

ATLANTIC MUTUAL INSURANCE	§	BEFORE THE STATE OFFICE
CO.	§	
	§	
V.	§	OF
	§	
CURTIS L. ADAMS, D.C.	§	ADMINISTRATIVE HEARINGS

**DECISION AND ORDER**

Atlantic Mutual Insurance Company (Carrier) has appealed the decision of the Independent Review Organization (IRO) ordering reimbursement for office visits and therapy provided to injured worker \_\_\_\_ (Claimant). After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that Carrier has failed to show by a preponderance of the evidence that the services in issue were not medically necessary. Therefore, Curtis L. Adams, D.C. (Provider) is entitled to reimbursement in the sum of \$1,828.

**I. BACKGROUND**

Claimant suffered a compensable, work-related injury to his foot in \_\_\_\_\_. Thereafter, Claimant began receiving treatment for the injury from Provider. As part of his course of treatment, Claimant visited Provider extensively between November 2000 and July 2002. Claimant's treatment consisted of office visits with Provider (which frequently included chiropractic manipulation), one-on-one physical therapy, and group physical therapy. At issue in this proceeding are dates of service of June 18, 20, 21, 24, 25, and 26, 2000. For each of these dates of service, Provider billed Carrier for an office visit and for physical therapy. Specifically, Provider billed \$328 per day for each date of service, except on June 20, 2002, for which Provider billed only \$188. As noted above, the total amount in dispute is \$1,828. Carrier declined to reimburse the treatments, contending that they were not medically necessary.

Based on Carrier's denial of reimbursement, Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission). The matter was referred to an IRO designated by the Commission for the review process. The IRO determined that the services in issue were medically necessary treatment for Claimant's compensable injury. Carrier then requested a hearing before the State Office of Administrative Hearings (SOAH). The hearing convened on October 14, 2003, with ALJ Craig R. Bennett presiding. Carrier appeared through its

attorney, Steve Tipton. Provider represented himself and appeared by telephone. The hearing concluded and the record closed that same day. No parties objected to notice or jurisdiction.

## II. DISCUSSION AND ANALYSIS

Carrier raises two issues. First, Carrier argues that Provider failed to request reconsideration of Carrier's reimbursement denial as required by the Commission's rules. For this reason, Carrier contends that Provider has not met the prerequisites for initiating medical dispute resolution and, therefore, Carrier is not liable for reimbursing Provider. Next, Carrier argues that the treatment given to Claimant by Provider was not medically reasonable and necessary. Specifically, Carrier asserts that Claimant's injury was relatively minor and the 200+ treatments billed by Provider between November 2000 and July 2002 reflect clearly excessive and ineffective treatment. Although only six dates of service are in issue, Carrier argues that the totality of the treatments should be considered in determining whether the disputed dates of service were medically necessary.

After considering the arguments and evidence presented, the ALJ finds that Carrier has failed to establish by a preponderance of the evidence that Provider is not entitled to reimbursement. Specifically, the ALJ notes that the evidence in the record supports a finding that Provider did properly request reconsideration of Carrier's denial of reimbursement. Specifically, Provider testified that he properly submitted the reconsideration requests to Carrier. Although Carrier challenges this and points to a lack of documentary evidence to support such testimony, Carrier fails to present competent evidence disputing Provider's testimony. Rather, Carrier relies on an absence of corroborating evidence showing that reconsideration had been requested. However, the lack of corroborating evidence is not sufficient to negate Provider's clear testimony that reconsideration was requested. As noted, it is Carrier's burden to show that reconsideration was not requested. It has failed to present evidence sufficient to meet that burden.

Next, the ALJ finds that Carrier has failed to present any competent evidence that would allow the ALJ to conclude the treatment in issue was not medically necessary. Instead of presenting persuasive expert testimony or evidence, Carrier basically relies on (1) the intuitive argument that such extensive treatment for a minor injury simply cannot be justified and (2) the contention that the

documents in the file do not show improvement over the extensive course of treatment and, therefore, such treatment must not have been effective or medically necessary.<sup>1</sup> At first blush, the treatment does appear to be more extensive than would appear warranted and the efficacy of the treatment is questionable based on the record; however, the ALJ's own assumptions or intuitive thoughts are not competent evidence. And, the ALJ is constrained to base his decision on the *competent evidence* in the record.

In reviewing the record, the ALJ concludes that the medical evidence presented supports only a finding of medical necessity. First, Provider testified to the medical necessity and reasonableness of the treatments in issue. Next, the evidence shows that Claimant had not reached maximum medical improvement by May 23, 2002, thus reflecting the need for continued treatment just a month before the treatments in issue were provided. Although it is not evidence *per se*, the ALJ notes also that the IRO reviewer found the treatments to be medically necessary. In considering the record before him, then, the ALJ simply cannot find that the preponderance of the evidence shows that the treatments were not medically necessary. For this reason, Carrier has failed to meet its burden of proof and is liable for reimbursing the treatments in issue. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

### III. FINDINGS OF FACT

1. \_\_\_\_ (Claimant) suffered a compensable, work-related injury in \_\_\_\_.
2. Atlantic Mutual Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for his compensable injury.
3. In the course of treatment for his compensable injury, Claimant saw Curtis L. Adams (Provider) extensively between November 2000 and July 2002. Claimant's treatment consisted of office visits (which frequently included chiropractic manipulation), one-on-one physical therapy, and group physical therapy.

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<sup>1</sup> Carrier also argues that, although one-on-one services were billed, they were not provided as such; instead, the services provided were actually group therapy. Carrier goes on to assert that one-on-one therapy cannot be deemed medically necessary if the Provider did not even elect to provide such services. The ALJ construes this as a back-door attempt to argue that the services were not billed properly or that the documentation does not support that the services were provided as billed. However, Carrier did not raise these reasons for denial in any of the explanations of benefits or at any level prior to the contested case hearing. Under the circumstances, the mere fact that services may have been provided slightly differently than billed is not evidence that the billed services were not medically necessary. So, the ALJ rejects this argument.

4. At issue in this proceeding are dates of service of June 18, 20, 21, 24, 25, and 26, 2000.
5. For each of the dates of service in issue, Provider billed Carrier for an office visit and for therapy. Specifically, Provider billed \$328 for each date of service, except on June 20, 2002, for which Provider billed only \$188. The total amount billed and in dispute is \$1,828.
6. Carrier denied reimbursement for the services, contending they were not medically necessary.
7. Provider sought reconsideration by Carrier of its denial of reimbursement.
8. After Carrier maintained its denial of reimbursement, Provider requested medical dispute resolution by the Texas Workers' Compensation Commission's Medical Review Division (MRD), which referred the matter to an Independent Review Organization (IRO).
9. After conducting medical dispute resolution, the IRO physician reviewer determined that the services in issue were medically necessary.
10. Based on the IRO decision, MRD ordered reimbursement on January 15, 2003.
11. On January 28, 2003, Carrier requested a hearing and the case was referred to the State Office of Administrative Hearings (SOAH).
12. Notice of the hearing was sent by the Commission to all parties on March 4, 2003.
13. On October 14, 2003, Administrative Law Judge Craig R. Bennett convened a hearing in this case. Carrier appeared through its attorney, Steve Tipton. Provider represented himself and appeared by telephone. The hearing concluded and the record closed that same day.

#### **IV. CONCLUSIONS OF LAW**

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.
2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.
3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.
4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.
5. Carrier has the burden of proof. 28 TEX. ADMIN. CODE §§ 148.21(h) and 133.308(w).

6. Carrier failed to show, by a preponderance of the evidence, that Provider did not properly request reconsideration of Carrier's denial of reimbursement for the services in dispute.
7. Carrier failed to show, by a preponderance of the evidence, that the services in issue were not reasonable and necessary medical care for Claimant under TEX. LAB. CODE ANN. §§ 408.021(a)(1-3) and 401.011(19).
8. Carrier is liable to reimburse Provider the sum of \$1,828 for the office visits and therapy provided to Claimant during June 18-26, 2002, consistent with the order of the Medical Review Division of the Commission dated January 15, 2003.

**ORDER**

IT IS, THEREFORE, ORDERED that Atlantic Mutual Insurance Company reimburse Curtis L. Adams, D.C. the sum of \$1,828 plus interest for the treatments provided to Claimant between June 18, 2002, and June 26, 2002.

**SIGNED this 24th day of October 2003.**

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**CRAIG R. BENNETT  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS**