be documented by the health care provider. If this treatment appears not to be related to the treatment provided to the injured employee for the compensable injury, then the health care provider should inform the injured employee that this treatment may not be covered by the workers' compensation insurance carrier. The health care provider should clearly document the rationale for such treatment, its relation to the compensable injury and its relation to the treatment provided to the injured employee for the compensable injury.

- (f) Diagnostic Procedures.
 - (1) Introduction. This subsection provides an average timeline in which to utilize certain listed diagnostic studies. The actual need for the diagnostic studies will be dependent on both the amount of time that has passed since the date of injury and on the injured employee's documented clinical condition. If the clinical condition of the injured employee is more severe, certain tests may be required sooner than is proposed in this guideline.

 - (2) List of Diagnostic Interventions. The following subdivisions of this paragraph comprise a list of diagnostic interventions:
 - (A) history and physical:
 - (i) identify mechanism of injury;
 - (ii) correlate patient's association of complaint with mechanism of injury; and
 - (iii) correlate mechanism of injury and resultant body area(s) of injury;

 - (B) plain X-ray:
 - (i) five views;
 - (ii) two views; and/or
 - (iii) flexion/extension views;

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- (C) laboratory tests;
 - (D) myelogram;
 - (E) CT scan;
 - (F) MRI;
 - (G) CT Scan augmented with myelography;
 - (H) IV enhanced CT Scan;
 - (I) gadolinium MRI - only with a history of prior surgery, failed back surgery, or to rule out an infection;
 - (J) radionucleotide bone scan:
 - (i) nucleotide;
 - (ii) dual photon; or
 - (iii) P.E.T.;
 - (K) EMG/nerve conduction studies [excluding Somatosensory Evoked Potential (SEPs)];
 - (L) diagnostic selective spinal nerve block injection - done under fluoroscopy control; (refer to subsection (e)(2)(T)(iv) of this section);
 - (M) diagnostic facet injection - done under fluoroscopy control both diagnostic and therapeutic (refer to subsection (e)(2)(T)(ii) of this section);
 - (N) discography - discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the amount of dye accepted, the pressure necessary to inject the material, the configuration of the opaque material, and the reproduction of the patient's pain. Discography is useful in select situations. (refer to subsection (f)(3)(D) of this section)
 - (O) functional capacity evaluation; or
 - (P) mental health evaluation.
- (3) Time Recommendations for Listed Diagnostic Interventions.
- (A) Recommended diagnostics at zero to six weeks include the diagnostic interventions listed in (2)(A), (B), and (C) of this subsection.
 - (B) Recommended diagnostics at six weeks to four months includes the diagnostic interventions listed in (2)(D) - (L) of this subsection.
 - (C) Recommended diagnostics at greater than four weeks includes the diagnostic interventions listed in (2)(M) of this subsection.
 - (D) Discography listed in (2)(N) should usually be performed after six months from date of injury and only after appropriate imaging studies such as an MRI or CT/myelogram has been performed with questionable, suggestive

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or abnormal findings. Discography should not be the sole determining factor or justification for a surgical intervention. A positive discogram correlates the reproduction of the patient's pain with an imaging study and a control. The following indicators (which also appear in chart 6 of the surgical algorithms) usually occur for discography to be appropriate:

- (i) the patient has had unremitting lower back pain resistant to conservative care for more than six months; and
- (ii) significant psychosocial issues are not dominant or have been addressed; and
- (iii) suspected painful discs and one normal disc by MRI are injected; and
- (iv) results of appropriately and carefully performed provocative and imaging tests are combined

(E) The diagnostic interventions listed in (2)(O) - (P) of this subsection may occur at any time after the initial date of injury. Once the injured employee has sufficiently recovered, a Functional Capacity Evaluation is usually performed to determine whether or not the injured employee is considered a candidate for a work hardening or work conditioning program. These tests are usually performed just prior to entry into the program and at the end of the program to determine the injured employee's level of physical ability and his/her capability to return to work.

(g) Phases of Nonoperative Care.

- (1) Introduction to Nonoperative Treatment Tables. The treatments, set out in the following tables, represent treatment that is reasonable and medically necessary for a given period of time according to the diagnosis(es). The "Treatment Interventions" sections of the Treatment Tables are in alphabetical order and do not infer numerical sequence. There will be some injured employees who require less treatment, and other injured employees who require more treatment than is outlined. This document serves as a guideline and should not be used as the sole reason for denial or requirement of treatment. The provision of specific services to an injured employee is dependent on the injured employee's diagnosis, and response to treatment.
- (2) Initial Phase of Care, Duration 0-8 weeks. This phase of care is generally considered to be appropriate for injured employees immediately following the compensable injury; however, the injured employee in this phase of care may also be an early postoperative patient or may be experiencing an acute exacerbation of his/her chronic condition. Since partial or total cessation of work over a brief period of time is also considered to be part of the initial phase of care, further

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treatment by a health care provider may not be considered necessary at this phase of care. Little or no deconditioning has occurred due to the injury, immobilization or decreased activity. The goals for this phase of care are to prevent disease, alleviate or minimize the effects of the illness or injury and to maintain function

- (3) Intermediate Phase of Care, Duration 0-8 weeks. This phase of care is for those injured employees who have not returned to productivity after the normal healing process. This phase of care is designed to facilitate return to productivity, including return to work in either full or modified duty, before the onset of a chronic condition. This phase of care may also be indicated for the injured employee whose physical capacity to work still does not meet the current or expected job requirements after adequate treatment, thereby causing an inability to return to full duty. It is individualized, time limited and of limited intensity. The injured employee has a history of a limited-to-good response to early primary treatment with persistent symptoms limiting activities of daily living. The objective physical examination demonstrates findings suggestive of early deconditioning including loss of range of motion and/or strength with limitation of activities of daily living. Evidence of mental health or psychosocial barriers may be present which impede the injured employee's clinical progress.
- (4) Tertiary Phase of Care, Duration 0-6 weeks.. This phase of care is interdisciplinary, individualized, coordinated and intensive. It is designed for the injured employee who demonstrates physical and psychological changes consistent with a chronic condition. Psychosocial issues such as substance abuse, affective disorders, and other psychological disorders may be present. There is a documented inhibition of physical functioning evidenced by pain sensitivity, and nonorganic signs such as fear which produce a physical inhibition or limited response to reactivation treatment. This phase of care may also be indicated for the injured employee whose physical capacity to work still does not meet the current or expected job requirements after adequate treatment, thereby causing an inability to return to full duty. This situation would be evidenced by an excessive transitional period of light duty or significant episodes of lost work time due to the need for continued medical treatment. This phase of care is also indicated for those injured employees who cannot tolerate either initial or intermediate phases of care. The usual duration for this phase of care is generally up to six weeks.
- (5) Criteria to Distinguish between Intermediate and Tertiary Phases of Care. Many factors may determine the choice between intermediate and tertiary phases of care. In general, if lower cost intermediate treatment can be effective, this phase of care is preferred over the more expensive tertiary care. However, if the documented condition of the injured employee indicates the need for more intensive treatment, the tertiary phase of care may be more appropriate. Key factors in determining the need for intermediate versus tertiary care include:

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- (A) the time elapsed since injury;
 - (B) the presence of psychosocial barriers to recovery such as but not limited to depression, substance abuse, personality disorder, etc., and the severity of these barriers;
 - (C) the lack of responsiveness to previously attempted treatment;
 - (D) the severity of physical/functional deconditioning;
 - (E) socioeconomic barriers to recovery; and/or
 - (F) failed back surgery.
- (6) Post-tertiary treatment. Injured employees are entitled to the reasonable and necessary medical benefits for the duration of the injury. In some cases injured employees will require treatment after they have reached MMI or after they have completed the tertiary phase of treatment. Treatment should be provided to control pain or other symptomology, maintain function and/or to help the injured employee remain at work. Treatment provided post MMI or after the tertiary phase of care is typically aimed towards one or more of these three goals. Interventions for these injured employee are generally provided at a lower frequency than in the three phases of care outlined in the treatment tables. Examples of interventions that might be utilized include office visits, manipulations, home exercise, injections, and medications. Preauthorization is applicable to any services listed in the preauthorization rule. Other services are subject to retrospective bill review for medically reasonable and necessary treatment and/or payment amount. Health care providers who provide services to injured employees after the tertiary phase of care or after MMI, who are not paid for their services may apply to Commission's Medical Dispute Resolution section, for resolution of the issue of medical necessity or bill payment amount. To receive payment for services, a treatment must be related to the compensable injury and be reasonable and necessary treatment for that injury. As with all medical services, health care providers are responsible for appropriate utilization of medical services. Health care providers may be sanctioned or removed from the Approved Doctor List for over utilization of health care services. Insurance carriers must review treatments in accordance with the standards set forth by the Texas Department of Insurance Utilization Review Rules. An insurance carrier operating outside the parameters of these rules may be subject to regulatory sanctions and/or criminal charges by the Texas Department of Insurance. An insurance carrier who unreasonably denies medical benefits may be subject to sanctions by the Texas Workers' Compensation Commission.

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- (7) Phase of Care Tables.
 - (A) Table I. Initial Phase of Care.
 - (B) Table II. Intermediate Phase of Care.
 - (C) Table III. Tertiary Phase of Care.
 - (D) Table IV. Surgical Intervention.

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Texas Workers' Compensation Commission Figure: 28 TAC §134.1001 (g)(7)(A)

Phases of Care Tables.

(A) TABLE I. INITIAL PHASE OF CARE	
DURATION:	0 - 8 weeks
DESCRIPTION:	This intervention is generally performed in the acute phase. Little or no deconditioning has occurred due to the injury, immobilization, or decreased activity. This phase of care may be used for any level of severity of injury according to the clinical indicators. Successful treatment (leading to Maximum Medical Improvement (MMI)) is accomplished in 60-80% of musculoskeletal soft tissue injuries, requiring only limited medical intervention.
CLINICAL INDICATORS: (May include but not limited to)	<ol style="list-style-type: none"> 1) Brief history of acute injury with early positive response to treatment (i.e., early symptomatic relief). 2) No urgent surgical indicators on physical examination (i.e., progressive neurological deficit, myelopathy, or incapacitating pain). 3) No significant structural pathology, suggesting surgical solutions. 4) Post acute or chronic patient with acute exacerbation. 5) Early post-operative patient.
GOAL OF INITIAL INTERVENTION:	To prevent progression of disease, alleviate or minimize the effects of the illness and to maintain function.
ASSESSMENTS:	Diagnostic Testing [Refer to subsection (f)] History and physical examination including neurological evaluation.
TREATMENT INTERVENTION: (May include but not limited to)	<p>Acupuncture [Refer to subsection (e)(2)(V) and (e)(3)(G)]</p> <p>Behavioral Pain Management (examples include, but not limited to: cognitive-behavioral psychotherapy, relaxation training, instrumental biofeedback, coping skills training).</p> <p>Education</p> <ul style="list-style-type: none"> ▶Back School ▶Neuromuscular Reeducation ▶Anatomical Relationships ▶Ergonomics Instruction <p>Exercise</p> <p>Injections [Refer to subsection (e)(2)(T)-(U) and (e)(3)(G)]</p> <p>Limited Activity</p> <ul style="list-style-type: none"> ▶Bed Rest (2 - 3 days) ▶Modified/Transitional Work ▶Work Cessation Consideration <p>Manipulations [Refer to subsection (e)(2)(E) and (e)(3)(E)]</p> <p>Mental Health Evaluation</p> <p>Medication</p> <p>Orthotics</p> <p>Physical Medicine Treatment [refer to subsection (e)(2)(D) and (e)(3)(C)]</p> <ol style="list-style-type: none"> (1) Attended modalities and procedures (2) Unattended modalities (limited to a maximum of two (2) weeks, if used solely) (3) Concurrent home program <p>TENS [Refer to subsection (e)(2)(G) and (e)(3)(F)]</p>

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EXPECTED OUTCOME:	Return to work and/or Maximum Medical Improvement (MMI).
RETURN TO WORK ISSUES:	Functional Capacity Evaluations Job Site Analysis A mild level of severity allows return to work within 0-8 weeks, with or without modified/transitional work.
FAILURE TO RESPOND:	Documented failure to respond at any time to treatment may require additional diagnostic tests and/or treatment consistent with greater level of severity.

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Texas Workers' Compensation Commission Figure: 28TAC §134.1001 (g)(7)(B)

(B) TABLE II. INTERMEDIATE PHASE OF CARE	
DURATION:	0 - 8 weeks
DESCRIPTION:	This intervention is for those individuals who have not returned to productivity after the normal healing process. This phase of care is designed to facilitate return to productivity, including return to work in either full or modified duty, before the onset of a chronic condition. It is individualized, time-limited and of limited intensity. It is designed to prevent chronic disability, occurring because of progressive deconditioning and development of psychosocial barriers to return to work.
CLINICAL INDICATORS: (May include but not limited to)	<ol style="list-style-type: none"> 1) History of an injury or illness with limited-to-good response to early initial treatment (persistent symptoms with limitation of activities of daily living). 2) Objective physical examination findings suggestive of early deconditioning (loss of motion and/or strength with limitation of activities of daily living). 3) No significant structural pathology suggesting surgical solutions. 4) Evidence of mental health/psychosocial barriers impeding progress.
GOAL OF INTERMEDIATE INTERVENTION:	Arresting and preventing progressive physical deconditioning and appearance of psychosocial barriers to return to work with a reactivation process, generally associated with the post-acute and early postoperative periods.
ASSESSMENTS:	<p>Diagnostic Testing [Refer to subsection (f)]</p> <p>The type of assessments utilized in this phase of treatment depend on the level of severity associated with the diagnosis. Functional capacity evaluations may be necessary to assess work tolerance before intervention and return to work release. Mental health evaluation to identify psychosocial barriers, or the need for behavioral pain management may be appropriate. Documentation is required to substantiate the need for further testing.</p>

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<p>TREATMENT INTERVENTION: (May include but not limited to)</p>	<p>Aerobic Conditioning Behavioral Pain Management (examples include, but not limited to: cognitive-behavioral psychotherapy, relaxation training, instrumental biofeedback, coping skills training). Education Programs ▶Emphasis on > Acute ▶Increased Mobilization vs Strength ▶Concurrent Home Programs Exercise Injections [Refer to subsection (e)(2)(T)-(U) and (e)(3)(G)] Manipulations [Refer to subsection (e)(2)(E) and (e)(3)(E)] Manipulations Under Anesthesia Medication Mental Health Intervention Physical Medicine Treatment [Refer to subsection (e)(2)(D) and (e)(3)(C)] (1) Attended modalities and procedures (2) Unattended modalities (limited to a maximum of two (2) weeks, if used solely) (3) Concurrent home program Single or Interdisciplinary Programs ▶Work Hardening [Refer to subsection (e)(2)(L)] ▶Outpatient Medical Rehabilitation [Refer to subsection (e)(2)(L)] ▶Work Conditioning [Refer to subsection (e)(2)(L)] TENS [Refer to subsection (e)(2)(G) and (e)(3)(F)]</p>
<p>EXPECTED OUTCOME:</p>	<p>Return to work and/or Maximum Medical Improvement (MMI).</p>
<p>RETURN TO WORK ISSUES:</p>	<p>Functional Capacity Evaluations Job-Site Analysis The moderate level of severity is appropriate for a patient medically expected to return to work in less than six months, either with a full release or at minimally modified duty expected to last three months or less. Treatment response to initial and/or intermediate interventions should result in a return to full duty (or minimally modified) work. There may possibly be limitations restricting some heavy jobs, even after the injured employee has completed the transitional modified duty period and reached Maximum Medical Improvement. Return to full duty work may not always be possible and may necessitate the introduction of post-medical vocational rehabilitation services by referral to Texas Rehabilitation Commission.</p>
<p>FAILURE TO RESPOND:</p>	<p>Documented failure to respond may require additional diagnostic tests and/or treatment consistent with greater severity. Consider referral for mental health evaluation/assessment [see Mental Health Treatment Guideline - subsection (g)].</p>

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Texas Workers' Compensation Commission Figure: 28TAC §134.1001 (g)(7)(C)

(C) TABLE III. TERTIARY PHASE OF CARE	
DURATION:	0 - 6 weeks
DESCRIPTION:	This is interdisciplinary, individualized and intensive treatment designed for injured employees already demonstrating physical and psychological changes consistent with chronic disability. In general, differentiation from intermediate treatment includes medical direction, intensity of services, severity of injury, individualized programmatic protocols with integration of physician, mental health and disability or pain management services and specificity of physical/psychosocial assessment.
CLINICAL INDICATORS: (May include but not limited to)	<ol style="list-style-type: none"> 1) Documented history of persistent failure to respond to nonoperative and/or operative treatment, which surpasses the usual healing period of > 4 - 6 months post-injury and/or post-surgery, or special cases with severe mental health issues which last >2 months without response to initial or intermediate treatment. 2) History of significant psychosocial disturbance (i.e., substance abuse, affective disorders, psychiatric conditions.) 3) Inhibition of physical functioning regarding relative work and Activities of Daily Living requirements as evidenced by pain sensitivity, nonorganic signs, fear producing physical inhibition or limited response to reactivation treatment and documented by quantitative physical examination or functional capacity testing. 4) Heavy job demands with inability to match physical capacity to work demands after adequate treatment causing inability to return to uninterrupted full duty. This situation would be evidenced by an injured employee assigned to an excessive transitional period of light duty and/or significant episodes of lost time from work due to medical treatment. The inability to match the injured employee skills to any job availability may necessitate medical rehabilitation with or without vocational rehabilitation. 5) Injured employees who cannot tolerate initial or intermediate phases of care. 6) See also Mental Health Treatment Guideline subsection (i) - Criteria for Referral to Other Programs.
GOAL OF TERTIARY INTERVENTION:	To represent the tertiary phase of nonoperative or postoperative treatment for severe cases, with the goal of giving injured employees an opportunity for cooperating actively in programs designed to achieve Maximum Medical Improvement. Return to full duty work may not always be possible and may necessitate the introduction of post-medical vocational rehabilitation services by referral to Texas Rehabilitation Commission.
ASSESSMENTS:	Diagnostic Testing [Refer to subsection(f)] Standard history and physical examination must be accompanied by mental health assessment and functional capacity evaluation of whole-body performance. The specific testing chosen and the need for serial assessments, may be individualized to the specific injured employee or programmatic protocols, based on documentation of effective outcomes of return to work, lower risk of recurrent disability and decreased future medical utilization.

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<p>TREATMENT INTERVENTION: (Including but not limited to)</p>	<p>Behavioral Pain Management (examples include, but not limited to: cognitive-behavioral psychotherapy, relaxation training, instrumental biofeedback, coping skills training). Injections [Refer to subsection (e)(2)(T)-(U) and (e)(3)(G)] Manipulations [Refer to subsection (e)(2)(E) and (e)(3)(E)] Manipulations Under Anesthesia Medication Mental Health Intervention Physical Medicine Treatment [Refer to subsection (e)(2)(D) and (e)(3)(C)] (1) Attended modalities and procedures (2) Unattended modalities (limited to a maximum of two (2) weeks, if used solely) (3) Concurrent home program Single or Interdisciplinary Programs ▶Chronic Pain Management [Refer to subsection (e)(2)(F)] ▶Work Hardening [Refer to subsection (e)(2)(L)] ▶Outpatient Medical Rehabilitation [Refer to subsection (e)(2)(L)] ▶Work Conditioning [Refer to subsection (e)(2)(L)]</p>
<p>EXPECTED OUTCOME:</p>	<p>Should be the last remaining medical option before Maximum Medical Improvement (MMI).</p>
<p>RETURN TO WORK ISSUES:</p>	<p>Job-Site Analysis Functional Capacity Evaluations The severe level of severity allows return to work within 4 - 6 months with or without a transitional period of modified duty (not to exceed 4 months). Treatment response to tertiary interventions will ultimately allow a return to full duty (or permanently modified) work. There will likely be some limitations restricting medium-to-heavy jobs accompanied by some permanent impairment, but with the injured employee always able to reach MMI following surgical and/or initial, intermediate and/or tertiary nonoperative interventions. Other outcomes include vocational rehabilitation, or voluntary decision to leave the work force. Return to full duty work may not always be possible and may necessitate the introduction of post-medical vocational rehabilitation services by referral to Texas Rehabilitation Commission.</p>
<p>FAILURE TO RESPOND:</p>	<p>Documented failure to respond at any time to treatment may require additional diagnostic tests and/or treatment consistent with greater level of severity. Consider mental health evaluation.</p>

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Texas Workers' Compensation Commission Figure: 28TAC §134.1001 (g)(7)(D)

(D) TABLE IV. SURGICAL INTERVENTION	
CLINICAL INDICATORS: (May include but not limited to)	<ol style="list-style-type: none"> 1) Documented history of failure to respond to initial and/or intermediate treatment with symptoms suggestive of surgically treatable lesion (i.e., persistent pain, limitation of activities of daily living, or perceived weakness) and, 2) Physical examination findings consistent with surgically treatable lesion (i.e., hyperesthesia, weakness, or loss of motion) or, 3) Structural diagnostic testing, i.e., MRI, CT, myelogram, discogram-computerized axial tomogram, consistent with a surgically treatable lesion noted on the above diagnostics. Surgery would not occur except on objective findings of structural defects.
EXPECTED OUTCOME:	<ol style="list-style-type: none"> 1) Participate in initial, intermediate, or tertiary post-operative treatment. 2) Return to Work. 3) Maximum Medical Improvement (MMI) after appropriate care.
RETURN TO WORK ISSUES:	The marked level of severity allows return to work within 2 - 6 months postoperatively with or without a transitional period of modified duty (not to exceed 4 months) after initial, intermediate and/or tertiary intervention. There may possibly be limitations restricting medium or heavy work upon return to full duty (regular or permanently modified) and require job matching in these cases, even after the injured employee has completed a period of transitional modified duty and reached Maximum Medical Improvement.
FAILURE TO RESPOND:	Documented failure to respond at any time to treatment may require additional diagnostic tests and/or treatment consistent with greater level of severity. If surgery is refused and rehabilitation is also declined, the treating physician and/or health care provider may determine that the injured employee has reached Maximum Medical Improvement (MMI). Failure to respond or refusal of surgery may indicate a need for mental health evaluation.

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(h) Assessments/Evaluations

- (1) Interdisciplinary Assessment. In certain cases involving either surgical or nonoperative treatment, an interdisciplinary assessment may be needed. This assessment may include:
 - (A) Sequelae of Injury. Injuries may produce a variety of unanticipated nonoperative or postoperative sequelae, including problems with other joints/regions due to deconditioning, chronic or progressive neurological conditions, urological problems, or a variety of mental health disturbances. Any or all of these may result in the need for an interdisciplinary assessment to determine what treatment options are needed to bring the injured employee to the highest functional level.
 - (B) Intercurrent Illness. If an injured employee is suffering from a variety of intercurrent illnesses (hypertension, cardiac disease, diabetes, etc.), an interdisciplinary assessment may be needed to determine the treatment options required to bring the injured employee to the highest functional level. The intercurrent illnesses may require medical management and services necessary to stabilize the injured employee, and recommendations should be forwarded to the treating doctor for decision. When stabilizing treatments and services are performed, the health care provider should clearly document the rationale for such treatment as referenced in (e)(4). Treatment for the intercurrent illness may/may not be related to the compensable injury and therefore, may/may not be the responsibility of the workers' compensation carrier.
 - (C) Risk Factors for Complications. Some injured employees may have risk factors in their personal or family history which may affect the delivery of care. In particular, injured employees expecting to undergo surgery or to undergo an exercise program may demonstrate a variety of cardiovascular risk factors necessitating additional evaluations and modification to the treatment plan.
- (2) Functional Capacity Evaluations. This paragraph specifically discusses the issues of functional capacity evaluations. These measurements have been used to monitor the injured employee's clinical progress; to guide the doctors and/or therapists in determining an exercise program and to provide objective data to determine a permanent physical impairment.
 - (A) Physical Examination vs. Functional Abilities Tests: A physical examination usually consists of a qualitative estimate of the injured employee's physical or functional ability. Functional abilities tests include the following: activities of

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daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing); hand function tests which measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices; submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and static positional tolerance (observational determination of tolerance for sitting or standing).

(B) A physical examination and neurological evaluation may include the following:

- (i) appearance: observation and palpation;
- (ii) flexibility (extremity joint or spinal region): usually observational;
- (iii) posture and deformities;
- (iv) vascular integrity;
- (v) dermatomal sensation: observational, to detect neurological sensory deficit;
- (vi) myotomal strength: usually observational, by manual muscle testing, to detect gross neurological motor deficits; and
- (vii) reflexes to detect neurological reflex asymmetry

(C) A functional capacity evaluation of the whole person or multiple areas of the body may include the following:

- (i) isometric lifting: NIOSH standard leg lift, torso lift, arm lift or extremity isometric test using measurement device;
- (ii) isokinetic lifting: controlled speed floor-to-knuckle, knuckle-to-shoulder lifts using measurement devices and standardized protocols;
- (iii) isoinertial lifting: standardized free weight lifting tests;
- (iv) activities of daily living tests: standardized tests (but often observational) of generic functional tasks (i.e. pushing, pulling, kneeling, squatting, carrying, climbing, etc.)
- (v) hand function tests: measurement of fine/gross motor coordination, grip strength, pinch strength, manipulation tests, etc., using measurement devices;
- (vi) submaximal cardiovascular endurance tests: measurement of aerobic capacity using bicycle or treadmill; and
- (vii) static positional tolerance: observational for tolerance of sitting or standing tolerance.

(3) Appropriate and Inappropriate Testing.

(A) Evaluations Appropriate to Phase of Care. The actual need for diagnostic

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studies is dependent on both the amount of time that has passed since the date of injury and on the injured employee's documented clinical condition. To determine the level of testing appropriate for the injured employee, please refer to subsection (f) (relating to Diagnostic Procedures) of this section.

- (B) Inappropriate Testing. Certain tests and procedures are inappropriate for the assessment of work-related injuries. Some examples include tests performed only to assess the injured employees' efforts, physical capacity evaluations for a joint or body region not related to the compensable injury or invalid or scientifically unjustifiable techniques.

- (i) Treatment Algorithms. Charts (1) - (6) of this subsection present commonly pursued courses of treatment for spinal injuries depending on presenting conditions and associated factors. Algorithms are provided for progressive decisions relating to treatment approaches as well as commonly recognized treatment procedures. The treatment algorithms presented in this guideline offer greater potential for agreement between health care providers and payors on medical utilization for specific conditions than use of ICD-9 codes alone. Health care providers who pursue treatment at variance with the guideline are subject to greater documentation requirements.
 - (1) Initial Approach to Treatment of Spinal Injury Chart 1.
 - (2) Fracture and/or Dislocation Chart 2.
 - (3) Soft Tissue Injury Chart 3.
 - (4) Peri-Operative Algorithm Chart 4.
 - (5) Surgical Treatment Chart 5.
 - (A) Surgical Treatment Subchart 5A.
 - (B) Surgical Treatment Subchart 5B.
 - (C) Surgical Treatment Subchart 5C.
 - (6) Treatment Continuation Chart 6.

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In order to view the following charts, you must go back to the Table of Contents for Preambled Rules, under Chapter 134.1001, you will see “Charts for Chapter 134.1001”...please click on the word “charts” go to the chart file.

Chart 1

Chart 2

Chart 3

Chart 4

Chart 5

Chart 5A

Chart 5B

Chart 5C

Chart 6

(j) Glossary.

- (1) Acceptable Standards of Care - outlines some of the types of tests and treatments which are generally accepted by the professional organizations.
- (2) Active Care vs. Passive Care.
 - (A) Active care - modes of treatment or care requiring that the injured employee participate in and be responsible for the phase of care received.
 - (B) Passive care - modes of treatment or care which do not require the injured employee to participate in his/her care; i.e., the care is "done to" or "applied to" the injured employee (e.g., hot packs or cold packs)
- (3) Acute - medical condition having rapid onset, severe symptoms, and usually a short course.
- (4) Aggravation - an act or circumstance that intensifies or makes worse a pre-existing condition.
- (5) Algorithm - a suggested step-by-step procedural pathway for solving a problem or accomplishing some end.
- (6) Assessment/Evaluation -the act or process of inspecting or testing for evidence of injury, disease or abnormality.
- (7) Axial pain - central midline neck, mid-back, or low back pain.
- (8) Back disability index (BDI) - also known as the Oswertry Low Back Pain Disability

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Questionnaire. This is a 10 question instrument completed by the patient at evaluation/re-evaluation. Each question has six distractors for patient answer selection. Each question distractor set is scored 0-6. A total of a maximum score of 50 is possible. Results are reported in percent impairment for activities of daily living. It has been validated by multiple studies and is responsive to clinical change.

- (9) Behavioral pain management - application of interventions derived from the behavioral sciences designed to:
 - (A) reduce/control pain, neurological, musculoskeletal, and circulatory symptoms, and their associated behavioral manifestations,
 - (B) increase physical functioning and activities of daily living,
 - (C) reduce fear of pain and risk of re-injury, or
 - (D) teach coping strategies for modifying symptoms or adapting to permanent loss of physical functioning (if present); and
 - (E) lead to patient's independent, self-directed application of these techniques. Examples include, but are not limited to: cognitive-behavioral psychotherapy, relaxation training, instrumental biofeedback, coping skills training.
- (10) Chronic - medical condition with recurrent symptoms of long duration
- (11) Chronic Pain Management - a program which provides coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain syndrome.
- (12) Compensable Injury - is defined as an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle.
- (13) Clinical Plateau - a period of time of relative stability in which the injured employee displays minimal or minor changes in his/her condition.
- (14) Clinical Progress vs. Lack of Clinical Progress.
 - (A) Clinical progress - documented objective improvement in the condition of the injured employee in response to the injured employee's current treatment program.
 - (B) Lack of clinical progress - documented objective absence of change in the condition of the injured employee over a period of time of no less than one

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month, requiring re-evaluation of the injured employee's condition and re-evaluation of the current treatment program.

- (15) Consulting Doctor - a doctor who provides an opinion or advice regarding the evaluation and/or management of a specific problem, as requested by the treating doctor, the Commission, or the insurance carrier. A consulting doctor may only initiate diagnostic and/or therapeutic services with approval from the treating doctor. (See the definition of referral doctor in paragraph 44 of this subsection).
- (16) Decompensation - the inability of the body to maintain adequate functioning in the presence of an injured, abnormal, or nonfunctioning body system.
- (17) Diagnosis - the art or act of identifying a disease or injury from evaluation of its signs and symptoms
- (18) Diagnostic Module - a standard which establishes normal parameters or boundaries of time within which to perform studies to assist in identifying a disease, injury or abnormality.
- (19) Diagnostic Test - objective studies performed to assist in identifying a disease, injury, or abnormality.
- (20) Doctor - a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.
- (21) Exacerbation - an increase in the seriousness of a previously diagnosed disease or disorder as marked by greater intensity in the signs or symptoms of the patient being treated.
- (22) Examination - the act or process of inspecting or testing for evidence of disease, injury, or abnormality.
- (23) First - preceding all others in time.
- (24) First Doctor - the initial doctor who evaluates and treats the injured employee, and who may or may not ultimately become the treating doctor.
- (25) Focus Review - to critically examine the prospective, concurrent, and retrospective care received by the injured employee as related to the compensable injury.
- (26) Frequency of Intervention - the number of occurrences in a specified time in which the health care provider acts to treat the injured employee.

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- (27) Functional Capacity Evaluation - a battery of tests administered and evaluated to determine the injured employee's ability to perform tasks related to both his or her daily activities and his or her job performance. This evaluation consists of the following elements:
- (A) a physical examination and neurological evaluation which includes an assessment of the physical appearance of the injured employee, flexibility of the extremity joint or spinal region, posture and deformities, vascular integrity, the presence or absence of sensory deficit, muscle strength and reflex symmetry;
 - (B) a physical capacity evaluation which includes quantitative measurement of range of motion and muscular strength and endurance; and
 - (C) a dynamic functional abilities test which includes activities of daily living, hand function tests, cardiovascular endurance tests, and static/dynamic positional tolerance.
- (28) Health Care - all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term does not include vocational rehabilitation. The term includes:
- (A) medical, surgical, chiropractic, podiatric, optometric, dental, nursing, and physical therapy services provided by or at the direction of a doctor;
 - (B) physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a doctor;
 - (C) psychological services prescribed by a doctor;
 - (D) the services of a hospital or other health care facility;
 - (E) prescription drugs, medicines, or other remedy; and
 - (F) a medical or surgical supply, appliance, brace, artificial member or prosthesis, including training in the use of the appliance, brace, member or prosthesis.
- (29) Health Care Facility - means a hospital, emergency clinic, outpatient clinic, or other facility providing health care.
- (30) Health Care Practitioner.

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- (A) an individual who is licensed to provide or render and provides or renders health care; or
 - (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor.
- (31) Health Care Provider - a health care facility or health care practitioner
- (32) Impairment - any anatomic or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent.
- (33) Initial Phase of Care - this phase of care is generally considered to be appropriate for injured employees immediately following the compensable injury; however, the injured employee in this phase of care may also be an early postoperative patient or may be experiencing an acute exacerbation of his or her chronic condition. Since partial or total cessation of work over a brief period of time is also considered to be part of the initial phase of care, further treatment by a health care provider may not be considered necessary at this phase of care. Little or no deconditioning has occurred due to the injury, immobilization or decreased activity. Duration of this phase of care is 0-8 weeks. (The goals are to prevent disease, alleviate or minimize the effects of the illness or injury and to maintain function.)
- (34) Interdisciplinary Programs - programs in which the delivery of services is provided by more than one type of health care service (e.g., occupational therapy, physical therapy, counseling services, medical services) and in which there is a coordination between the disciplines regarding the care plan and the delivery of care to the injured employee. This type of program includes work hardening, outpatient rehabilitation, and chronic pain management.
- (35) Intermediate Phase of Care - This phase of care is for those injured employees who have not returned to productivity after the normal healing process. This phase of care is designed to facilitate return to productivity, including return to work in either full or modified duty, before the onset of a chronic condition. This phase of care may also be indicated for the injured employee whose physical capacity to work still does not meet the job requirements for heavy physical labor after adequate treatment, thereby causing an inability to return to full duty. It is individualized, time limited and of limited intensity. The injured employee has a history of a limited-to-good response to early initial treatment with persistent symptoms limiting activities of daily living. The objective physical examination demonstrates findings suggestive of early deconditioning including loss of range of motion and/or strength with limitation of activities of daily living. Evidence of mental health or psychosocial barriers may be

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present which impede the injured employee's clinical progress. Duration of this phase of care is 0-8 weeks.

- (36) Intermediate Treatment - refer to paragraph (32) of the subsection regarding intermediate phase of care.
- (37) Intervention - the act or fact of interfering with a condition to modify it or with a process to change its course
- (38) Maximum Medical Improvement (MMI) - the earlier of the following items:
 - (A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;
 - (B) the expiration of 104 weeks from the date on which income benefits begin to accrue or
 - (C) the date determined as provided by §408.104 of the Texas Labor Code.
- (39) Medical Necessity - the determination that the tests or treatment provided is required based on the presenting signs or symptoms.
- (40) Module - a standard or unit of measurement
- (41) Neck disability index (NDI) - was developed as a modification of the BDI and has been separately validated for neck pain/impairment. It is scored in the same manner as the BDI.
- (42) Objective Findings - signs, or test results that can be measured or quantified or are otherwise perceptible to persons other than the affected individual. A medical finding of impairment resulting from a compensable injury, based on competent medical evidence, that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.
- (43) Outpatient Medical Rehabilitation - a program of coordinated and integrated services, evaluation, and/or treatment with emphasis on improving the functional levels of the persons served. The program is interdisciplinary in nature and is applicable to those persons who have severe functional limitations of recent onset or recent regression or progression or those persons who have not had prior exposure to rehabilitation. Services may be directed toward the development and/or maintenance of the optimal level of functioning and community integration of the persons served.

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- (44) Phases of Care - the stages in the treatment of an injury or illness (initial, intermediate, and tertiary phases of care).
- (45) Proper Clinical Documentation - written records which meet the requirements outlined by statute and rule and which convey the following information to the required parties:
 - (A) a description of the injury, including the extent, severity and events surrounding that injury;
 - (B) a description of any pre-existing, complicating and/or any non-related conditions;
 - (C) a treatment plan, including proposed method, frequency, and probable duration of treatment, with expected outcomes;
 - (D) updates to the treatment plan as needed, including the clinical progress of the injured employee, and any revisions needed to the treatment plan in light of the injured employee's response to treatment;
 - (E) education/information provided to the injured employee regarding his or her injury and treatment plan, and the injured employee's compliance with this treatment plan; and
 - (F) the need for deviation from the guideline, if necessary.
- (46) Radiculopathy - disease of the nerve roots often causing pain, weakness or other symptoms in the distribution of the nerve root.
- (47) Reason for Denial - refer to paragraph (45) of this subsection on screening criteria.
- (48) Referral - the process of directing or redirecting a medical case or a patient to an appropriate specialist or agency for definitive treatment.
- (49) Referral Doctor - a consulting doctor who initiates health care treatments at the request or with the consent of the treating doctor.
- (50) Referred pain - pain felt in a part other than that in which the cause that produced it is situated.
- (51) Screening Criteria - a set of established elements or boundaries beyond which testing or treatment may be denied.

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- (52) Self-referral - the direction of a patient to another doctor, institution or facility whereby the referring doctor has a financial or conflict of interest element.
- (53) Significant Neurological Deficit - signs of sensory impairment, progressive numbness, or increased physiological impairment such as severe weakness, bowel or bladder dysfunction directly related to the spinal injury;
- (54) Single Point of Contact - one person whom the doctor/health care provider(s) may contact for all questions regarding a specific injured employee.
- (55) Sprain - an injury to a ligament
 - (A) Mild (Grade 1) - only a few fibers are torn; ligament is mostly intact and the joint is stable;
 - (B) Moderate (Grade 2) - more fibers are torn, resulting in some instability with abnormal joint motion and some functional loss;
 - (C) Severe (Grade 3) - ligaments are completely disrupted and instability may be severe (synonymous with marked).
- (56) Standard - established by authority, custom, or general consent as a model or example; the generally accepted norm for quality and quantity.
- (57) Static - characterized by a lack of movement or change.
- (58) Strain - an injury to a muscle and/or tendon.
 - (A) Mild (Grade 1) - only a few fibers are torn; muscle/tendon unit is mostly intact and functional;
 - (B) Moderate (Grade 2) - more muscle fibers are torn resulting in muscle pain with contraction;
 - (C) Severe (Grade 3) - muscle fibers or tendons are completely disrupted, extreme pain and loss of use of muscle.
- (59) Subacute - medical condition between acute and chronic but with some acute features.
- (60) Subjective Complaints - report of symptoms, perceivable only by the injured employee, relating to the injury and which cannot be independently verified or

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confirmed by recognized laboratory or diagnostic tests or observable by physical examination.

- (61) Tertiary Phase of Care - this phase of care is interdisciplinary, individualized, coordinated, and intensive. It is designed for the injured employee who demonstrates physical and psychological changes consistent with a chronic condition disability. In general, differentiation from intermediate treatment includes medical direction, intensity of services, severity of injury, individualized programmatic protocols with integration of physician, mental health, and disability or pain management services and specificity of physical/psychosocial assessment. This phase includes a documented history of persistent failure to respond to nonoperative or operative treatment which surpasses the usual healing period for that injury. Psychosocial issues such as substance abuse, affective disorders, and other psychological disorders may be present. This phase of care is indicated by a documented inhibition of physical functioning evidenced by pain sensitivity, loss of sensation, and nonorganic signs such as fear which produce a physical inhibition or limited response to reactivation treatment. This phase of care may also be indicated for the injured employee whose physical capacity to work still does not meet the job requirements for heavy physical labor after adequate treatment, thereby causing an inability to return to full duty. This situation would be evidenced by an excessive transitional period of light duty or significant episodes of lost work time due to the need for continued medical treatment. This phase of care is also indicated for those injured employees who cannot tolerate either initial or intermediate phases of care. Duration of this phase of care is 0-6 weeks
- (62) Tertiary Treatment - health care rendered during the tertiary phase of care.
- (63) Time Limited - a specific duration of clock or calendar time which is not exceeded on a routine basis.
- (64) Treating Doctor - the doctor primarily responsible for the employee's health care for an injury.
- (65) Treatment Duration - calendar time allowed for treatment for a specific phase of care.
- (66) Treatment Module - a standard which establishes routine parameters of time within which to provide therapy for the illness or injury.
- (67) Treatment Plan - a written document which must contain the following components:
 - (A) type of intervention/treatment modality

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- (B) frequency of treatment;
 - (C) expected duration of treatment;
 - (D) expected clinical response to treatment; and
 - (E) specification of a re-evaluation timeframe.
- (68) Work Conditioning - a highly structured, goal-oriented, individualized treatment program using real or simulated work activities in conjunction with conditioning tasks. Work conditioning is a single disciplinary approach.
- (69) Work Hardening - a highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the persons served to return to work. Work Hardening programs are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral, and vocational needs of the injured employee. Work Hardening provides a transition between management of the initial injury and return to work while addressing the issues of productivity, safety, physical tolerances, and work behaviors. Work Hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks. These activities are used to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic, behavioral, attitudinal, and vocational functioning of the persons served.
- (k) Severability. Where any terms or provisions of this rule are determined by a court of competent jurisdiction to be inconsistent with any applicable law, the applicable law will apply, and the remaining terms and provisions of this rule shall remain in effect.