DOCKET NO. 453-03-3465.M5
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NEUROMUSCULAR INSTITUTE OF TEXAS, PA, PETITIONER	§	**BEFORE THE STATE OFFICE**
VS.	§	**OF**
LIBERTY MUTUAL INS. CO., RESPONDENT	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

After an Independent Review Organization (IRO) determined treatment provided by Neuromuscular Institute of Texas, PA (Provider) was not medically necessary, the Provider appealed. The Carrier, Liberty Mutual Insurance Company, argued the treatment did not improve the workers' compensation claimant's carpal tunnel syndrome and should have been stopped prior to the disputed dates of service, January 21, 2002 through June 28, 2002. Because the claimant experienced temporary relief from time to time, the Provider argued the reasonableness of its treatment. In this decision, the administrative law judge (ALJ) agrees with the Carrier that treatments were ineffective and should have been discontinued by the disputed dates.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

Notice and jurisdiction were not contested, and those issues are addressed only in the findings of fact and conclusions of law. The appeal hearing was held August 5, 2003, before the undersigned ALJ. Attorneys David T. Duncan, Jr., and Kevin J. Franta represented the Provider and Carrier, respectively. The record closed at the conclusion of the hearing.

II. DISCUSSION

1. Background

The claimant experienced a work-related injury on ___, and was diagnosed as having bilateral, carpal tunnel syndrome and myofascial pain of the upper trapezius, cervical paraspinals, thoracic paraspinals, and left phomboids. She was treated by the Provider, primarily with chiropractic manipulation, occupational therapy, and physical medicine from December 12, 2000, until December 2002. By January 2002, the claimant had already had over 100 chiropractic visits without experiencing lasting improvement.

According to the Table of Disputed Services, treatment was provided under the following CPT codes:

97010 (application of a modality to one or more areas; hot and cold packs);
97110 (therapeutic exercises to develop strength and endurance, range of motion, and flexibility);
97014 (electrical stimulation);
97035 (ultrasound);
97250 (myofascial release, soft-tissue mobilization);

97261 (each additional area);
99090 (analysis of computer-stored information);
99080-73 (special reports);
99213 (extended office visit); and
99213-MP (office visit with manipulation).

The Carrier's representative said the amount in dispute is $3,426; however, the maximum allowable reimbursement as shown on the table totals $18,440.[1]

The IRO reviewer determined that, although a few weeks of therapy may have been appropriate after the claimant's carpal tunnel release surgery in October 2001, the Provider's care did not improve her condition and should have been stopped. Consequently, the reviewer determined the disputed treatments were not medically necessary.

2. Treatments and Opinions

On October 10, 2001, William R. Culver, M.D., examined the claimant at the Carrier's request. By this time, the claimant had received approximately 90 chiropractic manipulations. Dr. Culver wrote in his report that no more than 24 chiropractic visits should have been provided and anything more was excessive. He also thought surgery was an appropriate option for the claimant since conservative treatment had failed to help her. "Following surgery," Dr. Culver wrote, "she will need some physical therapy, not to exceed 3-4 visits per wrist. Then she can be instructed in a home program."[2]

The claimant had left carpal tunnel-release surgery on October 16, 2001. After her surgery and before the disputed dates of service, the claimant was treated with chiropractic care on six dates, and she also had fourteen physical therapy sessions. On December 20, 2001, the Provider requested preauthorization for 24 office visits to begin on November 5, 2001, and end on January 16, 2002. The Carrier preauthorized the continuation of occupational therapy for twelve days during four weeks, beginning November 5, 2001.[3]

During an occupational therapy session on February 1, 2002, the claimant reported pain of four to five on a one-to-ten scale.[4] On February 5, 2002, the Provider requested more occupational therapy (three times a week for four weeks) to include CPT codes 97110 and 97250.[5] In reviewing the record, the ALJ did not find a preauthorization form for these dates, but on the table of disputed services, the Provider wrote, "[the occupational therapist] was re-authorized for post-op therapies, second round, preauthorization [*sic*]."[6]

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[1]Ex. 2, pp. 10, 23, 34, 48, 57, 67, 77, 91, and 98.

[2]Ex. 2, pp. 348-354.

[3]Ex. 1, p. 124; Ex. 3, p. 631.

[4]Ex. 2, pp. 380-381.

[5]Ex. 2, p. 382.

[6]Ex. 2, p. 10.

In a May 14, 2002, functional capacity evaluation report, the occupational therapist summed up the three-hour test results in this way:

> Patient appears to be a good candidate for chronic pain management due to the extensive failed treatment approaches. Patient would benefit from program to decrease the intensity, duration, and frequency of her pain.[7]

As of June 2003, the claimant was still unable to return to work.[8] She reported her pain at a level seven out of ten.[9]

The only witness at the hearing, Thomas B. Sato, D.C., testified in some detail about the Provider's treatment. Before the claimant's surgery, she had approximately 92 chiropractic treatments, twenty physical therapy sessions, and five trigger point injections. After a clinical trial of care when the claimant was not improving, the Provider should have realized further treatments were inappropriate, Dr. Sato said. From time to time, the claimant had temporary relief, but the Provider's staff members referred the claimant for trigger point injections and surgery because the care they provided had not resolved the claimant's condition.[10] Nevertheless, after her surgery, the claimant received the same type of care that had been ineffective for her before the surgery. In Dr. Sato's opinion, this treatment was not medically necessary.

3. Parties' Arguments

Even though the claimant experienced only temporary relief from time to time, the Provider argued this was sufficient to justify medical necessity. Some claimants live with chronic conditions, and it is appropriate to use medical care to make an injured workers' life as good as it can be.

The Carrier agreed that some treatment was medically reasonable as a clinical trial. On the other hand, the Carrier noted, the claimant had more than 100 treatments before the surgery and more than two dozen after, and treatment provided after the surgery did not improve the claimant's pain level.

III. APPLICABLE LAW

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. "Health care" includes all reasonable and necessary medical services. The employee is specifically entitled to health care that cures or relieves

[7]Ex. 2, p. 414.

[8]Ex. 2, p. 626.

[9]Ex. 2, pp. 441-442.

[10]Ex. 2, p. 176.

the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.[11]

Certain categories of health care require preauthorization before they can be provided. Preauthorization is granted if there is prospective showing of medical necessity. Rehabilitation programs are one type of treatment for which preauthorization is required.[12]

IV. ANALYSIS

The parties did not address whether the occupational therapy component of Provider's treatments should have been preauthorized, and the Provider failed to prove any treatments were preauthorized as of January 21, 2002. But, even assuming preauthorization was not required, the Provider failed to meet its burden of proving medical necessity.

The claimant had experienced no pain or function improvement from the Provider's care before the surgery; she underwent left carpel tunnel surgery because the Provider's earlier treatments had proven ineffective. Even so, the Provider continued with the same care for the claimant after her surgery, and the treatments did not resolve symptoms on either side. Thus, the ALJ finds that the Provider failed to meet its burden of proving the treatments on the disputed dates of service cured or relieved the effects naturally resulting from the compensable injury, provided pain relief, or enhanced the claimant's ability to work. Therefore, the appeal should be denied.

1. FINDINGS OF FACT

1. On ___, a workers' compensation claimant sustained a work-related injury, and her employer was insured through Liberty Mutual Insurance Company (the Carrier).

2. The claimant was diagnosed as having bilateral, carpal tunnel syndrome and myofascial pain of the upper trapezius, cervical paraspinals, thoracic paraspinals, and left phomboids.

3. The Provider treated the claimant primarily with chiropractic manipulation, occupational therapy, and physical medicine from December 12, 2000, until December 2002.

4. By October 10, 2001, the claimant had received approximately 92 chiropractic treatments, twenty physical therapy sessions, and five trigger point injections without experiencing lasting improvement.

5. After the claimant had left carpal tunnel-release surgery on October 16, 2001, she was treated with chiropractic care on six dates, and she also had fourteen physical therapy sessions between October 16, 2001, and January 21, 2002.

[11] TEX. LAB. CODE ANN. § 401.011(19); TEX. LAB. CODE ANN. § 408.021.

[12] 28 TEX. ADMIN. CODE §134.600 (h)(10).

6. The Carrier denied treatment provided January 21, 2002 through June 28, 2002, under the following CPT codes:

97010 (application of a modality to one or more areas; hot and cold packs);
97110 (therapeutic exercises to develop strength and endurance, range of motion, and flexibility);
97014 (electrical stimulation);
97035 (ultrasound);
97250 (myofascial release, soft-tissue mobilization);
97261 (each additional area);
99090 (analysis of information stored in computers);
99080-73 (special reports);
99213 (extended office visit); and
99213-MP (office visit with manipulation).

7. On February 1, 2002, the claimant had pain of four to five on a one-to-ten scale.

8. By May 14, 2002, the Provider recommended chronic pain management due to the extensive failed treatment approaches it had utilized.

9. From time to time, the claimant experienced temporary relief as a result of the Provider's care, but the relief was not lasting and did not resolve the claimant's condition.

10. As of June 2002, the claimant was still unable to return to work and reported her pain at a level seven out of ten.

11. After a clinical trial of care when the claimant was not experiencing improvements, the Provider should have realized further treatments were inappropriate.

12. On April 18, 2003, an Independent Review Organization (IRO) reviewer issued a decision that declined to order payment to the Provider.

13. On May 13, 2003, the Medical Review Division of the Texas Workers' Compensation Commission reviewed the IRO's decision and forwarded it to the parties.

14. By request dated May 19, 2003, the Provider timely appealed the IRO's decision.

15. The Commission sent the parties notice of the appeal hearing on June 12, 2003.

16. The notice of hearing 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.

17. The appeal hearing was held August 5, 2003, at the State Office of Administrative Hearings (SOAH), and both parties were represented.

VI. CONCLUSIONS OF LAW

1. 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.

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

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TAC § 148.4.

4. The Provider had the burden of proving its treatment was medically necessary for the compensable injury. 28 TAC § 148.21(h).

5. The Provider failed to sustain its burden of proof.

ORDER

It is ORDERED that the appeal of Neuromuscular Institute of Texas, PA. regarding services provided January 21, 2002 through June 28, 2002, is denied, and Liberty Mutual Insurance Company is relieved of any responsibility for paying the disputed claims.

Signed October 3, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

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SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE