SOAH DOCKET NO. 453-04-5894.M5
TWCC MR NO. M5-04-0757-01

TEXAS MUTUAL INSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ABILENE HEALTHCARE AND	§	
INJURY CLINIC,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) appealed in part the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission) ordering reimbursement to Abilene Healthcare and Injury Clinic (Provider) for manual traction and myofascial release that were provided to Claimant between March 28, 2003, and July 1, 2003. Provider appealed that portion of the MRD decision denying reimbursement for neuromuscular re-education and office visits with manipulation provided on the disputed dates of service. The Administrative Law Judge (ALJ) finds the disputed treatments were not reasonable and medically necessary. Therefore, Provider is not entitled to reimbursement from Carrier.

I. PROCEDURAL HISTORY

ALJ Sharon Cloninger convened the hearing on October 28, 2004, in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Carrier was represented by Ryan T. Willett, attorney. Provider appeared via telephone through G. Hal Lewis, D.C., and Donald MacPhail, attorney. The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law below. After evidence was presented, the hearing concluded and the record closed that same day.

II. BACKGROUND

Claimant suffered a compensable injury to her neck, upper back, and low back on ___, when she slipped and fell at work. She was diagnosed with cervicothoracic sprain,[1] lumbosacral sprain,[2] contusion to the sacral coccygeal area of the spine,[3] bilateral shoulder internal

1 Cervicothoracic sprain is tearing or stretching of a ligament where the neck and upper back come together. TMI Exh. 3, 13.

2 Lumbosacral sprain is tearing or stretching of a ligament where the pelvis and low back come together. *Id.*

3 Contusion to the sacral coccygeal area of the spine is basically a bruise to the tailbone. *Id.*

Derangement,[4] and sciatica.[5] A possible complicating factor for Claimant was that she has multiple sclerosis, which was diagnosed in 1992.[6] The results of a functional capacity evaluation performed on July 11, 1995, indicated Claimant was capable of returning to her sedentary job as a data entry clerk.[7] On August 17, 1996, she was found to be at maximum medical improvement (MMI), with a whole body impairment rating of zero percent.[8]

Claimant became Provider's patient on March 25, 2003-nearly eight years after her compensable injury occurred-at which time she was experiencing muscle spasms and dyskinesia.[9] Provider diagnosed Claimant to have cervical and lumbar strain, carpel tunnel syndrome, and sciatic neuritis.[10] Provider's treatment of Claimant from March 28, 2003, through July 1, 2003, included myofascial release, manual traction, neuromuscular re-education, and office visits with manipulations.

Provider's request for reimbursement for the treatment and services was denied by Carrier. Provider appealed Carrier's denial before the Commission's Medical Review Division (MRD). On April 8, 2004, the MRD denied Provider's appeal in part and granted it in part, following its review of a January 29, 2004 decision issued by an independent review organization (IRO) finding the manual traction and myofascial release to be reasonable and medically necessary, but recommending denial of reimbursement for neuromuscular re-education and office visits with manipulations.

III. APPLICABLE LAW

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. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment. TEX. LAB. CODE '408.021(a).

IV. EVIDENCE AND DISCUSSION

Carrier offered three sets of documents and two depositions, which were admitted. Provider testified on his own behalf, and his proffered exhibit was admitted.

A. Testimony of G. Hal Lewis, D.C.

---

4 Bilateral shoulder internal derangement means that the muscles and tendons are not holding the shoulder in the correct position when moved, or that there is a problem within the joint. TMI Exh. 3, 13-14.

5 Sciatica is a condition of the sciatic nerve that causes pain down the back of the buttock into the back of one or both thighs and legs. TMI Exh. 3, 14.

6 Testimony of Dr. Lewis, and TMI Exh. 3, 14.

7 TMI Exh. 3, 16.

8 TMI Exh. 3, 20.

9 Dyskinesia is impairment of voluntary movements resulting in fragmented or jerky motions (as in Parkinsons disease). *Merriam Webster=s Medical Dictionary* (1995), at 191.

10 TMI Exh. 3, 22.

G. Hal Lewis, D.C., testified on behalf of Provider that, as Claimant's treating doctor, he aggressively addressed her ___ soft tissue injury on the disputed dates of service. He said manual traction, myofascial release, and neuromuscular re-education can be effective in treating an injury eight years later, if there is a misalignment in structure and the patient needs to increase her strength and flexibility. He said that multiple sclerosis is a complicating factor for Claimant, although he did not treat her for that.

Dr. Lewis pointed out that Claimant's condition improved during treatment, with relief to the point she could perform her daily activities of living. When Claimant began treatment, her pain level was 10 in the low back and 4 out of 10 in the thoracic region, and she walked with a cane. By July 2003, Claimant's low back pain was at 5 out of 10, her thoracic pain was at 2 out of 10, and she walked without a cane. He said he only treated her on 24 dates of service, while the Mercy Guidelines recommend 66-132 visits for a chronic patient, even eight years after the injury occurred.

1. Neuromuscular re-education

Dr. Lewis said the neuromuscular re-education, which has been used in the chiropractic community for about 15 years, improved Claimant's physical condition and promoted her recovery.

2. Manual traction

Dr. Lewis said when Claimant began treatment, she limped, had rounded shoulders, and walked with a cane. He said manual traction, which is used to separate the adhesion of scar tissue in muscle, promoted her healing and recovery and improved her physical function.

3. Myofascial release

Dr. Lewis explained that in trauma, a patient often injures the fascia, or the connecting tissue that holds muscle together, as well as the muscle itself. He said fascia scar tissue can be a source of continuing pain. He explained that in myofascial release, the doctor uses stretching and twisting with his hands to separate and eliminate scar tissue in the fascia, which is full of millions of nerve endings. He said the technique gives patients some degree of relief, even if temporary, in every instance. He said myofascial release promotes the healing and recovery of the patient.

4. Office visits with manipulation

Dr. Lewis testified that, although it is possible to provide manual traction, myofascial release, and neuromuscular re-education without an office visit, the office visits were medically necessary because Claimant needed to be monitored to see how her condition had changed with the application of various techniques. Dr. Lewis particularly mentioned that Claimant's vital signs changed, and were monitored by a nurse.

B. Deposition Testimony of R. Scott Herbowy, Licensed Physical Therapist

R. Scott Herbowy, licensed physical therapist, testified that the disputed services were not reasonable or medically necessary to treat lumbar strain, a soft tissue injury, eight years after the

compensable injury occurred.[11]

Mr. Herbowy said it is clear from the objective evaluations conducted by Provider on March 25, April 10, and May 8, 2003, in which there are slight range of motion changes, that Claimant was not making progress, despite her subjective claims of improvement.[12] He said likewise that the statement "Patient's ability to perform activities of daily living is improving," is not substantiated by objective data.[13]

1. Neuromuscular re-education

Mr. Herbowy said neuromuscular re-education is medically indicated when a patient has deficits in balance, coordination, proprioception, kinesthetic awareness and posture. He said he did not see any indication in the medical records that Claimant had any of the aforementioned deficits.[14] He added that there is nothing in Provider's daily notes to explain if the neuromuscular re-education was provided in a one-on-one setting as required, or to explain what exercises were done.[15]

Mr. Herbowy opined that Claimant's gait difficulties epitomized by her use of a cane could be due either to her compensable injury or to her multiple sclerosis, which is a degenerative condition of neurological impairment. He said a lumbar spine problem will rarely result in a gait deviation or abnormality that would require the use of any assistive device. He said it is not clear from the medical records if the neuromuscular re-education was intended to treat Claimant's compensable injury or to treat her multiple sclerosis.[16]

2. Manual traction

Mr. Herbowy described manual traction as unloading of the spine, typically performed by clinician by taking an area of the spine and distracting it longitudinally.[17] He said a passive modality such as manual traction is not indicated eight years post-injury.[18]

3. Myofascial release

11 TMI Exh. 4, 7-8, 11-12, and 37.

12 TMI Exh. 4, 31-32.

13 TMI Exh. 4, 33.

14 TMI Exh. 4, 19-20.

15 TMI Exh. 4, 20.

16 TMI Exh. 4, 35.

17 TMI Exh. 4, 20-21.

18 TMI Exh. 4, 27.

Mr. Herbowy said myofascial release is indicated if a patient has soft tissue restrictions.[19] He said a passive modality such as myofascial release is not indicated eight years post-injury.[20]

4. Office visits with manipulation

Mr. Herbowy did not specifically address office visits with manipulation, but said none of the disputed services were reasonable or medically necessary.

C. Deposition Testimony of William DeFoyd, D.C.

William DeFoyd, D.C., testified on behalf of Carrier that Provider's treatment of Claimant was not reasonable or medically necessary to treat her compensable injury.[21] He said there is no information regarding how the symptoms Provider treated Claimant for in 2003 are a direct result and continuation of her 1995 compensable injury.

Dr. DeFoyd also pointed out that Provider's treatment notes for Claimant did not vary from March 26, 2003, through July 1, 2003. He said if a patient is improving, there should be a progression in treatment, and a decrease in passive care and frequency of treatment; if the patient is not improving, there should be a change in treatment.[22] He said neither of these things happened in Provider's treatment of Claimant.

Dr. DeFoyd described myofascial release and manual traction as passive modalities, which he said are not likely to be of significant lasting benefit eight years after a sprain-strain injury occurs, because the tissues have long since healed.[23] He said passive treatment is indicated in the first few days or weeks after the occurrence of a musculoskeletal injury, or later on if it is being used to reactivate someone in the early stages of an active rehabilitation program.[24] Dr. DeFoyd said that Provider's treatment did not fit into either of these categories, because the injury had occurred some eight years earlier, and Provider was not engaging Claimant in active rehabilitation, except possibly in neuromuscular re-education, but the records are too vague to know.[25]

1. Neuromuscular re-education

Dr. DeFoyd said Provider did not show medical necessity for the neuromuscular re-education services.[26] He said the medical records contain no information as to the purpose for Claimant's

---

19 TMI Exh. 4, 24.

20 TMI Exh. 4, 27.

21 TMI Exh. 3, 43.

22 TMI Exh. 3, 37-38.

23 TMI Exh. 3, 31.

24 TMI Exh. 3, 32.

25 TMI Exh. 3, 33 and 36.

26 *Id.*

neuromuscular re-education, or what was done in the way of exercises, and why. He said Provider's notes do not indicate what specific activities were done, the frequency, duration, and intensity of each activity, or Claimant's response to the re-education.[27]

2. Manual traction

Dr. DeFoyd testified that he does not know why manual traction was performed on Claimant, because the medical records contain no information regarding how or why the manual traction was done, or how Claimant responded to the treatment.[28]

3. Myofascial release

As to myofascial release, Dr. DeFoyd testified that there is insufficient information in the medical records to indicate which muscles were treated, except for the generic notation "lumbar region," and how Claimant responded, except to say she tolerated the treatment well. He said any resulting changes to her range of motion or pain level were not mentioned.[29]

4. Office visits with manipulation

Dr. DeFoyd did not specifically address this treatment.

V. ANALYSIS AND CONCLUSION

A. Analysis

The ALJ is persuaded by the evidence that myofascial release and manual traction were not reasonably required by the nature of Claimant's compensable injury to cure or relieve the effects naturally resulting from her injury, promote recovery, or enhance Claimant's ability to return to or retain employment. According to Dr. DeFoyd and Mr. Herbowy, these passive modalities provided no medical benefit to Claimant eight years post-injury, although they could have if the Claimant had suffered an exacerbation of her compensable injury, or if the treatment was necessary to prepare her for active rehabilitation. There is no evidence that she suffered an exacerbation, or that she was being prepared for active rehabilitation.

The ALJ is also persuaded that Provider should not be reimbursed for office visits with manipulations. Dr. Lewis explained that manipulations can be done without office visits, but that it was necessary in Claimant's case for a nurse to monitor her vital signs during treatment. However, the CPT code used for office visits with manipulation, CPT Code 99213-MP, requires two of three key components to be met: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The ALJ finds that having a nurse monitor a patient's vital signs does not fulfill the CPT code requirement, so reimbursement is not warranted.

---

27 TMI Exh. 3, 25.

28 TMI Exh. 3, 27.

29 TMI Exh. 3, 28-29.

The ALJ finds that Claimant's neuromuscular re-education was not medically necessary. The evidence was insufficient to show that the treatment cured or relieved effects naturally resulting from Claimant's compensable injury, promoted her recovery, or enhanced her ability to return to work or retain employment. Neuromuscular re-education is medically indicated when a patient has deficits in balance, coordination, proprioception, or kinesthetic awareness and posture. The medical records do not show that Claimant had any of the aforementioned deficits. Also, the medical records contain no information as to the purpose for the treatment, what exercises were done, their frequency, duration, and intensity, or Claimant's response to the re-education. In his testimony, Dr. Lewis did not explain how the neuromuscular re-education was medically indicated for Claimant, or describe the exercises and Claimant's response to them. Without that information, the ALJ must conclude that reimbursement for neuromuscular re-education is not warranted.

B. Conclusion

For the aforementioned reasons, the ALJ finds Carrier should not reimburse Provider for manual traction, myofascial release, neuromuscular re-education, and office visits with manipulation provided to Claimant from March 28, 2003, through July 1, 2003.

VI. FINDINGS OF FACT

1. Claimant sustained a compensable work-related injury to her neck, upper back, and low back on ___, when she slipped and fell while working for a company whose workers' compensation insurance carrier at the time was Texas Mutual Insurance Company (Carrier).

2. Claimant was diagnosed to have cervicothoracic sprain, lumbosacral sprain, contusion to the sacral coccygeal area of the spine, bilateral shoulder internal derangement, and sciatica.

3. The results of a functional capacity evaluation performed on July 11, 1995, indicated Claimant was capable of returning to her sedentary job as a data entry clerk.

4. On August 17, 1996, Claimant was found to be at maximum medical improvement (MMI), with a whole body impairment rating of zero percent.

5. Abilene Healthcare and Injury Clinic (Provider) began treating Claimant, who was experiencing muscle spasms and dyskinesia, on March 25, 2003.

6. A possible complicating factor related to Claimant's treatment is that she has multiple sclerosis, which was diagnosed in 1992.

7. Provider's treatment of Claimant from March 28, 2003, through July 1, 2003, included myofascial release, manual traction, neuromuscular re-education, and office visits with manipulation.

8. give modalities such as myofascial release and manual traction are indicated for either acute care or for reactivating a patient who is entering active rehabilitation.

9. Claimant did not suffer an exacerbation of her compensable injury on or near the date Provider began treating her, so did not need acute care on the disputed dates of service.

10. Provider did not treat Claimant with active rehabilitation.

11. Myofascial release and manual traction were neither reasonable nor medically necessary to treat Claimant's compensable injury.

12. Neuromuscular re-education is the re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and standing activities.

13. Claimant did not suffer from balance, proprioceptive, or coordination problems as a result of her compensable injury.

14. Neuromuscular re-education was not reasonable or medically necessary to treat Claimant's compensable injury.

15. Office visits with manipulation were not medically necessary to treat Claimant's compensable injury.

16. Provider sought reimbursement from Carrier for the treatments rendered to Claimant.

17. Carrier denied Provider's claim for the above services.

18. Provider filed a request for medical dispute resolution with the Texas Workers' Compensation Commission's Medical Review Division (MRD).

19. After its review of the January 29, 2004 independent review organization (IRO) decision issued in this dispute, the MRD issued a decision on April 8, 2004, stating that Carrier prevailed on the issue of medical necessity as to the neuromuscular re-education and office visits with manipulations, and Provider prevailed as to the manual traction and myofascial release.

20. On April 30, 2004, Carrier requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MRD decision as to the myofascial release and manual traction, and on May 3, 2004, Provider requested a hearing before SOAH to contest the MRD decision as to the neuromuscular re-education and office visits with manipulation.

21. On June 4, 2004, notice of the hearing in this case was mailed to Provider and Carrier.

22. The notice 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 sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

23. On October 28, 2004, SOAH Administrative Law Judge Sharon Cloninger held a hearing on the Petitioner's appeal in the William P. Clements Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Carrier was represented by Ryan Willett, attorney. Provider appeared via telephone through G. Hal Lewis, D.C., and Donald MacPhail, attorney. The hearing concluded and the record closed that same day.

VII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction to decide the issues presented in this case, pursuant to the Texas Workers' Compensation Act, TEX. LABOR CODE ANN. §413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this case, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. §413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

3. Carrier timely filed notice of appeal of the decision of the Commission's MRD, as specified in 28 TEX. ADMIN. CODE (TAC) § 148.3.

4. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TAC § 148.4(b).

5. As the party contesting the MRD decision, Carrier had the burden of proving by a preponderance of the evidence, pursuant to 28 TAC §148.21(h) and (i), that the myofascial release and manual traction were not reasonable or medically necessary.

6. As the party contesting the MRD decision, Provider had the burden of proving by a preponderance of the evidence, pursuant to 28 TAC §148.21(h) and (i), that the neuromuscular re-education and office visits with manipulation were reasonable and medically necessary.

7. Based on the above Findings of Fact and pursuant to TEX. LABOR CODE § 408.021(a), Provider's treatment of Claimant's compensable injury was not reasonable and medically necessary.

8. Based on the above Findings of Fact and Conclusions of Law, Carrier's appeal should be granted, Provider's appeal should be denied, and Provider should not be reimbursed for the disputed services.

ORDER

Texas Mutual Insurance Company is not to reimburse Abilene Healthcare and Injury Clinic for treatment and services rendered to Claimant from March 28, 2003, through July 1, 2003.

SIGNED December 22, 2004.

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS