DOCKET NO. 453-03-3357.M5
MRD Tracking No.: M5-03-0878-01

MAIN REHAB & DIAGNOSTIC,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	**OF**
	§	
LIBERTY MUTUAL FIRE INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Main Rehab & Diagnostic (Provider) seeks reimbursement of $9,372.00[1] from Liberty Mutual Fire Insurance Company (Carrier) for office visits, therapeutic procedures, chiropractic manipulations, and other services administered to an injured worker (Claimant) from June 12, 2002, to September 9, 2002. This decision finds that Provider failed to show by a preponderance of the evidence the medical necessity of the manipulations, therapeutic procedures, most of the office visits, and the temperature and sensory tests. However, Provider did establish the medical necessity of two additional monthly office visits. Therefore, Carrier is directed to pay Provider $96.00 for two additional office visits. All remaining claims are denied.

I. STATEMENT OF CASE

Administrative Law Judge (ALJ) Catherine C. Egan convened a hearing on August 7, 2003. Attorney Scott Hilliard appeared and represented Provider. Attorney Kevin Franta appeared and represented Carrier. Notice and jurisdiction, which were not disputed, are addressed in the Findings of Fact and Conclusions of Law without discussion here. After the parties presented evidence,[2] the record was closed.

II. BACKGROUND

On ___, while at work, Claimant was struck on the back of his neck and head by two 2 x 4's. Claimant experienced neck pain that radiated into his arms and was treated by Terry Roach, D.O.[3] Dr. Roach subsequently referred Claimant to Southwest Neurological Associates. On November 9, 2001, Thomas S. Ellis, M.D. of Southwest Neurological Surgery Associates, P.A. examined Claimant. An MRI was done the same day which showed:

- Frank central and foramina stenosis C6-C7 with cord pancaking.
- Mild uncovertebral degeneration changes C5-C6.
- Slightly prominent oropharyngeal posterior soft tissue as above. Central T2 intensity likely Tornwald Cyst.

---

1. Petitioner Ex. 5 at 15-21 (Table of Disputed Services).

2 In addition to testimony, the parties presented 598 pages of documentary evidence.

3 Carrier Ex. 1 at 20 and Petitioner Ex. 5 at 280.

After examining Claimant and reviewing the MRI scan,[4] Dr. Ellis diagnosed Claimant as having "a disk herniation at the C6-7 level with canal stenosis and cord compression."[5] While not seeing any "high signal in the cord," Dr. Ellis reported that "the cord is clearly flattened from both anterior and posterior aspects."[6] After explaining that this type of spinal cord compression could cause death, hemorrhage, stroke, infection, spinal fluid leak, minor to devastating neurologic deficits,
among other things, Dr. Ellis recommended Claimant undergo an "anterior cervical decompression and fusion with instrumentation."[7] According to Dr. Ellis' report, Claimant agreed.

However, the surgery was not scheduled because Carrier disputed whether Claimant's compensable injury included his neck and headaches. On June 21, 2002, the parties presented argument and evidence at a benefit contested case hearing before a Texas Workers' Compensation Commission (Commission) hearing officer. The Commission hearing officer determined that the ___, compensable injury included Claimant's neck injury and his headaches and ordered the Carrier to pay medical and income benefits.[8]

On May 10, 2002, Claimant went to Provider's clinic for treatment. Claimant told Osler Kamath, D.C. that he had received little treatment for his injury. After examining Claimant, Dr. Kamath diagnosed Claimant's condition as cervical disk disorder, nerve root injury, headaches, and muscle spasms.[9] Dr. Kamath did not have Claimant's previous medical records then. However, he did refer Claimant to Crawford Sloan, M.D. and James Laughlin, D.O., F.A.C.O.S., for medical consultations.

Dr. Sloan stated in his May 14, 2002, report that the reason for the referral was Claimant's complaints of headaches, vertigo, dizziness, right arm/hand pain with numbness over his palm and dorsum of his right hand.[10] After examining Claimant, Dr. Sloan's diagnostic impressions included the following:

- W/C falling object injury
- Cervical strain/sprain
- R/O cervical herniated disc
- Closed head injury; without loss of consciousness
- Headache and dizziness[11]

4 Petitioner Ex. 5 at 172-173.

5 Carrier Ex. 1 at 22.

6 *Id.*

7 Carrier Ex. 1 at 22.

8 Petitioner Ex. 5 at 26-28.

9 Petitioner Ex. 5 at 302.

10 Carrier Ex. 1 at 23 and Ex. 5 at 189.

11 Carrier Ex. 1 at 25.

Dr. Sloan recommended that Claimant continue conservative therapy modalities and treatment.[12]

Dr. Laughlin examined Claimant on June 12, 2002, and noted that Claimant's previous treatment included "pain medication, muscle relaxing medication, physical therapy, and rehabilitation."[13] According to Dr. Laughlin, Claimant suffered with cervical radiculopathy and recommended that Claimant try epidural steroid injections before considering surgery. He also recommended that Claimant continue with conservative care.

Between June 12, 2002, and September 9, 2002, Provider provided chiropractic services including office visits (CPT 99213), therapeutic exercises (CPT 97110), myofascial release (CPT 97250), joint mobilization (CPT 97265) and other services administered to relieve pain, and test his condition. During this time, Dr. Laughlin scheduled the epidural steroid injections for Claimant.[14] The epidural steroid injections did not resolve Claimant's condition.

On September 12, 2002, George B. Crisp Jr., M.D. examined Claimant and concluded that Claimant had a "large ruptured disc at C6-7, causing spinal cord compression and narrowing of the canal."[15] Dr. Crisp concurred with Dr. Ellis that Claimant needed to undergo an anterior cervical discectomy and fusion.[16] On October 23, 2002, Dr. Crisp performed spinal surgery on Claimant.[17]

Carrier denied payment for Provider's services from June 12 to September 9, 2002, stating in the explanation of benefits (EOB) that, "based on peer review, further treatment is not recommended (X435)."[18] Provider appealed and the dispute was referred by the Commission to an Independent Review Organization (IRO).

The IRO upheld the Carrier's denial for lack of medical necessity. The IRO noted the medical record submitted to it by the parties did not include Dr. Laughlin's report or further testing and evaluations. In addition, Claimant's "subjective and objective symptoms never changed."[19] The IRO found that because of a lack of evidence, "this treatment is deemed unnecessary."[20] This appeal followed.

---

12 *Id.*

13 Petitioner Ex. 5 at 193 and 194.

14 Petitioner Ex. 5 at 206.

15 Petitioner Ex. 5 at 244.

16 Carrier Ex. 1 at 60.

17 Carrier Ex. 1 at 65.

18 Petitioner Ex. 5 at 29 to 164.

19 Petitioner Ex. 5 at 9

20 Petitioner Ex. 5 at 9.

III. MEDICAL NECESSITY

A. Provider's Position

Dr. Kamath testified that when Claimant came in for treatment, Claimant had none of his medical records. Although Dr. Kamath requested Claimant's medical records from his previous treating doctor, it took two to three weeks before Dr. Kamath received them. Consequently, Dr. Kamath explained, he did not have the benefit of the November 9, 2001 MRI or Dr. Ellis' report when he began treating Claimant. He did, however, refer Claimant to Dr. Sloan and Dr. Laughlin, both of whom recommended Claimant continue with conservative care. This care included low impact exercises, myofascial release, and joint mobilization. For a patient with a severe spinal cord injury, Dr. Kamath opined that this treatment regime increases the patient's range of motion (ROM), decreases the patient's muscle spasms, increases the patient's muscle strength, increases the patient's activities of daily living (ADLs), and enhances the success of surgery. Dr. Kamath claims that his services were rendered consistent with § 408.021(a) of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. LABOR CODE ch. 401 et seq. The nerve conduction study done on August 2, 2002,[21] Dr. Kamath argued, showed that Claimant had significant nerve damage, and that Claimant had documented improvement in his ROM and ADLs. All physical therapy was discontinued on August 26, 2002, prior to Claimant's surgery. The last office visit prior to surgery was September 9, 2002.

B. Carrier's Position

In support of its decision to deny reimbursement for the treatments, Carrier argued that not only were the chiropractic services not medically necessary, but they were contraindicated. The severity of Claimant's spinal cord injury required surgical intervention, not chiropractic manipulations.

Dr. Kamath had his chiropractic license a little over three years when he began treating Claimant. Dr. Kamath received Dr. Ellis's report two to three weeks after he began treating Claimant. Although Dr. Ellis stressed that Claimant's spinal cord was compressed and that his neck needed to be immobilized until surgery, Dr. Kamath chose not to call Dr. Ellis to discuss his findings, but instead chose to manipulate Claimant's spine. These manipulations included moving spinal joints above the herniated disk, according to Dr. Kamath. Nicholas Tsourmas, M.D., a board certified orthopedic surgeon, opined that such manipulations could have further damaged Claimant's spine. That Claimant was not injured further was fortuitous.

Dr. Tsourmas reviewed the Claimant's medical records including Dr. Ellis' report and the November 2001 MRI. The spinal cord compression was caused when herniated disk placed pressure on the spinal cord. When direct pressure is placed on the spinal cord, it is called a myelopathy. Dr. Tsourmas advised that this is the type of injury that results in quadriplegic and paraplegic casualties C it is much more serious than an injury to a peripheral nerve. According to Dr. Tsourmas, Dr. Kamath's treatments (particularly mobilizing the neck joints) would not relieve or cure Claimant's myelopathy, but could have made the condition worse.

21 Petitioner Ex. 5 at 224.

Dr. Tsourmas testified that he was not surprised when Claimant's condition did not improve from Provider's treatments. Dr. Crisp reported that Claimant continued to have problems after his treatments by Dr. Kamath. Claimant told Dr. Crisp that:

> the headache and neck pain are still bothering him a great deal. He also developed tremors in his hands, particularly on the right. . . .He stated the pain he has is quite severe and is aggravated significantly by coughing, sneezing and movements of his head. Looking down causes him to feel a little dizzy, and also makes his neck hurt. Looking down is uncomfortable, as is rotation of the head.[22]

All of Claimant's complaints were consistent with a myelopathy, explained Dr. Tsourmas. The continuation of these complaints after Dr. Kamath's treatments, show how ineffectual the treatments were in addressing Claimant's condition. Moreover, the passive modalities did not provide even temporary benefits, such as pain relief. Dr. Tsourmas dismissed Dr. Kamath's temperature test (used to detect painful areas) and sensory tests as not medically credible because they are not substantiated by any medical tests or literature. Likewise, he opined that the use of the EMS, an electronic device to substitute a painless tingling sensation for pain in the neck or arm, would not relieve or cure Claimant's condition this late after the injury.

Dr. Tsourmas did agree that the epidural steroid injections could provide temporary and partial relief for Claimant's condition. Likewise, monthly office visits might be medically necessary. Muscle testing could be billed separately under CPT 97750, but Dr. Tsourmas explained he usually bills this as part of an office visit.

C. ALJ's Analysis

Pursuant to the Texas Workers' Compensation Act, an employee who has sustained 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 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. LABOR CODE § 408.021(a). Health care includes all reasonable and necessary medical services. LABOR CODE § 401.011(19)(A). Provider has the burden of proving the medical necessity of the services provided to Claimant. 28 TEX. ADMIN. CODE (TAC) §§ 148.21 (h) and (i); 1 TAC § 155 41.

The issue is whether the chiropractic services provided by Dr. Kamath to Claimant prior to Claimant's spinal surgery were medically necessary. The Carrier's expert, Dr. Tsourmas, agreed that a monthly office visit and the epidural steroid injections were medically necessary. He challenged Dr. Kamath's decision to move Claimant's neck with chiropractic manipulations or passive therapy as medically unnecessary and potentially harmful given the risk associated with a herniated disk compressing the spinal cord. Such manipulations and therapy could have complicated Claimant's myelopathy.

The ALJ finds that Dr. Kamath failed to show by a preponderance of the evidence that the weekly office visits with the joint mobilization, myofascial release, and passive modalities were medically necessary when a patient has a compressed spinal cord. Dr. Kamath further failed to

22 Petitioner Ex. 5 at 241.

prove
by a preponderance of the evidence that his services either relieved or cured Claimant's medical condition. Indeed, Claimant's medical condition and complaints remained the same. As for the temperature test or the sensory test, there was insufficient evidence to show that they were medically necessary or even medically acceptable. Dr. Tsourmas' emphatic testimony that neither are recognized as valid in the medical profession was left unchallenged by any meaningful evidence.

In conclusion, the ALJ finds that Provider is entitled to payment for two additional monthly office visits, but nothing further. Carrier has already paid for an office visit in July and August, therefore, Provider is entitled to payment for the June and September monthly office visit totaling $96.00 ($48x2).

IV. FINDINGS OF FACT

1. On ___, Claimant suffered a neck and head injury compensable under the Texas Workers' Compensation Act and for which Liberty Mutual Fire Insurance Company (Carrier), was Claimant' employer's workers' compensation insurance carrier.

2. On November 9, 2001, Thomas S. Ellis, M.D., of Southwest Neurological Surgery Associates, P.A. examined Claimant and had an MRI taken of Claimant's neck.

3. The MRI showed:

    - Frank central and foramina stenosis C6-C7 with cord pancaking.
    - Mild uncovertebral degeneration changes C5-C6.
    - Slightly prominent oropharyngeal posterior soft tissue as above. Central T2 intensity likely Tornwald Cyst.

4. Claimant suffered with a disk herniation at the C6-7 level with canal stenosis and cord compression.

5. Claimant's neck injury was so severe that it could have caused death, hemorrhage, stroke, infection, spinal fluid leaks, and neurologic deficits.

6. Claimant's neck injury required an anterior cervical decompression and fusion to correct.

7. Until the surgery could be performed, Claimant's neck should have been immobilized to prevent further pressure on the spinal cord.

8. On May 10, 2002, Claimant went to Provider's clinic without his medical record and was seen by Osler Kamath, D.C.

9. After examining Claimant, Dr. Kamath diagnosed Claimant as suffering from cervical disk disorder, nerve root injury, headaches, and muscle spasms.

10. Dr. Kamath did not have either Dr. Ellis's findings and recommendations or the MRI results for a couple of weeks following his initial evaluation of Claimant.

11. Once Dr. Kamath received Dr. Ellis's report and the MRI result he did nothing with them.

12. Dr. Kamath did refer Claimant for a medical consultation to two doctors: Crawford Sloan, M.D. and James Laughlin, D.O., F.A.C.O.S.

13. Both doctor's recommended further conservative care. Dr. Laughlin also recommended that Claimant try epidural steroid injection before undergoing surgery. Neither doctor conferred with Dr. Ellis.

14. Between June 12, 2002 and September 9, 2002, Provider treated Claimant with therapeutic exercises, joint mobilization, and myofascial release.

15. On September 12, 2002, George B. Crisp Jr., M.D. examined Claimant and diagnosed Claimant as suffering with a large ruptured disk at C6-C7 that was compressing Claimant's spinal cord.

16. Claimant still suffered with neck pain and headaches, had tremors in his hand, and became dizzy when he looked down. Coughing, sneezing and moving his head, aggravated the pain.

17. The treatments provided by Providers from June 12, 2002, to September 9, 2002, did not relieve or cure Claimant's compensable injury.

18. The evidence was insufficient to show by a preponderance of the evidence that Claimant received any temporary or permanent relief from Provider's treatment and services.

19. It was medically necessary to examine and monitor Claimant's condition monthly, justifying a monthly office visit.

20. Provider timely sent Carrier claim forms requesting payment for the medical services and treatment provided to Claimant between June 12, 2002, and September 9, 2002.

21. Carrier's explanation of benefits (EOB), addressing the services furnished by Provider from June 12, 2002 to September 9, 2002, stated that Carrier was denying payment because Provider's services were not medically necessary. Provider appealed.

22. On February 10, 2003, the independent review organization (IRO) conducted an independent review of the treatment Provider furnished Claimant.

23. The IRO found that the treatments Dr. Kamath provided Claimant between June 12, 2002 and September 9, 2002, were not medically necessary.

24. On April 16, 2003, based on the IRO's decision, the Medical Review Division (MRD) of the Texas Workers' Compensation Commission's (Commission) denied reimbursement to the Provider for treatment and services furnished to Claimant between June 12, 2002 and September 9, 2002, except for the office visit conducted on August 21, 2002, which was approved because neither party submitted the EOB.

25. Provider timely requested a hearing on the MRD decision.

26. On June 4, 2003, the Commission issued a notice of hearing to the parties. The notice contained a statement of the time and place 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.

27. On August 7, 2003, the hearing convened in Austin, Texas, before Administrative Law Judge Catherine C. Egan (ALJ). The Commission did not participate in the hearing. Attorney Scott Hilliard appeared and represented Provider. Attorney Kevin Franta appeared and represented Carrier.

28. It was medically necessary for Provider to conduct a monthly office visit to monitor Claimant's condition.

29. The medical treatment provided to Claimant, except two additional office visits, was not medically necessary.

30. Two additional office visit, one for the month of June 2002, and one for the month of September, were medically necessary.

V. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction related to this matter pursuant to TEX. LAB. CODE ANN. § 413.031.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

3. Provider timely requested a hearing, as specified in 28 TEX. ADMIN CODE (TAC) § 148.3.

4. Proper and timely notice of the hearing was provided in accordance with GOVT CODE §§ 2001.051 and 2001.052.

5. Provider has the burden of proof in this proceeding pursuant to 28 TAC §§ 148.21(h) and (i); 1 TAC §155.41.

6. Based on the above findings, Provider failed to prove by a preponderance of the evidence that the medical treatment Provider furnished Claimant from June 12, 2002, to September 9, 2002, except for two additional office visits, were medically reasonable and necessary to relieve the effects of the compensable injury suffered by Claimant, within the meaning of LABOR CODE §§ 408.021 and 401.011(19).

7. Provider is entitled to reimbursement of $96.00 for two additional office visits.

ORDER

IT IS ORDERED that Liberty Mutual Fire Insurance Company shall pay reimbursement to Main Rehab & Diagnostic in the amount of $96.00 for two additional office visits provided to Claimant for the months of June and September. All other claims of Main Rehab & Diagnostic for reimbursement from Liberty Mutual Fire Insurance Company for services provided to Claimant from June 12, 2002, to September 9, 2002, are denied.

SIGNED October 9th, 2003.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS