SOAH DOCKET NO. 453-05-3201.M5
MDR NO. M5-04-1958-01

TEXAS MUTUAL INSURANCE COMPANY	§	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	§	**OF**
	§	
DANIEL BUENTELLO, D.C., AND NEUROMUSCULAR INST. OF TEXAS	§	
	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) has challenged a decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) in a dispute regarding the medical necessity of chiropractic services provided by Daniel Buentello, D.C., and Neuromuscular Institute of Texas (collectively, Provider) to an injured claimant between May 29 and October 6, 2003. The MRD's decision was based on the findings of an independent review organization (IRO), which concluded that Carrier improperly denied reimbursement for all of the services in dispute.[1] Carrier challenged the decision on the basis that the treatment at issue was, in fact, not medically necessary within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act, TEX. LABOR CODE ANN. ch. 401 *et seq.* The amount in controversy is $3,598.26.[2]

The Administrative Law Judge (ALJ) concludes that the services in dispute should be reimbursed.

[1] The MRD also found some services not reimbursable based on other grounds, but those findings were not appealed by Provider and are not at issue here.

[2] Post-hearing, Carrier agreed to pay for all of the disputed services provided from May 1 to May 23, 2003, with the exception of one unit of ultrasound therapy on May 5 and 8, and Provider agreed to withdraw those two items. Carrier also agreed to pay for two services provided on September 30 and October 6, 2003. Because the parties are in agreement, the Administrative Law Judge has not included those amounts in this figure.

I. JURISDICTION, NOTICE AND PROCEDURAL HISTORY

The hearing in this matter was convened June 16, 2005, at the State Office of Administrative Hearings with ALJ Carol S. Birch presiding. Carrier was represented by its attorney, Timothy Riley. Provider was represented by Allen T. Craddock, attorney. After presentation of evidence and argument by the parties, the hearing was adjourned the same day. The record closed on July 20, 2005, after the filing of the final written closing argument. The evidence on the issue of medical necessity consisted of medical records submitted by both parties, and the testimony of Dr. Buentello and Timothy Fahey, D.C.

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

II. DISCUSSION

1. Background Facts

The record revealed the claimant suffered a compensable injury to his lower back on ___, while lifting and twisting from a bent position. It appears from the record that claimant initially sought treatment in Mexico because he was told that his employer did not carry workers' compensation insurance. He began chiropractic care with Provider in April 2003, and was ultimately diagnosed by a neurologist as having two herniated discs.

Over a ten-week period from May to mid-July, Provider provided 24 sessions of chiropractic treatment to the claimant, only 11 of which remain in dispute. The treatments appear to have been a combination of passive and active modalities, depending, at least in part, on the claimant's tolerance to such activities. The services included, generally, hot/cold packs, ultrasound, myofascial release, therapeutic exercises and activities, aquatic therapy, neuromuscular re-education, joint mobilization, manual therapy, and electrical stimulation. It also appears that the claimant was doing some exercises at home.

The claimant had surgery on July 17, 2003, to address one of the herniated discs; the surgery consisted of a right L5-S1 laminectomy, diskectomy, and forminotomy with graft. After the surgery, 22 additional office visits and therapy sessions were administered by Provider, of which only eight of those immediately following the surgery are in dispute.

When Provider billed Carrier for the dates of service disputed in this proceeding, Carrier denied payment for all treatments and office visits during that period of time on the basis that they were not medically necessary.

B. IRO Decision

Based on a review of the medical records, the IRO physician, an orthopedic surgeon, found that: [t]he disputed services were performed in the pre and post-surgical period to deal with the patient's difficulty. The treatments were appropriate, reasonable and necessary and were not excessive. The notes adequately document and justify the ongoing treatment during this time. The reviewer concluded that all of the services provided on the disputed dates of service were medically necessary.

C. Applicable Law

Under Texas 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. TEX. LABOR CODE § 408.021. The statute provides that the purposes for which health care is to be rendered to a claimant include any 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.

The types of health care to which an employee is entitled are similarly broad, including "all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services." TEX. LABOR CODE § 401.11(19).

Although the law describes few limitations on a claimant's entitlement to care, the law places

upon the treating physician an obligation to maintain efficient utilization of health care. TEX. LABOR CODE § 408.025(c).

D. Burden of Proof

Under the Commission's rules, an IRO decision is deemed a Commission decision and order.[3] The burden of proof in this case is on Carrier to prove by a preponderance of the evidence that the disputed services were reasonable and necessary medical treatments.[4]

E. Argument and Analysis

The basic facts are not in dispute in this case, although the parties' interpretations of the medical evidence differ significantly. Carrier argued that the treatment at issue was not medically necessary as follows:

- One-to-one therapy was not reasonable or necessary.
- Passive care after May 23, 2003, was not medically reasonable or necessary because the claimant's condition did not improve under this care.

Provider responded by pointing out the following:

- The pre-surgery care provided was intended to, and did, decrease the claimant's pain and spasm while waiting for surgery to be performed.
- The post-operative care was reasonable and necessary to decrease pain and spasm, and increase range of motion.
- The care provided was done on the advice of one or more physicians.
- One-to one therapy was necessary for this patient because his pain levels and his tolerance for the exercises had to be closely monitored.

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[3] 28 TEX. ADMIN. CODE § 133.308(p)(5).

[4] 28 TEX. ADMIN. CODE §§ 133.308(p)(5), 148.14(a).

- The care provided was not excessive.

Carrier bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. In the ALJ's view, it has not met that burden. Because Dr. Buentello's testimony, which was supported by the record, was at least as persuasive as that of Dr. Fahey, Carrier clearly has not demonstrated by a preponderance of the evidence that the prior decisions of the IRO and MRD in this case should be overturned.

Based on the evidence in this case as discussed above, and as set forth in the findings of fact, the ALJ concludes Carrier failed to meet its burden of proof to show that chiropractic care was not reasonable and necessary for the disputed dates of service to treat the claimant's injuries. Although all of the evidence presented was not discussed in this decision, it was considered. The findings of fact and conclusions of law are based on all of the evidence in the record.

III. FINDINGS OF FACT

1. An injured worker, the claimant, suffered compensable injuries to his lower back on ___, while lifting and twisting from a bent position.

2. At the time of the claimant's injury, his employer had workers' compensation insurance with Texas Mutual Insurance Company (Carrier).

3. The claimant began treatment with Daniel Buentello, D.C., and Neuromuscular Institute of Texas (Provider) in April 2003.

4. The claimant was diagnosed with two herniated discs.

5. Over a ten-week period beginning in May 2003, Provider provided 24 sessions of chiropractic treatment to the claimant, 11 of which are in dispute in this proceeding, which generally consisted of some combination of active and passive modalities including hot/cold packs, ultrasound, myofascial release, therapeutic exercises and activities, aquatic therapy, neuromuscular re-education, joint mobilization, manual therapy, and electrical stimulation.

6. Following the claimant's surgery on July 17, 2003, Provider provided an additional 22 office visits and therapy sessions, of which eight are in dispute.

7. Carrier denied the requested reimbursement for those 19 dates of service.

8. Provider made a timely request to the Texas Workers' Compensation Commission (the Commission) for medical dispute resolution with respect to the services in dispute.

9. The Commission referred the dispute to an independent review organization (IRO), which concluded that the services in dispute were medically necessary.

10. The Commission's Medical Review Division (MRD) reviewed and concurred, in relevant part, with the IRO's decision.

11. Carrier timely requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.

12. The Commission mailed notice of the hearing setting to the parties on February 3, 2005.

13. A hearing in this matter was convened on June 16, 2005, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Carol S. Birch, an Administrative Law Judge with SOAH. Provider and Carrier were represented and participated in the hearing.

14. The amount in dispute is $3,598.26.

15. The services at issue were not excessive.

16. The services at issue were medically necessary.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. § 413.031.

2. SOAH 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 Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN ch. 2001 and the Commission's rules, 28 TEX. ADMINISTRATIVE CODE (TAC) § 133.305(g) and §§ 148.001-148.028.

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

5. Carrier, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.14(a).

6. Carrier did not meet its burden of proving that Provider should not be reimbursed for the services in dispute.

7. Pursuant to TEX. LABOR CODE ANN. § 413.031, Carrier should reimburse Provider $3,598.26.

ORDER

IT IS THEREFORE, ORDERED that Texas Mutual Insurance Company shall reimburse Daniel Buentello, D.C., and Neuromuscular Institute of Texas $3,598.26, plus interest, for the services in dispute in this proceeding.

SIGNED on September 19, 2005.

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CAROL S. BIRCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS