DOCKET NO. 453-03-2248.M5
TWCC NO. M5-02-2877-01

TEXAS MUTUAL INSURANCE COMPANY, Petitioner	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
MEDPRO CLINICS, INC., Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier), sought to reverse the decision by an Independent Review Organization (IRO) that the treatment rendered to the injured worker, _____(Claimant), which consisted of passive physical therapy modalities provided under the supervision of a chiropractor beyond four weeks, was medically necessary. This decision disagrees with the IRO, finding the nine sessions for a total MARS rate of $684 were not medically necessary and should not be reimbursed.

I.
PROCEDURAL HISTORY

The Administrative Law Judge (ALJ) convened the hearing on April 10, 2003. The Carrier was represented by attorney Patricia Eads. David Ben Isaac Rabbani, D.C., represented Medpro Clinics, Inc. (Provider, Dr. Rabbani). The hearing concluded and the record closed on the same date.

II.
DISCUSSION

ISSUE: Was the passive therapy given the Claimant beyond four weeks medically necessary, when the documentation showed no improvement in the Claimant's symptoms from repetition of the same passive modalities?

A. Background

The Injury and Initial Treatment

On_____, the 44 year old Claimant was standing on a scaffold as his partner handed him a 200 pound concrete stone. As he was bending down to put it on the ground, he felt a pop in his low back and immediate pain. Despite the pain, he continued working, because he was told to. Finally, on December 19 he was unable to work due to the severe pain in his low back. He initially was treated by Dr. Julio Cadenas at Concentra, who released him that day with medications, three days of physical therapy, and a modified job description for his employer's consideration.

Because the Claimant was unhappy with the care he had received, he sought treatment from Dr. Rabbani starting on January 2, 2002. By that time, the Claimant reported constant bilateral lumbar pain (sharp and burning) that was more noticeable on the left, but no radiating pain. Among the positive clinical assessments Dr. Rabbani found were bilateral hip pain, bilateral sacroiliac pain,

severe muscle tightness in the paralumbar muscles, and range of motion values in the lumbar spine as follows: flexion 60E, extension 10E, right and left lateral flexion 20E. The doctor planned spinal manipulation and appropriate physical modalities for about four weeks, and the Carrier paid for those weeks of treatment.

The Contested Treatment

When the Claimant was reevaluated on January 28, he complained of sharp, constant bilateral low back pain with radiating pain down his left buttock. He had difficulty standing fully erect, and the pain worsened if he had to stand more than 10 minutes. His clinical assessments included bilateral lumbar (not hip) pain, straight leg raising positive for left sided pain, and range of motion values in the lumbar spine as follows: flexion 70E, extension 15E, right and left lateral flexion 20E. There was severe pain in extension and left lateral flexion, and past 60E of lumbar flexion, the pain began to radiate down the lateral aspect of his left leg. An MRI performed on January 31, 2002, revealed posterior discal bulging at L5-S1 with a peripheral annular tear of 4 - 5 mm. with no neurogenic compromise. Therefore, Dr. Rabbani referred the Claimant to a pain specialist.

On February 1, Dr. Uday Doctor, an anesthesiologist, reviewed the Claimant's x-rays and initial MRI and suspected a spondylitic pars[1] fracture at the L5 pars. He assessed the source of the pain as the pars fracture versus an acute facet-based pain. Dr. Doctor recommended a diagnostic work up at L5 pars, followed by a facet block at L4/L5 and L5/S1.

Daily patient records for the contested February treatments by the Provider reveal that the Claimant reported a pain level of 10 with either no change in his condition or an intensifying of pain each treatment session. The treatment to the lower back consisted of heat, five minutes of ultrasound, massage, interferentral treatment (electrical stimulation to the patient) for 15 minutes, and very gentle spinal adjustments. The Carrier denied payment for bills covering February 6 - 25, a total of nine visits, contending the treatment exceeded medically accepted utilization review criteria.

When Dr. Rabbani reevaluated the Claimant on February 25, he had constant sharp and cramping bilateral low back pain with radiating pain down his left buttock and thigh. For the most part, his pain had intensified. Straight leg raising was positive for left sided pain. Range of motion values in the lumbar spine were: flexion 50E, extension 12E, right and left lateral flexion 20E. There was severe pain in flexion, and past 60E of lumbar flexion, the pain began to radiate down the lateral aspect of his left leg. At that point, Dr. Rabbani, who had continued treating the Claimant through February 25, declared him at a "plateau" and decided to wait until Dr. Doctor gave him the first nerve block on February 28 to see how he responded.

[1] "Pars" means an anatomical part. In this case, the defect means either a break or failure of the bone to ossify in that location of the spine.

Treatment & Assessments After February 26

The February 28 nerve block gave the Claimant significant pain relief. During the operative procedure, Dr. Doctor felt there was a leak in the arthrogram, again suspecting a pars defect at L4-5 bilaterally. When Dr. Rabbani examined the Claimant on March 6, he reported an overall relief from pain of 30%, with no leg or buttock pain, but sharp and constant bilateral lumbar pain with occasional spasms. His clinical assessment that day revealed straight leg raising negative bilaterally and positive lumbar, but not hip, pain, with the following range of motion values: flexion 60E, extension 30E, left lateral flexion 20E, and right lateral flexion 15E, left SLR 85E, and right SLR 100E. There was pain in flexion and left and right lateral flexion.

Other treatments the Claimant had thereafter included a second nerve block on May 16 that caused him to feel worse. As of July 1, he had dull, constant pain on both sides of his low back, pain radiating into the left thigh, negative straight leg raise, and range of motion values as follows: flexion 60E, extension 15E, left lateral flexion 20E, and right lateral flexion 30E, with pain in all planes of motion. On July 1, an MRI of the lumbar spine with contrast displayed the injury site as described above, and showed a non-acute spondylitic defect at L-5, as well as mild facet hypertrophy at L4-5 and L5-S1.

Dr. Doctor performed a diskogram procedure on the Claimant on July 24, 2002. The diskogram was positive for low back pain stemming from the annular tearing inside the L5-S1 disc. Dr. Doctor stated the local anesthetic and steroids inside the disk gave the Claimant significant relief. Thus, he referred him back to Dr. Rabbani for work conditioning/work hardening.

The Claimant was given a Functional Capacity Evaluation (FCE) on August 22, and he started a work hardening program on August 26. According to Dr. Rabbani, the Claimant did well in work hardening and was released after only four weeks of the program.

The IRO Decision

According to the IRO, the Claimant had a defect at L5, but it was unclear whether the spondylolysis[2] was slipped or stable. The IRO decision found that the Medicine Ground Rules in the Medical Fee Guideline [3] state that the exclusive use of physical medicine modalities is limited to a maximum of two weeks unless documentation substantiates the need for continued use of the modalities. Because the documentation showed that the Claimant displayed a positive response from the treatment provided, the IRO concluded it should be considered compensable. Furthermore, it noted that the treatment provided fell within the Mercy Guidelines, TCA Guidelines for Chiropractic Quality Assurance and Practice Parameters, and within the Spine Treatment Guideline (STG)[4] (in effect at the time of the injury).

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[2]"Spondylolysis" means disintegration or dissolution of a vertebra. MERRIAM WEBSTER'S MEDICAL DICTIONARY (1995).

[3]28 TEX. ADMIN. CODE § 201(10)(b).

[4]28 TEX. ADMIN. CODE §134.1001.

B. Carrier's Evidence & Arguments

David Alvarado, D.C., testified for the Carrier. He felt Dr. Rabbani's treatment violated the STG, because no progression was noted in the Claimant's symptoms. When the Claimant was unresponsive to the first two weeks of passive therapy, Dr. Alvarado would have monitored the patient but not actively treated him and made the appropriate referrals. Additionally, Dr. Alvarado testified the care violated the Mercy Guidelines, which state that repeated use of acute care modalities (*i.e.,* passive therapy) causes chronicity, physical dependence, and overutilization. He also referenced a 1991 study that found four weeks of spinal manipulations sufficient to treat an injury.

Dr. Alvarado noted that when the MRI with contrast was done in July 2002, the radiologist described the pars defect as not having an acute process associated with it. In Dr. Alvarado's opinion, with a stable fracture of the spine, which is what the pars defect amounted to, the Provider should have sought the opinion of an orthopedic surgeon to see whether low impact exercise was appropriate for the Claimant. Then, with the approval of an orthopedist, Dr. Alvarado testified active modalities should have been included in the treatments thereafter (active physical therapy such as use of a treadmill and bicycle) and a home exercise program.

Dr. Alvarado testified that the mechanics of the injury does not indicate that a pars fracture would have been a likely result. A pars fracture would most likely have come from blunt trauma to the area, such as from a long fall, whereas this was a lifting injury. The Claimant's recovery did not indicate the care was appropriate, and it occurred months after the care.

C. Provider's Evidence & Arguments

Dr. Rabbani contended that with a pars fracture, it would have been dangerous to treat the Claimant with active therapy. He proved that pars defects are not congenital, but a patient can be born with a predisposition to develop a pars defect. Perhaps by implication, Dr. Rabbani thought the mechanism of injury could explain the pars fracture; *i.e.*, if the Claimant had a predisposition to develop a pars defect, lifting the heavy concrete might have caused the fracture.

Dr. Rabbani felt three areas could have been causing the Claimant's pain: the joint, the torn disc, and the pars fracture. He referred the Claimant to Dr. Doctor, who treated the joint problem with nerve blocks, but they only gave short term relief. The torn disc, while painful, would not have produced level 10 pain for more than a few weeks; it should have healed in between six and twelve weeks. According to Dr. Rabbani, if he had referred the Claimant to an orthopedic surgeon, the surgeon would only have given medication and told him not to do active modalities.

The Provider continued passive therapy because of the level of pain, the fracture, and a desire not to "abandon" the patient. Dr. Rabbani testified that the Claimant felt better from each treatment for about two days, and then the pain would be back at level 10.[5] Dr. Rabbani testified it takes longer than four months for a pars fracture to heal, but he knew it would in time. Thus, he testified the July MRI description of the fracture as "non-acute" meant the fracture may have healed well enough after seven months that it did not appear acute to the radiologist.

[5] However, nothing about this pain relief is documented.

Dr. Rabbani testified that he sees between 60 and 80 patients per day, three days per week. Apparently, he designs the treatments, and licensed physical therapists carry them out. He would have talked to the Claimant or heard reports about his progress from his staff. Dr. Rabbani testified the Claimant's pain had mostly disappeared by June or July. As mentioned above, the treatment notes reflect the Claimant still had significant pain on July 1, but clearly the pain improved significantly that month, because the Claimant began work hardening in August. In Dr. Rabbani's opinion, the source of the Claimant's pain had been the pars fracture, which had healed.

D. Analysis & Conclusion

This was not an easy case to decide. Dr. Rabbani may be correct that active therapy would have been inappropriate in this case because of the pars fracture, but his general theory about Claimant's case is not supported by the medical records. While Dr. Doctor thought the source of the Claimant's pain might have been the pars defect, it appears that the July MRI indicating the defect was not acute did not support that theory. Surely Dr. Doctor did the diskogram to look more closely at the disc as the source of the pain, and he found that it was the source. It appears that the agents used during the diskogram finally lessened the Claimant's pain - not the healing of a pars defect. Therefore, Dr. Alvarado's argument that the pars defect was not caused by this injury and was not the source of the pain makes sense.

Whatever the cause of the Claimant's pain, however, the problem with the Provider's treatment is that there is no documentation to show the Claimant received any relief or improvement in his condition from the contested days of passive therapy. After the first four weeks of treatment, the Claimant's pain was just as bad, and it had worsened in that his pain did not radiate on January 2, but it had begun to radiate down his left buttock by January 28. The IRO's statement to the contrary is simply wrong. Without documentation of any kind, Dr. Rabbani's testimony that the patient reported brief relief from the therapy is not credible given the size of his caseload. Even if there was no documentation of pain relief, the ALJ finds Dr. Rabbani could have proved that by calling another witness with personal knowledge about the Claimant's day-to-day treatment - either the Claimant, or perhaps the therapist who worked with the Claimant.

Without proof that the passive treatments relieved pain, they still could have been medically necessary if they improved the Claimant's ability to function. However, they did not, except for a slight increase in range of motion values between January 2 and January 28. His symptoms on January 28 included straight leg raising positive for left sided pain, and range of motion values in the lumbar spine as follows: flexion 70E, extension 15E, right and left lateral flexion 20E. When tested on February 25, straight leg raising was positive for left sided pain, and his range of motion values in the lumbar spine had decreased: flexion 50E, extension 12E, right and left lateral flexion 20E.

Finally, the Medicine Ground Rules in the Medical Fee Guideline state that the exclusive use of physical medicine modalities is limited to a maximum of two weeks unless documentation substantiates the need for continued use of the modalities.[6] Additionally, the STG Ground Rules state documentation of continued improvement should justify the continuation of physical medicine therapy.[7] Given the lack of documentation of any improvement in pain level or ability to function in

[6] 28 TEX. ADMIN. CODE §134.201(10)(b).

[7] 28 TEX. ADMIN. CODE §134.1001(e)(2)(D).

this case, the ALJ finds the Carrier proved that the treatments were not medically necessary, and payment for them should be denied.

III.
FINDINGS OF FACT

1 On_____., the 44 year old Claimant, was standing on a scaffold as his partner handed him a 200 pound concrete stone. As he was bending down to put it on the ground, he felt a pop in his low back and immediate pain.

2 The Claimant sought treatment from David Ben Isaac Rabbani, D.C., at Medpro Clinics, Inc. (Provider) starting on January 2, 2002.

a. By that time, the Claimant had constant bilateral lumbar pain that was more noticeable on the left, but no radiating pain. He also had bilateral hip pain, bilateral sacroiliac pain, severe muscle tightness in the paralumbar muscles, and range of motion values in the lumbar spine as follows: flexion 60E, extension 10E, right and left lateral flexion 20E.

b. The doctor planned spinal manipulation and appropriate physical modalities for about four weeks, and the Carrier paid for those weeks of treatment.

3. As of January 28, the Claimant's pain level was just as bad (constant and bilateral in the low back), and it had worsened in that his pain did not radiate on January 2, but it had begun to radiate down his left buttock by January 28.

a. His clinical assessments included bilateral lumbar (not hip) pain, straight leg raising positive for left sided pain, and range of motion values in the lumbar spine as follows: flexion 70E, extension 15E, right and left lateral flexion 20E.

b. Although he was slightly more flexible, the Claimant's pain was severe in extension and left lateral flexion; beyond 60Eof flexion, the pain radiated down his left leg.

4. An MRI performed on January 31, 2002, revealed posterior discal bulging at L5-S1 with a peripheral annular tear of 4 - 5 mm. with no neurogenic compromise.

5. When the Claimant was treated by Dr. Rabbani for nine sessions covering February 6 - 25, documentation revealed that the Claimant reported a pain level of 10 with either no change in his condition or an intensifying of pain at each treatment session.

a. The treatment to the lower back consisted of strictly passive modalities: heat, five minutes of ultrasound, massage, interferentral treatment for 15 minutes, and very gentle spinal adjustments.

b. The Carrier denied payment for bills covering the nine visits, contending the treatment exceeded medically accepted utilization review criteria.

6. On February 25 the Claimant had constant sharp and cramping bilateral low back pain with radiating pain down his left buttock and thigh. For the most part, his pain had intensified.

a. Straight leg raising was positive for left sided pain.

b. Range of motion values in the lumbar spine had decreased from those referenced in Finding 3 as follows: flexion 50E, extension 12E, right and left lateral flexion 20E.

7. A pain specialist, Dr. Uday Doctor, began seeing the Claimant on February 1. He suspected a spondylitic pars fracture at the L5 pars as being the source of the pain versus an acute facet-based pain. Dr. Doctor recommended a diagnostic work up at L5 pars, followed by a facet block at L4/L5 and L5/S1.

a. Dr. Doctor did a nerve block on the Claimant on February 28 that gave the Claimant significant pain relief.

b. A second nerve block on May 16 caused the Claimant to feel worse.

c. On July 1, an MRI of the lumbar spine with contrast displayed the torn disc and showed a non-acute spondylitic defect at L-5, as well as mild facet hypertrophy at L4-5 and L5-S1.

d. Dr. Doctor performed a diskogram on July 24, 2002. It was positive for low back from annular tearing inside the L5-S1 disc. The local anesthetic and steroids inside the disk gave the Claimant significant relief, making him eligible for work hardening.

e. The Claimant started work hardening on August 26 and did well in the program.

IV.
CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issues presented pursuant to the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. §413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a Decision and Order, pursuant to §413.031 of the Act and TEX. GOV'T CODE ch. 2003.

3. An employee who sustains a compensable injury is entitled to health care that relieves the effects naturally resulting from the injury, promotes recovery, and enhances the ability to return to or retain employment. Act §408.021.

4. As referenced in the Findings 3 and 5 - 7, the passive therapy Claimant received did not reduce his pain or promote his recovery. Thus, it was not medically necessary.

5. As referenced in Findings 5 and 6, documentation of improvement did not justify the continuation of physical medicine therapy as required by the Spine Treatment Guideline Ground Rules, which were in effect at the time of the injury. 28 TEX. ADMIN. CODE §134.1001(e)(2)(D).

6. As referenced in Finding 5 and 6, Provider's treatment violated the Medicine Ground Rules

in the Medical Fee Guideline, because documentation did not substantiate the need for continued use of the modalities on the dates in controversy. 28 TEX. ADMIN. CODE §134.201(10)(b).

7. Based on the foregoing, the Provider is not entitled to payment for the nine sessions of treatment given the Claimant between February 6 - 25, 2002.

ORDER

IT IS THEREFORE, ORDERED that the decision of the Independent Review Organization is reversed, and Texas Mutual Insurance Company is not required to pay Medpro Clinics, Inc. for the February 6 - 25, 2002 treatments.

ISSUED this 30th day of May 2003.

BARBARA C. MARQUARDT
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS