SOAH DOCKET NO. 453-04-4179.M5
TWCC MDR NO. [M5-03-2740-01]

ERIC A. VANDERWERFF, D.C., **Petitioner**	:	**BEFORE THE STATE OFFICE**
v.	:	**OF**
LUMBERMAN'S MUTUAL CASUALTY COMPANY, **Respondent**	:	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

Eric A. Vanderwerff, D.C., (Provider) appealed the decision of Independent Review Incorporated, an independent review organization (IRO) certified by the Texas Department of Insurance, in Texas Workers' Compensation Commission (TWCC) Medical Review Division (MRD) tracking number M5-03-2740-01, denying reimbursement for medical services provided to the Claimant. Additionally, the Provider appealed the MRD's decision denying reimbursement for services not considered by the IRO. This decision orders that Lumberman's Mutual Casualty Company (Carrier) is required to reimburse the Provider $2,355 of the $10,355 claimed.

The Administrative Law Judge (ALJ) convened a hearing on June 1, 2004. The hearing was concluded and the record closed that date. The Provider appeared telephonically and was represented by William Maxwell, attorney. The Carrier appeared through W. Jon Grove, attorney.

II. EVIDENCE AND BASIS FOR DECISION

The issue presented in this proceeding is whether the Carrier should reimburse the Provider $10,355 plus interest for medical services provided between July 16, 2002, and December 2, 2002, and billed under CPT Codes 99213 (office visit), 97250 (myofascial release), 97261 (manipulation of

an additional area), 97265 (joint mobilization), and 97014 (electrical stimulation). The Carrier argued that the medical services provided to the Claimant from August 19, 2002, to December 2, 2002, were not medically necessary or reasonably required to treat the compensable injury. Further, reimbursement for the services delivered from July 16, 2002, to August 18, 2002, was denied on the basis that relevant information was not submitted to support delivery of the services.[1]

The documentary record in this case consisted of two packets of medical records (Pet. Exh. 1 - 160 pages, and Res. Exhs. 1, 2, and 3 - 373 pages). Also, the Provider testified in his own behalf and Stephen Tomko, D.C., testified for the Carrier.

The record revealed that on _____, the Claimant, a 34-year-old man, suffered an injury to his lower back while moving duct material. An MRI showed that the Claimant had mild degenerative changes at the L4-L5 and L5-S1 spinal levels, mild diffuse annular bulging at the L5-S1 level with a small disc herniation, and mild annular bulging centrally and to the right at L4-L5 with mild posterior ridging and associated mild disc protrusion. The Petitioner began treating the Claimant with passive treatment modalities on March 5, 2002, and continued the same treatment until December 2, 2002.

Dr. Tomko, who was licensed in Texas in 1978, reviewed the Claimant's medical records. He testified that the passive treatment provided to the Claimant went well beyond normal treatment parameters, which are four to six weeks. Dr. Tomko stated that an initial period of passive treatment should be followed by active treatment. According to Dr. Tomko, the Claimant's medical records did not contain any documentation that active treatment had been utilized. In response, the Provider testified that active care was started shortly after he began treating the Claimant, but that it was not either billed or documented in the Claimant's medical records due to mistake. The Provider's testimony that active treatment was delivered does not cure the failure to document the record. The

[1] In summary, this case had both a fee dispute and a medical necessity dispute.

Provider failed to show that passive care beyond the normal treatment parameters was medically necessary or reasonably required to treat the Claimant's injury from August 19, 2002, to December 2, 2002.

The medical records show that the treatment billed from July 16, 2002, to August 18, 2002, was both delivered to the Claimant and adequately documented. The Provider should be paid for these services.

In conclusion, the provider failed to prove that the medical services delivered from August 19, 2002, to December 2, 2002, were medically necessary and reasonably required to treat the Claimant's compensable injury. As testified to by Dr. Tomko, the passive treatment delivered to the Claimant went well beyond normal treatment parameters and there was no evidence in the documentary record that active treatment was ever given to the Claimant. Finally, the documentary record did show that the Provider should be reimbursed for treatment delivered from July 16, 2002, and August 18, 2002.

III. FINDINGS OF FACT

1. On _____, the Claimant suffered a compensable injury to his lower back.

2. The Claimant's injury is covered by workers' compensation insurance written for the Claimant's employer by Lumberman's Mutual Casualty Company (Carrier).

3. The Claimant was treated with passive chiropractic care beginning March 5, 2002, and continuing to December 2, 2002, by Eric A Vanderwerff, D.C. (Provider) following a diagnosis of lumbar disc disorder without myelopathy, thoracolumbar closed dislocation, muscle spasm, and disturbance of skin sensation.

4. The Provider's treatment of the Claimant's injury was billed under CPT Codes 99213 (office visit), 97250 (myofascial release), 97261 (manipulation of an additional area), 97265 (joint mobilization), and 97014 (electrical stimulation).

5. The medical services in dispute were provided from July 16, 2002, to December 2, 2002.

1. Reimbursement for the services provided from July 16, 2002, to August 18, 2002, was denied on the basis that relevant information was not submitted to support delivery of the services in the amount of $2,355.

2. Reimbursement for the services provided from August 19, 2002, to December 2, 2002, was denied on the basis that the treatment was not medically necessary or reasonably required to treat the compensable injury in the amount of $10,000.

6. Passive treatment of the Claimant's injury was appropriate for four to six weeks.

7. An active treatment program started at the conclusion of the passive treatment program would have been appropriate to treat the Claimant's injury.

8. There was no documentation in the medical records showing that the Claimant was treated with an active treatment program from August 19, 2002, to December 2, 2002.

9. The medical records show that the treatment billed from July 16, 2002, to August 18, 2002, was both delivered to the Claimant and adequately documented.

10. The Provider timely requested dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC).

11. On January 27, 2004, the MRD issued its decision concluding that the disputed expenses should not be paid, and the Provider timely appealed this decision.

12. TWCC sent notice of the hearing to the parties on March 22, 2004. 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.

13. The hearing on the merits convened June 1, 2004, before Michael J. Borkland, Administrative Law Judge. The Provider appeared telephonically and was represented by William Maxwell, attorney. The Carrier appeared through W. Jon Grove, attorney.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (TWCC) has jurisdiction to decide the issues presented pursuant to TEX. LABOR CODE '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. LABOR CODE '413.031 and TEX. GOV'T CODE ch. 2003.

3. Based on Finding of Fact No. 12, the Notice of Hearing issued by TWCC conformed to the requirements of TEX. GOV'T CODE '2001.052.

4. The Provider has the burden of proving by a preponderance of the evidence that he should prevail in this matter. TEX. LABOR CODE '413.031.

5. Based on Findings of Fact Nos. 5b - 8, the Provider failed to prove that reimbursement for treatment provided from August 19, 2002, to December 2, 2002, should be ordered.

6. Based on Findings of Fact Nos. 5a and 9, the Provider proved that reimbursement for treatment provided from July 16, 2002, to August 18, 2002, should be ordered.

ORDER

IT IS, THEREFORE, ORDERED that Lumberman's Mutual Insurance Company shall reimburse Eric A. Vanderwerff, D.C. for fees incurred in treating the Claimant in the amount of $2,355.

SIGNED July 23, 2004.

MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS