SOAH DOCKET NO. 453-03-4461.M5
MDR Tracking No. M5-03-1686-01

MAIN REHAB AND DIAGNOSTIC,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	**OF**
	§	**ADMINISTRATIVE HEARINGS**
v.	§	
	§	
LIBERTY MUTUAL FIRE	§	
INSURANCE CO.,	§	
Respondent		

DECISION AND ORDER

I. INTRODUCTION

Main Rehab and Diagnostic (Provider) has appealed a decision of the Texas Workers' Compensation Commission (TWCC) Medical Review Division (MRD), which was based on an independent review organization (IRO) review. The IRO agreed with Liberty Mutual Fire Insurance Co. (Carrier) and certain peer reviewers that certain services (Disputed Services) that the Provider furnished to ___ (Claimant) were not reasonably medically necessitated by the Claimant's compensable injury.

The total amount in controversy is $4,053. Effectively, as explained below, the only issue is whether the Disputed Services were medically necessitated by the compensable injury.

The Administrative Law Judge (ALJ) finds that one of the Disputed Services, which had an maximum allowable reimbursement (MAR) of $36, was reasonably medically necessary. He cannot find that the remaining Disputed Services were necessary. The ALJ orders the Carrier to reimburse the Provider $36 for the one necessary service and denies the Provider's request to be reimbursed for the remaining Disputed Services.

II. BACKGROUND

The Claimant's compensable injury was to her neck and lower back. The injury initially caused pain and stiffness in her neck and back and tingling in her right hand. The Claimant also had a mild disc protrusion in her spine. The disc was partially dehydrated and bone had grown partially around it. That suggested that the disc protrusion had been there for quite some time, but it was likely that the compensable injury aggravated it.

The Provider began conservatively treating the Claimant five days after she was injured. During office visits he provided passive therapy, *i.e.* chiropractic manipulations, and the Claimant participated in one-to-one therapeutic exercises. The Provider furnished those same services approximately three times per week from March 26, 2002, through at least September 12, 2002.

Three peer reviews of the Claimant's case were performed. Two of the peer reviewers found that further conservative care, like that the Provider was furnishing, was not necessary after June 13, 2002, to treat the compensable injury. The third reviewer found that "chiropractic care" should be completed by August 11, 2002, suggesting any such service after that date was not necessary. With one exception, all of the Disputed Services were provided after August 11, 2002.

Even the Carrier agrees that it was reasonable for the Provider to treat the Claimant's injury with passive therapy and therapeutic exercise for approximately four weeks. In fact, the Carrier paid for those services. Because it was provided within the first four weeks to check the Claimant's progress under that conservative care, the ALJ finds that one of the Disputed Services, range-of-muscle testing with an MAR of $36 provided on April 11, 2002, was also reasonably necessary to treat the Claimant's compensable injury.

III. MEDICAL NECESSITY IS THE ONLY DISPUTED ISSUE

With rare exceptions, a Carrier's explanation of benefits (EOB) denying reimbursement limits the scope of any subsequent medical-fee-reimbursement dispute.[1] In this case, the Carrier's EOBs indicated that reimbursement was being denied "based on peer review, further treatment is not recommended." The Provider, who admits that it has the burden of proof, argues that it need only show that the reason given for the denial in the EOBs was incorrect. That is true.

In this case, however, the Provider can only show that the reason for denial stated in the EOB was wrong by showing that the peer reviewers were wrong. Since each peer reviewer found that further treatment was unnecessary after a date prior to the dates in dispute, the Provider can only refute the peer reviewers by showing that the Disputed Services were medically necessary to treat the compensable injury.

IV. MEDICAL NECESSITY OF DISPUTED SERVICES

With the one exception already discussed, the Provider failed to show the Disputed Services were reasonably necessary. In fact, the evidence tends more to show that they were unnecessary.

The Provider reasons that his services were necessary because the Claimant eventually had a positive outcome. The Provider testified that the Claimant eventually recovered, apparently after the service dates in dispute in this case, without back surgery and was able to return to work. The evidence does not show, however, that the Claimant's services produced or even contributed to that outcome.

After the Provider treated the Claimant for four weeks after the injury, it was clear that the Provider's care was not benefitting the Claimant. The Provider's own contemporaneous notes from the date he began treatment March 26, 2002 through the date of the last service in dispute September 17, 2002 a period of nearly six months, do not indicate any improvement in the Claimant's subjective complaints or range of motion or the Provider's objective findings. In fact, by May 23, 2002, the Claimant's pain and ability to engage in activities of daily living had deteriorated below what they had been when the Provider began treating her.

[1] See SOAH Docket No. 453-99-2021.M5 (July 20, 2000, ALJ Rusch); SOAH Docket No. 453-99-3399.M5 (May 18, 2000, ALJ Pacey); SOAH Docket No. 453-96-1446.M4 (Nov. 12, 1996, ALJ Corbitt); SOAH Docket No. 453-97-0973.M4 (May 14, 1998, ALJ Card); and SOAH Docket No. 453-00-1570.M5 (Oct. 20, 2000, ALJ Smith).

Nevertheless, the Provider argues the exercise services were necessary to increase the effectiveness of other necessary services. On August 29, 2002, George A. Farhat, M.D., injected pain medication into the Claimant's lumbar spinal facet joints to relieve her pain. The Provider argues his exercise services increased the effectiveness of those facet injections.

The Carrier does not dispute that injections are more effective when combined with exercise. However, the Provider failed to show why the Claimant could not have exercised on her own. Moreover, the Provider's notes from the time that the facet injections were provided do not even mention those injections, undermining his contention that the exercise therapy was given to boost the effectiveness of the injections. Given those gaps and the Claimant's lack of progress, in fact regression through the disputed dates, the ALJ cannot find that the disputed therapeutic exercises were medically necessary.

Even if the disputed office visits were not necessary to provide passive therapy, *i.e.* chiropractic manipulations, the Provider argues that they were necessary to fulfill his obligation to monitor the Patient's care. The ALJ does not agree.

At the Provider's instruction, the Claimant visited the Provider 14 times in five weeks during the period in dispute. In fact, the Claimant, as instructed, had visited the Provider at approximately that same frequency for six months. The Provider offered no evidence to support his contention that such extremely frequent visits were necessary to monitor the Claimant's condition. Given that gap and the Claimant's lack of progress, in fact regression through the disputed dates, the ALJ cannot find that the disputed office visits were reasonably medically necessitated by the Claimant's compensable injury.

That leaves two disputed muscle-testing services and one disputed temperature-gradient study provided to the Claimant in August 2002. The Provider offered no evidence to show why these services, provided nearly five month after the injury and after five months of ineffective therapy and exercise, were necessary. For that reason, the ALJ cannot conclude that they were.

V. SUMMARY

Based on the above, the ALJ finds that the range-of-muscle testing that the Provider furnished the Claimant on April 11, 2002, was reasonably medically necessary and orders the Carrier to reimburse the Provider the $36 MAR for it. The ALJ cannot find that the other Disputed Services were reasonably medically necessary, and the Provider's request to be reimbursed for them is denied.

VI. FINDINGS OF FACT

1. ___ (Claimant) sustained a work-related injury on ___, while her employer was ___ and its workers' compensation insurer was Liberty Mutual Fire Insurance Co. (Carrier).

2. The Claimant's compensable injury was to her neck and lower back, which initially caused pain and stiffness in her neck and back and tingling in her right hand.

3. The Claimant also had a mild disc protrusion in her spine that predated the compensable injury but was aggravated by that compensable injury.

4. The Claimant's Treating Doctor was Osler Kamath, D.C., doing business as Main Rehab and Diagnostic (Provider).

5. The Provider began treating the Claimant on March 26, 2002, with passive and active therapies.

6. The Provider continued to treat the Claimant with active and passive therapies approximately three times per week nearly every week from March 26, 2002, through at least September 12, 2002.

7. Among other services, the Provider provided services (Disputed Services) to the Claimant with current procedural terminology (CPT) codes and maximum allowable reimbursements (MARs) as follows:

CPT CODE	SERVICE	MAR	DATES (2002)
95851	Range-of-muscle testing	$36	4/11, and 8/26
99213	Mid-level office visit	$48	8/13, 8/14, 8/19, 8/20, 8/21, 8/22, 8/26, 8/27, 8/28, 9/9, 9/10, 9/11, 9/12, and 9/17
97110	One-on-one therapeutic exercises	$175	8/13, 8/14, 8/19, 8/20, 8/21, 8/22, 8/26, 8/27, 8/28, 9/3, 9/9, 9/10, 9/11, and 9/12
97750-MT	Muscle testing	$86	8/13, and 8/27
97340-WP	Temperature-gradient study	$336	8/14

8. It is reasonable to initially treat a patient with a spinal soft-tissue injury, like the Claimant's compensable injury, with four weeks of conservative care, including passive and active therapies.

9. The Provider reasonably provided conservative care to the Claimant until April 18, 2002, four weeks after she was injured.

10. The CPT Code 95851, range-of-muscle testing, that the Claimant provided the Claimant on April 11, 2002, to check the Claimant's progress, was reasonably medically necessary to treat the Claimant's compensable injury.

11. The Claimant's subjective complaints and range of motion and the Provider's objective findings concerning the Claimant's condition did not significantly improve from the date the Provider first examined her, March 26, 2002, through at least September 12, 2002.

12. By May 23, 2002, the Claimant's pain and ability to engage in activities of daily living had deteriorated below what they had been when the Provider's treatment of her began on March 26, 2002.

13. On June 13, 2002, Gary D. Martin, D.C., performed a peer-review examination of the Claimant and found that the Claimant:

    1. had reached maximum medical improvement (MMI) with a whole person impairment rating of five percent by that date,
    2. had no need for further conservative care like that the Provider was furnishing; and
    3. could return to work on restricted duty at that time and full duty one month later.

14. On August 5, 2002, Michael Kapsner, D.C., performed a peer review of the Claimant's medical history and concluded that chiropractic care, should be completed by August 11, 2002.

15. On October 25, 2002, Page W. Nelson, M.D., performed a peer review of the Claimant's medical history related to the compensable injury and concluded that the further treatment by the Provider was not necessary after June 13, 2002, when the Claimant reached MMI.

16. The Provider timely sought reimburse of the MARs, totaling $4,053, from the Carrier for the Disputed Services.

17. Based on the above peer reviews finding further treatment like that the Provider furnished was not necessary after August 11, 2002, at the latest, the Carrier timely submitted explanations of benefits (EOBs) to the Provider denying him reimbursement for the Disputed Services.

18. The Provider timely filed a request for medical dispute resolution with the Texas Workers' Compensation Commission (TWCC), which referred it to an independent review organization (IRO).

19. The IRO reviewed the medical dispute and found that the Disputed Services were not medically necessitated by the Claimant's compensably injury.

20. After the IRO decision was issued, the Provider asked for a contested-case hearing by a State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ) concerning the medical dispute.

21. Notice of a October 10, 2003, hearing in this case was mailed to the Provider and the Carrier on August 21, 2003.

22. On October 10, 2003, ALJ William G. Newchurch held a hearing on this case at the William P. Clements, Jr. Building, 300 W. 15th Street, 4th Floor, Austin, Texas. The hearing concluded that same day.

23. The record closed on October 22, 2003, when the Provider submitted an agreed list of the Disputed Services, which was admitted into evidence by agreement of the Parties.

24. The Carrier appeared at the hearing through its attorney, Charlotte Salter.

25. The Provider telephonically appeared at the hearing and was represented by his attorney, Scott C. Hilliard, who also telephonically appeared.

VII. CONCLUSIONS OF LAW

1. 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 TEX. LABOR CODE ANN. (Labor Code) §§ 402.073(b) and 413.031(k) (West 2003) and TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003 (West 2003).

2. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

3. Based on the above Findings of Fact and Gov't Code § 2003.050 (a) and (b), 1 TEX. ADMIN. CODE (TAC) § 155.41(b) (2003), and 28 TAC §§ 133.308(v) and 148.21(h) (2002), the Provider has the burden of proof in this case.

4. 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 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).

5. Based on the above Findings of Fact and Conclusions of Law, the Provider must prove that the peer reviewers were wrong and that the Disputed Services were reasonably medically necessitated by the Claimant's compensable injury.

6. Based on the above Findings of Fact and Conclusions of Law, the range-of-muscle testing service that the Provider furnished the Claimant on April 11, 2002, was reasonable medically necessary to treat the Claimant's compensable injury and the Carrier should reimburse the Provider the $36 MAR for it.

7. The evidence does not show that the remaining Disputed Services were reasonably medically necessitated by the compensable injury, and the Provider's request to be reimbursed for them should be denied.

ORDER

IT IS ORDERED THAT:

8. The Carrier shall reimburse the Provider $36, plus interest for the range-of-muscle testing service that the Provider furnished the Claimant on April 11, 2002; and

9. The Provider's request to be reimbursed for the remaining Disputed Services is denied.

SIGNED November 6, 2003.

WILLIAM G. NEWCHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS