DOCKET NO. 453-04-0847.M5

WILLIAM E. BARNES, D.C.	'	**BEFORE THE STATE OFFICE**
PETITIONER	'	
V.	'	
	'	**OF**
LIBERTY MUTUAL FIRE INSURANCE COMPANY	'	
RESPONDENT	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

Liberty Mutual Fire Insurance Company (Carrier) asserts that the disputed services, including office visits, massage therapy, spinal manipulation, trigger point therapy, and interferential current, performed from May 31, 2002, through January 22, 2003 (approximately $3,128.00) were not medically necessary. The Independent Review Organization (IRO) found that the disputed services were not medically necessary and should not be reimbursed. William E. Barnes, D.C., (Provider) appealed the IRO's decision. The Administrative Law Judge (ALJ) finds the disputed services were not medically necessary and should not be reimbursed.

II. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

On May 10, 2004, ALJ Michael J. O'Malley convened the hearing at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared through its attorney, William Maxwell. Carrier appeared through its attorney, Charlotte Salter. After the evidence was presented, the parties filed post-hearing briefs, closing the record on July 15, 2004.

III. BACKGROUND, EVIDENCE, AND DISCUSSION

1. Background

On ___, Claimant ___ suffered a work-related injury. While bending over to place something on the floor of an oil rig, Claimant fell to the floor on his left wrist, causing a tear in his lower back. On June 10, 1999, Timothy L. Davis, D.C., began to treat Claimant. Dr. Davis diagnosed him with lumbar disc syndrome with sprain/strain and spasms. Dr. Davis treated Claimant with spinal manipulation and multiple passive modalities for back pain. On June 18, 1999, an MRI suggested mild disc desiccation at L4/5; disc herniation was also suggested at central L5/S1. On October 28,

1999, Claire Tibiletti, M.D., performed a lumbar discogram with follow-up lumbar CT interpreted by Thomas Arnold, M.D., suggesting lumbar disc herniation at L5/S1. Claimant then underwent multiple epidural steroid injections and was given several medications for management of his pain and spasms. Dr. Davis continued to treat Claimant with chiropractic care and passive modalities. On November 10, 2000, Claimant began chiropractic care with Marc McDaniel, D.C.

On September 18, 2001, David Fletcher, M.D., performed an impairment evaluation and found Claimant to be at maximum medical improvement with a 28 percent whole person impairment. A designated doctor impairment evaluation provided by Jeff Cunningham, D.C., on September 19, 2001, found Claimant to be at a 31 percent whole person impairment level. Dr. Barnes began to treat Claimant on May 31, 2002.

2. Parties' Positions and Evidence

1. Provider's Position and Evidence

Provider's post-hearing brief presents a legal argument on the sufficiency of the explanation of benefits (EOBs). Provider relies on 28 TEX. ADMIN. CODE (TAC) 133.304(c) to support his argument that reasons for denial may not be considered at the State Office of Administrative Hearings (SOAH) unless the reasons were previously asserted in the EOBs. Provider contends that the ALJ must initially determine the scope of the dispute based on the reasons for denial submitted by Carrier in its EOBs. Provider claims that the reasons for denial in this case were wholly insufficient to support denial.

In another legal argument presented in brief, Provider argues that because Thomas Sato, D.C., Carrier's witness in this case, is not a practicing physician, his peer reviews should be disregarded. 28 TEX. ADMIN. CODE ' 19.1702(c)(3)(C). Additionally, Provider argues that the ALJ should apply the *Robinson* standards and disqualify the testimony of Dr. Sato. *E. I. DuPont de Nemours and Co., Inc. v. Robinson*, 923 S.W.2d 549, 556-560 (Tex. 1995).

At the hearing, Dr. Barnes testified on his own behalf. He testified that Claimant had a herniated disc, causing low back pain. Dr. Barnes recognized that Claimant had previously been treated by other physicians; however, he did not believe the previous treatments had successfully treated Claimant's condition. Based on his own diagnosis, Dr. Barnes began spinal manipulations (and other passive modalities) three times a week. He gradually reduced Claimant's treatments to two times a week, then one time a week, and then on an as-needed basis. Dr. Barnes testified that during his treatment of Claimant, Claimant was able to return to work.

Provider contends that his treatments relieved the effects naturally resulting from the compensable injury and helped Claimant retain employment. Texas Workers' Compensation Act, TEX. LAB. CODE ANN. (Labor Code) ' 408.021. And although the chiropractic care was passive care, Provider maintains that this is not a basis to deny reimbursement. Provider references the

North American Spine Society Clinical Guidelines for Multidisciplinary Spine Care Specialists (2000) (Clinical Guidelines) to support his position. According to Provider, the Clinical Guidelines allow for passive modalities to treat failed back syndrome if clinically indicated and not previously unsuccessful.

2. Carrier's Position and Evidence

Dr. Sato testified on behalf of Carrier. He testified that all of the chiropractic therapy provided by Dr. Barnes was passive and that passive therapy in the chronic stage of back pain was unlikely to provide any benefit. To support this position, Carrier notes that on January 22, 2003 (the last day of treatment), Dr. Barnes wrote that Claimant complained of sharp, aching, shooting, spastic, throbbing, cramping, and constricting pain-the type of pain Claimant complained of throughout his treatment with Dr. Barnes. Carrier further points out that on the last day of treatment, the intensity of the pain had not diminished, which prevented Claimant from carrying out daily activities. Carrier also disputes Dr. Barnes' claim that Claimant was able to return to work. According to Carrier, Dr. Barnes testified at the hearing that he did not know how often Claimant worked or what his job duties included. Carrier further notes that Dr. Barnes did not document in his clinical notes that Claimant had returned to work. Additionally, Carrier maintains that Dr. Barnes' treatment of Claimant was not supported by objective clinical findings or diagnostic tests. Finally, Carrier argues that Dr. Barnes' therapy should be considered unreasonable and unnecessary because it was simply a repetition of two prior unsuccessful courses of chiropractic treatment.

3. ALJ's Analysis

With regard to Provider's first legal issue the sufficiency of the EOBs Provider is correct that reasons for denial may not be considered at SOAH unless the reasons were previously asserted in the EOBs. However, that situation does not exist in this case. In reviewing the EOBs submitted in this case, the reason asserted at SOAH for denialBmedical necessityBis set forth in Carrier's EOBs as Code V. Carrier has authority to review medical bills and deny payment based on a number of reasons. 28 TAC 133.301(a). The Texas Worker's Compensation Commission (Commission) has provided a list of acceptable codes carriers must use when denying payment. 28 TAC 133.301(a)(1-9). Carrier used Code V as one reason for denying payment. Code V allows a Carrier to deny payment when it finds the service to be medically unreasonable and/or unnecessary (TWCC 62 (Rev. 07/00)).[1] Typically, if the reason for denial at SOAH had not been set forth in the EOBs, then a motion to dismiss, submitted prior to the hearing, would have been appropriate. In this case, Provider did not raise this issue before the hearing or at the hearing. Provider addressed this issue for the first time in his post-hearing brief; however, for the reasons discussed above, Provider's argument on this issue has no merit.

[1] Carrier's peer reviews, issued shortly after the EOBs, also indicated that denial was based on the lack of medical necessity.

Next, Provider requests that the ALJ not consider the Dr. Sato's peer reviews because 28 TAC 19.1702(c)(3)(C) requires Dr. Sato to be a practicing health care provider for to perform peer reviews. Having reviewed the relevant Commission rule, the ALJ finds that Provider's argument has no merit. The provision cited by Provider—28 TAC 19.1702(c)(3)(C)—does not support Provider's argument. This provision not only fails to support Provider's argument, but from the ALJ's review, does not even address this issue. Furthermore, Provider's argument is refuted under 28 TAC 133.304(g), which states that a peer reviewer shall be a licensed health care provider, as defined at Labor Code 401.011, of the same or similar specialty as the performing provider, shall be licensed to perform the treatment under review, and must not have been removed from the approved TWCC doctor list. Provider failed to show that Dr. Sato did not meet these criteria.[2]

Finally, Provider asserts that *Robinson* standards should be applied to disqualify Dr. Sato as an expert and to exclude his testimony. The ALJ notes that application of the *Robinson* standards would have been a pre-trial matter in which the parties would have had the opportunity to fully address this issue. Provider raises this issue in his post-hearing *reply* brief, preventing Carrier from addressing this issue. However, even if Provider had timely raised this issue, it has no merit in this case. Provider asserts that *Robinson* should be applied to exclude Dr. Sato's testimony because Dr. Sato does not regularly see patients and did not provide any treatise to support his testimony. Provider's arguments would not exclude Dr. Sato's testimony but would go to the weight given his testimony. For this case, the ALJ will consider Dr. Sato's testimony and assign it the appropriate weight, keeping in mind that Dr. Sato did not physically examine Claimant and does not currently have an active practice of treating patients.[3]

When Dr. Barnes began treating Claimant on May 31, 2002, he was aware that Claimant's injury had occurred on___. With Dr. Barnes' training and experience, it should have been clear that Claimant's condition was chronic. Dr. Barnes treated Claimant with passive therapy throughout the eight months of treatment with little variation in the modalities performed. Claimant's condition did not improve with treatment. In fact, and as noted by Carrier, on the last day of treatment (January 22, 2003), Claimant still had significant pain and diminished capacity to perform daily activities. Provider Ex. 1 at 133. Occasionally, Dr. Barnes would note that Claimant had shown some improvement, but during his eight months of treatment with Dr. Barnes, Claimant saw no real overall improvement in his condition and his condition often worsened. For example, on January 13,

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[2] Although Dr. Sato performed peer reviews for the services in dispute, he also testified at the hearing; therefore, arguments addressing his authority to conduct peers becomes less of an issue. The peer review arguments would have more relevance if Carrier was relying strictly on the peer review documents to support its position and did not call the doctor to testify. However, that was not the situation in this case.

[3] Although Dr. Sato did not examine Claimant in developing his opinion, the medical records in this case overwhelmingly support his position that Claimant was in a chronic condition and passive modalities would not be beneficial to treat his condition three years after the injury.

2003, Claimant had a pain level of 9 out of a possible 10 and was not able to carry out daily activities. Provider Ex. 1 at 127-128. Although Dr. Barnes testified that Claimant began to work during this time, the evidence on Claimant's employment was unclear. Dr. Barnes was unable to provide any details on the nature of the employment and his clinical notes did not document Claimant's employment. Dr. Barnes' notes frequently indicated that Claimant was in significant pain and unable to perform daily activities; therefore, it is unlikely that Claimant could have engaged in any meaningful employment during the time Dr. Barnes treated him.

In addition to the lack of progress made by Claimant in eight months of treatment, Dr. Barnes treatment was not supported by objective clinical findings or diagnostic tests. Dr. Barnes did not conduct any diagnostic tests during these eight months to confirm or refute his course of treatment. His treatment included massage therapy, spinal manipulation, trigger point therapy, and interferential current. *See e.g.*, Provider Ex. 1 at 126, 128, and 130. Furthermore, Claimant had previously received two similar courses of chiropractic treatment from Dr. Davis and Dr. McDaniel, which had been unsuccessful. On May 31, 2002, the evidence shows that Claimant was in a chronic condition and that repeated passive modalities would not resolve his condition. Accordingly, the ALJ finds Provider's chiropractic services from May 31, 2002, through January 22, 2003, were not medically necessary.

IV. FINDINGS OF FACT

1. On___, Claimant___ (Claimant) suffered a work-related injury. While bending over to place something on the floor of an oil rig, Claimant fell to the floor on his left wrist, causing a compensable tear in his lower back.

2. At the time of the injury, Claimant's employer had workers' compensation insurance through Liberty Mutual Fire Insurance Company (Carrier).

3. On June 10, 1999, Tim Davis, D.C., began to treat Claimant and diagnosed him with lumbar disc syndrome with traumatic sprain/strain and myospasms.

4. Dr. Davis treated Claimant with spinal manipulation and other passive modalities for back pain.

5. On June 18, 1999, an MRI suggested mild disc dessication at L4/5 and disc herniation at central L5/S1. A lumbar discogram also suggested disc herniation at central L5/S1.

6. Claimant underwent multiple epidural steroid injections and was given several medications for management of his pain and spasms.

7. On November 10, 2000, Claimant began chiropractic care with Marc McDaniel, D.C.

8. On September 18, 2001, David Fletcher, M.D., performed an impairment evaluation and found Claimant to be at maximum medical improvement with a 28 percent whole person impairment.

9. A designated doctor impairment evaluation provided by Jeff Cunningham, D.C., on September 19, 2001, found Claimant to be at a 31 percent whole person impairment level.

10. After having received extensive chiropractic treatment with passive modalities, Claimant again began to receive treatment with passive modalities from Dr. William E. Barnes on May 31, 2002.

11. Throughout Dr. Barnes' treatment, Claimant continued to complain of significant pain and was unable to perform daily activities.

12. From May 31, 2002, through January 22, 2003, Dr. Barnes' treated Claimant with passive modalities with little variation in the modalities performed.

13. Dr. Barnes' treatment included massage therapy, spinal manipulation, trigger point therapy, and interferential current.

14. Claimant's condition did not improve with Dr. Barnes' treatment.

15. Dr. Barnes' treatment was not supported by objective clinical findings or diagnostic tests.

16. On May 31, 2002, after having received two previous courses of chiropractic care with no improvement, Claimant clearly exhibited a chronic condition and further passive chiropractic care would not improve his condition.

17. The chiropractic care (with passive modalities) received by Claimant from May 31, 2002, through January 22, 2003, was not medically necessary to treat his chronic back condition.

18. On August 19, 2003, an Independent Review Organization (IRO) denied Provider reimbursement, finding that the chiropractic care was not medically necessary. On September 11, 2003, the Texas Workers' Compensation Commission (Commission) confirmed the IRO's decision.

19. On October 2, 2003, Provider appealed the IRO's decision.

20. The Commission sent notice of the hearing to the parties on October 27, 2003. The hearing notice informed the parties of the matter to be determined, the right to appear and be represented, the time and place of the hearing, and the statutes and rules involved.

21. The hearing was held on May 10, 2004, and the record closed on July 15, 2004. Carrier appeared through its attorney, Charlotte Salter. Provider appeared through his attorney, William Maxwell.

V. 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. LAB. CODE ANN. '' 402.073 and 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Proper and timely notice of the hearing was provided to the parties in accordance with TEX. GOV'T CODE ANN. '' 2001.051 and 2001.052.

3. Pursuant to 28 TEX. ADMIN. CODE ' 148.21(h), Provider had the burden of proving by a preponderance of the evidence that the chiropractic care performed from May 31, 2002, through January 22, 2003, was medically necessary.

4. Provider did not prove by a preponderance that the chiropractic care performed from May 31, 2002, through January 22, 2003, was medically necessary.

5. Carrier properly denied payment for the chiropractic services, using Code V, which allows a carrier to deny payment when it finds the service to be medically unreasonable and/or unnecessary. 28 TEX. ADMIN. CODE ' 133.301(a)(1-9).

6. Dr. Thomas Sato was qualified to be a peer reviewer in this case because he was a licensed health care provider, as defined at Labor Code 401.011, of the same or similar specialty as the performing provider, was licensed to perform the treatment under review, and had not been removed from the approved Texas Workers' Compensation Commission doctor list. 28 TEX. ADMIN. CODE 133.304(g)

7. The standards in *Robinson* would not apply to disqualify Dr. Sato as an expert and to exclude his testimony. *E. I. DuPont de Nemours and Co., Inc. v. Robinson*, 923 S.W2d 549, 556-560 (Tex. 1995).

8. Based on the Findings of Fact and Conclusions of Law, the chiropractic care provided Claimant from May 31, 2002, through January 2003, was not medically necessary; therefore, Provider should not be reimbursed for it.

ORDER

IT IS HEREBY ORDERED that Liberty Mutual Fire Insurance Company shall not reimburse William E. Barnes, D.C., for the chiropractic care performed from May 31, 2002, through January 22, 2003.

SIGNED August 27, 2004.

MICHAEL J. O'MALLEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING