

DAVID DOLEZAL, D.C., <i>Petitioner</i>	§	BEFORE THE STATE OFFICE
	§	
	§	
VS.	§	OF
	§	
LIBERTY MUTUAL INSURANCE COMPANY, <i>Respondent</i>	§	
	§	
	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

This case is a dispute over whether additional reimbursement is appropriate for seven weeks of post-annuloplasty treatment rendered to ____ (Claimant) by David Dolezal, D.C. (Provider) between April 1, 2002, and June 14, 2002. Provider sought reimbursement from Liberty Mutual Insurance Company (Carrier) for the full seven weeks of treatment, which Carrier denied. The Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) adopted the findings of the Independent Review Organization (IRO) that held Provider was entitled to only four of the seven weeks of post-annuloplasty treatment. In this Order, the Administrative Law Judge (ALJ) concludes Provider is not entitled to any additional reimbursement beyond the amount ordered by the MRD.

I.

JURISDICTION, NOTICE AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those matters will be addressed in the findings of facts and conclusions of law without further discussion here.

Provider appealed the findings and decision of the IRO, which was set out in MRD docket number M5-02-3119-01 issued on November 20, 2002. The IRO decision found Provider was entitled to reimbursement for only the first four weeks of treatment.¹ Provider appealed the IRO decision and sought reimbursement for the final three weeks of post-annuloplasty treatment it rendered to Claimant after April 26, 2002. Carrier did not appeal the decision from the IRO.

A hearing convened before the State Office of Administrative Hearings (SOAH) on February 5, 2003, with Steven M. Rivas, ALJ, presiding. Provider appeared and represented himself. Carrier appeared and was represented by Shannon Butterworth, attorney. The hearing adjourned and the record closed the same day.

¹The dates of service for the first four weeks of post-annuloplasty treatment are April 1, 2002, through April 26, 2002.

II. DISCUSSION

1. Background Facts.

On ____, Claimant sustained a compensable injury to his back. The circumstances of Claimant's injury are not in dispute. In 2002, one of Claimant's physicians, Ryan N. Potter, M.D., recommended Claimant undergo an annuloplasty procedure² as part of his ongoing treatment following his injury. Claimant underwent the annuloplasty procedure on March 6, 2002, and was subsequently referred to Provider who rendered seven weeks of post-annuloplasty treatment from April 1, 2002, through June 14, 2002. Carrier denied reimbursement for the services as not being medically necessary.

B. Applicable Law.

The Texas Labor Code contains the Texas Workers' Compensation Act (the "Act") and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims. In particular, the "Act," as noted in § 408.021, provides 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. Under the same statute, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

3. IRO Decision.

This dispute was referred to an IRO, which found the treatment rendered to Claimant for the first four weeks following the annuloplasty procedure from April 1, 2002, through April 26, 2002, was medically necessary. Conversely, the reviewer found the following three weeks of treatment after April 26, 2002, was not medically necessary and held Provider should not be reimbursed for those weeks. As its rationale, the reviewer noted during the entire seven weeks of treatment, Claimant's pain level was a two on a scale of one-to-ten, and no significant objective findings were documented. Therefore, the reviewer found additional treatment beyond four weeks was not medically necessary.³

4. Evidence and Arguments.

1. Provider.

2. Provider argued there was no validity to the IRO decision. First, Provider mentioned, it was irrational that the IRO held four weeks was a reasonable amount of time for post-

² An annuloplasty refers to a procedure similar to an intradiscal electrothermal therapy (IDET) procedure that is designed to relieve back pain due to damage to the discs between the spine bones. The procedure attempts to reconstruct a torn or ruptured annulus inside a vertebral disc.

³ Apparently the reviewer found that since Claimant's condition had not improved or worsened after the first four weeks, Claimant had reached a point where no further improvement was likely, and therefore further treatment was not necessary. However, this observation was not noted in the IRO decision.

surgery treatment. Provider pointed out under the Commission's Spine Treatment Guideline (STG), a reasonable amount of time for post-surgery treatment was eight weeks.⁴ Provider admitted the STG is abolished, but argued the IRO decision was "arbitrary" given the many years the STG was "in effect" and was regarded as "precedent." Furthermore, Provider argued, the entire post-surgical treatment rendered to Claimant lasted seven weeks, which is one week less than what the prior STG provisions held reasonable. Additionally, Provider argued the IRO decision did not cite the basis upon which the reviewed relied, and therefore, reimbursement should not be denied for any of the treatment rendered to Claimant.

Next, the Provider argued the treatment rendered to Claimant following the first four weeks *was* medically necessary. It can be reasonably inferred that the IRO reviewer believed treatment after four weeks was not necessary because Claimant's pain level remained the same for the entire seven weeks of treatment. Claimant reported that his pain level after the annuloplasty procedure was a two on a scale of one-to-ten, with one being the least amount of pain and ten being the greatest amount of pain. Provider argued that although Claimant's pain level remained at a two during the seven weeks of treatment, it was lower than Claimant's pre-surgery level, which was a four or five on the same scale. Furthermore, Provider argued just because Claimant's pain level was a two, there was no way to tell if Claimant's level could have improved further to a one or possibly zero without further treatment following the first four weeks. Therefore, Provider argued three more weeks of treatment was necessary to see if Claimant's condition would improve.

2. Carrier.

Carrier's general position is that none of Claimant's ongoing treatment was medically necessary.⁵ Carrier did not present any evidence that specifically addressed the treatment rendered by Provider but instead provided a series of reports prepared at or near the time Claimant underwent the treatment in question. The reports were prepared by Charles W. Kennedy, Jr., M.D., who reviewed Claimant's medical records and examined Claimant himself on February 5, 2002, before Claimant underwent the annuloplasty procedure.⁶ At that time, Dr. Kennedy noted Claimant had already undergone a "massive amount of treatment with numerous doctors over a period of time."⁷ Dr. Kennedy indicated Claimant was "totally consumed" with his injury and "extremely combative."

⁴ The Commission's Spine Treatment Guideline, 28 TEX. ADMIN. CODE § 134.1001(g)(2).

⁵ Carrier submitted reports from William E. Blair, M.D., and Patrick J. Thomas, D.C., that were drafted in 2001. Both reports indicate Claimant's then-current treatment was not medically necessary nor was there any reason to continue further treatment based on Claimant's "over-utilization of treatment," and "ineffective results." The reports are contained in Carrier's exhibit, pages 4-7 and 21-22.

⁶ Report of Dr. Kennedy, dated February 11, 2002. Pages 8-14 of Carrier's exhibit.

⁷ *See Id.* "He has had two full series of epidural steroid injections. He has had a two-level IDET, which was not effective."

Dr. Kennedy recommended Claimant undergo a psychological examination and be enrolled at an athletic club to treat any lingering symptoms from his compensable injury.⁸ Furthermore, Dr. Kennedy recommended Claimant “stop all additional other therapy.”

Dr. Kennedy supplemented his original report on February 28, 2002, six days before Claimant was scheduled to undergo the annuloplasty procedure. This report recommended Claimant undergo psychological treatment rather than physical rehabilitation because, Dr. Kennedy noted, Claimant had become obsessed with finding a “magic bullet” that could make him well. On April 4, 2002, after Claimant began post-annuloplasty treatment with Provider, Dr. Kennedy submitted another supplement to his original report and said, “his psychiatric problems are not related to his injury, however, I think a major part of the continuing problem that he has is psychosocial and that MMPI testing or something such as this would clarify those issues.”

Carrier finally argued the IRO decision was generous because it allowed reimbursement for four of the seven weeks of treatment. Carrier originally denied all seven weeks of treatment but did not appeal the IRO decision.

5. Analysis and Conclusion.

Carrier presented a lot of evidence in support of its position that most of Claimant’s treatment was not medically necessary, including the annuloplasty procedure and the post-annuloplasty treatment. The issue here is, specifically, whether or not the final three weeks of post-annuloplasty was medically necessary.

Provider has the burden of proving the final three weeks of treatment was medically necessary because the IRO decision states the treatment in question was not medically necessary. The first argument Provider presented was that there was no validity to the IRO decision because it was arbitrary and did not cite any sources upon which it relied to render its decision. Provider is correct in his observation that no sources are cited but unfortunately for Provider an IRO decision need not contain sources in order to be valid.

Under the Texas Labor Code § 413.031(e), a review of medical necessity for this type of treatment shall be conducted by an independent review organization under Article 21.58C of the Texas Insurance Code. Article 21.58C is titled Standards for Independent Review Organizations. Under subsection (b), the standards require a timely response of an IRO, confidentiality of medical records, qualifications of a reviewer, fairness in decision determinations, and timely notice of the results *including the clinical basis for the determination*. (Emphasis added) Provider’s argument is the reviewer did not include a clinical basis in the decision. The ALJ understands Provider’s argument that the rationale contained in the decision may not be very thorough or at least not as thorough as Provider would like. But there is no doubt the reviewer’s clinical basis for the determination is contained in the IRO decision.

⁸ See *Id.* Dr. Kennedy stated, “This has to be much more cost effective treatment plan than the extreme amount of workup that has been in place.”

The rationale for decision states:

“Given the fact that the patient’s pain level was 2 on a scale from 1 to 10, and there were no significant objective findings documented, additional post-annuloplasty protocol beyond 04/26/02 was not reasonable, customary or medically necessary.”

The IRO decision contains the necessary clinical basis and Provider did not address any other part of the decision that might question the validity of the decision. Therefore, the IRO decision meets the requirements set out in the Texas Labor Code and Texas Insurance Code, and is a valid decision and should not be a reason to award additional reimbursement to Provider.

Provider also argued the entire seven weeks of treatment should be reimbursed because under the former STG, eight weeks of post operative treatment was reasonable. In this case, Provider rendered only seven weeks of post-operative treatment but admitted the provisions outlined in the STG are now abolished. In other words, Provider argued the ALJ should follow a set of guidelines that no longer exist. Even if the ALJ followed the former STG, it would not be sufficient to prove Provider is entitled to additional reimbursement. The STG first of all was a guideline, not a mandatory set of rules. Second, the STG held eight weeks post-operative treatment was “reasonable,” not mandatory and not medically necessary in all cases. For instance, if a medically necessary treatment period was two weeks, the STG would not require treatment to last eight weeks. Furthermore, even if the STG were still in effect, Provider would have to prove the treatment beyond four weeks in this case was medically necessary. The Provider has the burden to prove he was entitled to reimbursement for the final three weeks of treatment. A request that the ALJ consider the former STG is not a sufficient argument to award additional reimbursement to Provider.

Finally, Provider argued the treatment following the first four weeks was medically necessary because there was no way to tell if Claimant’s pain level would improve unless further treatment was administered after the first four weeks. This argument is not valid because Provider tries to shift the burden to the Carrier to prove further treatment would not have brought further improvement after the IRO found the final three weeks of treatment was not medically necessary. In this matter, the burden is on the Provider to prove the treatment in question was medically necessary. The burden is not on the Carrier to prove further treatment would not have brought further improvement. Under the Commission’s rules, a claimant is entitled to health care that cures, relieves, or promotes recovery.⁹ There is no Commission rule that entitles a claimant to prolonged treatment so long as a carrier cannot prove the treatment will not bring about further improvement.

Based on all the evidence presented, the ALJ finds the Provider did not prove the IRO was incorrect when it awarded only four of seven weeks of post-annuloplasty treatment to Claimant.

⁹ TEX. LAB. CODE ANN. § 408.021.

III. FINDINGS OF FACT

1. Claimant ___ suffered a compensable injury on ___.
2. In 2002, Claimant underwent an annuloplasty procedure as part of his ongoing treatment.
3. Claimant was later referred to David Dolezal, D.C. (Provider), for post-annuloplasty treatment.
4. Provider rendered seven weeks of treatment to Claimant from April 1, 2002, through June 14, 2002.
5. Provider billed Liberty Mutual Insurance Company (Carrier) for the treatment it rendered to Claimant and Carrier denied reimbursement.
6. Provider filed a Request for Medical Review Dispute Resolution with the Texas Workers' Compensation Commission (the Commission), seeking reimbursement for the treatment rendered to Claimant.
7. The dispute was referred to an Independent Review Organization (IRO), which found Provider was entitled to reimbursement for the first four weeks of treatment it rendered to Claimant from April 1, 2002, through April 26, 2002.
8. The Commission's Medical Review Division (MRD) in docket number M5-02-3119-01 adopted the IRO decision in its findings and decision issued on November 20, 2002.
9. Provider timely appealed the IRO decision and sought reimbursement for the final three weeks of treatment it rendered to Claimant after April 26, 2002. Provider filed a request for hearing before the State Office of Administrative Hearings (SOAH) seeking additional reimbursement.
10. Carrier did not appeal the decision from the IRO.
11. Notice of the hearing was sent January 10, 2003.
12. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.
13. The hearing convened on February 5, 2003, with Steven M. Rivas, Administrative Law Judge (ALJ) presiding. Provider appeared and represented himself. Carrier appeared and was represented by Shannon Butterworth, attorney. The hearing adjourned and the record closed the same day.
14. The IRO decision met the standards of the Insurance Code and contained all the necessary elements, including the clinical basis for the determination.

15. The Claimant's pain level for the duration of the seven weeks of treatment remained at a two on a scale of one-to-ten.
16. There was no documentation of any significant objective findings of Claimant during the seven weeks of treatment rendered to Claimant.
17. Because Claimant's pain level remained unchanged and no significant objective findings were documented, the IRO decision found four of the seven weeks of treatment were medically necessary.
18. The Provider presented insufficient evidence that the final three weeks of treatment was medically necessary.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. ch. 401 *et seq.*
2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.
3. Provider timely filed its request for hearing as specified by 28 TEX. ADMIN. CODE § 148.3.
4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TEX. ADMIN. CODE § 148.4.
5. The Provider, as Petitioner, has the burden of proof in this matter under 28 TEX. ADMIN. CODE § 148.21(h).
6. Under TEX. LAB. CODE ANN. § 408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment..
7. Provider has failed to show, by a preponderance of the evidence, that the final three weeks of treatment Provider rendered to Claimant was medically necessary.
8. Pursuant to the foregoing Findings of Fact and Conclusions of Law, Provider is not entitled to any additional reimbursement for the three weeks of treatment it rendered to Claimant.

ORDER

IT IS, THEREFORE, ORDERED that Provider, David Dolezal, D.C., is not entitled to receive any reimbursement from the Carrier, Liberty Mutual Insurance Company, for the three weeks of treatment it rendered to Claimant from April 26, 2002, through June 14, 2002.

Signed this 4th day of April, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE