DOCKET NO. 453-04-1960.M5
TWCC NO. M5-03-1377-01

LIBERTY MUTUAL INSURANCE CO., Petitioner	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
MICHAEL H. MARGOLIES, D.C., Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Liberty Mutual Insurance Company (Carrier) appealed a decision by Maximus, an independent review organization certified by the Texas Department of Insurance, in Texas Workers' Compensation Commission (TWCC) Medical Review Division file number M5-03-1377-01 ordering reimbursement to a provider in the amount of $5,689 for treatment and services for an injured worker (Claimant).

I. PROCEDURAL HISTORY

On March 9, 2004, Georgie B. Cunningham, Administrative Law Judge (ALJ), convened a hearing at the State Office of Administrative Hearings, 300 West 15th Street, Austin, Texas. Attorney Charlotte Salter represented Carrier. Michael H. Margolies, D.C. (Provider) appeared *pro se*. Neither party challenged notice or jurisdiction. Following the presentation of evidence, the hearing closed on March 9, 2004.

II. DISCUSSION

The issue presented in this proceeding is whether Carrier should reimburse the Provider $5,689 plus interest for office visits, durable medical equipment, physical therapy, and records from February 2, 2002, through August 29, 2003. The documentary record in this case consisted of more

than one-thousand pages of medical records. The parties presented testimony by Kevin Tomsic, D.C.; Kimberley Lookingbill, the insurance claims manager for Provider; and Provider.

The evidence showed that Claimant suffered the compensable injury on _____. His initial diagnosis included a cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, and shoulder injury. On August 29, 2001, the diagnosis was expanded to include serious disc problems. Claimant subsequently received extensive diagnostic testing and treatment including an EMG, an MRI, x-rays, myelogram, CMT, therapeutic exercises, joint mobilization, myofascial release, trigger point injections, epidural steroid injections, axial traction, medication, physical therapy, and a partially-completed work hardening program. As of April 8, 2002, Provider had seen Claimant 102 times.

In the written opinion of Thomas B. Sato, D.C., The results of all diagnostic tests have been inconclusive and . . . and failed to adequately explain the cause for the persistent pain complaints. Dr. Sato made the following statement about Provider's care:

> This patient has had an impressive amount of treatment, apparently with less than satisfactory results. There is nothing in the reviewed medical file, which would support long-term treatment of this type. Uncomplicated sprain/strain injuries typically resolve with six to twelve visits and with complications an additional six to twelve sessions of therapy may be appropriate. . . . [T]reatment in this case has been excessive . . . .

According to Dr. Tomsic's testimony for Carrier, Claimant's need for care reached a plateau in November 2001, and no further chiropractic care was necessary. Nevertheless, Claimant had approximately 70 additional visits with the same kinds of services rendered. Provider's records failed to show reexamination and evaluation of Claimant, continued objective improvements, or that the treatment cured or relieved the compensable injury. Had the chiropractic treatment cured or relieved the initial injury, Claimant would not have needed the additional treatment from medical doctors. In fact, a medical doctor recommended surgery to address Claimant's spinal problems.

In Dr. Tomsic's opinion, the care Provider gave Claimant was well beyond the standard of care for the type of injury and the amount of elapsed time since the injury. It was his further opinion that medical futility occurred; *i.e.*, Provider delivered the same treatment over and over expecting different results though none occurred. Efficient delivery of care is not achieved when care is not altered to meet needs.

As to Provider's other claims for reimbursement for a neuromuscular stimulator, the batteries and electrodes for the stimulator, and transportation, the evidence does not support reimbursement. Under certain circumstances, a carrier may have to provide transportation reimbursement to a claimant, but the Commission's rule does not require reimbursement of a provider.

The medical records fail to establish a need for a neuromuscular stimulator so long after Claimant's injury. Carrier pointed to medical records on or near the date the equipment was provided that did not even reference the need for it. As established by Dr. Tomsic's testimony, Provider also failed to follow-up with Claimant and document the efficacy of care from having the use of the neuromuscular stimulator. Moreover, Provider attempted to break the sale of the equipment into component parts to avoid the necessity of securing preauthorization for durable medical equipment.

Although Provider attempted to establish in his testimony that the treatment delivered was within the chiropractic standards of care, was within accepted guidelines, and was reasonable and necessary, the ALJ finds that he did not relate facts to establish his arguments. For example, he pointed to an April 2002 report from a medical doctor to whom he had referred Claimant for an evaluation. The doctor recommended Claimant continue his physical therapy to work on stretching, strengthening, and stabilization; however, Provider did not establish why seven months post-injury he had not already given Claimant home exercises to achieve these goals. Neither did the records show reevaluation or improvement.

As another example of Provider's evidentiary problems, he directed attention to a June 2002

medical opinion that Claimant should have another epidural followed by three weeks of prescribed therapy with Provider. At some point Claimant declined additional epidurals. The medical records did not show whether Claimant had this epidural, why Provider continued treatment into October 2002, or whether a medical doctor ever issued such a prescription. Thus, this reference provided insufficient justification for the services.

Provider pointed to a utilization review on October 18, 2002, stating that continued office visits were necessary. This justification failed because the medical doctor performed the review determined that continued visits to *medical* doctors was necessary. Another utilization review by a chiropractor on the same date concluded that continued chiropractic care was not necessary.

Provider's records failed to document need, and Ms. Lookingbill's testimony merely addressed processing claims. Even though some of the medical opinions cited in the record differ about the necessity of treatment, the ALJ finds Carrier's evidence more convincing as to medical necessity. Statutory provisions and rules do not support Provider's premise that he should be reimbursed for Claimant's transportation or that the need for preauthorization for durable medical equipment may be avoided by pricing the equipment by component parts.

Based on the totality of the evidence, the ALJ concludes that the continued chiropractic care was not medically necessary obviating the need for reports. Likewise, the neuromuscular stimulator was not medically necessary nor can the need for preauthorization be avoided by billing in component parts. The Commission's rules do not provide for a provider to be reimbursed for a claimant's transportation. Thus, Carrier established by a preponderance of the evidence that it should be granted the requested relief.

III. FINDINGS OF FACT

1. On _____, the injured worker (Claimant) suffered a compensable injury with a diagnosis of cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, and shoulder injury.

2. On August 29, 2001, Claimant's diagnosis was expanded to include serious disc problems.

3. Claimant's injury is covered by workers' compensation insurance written for Claimant's employer by Liberty Mutual Insurance Company (Carrier).

4. On August 2, 2001, Michael H. Margolies, D.C., (Provider) began treating Claimant's injury.

5. Carrier declined reimbursing Provider $5,689 for office visits, durable medical equipment, physical therapy, and reports from February 2, 2002, through August 29, 2003.

6. Provider requested dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

7. On April 23, 2003, Maximus, an independent review organization certified by the Texas Department of Insurance, issued its decision agreeing that the office visits, durable medical equipment, physical therapy, and reports from February 2, 2002, through August 29, 2003, were medically necessary.

8. On November 12, 2003, MRD ordered Carrier to reimburse the Provider for the treatment and services specified in Finding of Fact No. 7.

9. On December 3, 2003, Carrier requested a hearing to dispute the MRD order.

10. On January 13, 2004, the Commission sent notice of the hearing to the parties. The hearing notice informed the parties of the matter to be determined, the right to appear and be represented by counsel, the time and place of the hearing, and the statutes and rules involved.

11. Provider saw Claimant for 102 visits.

12. Uncomplicated sprain/strain injuries typically resolve with six to twelve visits. Complicated sprain/strain injuries typically resolve with an additional six to twelve sessions.

13. The medical file did not support long-term chiropractic treatment.

14. Provider did not reexamine or reevaluate Claimant on a regular basis.

15. Provider's care was not altered to meet Claimant's needs.

16. Provider's office visits and physical therapy did not cure or alleviate the Claimant's pain.

17. Claimant needed treatment from medical doctors for spinal problems.

18. Provider's records did not address Claimant's needs for a neuromuscular stimulator six months post-injury.

19. Neuromuscular stimulators are usually used during the acute stage of care.

20. On February 4, 2002, Provider filed a claim for $495 for furnishing a neuromuscular stimulator to the Claimant for his home use.

21. Provider filed additional claims for batteries and electrodes for the neuromuscular stimulator.

22. Neither the neuromuscular stimulator nor the electrodes and batteries function separately.

23. The neuromuscular stimulator is durable medical equipment.

24. Provider has not sought nor received preauthorization for the durable medical equipment.

25. Provider sought reimbursement for transporting the Claimant for treatment at $17 per trip for a total of $170.

26. Between February 2, 2002, and August 29, 2003, Provider filed three claims for preparing records.

27. Provider's records were related to the office visits and treatment he provided Claimant.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (TWCC) has jurisdiction to decide the issues presented pursuant to TEX. LAB. CODE ANN. §413.031.

2. 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. §413.031 and TEX. GOV'T CODE ANN. ch. 2003.

3. Carrier timely filed its request for a hearing, as required by 28 TEX. ADMIN. CODE (TAC) §148.3.

4. The hearing notice conformed to the requirements of TEX. GOV'T CODE ANN. §2001.052 in that it 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 section of the statutes and rules involved; and a short plain statement of the matters asserted.

5. Carrier had the burden of proving by a preponderance of the evidence that it should prevail in this matter. 28 TAC §148.(h) and (i).

6. Provider's treatment and services furnished Claimant along with related reports between February 2, 2002, and August 29, 2003, were not medically necessary. TEX. LAB. CODE ANN. §413.031.

7. To be liable for certain services and supplies, a carrier must preauthorize the purchase. TEX. LAB. CODE ANN. §413.014.

8. Durable medical equipment costing over $500 requires preauthorization. 28 TAC §134.600(h)(11).

9. Durable medical equipment are those items that can withstand repeated use; are primarily used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury, or disease; and are appropriate for use in the injured worker's home. 28 TAC §134.201.

10. The neuromuscular stimulator with its required batteries and electrodes was a piece of durable medical equipment requiring preauthorization.

11. Carrier is not liable for the neuromuscular stimulator. 28 TAC §134.600(h)(11).

12. As provided in 28 TAC §134.6, carrier may be required to reimburse an injured employee for transportation to a health care provider under specified circumstances.

13. Provider does not qualify for travel reimbursement under 28 TAC §134.6.

ORDER

IT IS, THEREFORE, ORDERED that Liberty Mutual Insurance Company is not required to reimburse Michael H. Margolies, D.C. for the claims at issue.

SIGNED May 10, 2004.

GEORGIE B. CUNNINGHAM
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS