SOAH DOCKET NO. 453-04-4457.M5
TWCC NO. M5-04-0341-01

CHARLES A. SCOTT, D.C. **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
SOUTHWESTERN BELL TELEPHONE COMPANY, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

After an Independent Review Organization (IRO) determined that his treatment of Claimant from October 4 through December 12, 2002, was not medically necessary, Charles A. Scott, D.C. (Provider) requested a hearing. This decision finds that Provider did not prove that the disputed services were medically necessary healthcare for Claimant.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice, or venue. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.[1]

The hearing in this matter convened July 28, 2004, at the State Office of Administrative Hearings (SOAH), 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Charles Homer III presiding. The record was closed that same day. Provider appeared for himself, and Carrier Southwestern Bell Telephone Company (Carrier[2]) was represented by counsel, Kevin Franta.

[1] The parties agree that Provider has the burden of proof in this proceeding. 1 TEX. ADMIN. CODE (TAC) ' 155.41.

[2] The workers' compensation carrier for Southwestern Bell Telephone Company in this case is Liberty Mutual Insurance Company. The records before the MRD and the ALJ designate Southwestern Bell as the Carrier. For simplicity, the ALJ refers to Southwestern Bell as Carrier.

II. DISCUSSION

A. Claimant's Treatment History

On ____, Claimant, a customer service representative who used a computer keyboard all day long in her work, sustained a repetitive motion injury compensable under the Texas Workers' Compensation Act. When she began treatment with Provider the next day, Claimant complained of wrist pain and pain in her neck that radiated into her arms and hands. Provider began daily conservative treatment with chiropractic manipulations, traction, ultrasound, electrical stimulation, and massage.[3] A cervical spine MRI in June 2002 showed a central disc herniation at the C5-C6 level, apparently without compression of the spinal cord.[4]

A cervical spine MRI in August 2002 also showed a small central disc herniation at the C5-C6 level, and wrist MRIs that same date were normal. On August 23, 2002, Claimant saw J. Scott Smith, M.D., who recommended approximately one more month of therapy and, after that, consideration of surgery on her cervical spine. Claimant continued therapy with Provider through December 2002, with increased emphasis on active modalities after September 23**.**

2. Provider's Evidence

Provider testified that Carrier authorized a chronic pain management (CPM) program after his treatment was concluded. Provider argues that CPM is tertiary treatment, and may be authorized only after the efficacy of primary and secondary measures has been exhausted. Therefore, he argues, his secondary (post-acute) treatments of Claimant must have been medically necessary.

[3] Res. Exh. 1, 0008.

[4] Pet. Exh. 1, p. 9. The report contains both with . . . compression of the spinal cord and without compression of the spinal cord. *Id.* From the context and because the report also states slight degree of spinal stenosis at C5-C6, the ALJ infers that the first statement is a composition error and that there was no compression of the spinal cord.

Provider discussed an August 23, 2002, evaluation by orthopedist J. Scott Smith, M.D., who recommended that Claimant continue therapy with Provider for a month or so, and then consider a C5-C6 discectomy and fusion.[5] Provider emphasized Dr. Smith's assessment that Claimant had ongoing cervical radiculopathy with cervical pain secondary to C5-C6 disk pathology, and said that Dr. Smith's evaluation agreed with his own determination in that Claimant's injury was not a sprain or strain.

Provider also presented documentary evidence, including his initial evaluation of Claimant, daily reports of treatment, billing and other correspondence.[6]

3. Carrier's Evidence

Nick Tsourmas, M.D., testified that Claimant's injuries are musculo-skeletal and not disc-related. He testified that passive modalities are appropriate in the acute post-injury phase, but have little value five months after an injury. He disagreed with Provider that there was any indication for training in activities of daily living, aquatic therapy, or any form of one-on-one therapeutic exercises/activities, because Claimant had no other deficits that prevented Claimant from exercising at home or that contra-indicated land-based exercise and activity. On cross-examination, Dr. Tsourmas agreed that Provider's records showed an increase in Claimant's strength between September 24 and October 16, 2002, but said that no person who examined Claimant found a strength deficit.

Dr. Tsourmas also agreed that Carrier approved Claimant's tertiary care, but said that such approval is not a finding by medically trained persons, and cannot be considered as evidence of medical necessity in this case. Finally, he testified that each of the treatments and therapies given Claimant by Provider were not medically necessary.

[5] Pet. Exh. 1, p. 8.

[6] Pet. Exh. 1, 2, and 3.

Carrier offered documentary evidence in the form of reports by various reviewers, summarized as follows:

- $ Michael Kapsner, D.C. B Impliedly, there is no medical necessity because Dr. Kapsner believed in May 2002, that twelve weeks of chiropractic care would be appropriate.[7]

- $ Raj K. Reddy, M.D. B Dr. Reddy examined Claimant in January, 2003, and found no evidence of significant injury related to the disc protrusion in her neck. Dr. Reddy stated that there was no reason for surgery.[8]

- $ Dennis Shaughnessy, M.D. B examined Claimant May 28, 2002, and diagnosed possible cervical outlet syndrome and probable myofascial pain disorder.[9]

III. ANALYSIS

The ALJ concludes that Provider did not meet its burden of proving that the services he rendered were medically necessary for Claimant. In this case, the ALJ does not find that later authorization of a CPM program for Claimant implies that Provider's treatment during the disputed dates was medically necessary. From the evidence, Claimant may well have been ready for CPM after four, eight, or twelve weeks of therapy with Provider.

Although Dr. Smith's evaluation shows that Claimant benefitted from Provider's therapy until August 23, 2002, nothing in the record shows that Claimant received benefit from the October - December 2002 therapy, nor that Provider had different treatment goals than previously. Rather, it appears that Claimant had shown no positive response after August 23, 2002.

[7] Res. Exh. 1, p. A 0032.

[8] Res. Exh. 2.

[9] Res. Exh. 1, pp. A 0009-0010.

Dr. Smith's comments are not a sound basis for continuing therapeutic exercises/activities beyond September 27, 2002. Dr. Smith indicated, somewhat contradictorily, that Claimant said she has not made much improvement and that her physical therapy with Provider seems to have

benefited her. Most importantly, Dr. Smith recommended physical therapy for only another month after August 23, 2002, a time period that does not include any of the disputed services.

Throughout the hearing, Provider conveyed a sincere interest in Claimant's well-being that evidently prompted him to extend the disputed services beyond the time Dr. Smith recommended. But the evidence presented does not demonstrate that, at the time Provider rendered the services, those services were reasonably likely to accomplish any of the mandated treatment goals.[10] Therefore, Provider failed to meet his burden of proof, and his appeal should be denied.

IV. FINDINGS OF FACT

1. On ____, Claimant sustained a repetitive motion injury compensable under the Texas Workers' Compensation Act.

2. Liberty Mutual Insurance Company provides workers' compensation insurance covering Claimant's compensable injuries.

3. After Southwestern Bell Telephone Company, Respondent, denied the claims of Charles A. Scott, D.C., Provider, for certain services rendered to Claimant as being medically unnecessary, Provider requested medical dispute resolution through the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD).

4. The MRD issued a decision dated February 23, 2004, which found that no services Provider rendered to Claimant from October 4 through December 12, 2002, were medically necessary.

5. On March 9, 2004, Provider requested a hearing in response to the MRD decision and the case was referred to the State Office of Administrative Hearings (SOAH).

6. The Commission sent notice of hearing to all parties on April 13, 2004.

[10] Medically necessary health care is treatment that (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment. TEX. LABOR CODE ANN. ' 408.021

7. Claimant began a two-week course of daily therapies with Provider on May 14, 2002, and after two weeks was reduced to three visits per week.

8. Claimant continued her therapy with Provider from May 14 through December 12, 2002.

9. Claimant's compensable injuries are musculo-skeletal and not disc-related.

10. On September 23, 2002, Provider evaluated Claimant as unable to operate a keyboard.

11. The disputed services are office visits, kinetic activities, therapeutic procedures, aquatic therapy/exercises, and physical medicine treatments provided from October 4 through December 12, 2002.

12. Provider failed to show that Claimant benefitted from the office visits, treatments, and therapies provided between October 4 and December 12, 2002, or that she was in reasonable probability more likely than not to benefit from them.

V. CONCLUSIONS OF LAW

1. Provider timely appealed the IRO decision.

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 ' 413.031(k) of the Texas Worker's Compensation Act and TEX. GOV'T CODE ANN. ch. 2003.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. '' 2001.051 and 2001.052.

4. Provider Charles A. Scott, D.C. had the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) '' 148.21(h) and 133.308(w); 1 TAC ' 155.41.

5. Provider did not show that the disputed services were medically necessary for Claimant.

6. Based on the foregoing Findings of Fact and Conclusions of Law, Provider is not entitled to reimbursement for services he rendered to Claimant from October 4, 2002, through December 12, 2002.

ORDER

It is **ORDERED** that the request of Charles A. Scott, D.C. for reimbursement for services rendered to Claimant be, and the same is hereby, denied.

SIGNED September 27, 2004.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS