SOAH DOCKET NO. 453-05-4266.M5
MDR NO. M5-05-0617-01

LAWRENCE N. SMITH, D.C.	**§**	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	**§**	
	§	**OF**
	§	
AMERICAN HOME	**§**	
ASSURANCE COMPANY, Respondent	**§**	
		ADMINISTRATIVE HEARINGS

DECISION AND ORDER

Lawrence N. Smith, D.C. (Petitioner) requested a hearing to contest independent review organization (IRO) and Texas Workers' Compensation Commission (Commission)[1] Medical Review Division (MRD) determinations that certain services he provided to an injured worker (Claimant) from March 15, 2004, through August 20, 2004, were medically unnecessary. This decision concludes the Petitioner proved that some, but not all, services were necessary. American Home Assurance Company (Carrier) will be ordered to pay for the services found to be medically necessary, except for services related to the cervical spine, which Carrier contends is a non-compensable injury.[2] The State Office of Administrative Hearings (SOAH) does not have authority to determine whether an injury is compensable. If it is determined that the cervical spine injury is compensable, the Petitioner may request the hearing record to be reopened and the Carrier to be ordered to pay for medically necessary services to the cervical spine.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

[1] Effective September 1, 2005, the functions of the Commission were transferred to the newly-created Division of Workers' Compensation of the Texas Department of Insurance.

[2] Petitioner said he provided the disputed services primarily for a left-shoulder sprain/strain. He acknowledged, however, in closing argument, that some of the disputed services were for a cervical spine injury. This is confirmed by several records that are cited below.

The hearing convened on August 8, 2006, at the SOAH offices in the William P. Clements Building, 300 West 15th Street, Austin, Texas, before the undersigned Administrative Law Judge (ALJ). Petitioner appeared *pro se*. The Carrier appeared through its counsel Peter L. Macaulay. The hearing did not finish on August 8, 2006, and eventually was resumed and completed on October 2, 2006, at which time the record closed.

Because there was no notice or other jurisdictional issues, those matters are stated in the findings of fact and conclusions of law without further discussion here.

II. DISCUSSION

A. Background

The Claimant suffered an at-work injury on___, from lifting a case of water. She presented to the Medical Center of Mesquite (Mesquite Center) on February 16, 2004, where she rated her pain an 8 on a 1 to 10 scale, with 10 the most painful. The Mesquite Center diagnosed her as having a possible shoulder separation or dislocated shoulder and possible rotator cuff injury. Her range of motion was found to be intact. She received a sling for her left arm.

The Claimant presented to Petitioner on February 12, 2004, at which time he took her off work. She underwent eighteen days of treatments through March 11, 2004, that were paid for by the Carrier. The Carrier refused payment for services provided on and after March 15, 2006, through August 20, 2006. These services included treatments on about forty-nine separate days of treatment.

The Petitioner requested medical dispute resolution. An IRO issued a decision on December 10, 2004, concluding, among other matters, that (1) there was no documentation of objective or functional improvement in the condition and no evidence of a change of treatment plan to justify additional treatment in the absence of a positive response to prior treatment; (2) applicable treatment guidelines do not support continued treatment after a four-week time period without improvement; (3) there was insufficient documentation to support the medical necessity of the treatments; (4) an August 25, 2004 examination showed the Claimant' cervical range of motion had not materially improved; (5) there was nothing in the diagnosis or physical examination findings to support

neuromuscular reeducation services (CPT code 97112); and (6) the Petitioner failed to justify continued one-on-one treatment (CPT code 97110).[3]

The statutory standards applicable to the 2004 injury and treatments are contained in TEX. LABOR CODE ANN. §§8.021 and 401.011(19), under which employees are entitled to necessary health care. Section 408.021(a) provides, "n 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 compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment." Section 401.011(19) of the Labor Code provides that health care includes "all reasonable and necessary medical . . . services."

As the party requesting the hearing, Petitioner has the burden of proof.[4]

B. Analysis

A decision either for or against a finding of medical necessity is very difficult because there is strong evidence on both sides of the issue. Ultimately, however, the ALJ was convinced that continuing treatment was appropriate by the simple facts that the pain levels greatly improved during treatment and she was returned to work less than two months after her injury. These results go to the heart of the statute governing an injured worker' right to health care curing or relieving the effects of the injury and enhancing the worker' ability to return to work.

Moreover, the Claimant was returned to work without undergoing more invasive treatments such as epidural steroid injections. These results are good reasons to conclude that the services were medically necessary.

The ALJ' conclusion is supported by an April 1, 2004 report from James W. Galbraith, M.D., with whom the Petitioner consulted on the condition, stating that the Claimant should "[C] ontinue

[3] Ex. 4.

[4] 1 TEX. ADMIN. CODE (TAC) § 155.41(b); 28 TAC§148.14(a).

conservative treatment with Dr. Smith."[5] The ALJ' conclusion is also supported by the Petitioner' expert witness, Jeff Cunningham, D.C.,[6] who testified that the Claimant experienced good results over time and was returned to work fairly early in her treatment and by testimony from the Carrier' expert, Robert Michael Hamby, D.C.,[7] who said a gradual improvement over time is indicative of the medical necessity of treatment.

Dr. Hamby and several reviewing physicians working for an entity called "Consiliummd" found the Claimant failed to make progress under the Petitioner' care. The IRO reviewer said there was no documentation of objective or functional improvement in the condition. This finding was erroneous, however, with regard to the pain levels, as shown by visual analog scales (VAS)[8] and the Mesquite Center' records.[9] These records show the rated her pain as an 8 on February 11, 2004, and 0, 1, or 2 on August 12, 2004.[10] Her pain levels had some fluctuations, but generally improved greatly over time. Her pain was 6-7 on March 11, 2004; 6 or 6-7 on April 12, 2004; 4-5 on May 10, 2004; 5-6 on June 11, 2004; 3 on July 12, 2004; and 0-1-2 on August 12, 2004.[11] Dr. Cunningham explained it is normal for injured patients to experience exacerbations of their injuries, where they regress for a time before resuming a positive trend.

Dr. Hamby testified that the Claimant failed to make progress because her average pain level, from March until treatment ended in August, was between four and five. This testimony was unpersuasive since the Claimant' pain started at a high level and ended at a low level. Dr. Hamby'

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[5] Ex. 2 at 52.

[6] Dr. Cunningham has been performing peer reviews since 1997. He is a former member of the Texas Workers' Compensation Commission Quality Review Panel.

[7] Dr. Hamby is a licensed chiropractor in California and Texas. He has been appointed by two California governors to the California Board of Chiropractic Examiners. Dr. Smith question Mr. Hamby's possible role regarding an investigation into the practices of a California chiropractor. Dr. Hamby testified he was not involved in any improprieties, there are no complaints against him, and no action has been taken against him. The ALJ concludes there is no probative evidence of this nature that would impeach Dr. Hamby's testimony.

[8] Ex. 1 at 73-125.

[9] Ex. 2 at 41.

[10] All three numbers were circled. The Claimant did not record her pain levels on August 16, 18, and 20, 2004, the last three days of her treatment. Ex. 1 at 124-125.

[11] Ex. 1 at 74, 87, 98, 109, 114, and 123.

argument was so unconvincing that it detracted from his credibility in terms of an unbiased opinion.

The IRO reviewer, Dr. Hamby, and other Consiliummd reviewers concluded that the Petitioner' treatment of the Claimant was outside applicable guidelines that say, if improvement is not evident in the first weeks, treatment should be changed. According to Dr. Hamby, the Official Disability Guideline indicates a maximum of nine visits over eight weeks to determine whether treatment is working; the Expert Clinical Benchmark guideline for non-surgical upper extremity injuries indicates ten to twenty visits over a six to twelve week period, depending on the severity of the injury; and the New Zealand guidelines indicate six to eight visits over a four to six week period.

Dr. Hamby cited the American College of Occupational and Environmental Medicine Guidelines, second edition, as requiring a demonstration of extenuating circumstances to support prolonged treatment. He said no such justification was provided in this case and cited negative x-ray and MRI results. Dr. Cunningham acknowledged that if the treatment he was trying did not work after two weeks, he would take a different approach or refer his patient out.

Dr. Smith saw the on eighteen different occasions in the four-to-five week period preceding the disputed services. The pain levels did not appear to decrease dramatically during the first few weeks of treatment. Her pain level at the Mesquite Center on February 16, 2004, was 8, and was 6-7 on March 10, 2004; 7-8 on March 17, 2004; 5-6 on March 24, 2004; and 8-9 on April 1 and 2, 2004. Her pain then receded to 7-8 on April 5, 2004, and was down to 6-7 on April 12, 2004, approximately two months after her accident. However, she was returned to work by April and eventually her pain levels did improve. Dr. Hamby acknowledged that the guidelines are guidelines only and that some patients respond to treatment more slowly than others. Dr. Cunningham described the Claimant' injury as fairly severe. Again, in the ALJ' opinion, the overriding facts are that the improved significantly under the Petitioner' care without the necessity of invasive procedures and returned to work relatively early.

As argued by the Petitioner, Texas courts have confirmed that injured workers are entitled to health care that simply relieves pain as well as cures it. In *Travelers Insurance Company v. Wilson*, 28 S.W. 3d 42, 45-46 (Tex. App.-Texarkana 2000, no writ), the court construed the old workers' compensation law, which said injured workers are entitled to health care that cures and relieves an

injury to include care that provides pain relief only. As indicated above, the present statute says workers are entitled to health care that cures or relieves the effects of a compensable injury.

Dr. Hamby questioned certain records. He cited the Petitioner' records showing the Claimant doing a variety of hard physical exercises, including pushups with her toes or legs on a ball and hands on the floor. As an example, on March 10, 2004, she did 60 pushups, including 20 pushups that put a lot of stress on her shoulders. He noted that the Claimant weighed 280 pounds and estimated that, for the more difficult pushups, she would be pushing about 70 percent of her body weight, or about 196 pounds. He noted that she was returned to work later that month with a no-lifting and no-carrying restriction. At the end of April, she was restricted to 10 pounds lifting, although she was doing 90 pushups at the time. Dr. Smith did not present rebuttal testimony to explain the discrepancy between the pushups and her lifting restrictions. Dr. Hamby did acknowledge, however, that he is familiar with the possibility, during one-on-one exercises, of a chiropractor providing supervision and assistance to a patient or of modifying the exercises.

On its face, it is not possible to reconcile the discrepancy in the evidence between the exercises and her work restrictions. As acknowledged in Dr. Hamby' testimony, however, the could have been receiving assistance. It appears most likely that the was receiving substantial assistance or that the illustrations of the activities that the was performing[12] did not accurately reflect what she was doing. The ALJ is not convinced that Petitioner falsely stated the Claimant's work ability.

The IRO reviewer, Dr. Hamby, and some of the Consiliummd reviewers criticized the Petitioner' continued use of one-on-one therapy. The Petitioner provided one-on-one therapy at each of the visits.[13] The IRO reviewer said a home exercise program is preferable because a patient can perform the exercises on a daily basis. He[14] said the exercises contained in the medical record are the same exercises the Petitioner recommends for home exercise. He cited a study that concluded there is no strong evidence for the effectiveness of supervised training as compared to

[12] Ex. 1 at 56-57.

[13] Ex. 3.

[14] For convenience, the IRO reviewer is referred to in a particular gender, in this case the masculine gender.

home exercises. Dr. Smith did not testify, on the basis of his observations of the condition, that prolonged one-on-one therapy was necessary. Dr. Cunningham testified generally that the ability of patients to perform home exercises is very poor. He maintained that when injuries are in the acute or subacute stage, it can be dangerous to send a patient home with exercise instructions. He argued that anyone who exercises knows the value of a personal trainer. He asserted that the Claimant, at five feet six inches tall and 280 pounds, could have easily hurt herself at home. He testified that different patients have different needs and that the Claimant was handled appropriately.

The ALJ was not convinced of the need for one-on-one therapy for more than six months after the Claimant's injury. Dr. Cunningham's testimony showed that more-than-usual on-on-one therapy may have been appropriate in this case, but how much more in addition to the eighteen sessions the Carrier paid for was not proved. The Petitioner had the burden of proof. Because the ALJ was not convinced of the need for several additional months of one-on-one therapy performed on every visit and there was no evidence justifying payment for some lesser amount, he will not order the Carrier to pay for additional one-on-one therapy.

The IRO reviewer went to some length to question the need for neuromuscular reeducation services (CPT code 97112). He said there was nothing in the Claimant's diagnosis or physical examination findings to demonstrate the type of neuropathy that would necessitate this service. He cited a Medicare policy bulletin that said the service is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception, and that it can also be used for impairments that affect the body's neuromuscular system, but the documentation must clearly show the need for the treatment. He said there was no documented need for the treatment. Dr. Hamby agreed with the IRO reviewer. He testified that this service is for someone who has neurological imbalance, not for someone with a shoulder injury. He cited the Claimant's use of a wobble board on almost every visit. He said the wobble board is a device to help improve balance. He testified persuasively that wobble boards are unhelpful for shoulder injuries. The ALJ agrees that the provision of this service was not shown to be medically necessary.

The MRD order addressed certain CPT code 97112 services on February 20, 2004; March 10, 2004; and March 11, 2004, as encompassed within the dispute. MRD ordered the Carrier to pay

for those services. It is undisputed that the Carrier did not appeal that decision. As a result, the MRD decision ordering the Carrier to pay a total of $333.45 will stand.

MRD determined that the Petitioner should not receive reimbursement for services under CPT codes 98941, 97140-59, 97110, 97112 and 97530 performed on May 7, 2004, and services under CPT code 97140-59 on June 11, 2004, because neither party presented EOBs for those services. The Petitioner said in his opening statement that he did not submit the EOBs because the Carrier did not give them to him. He did not present any evidence to support that assertion, however. As a result, this order will conclude that there is no evidence to overturn the MRD decision, and the decision will stand.

MRD found that a March 26, 2004, CPT code 99080-73 work status report was paid in full. This finding does not appear to be disputed, and there was no contrary evidence. As a result, this finding will stand.

MRD found that CPT code 98941 services that are listed on the table of disputed services for the following dates were not billed and are, therefore, not in dispute: March 17, 2004; April 2, 5, 7, 9, 16, 28, and 30, 2004; May 3, 5, 10, 14, 19, and 28, 2004; June 7, 9, and 24, 2004; and July 12, 2004. MRD found that a CPT code 97530 service that was listed on the table of disputed services for April 9, 2004, was not billed and, therefore, is not in dispute. MRD did not recommend reimbursement for the following services on the table of disputed services because no HFCA was submitted: a CPT code 97530 service on April 12, 2004, and CPT codes 98941 and 97140-59 on April 14, 2004. The Petitioner agreed that these services are not part of the appeal and should not be reimbursed.

The Carrier disputed the compensability of the cervical spine injury in a TWCC-21 that was received by the Texas Workers' Compensation Commission on May 24, 2004.[15] The Petitioner's TWCC 73 work-status reports on March 21 and 24, 2004, and April 30, 2004, included diagnosis code 723-4, indicating cervical radiculopathy.[16] The Petitioner's notes[17] show the Claimant

[15] Ex. 2 at 34.

[16] Ex. 2 at 35-37.

complained of cervical spine pain through May 4, 2004, and underwent "cervical stabilization exercises" through August 16, 2004.[18] On that basis, the ALJ concludes that Petitioner's treatments for the included cervical-spine treatments.

SOAH is not authorized to decide whether an injury is compensable[19] and the evidence does not explicitly show which services were for the cervical spine. The ALJ will order the Carrier to pay for medically necessary services to the shoulder. He cannot order payment for services to the cervical spine, however, because of the compensability issue. The Petitioner may ask for the record to be reopened and the Carrier to be ordered to pay for all medically necessary services, if it is determined that services to the cervical spine were compensable.

In summation and on an overall basis, the ALJ is convinced that the services were generally medically necessary because the improved under the Petitioner's care, was returned to work at an early stage of her treatment, and did not undergo invasive treatments. However, the ALJ was not convinced of the medical necessity of all of the one-on-one physical therapy charged and of the neuromuscular reeducation.

IV. FINDINGS OF FACT

1. The injured worker (Claimant) suffered an at-work injury on___, after lifting a case of water.

2. The Claimant presented to Lawrence N. Smith (Petitioner) on February 12, 2004, at which time he took her off work.

3. The Claimant presented to the Medical Center of Mesquite (Mesquite Center) on February 16, 2004, where she rated her pain an 8 on a 1 to 10 scale, with 10 the most painful.

4. The Mesquite Center diagnosed the as having a possible shoulder separation or dislocated shoulder and possible rotator cuff injury.

5. The Mesquite Center placed a sling on the Claimant's left arm.

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[17] Ex. 2 at 64-85.

[18] Ex. 2 at 107.

[19] TEX. LAB. CODE ANN. Ch. 410.

6. The Claimant underwent eighteen days of treatments with Petitioner through March 11, 2004, that the employer's workers' compensation insurance carrier, American Home Assurance Company (Carrier), paid for.

7. The Carrier refused payment for services provided by the Petitioner on and after March 15, 2004, through August 20, 2004.

8. The Petitioner requested medical dispute resolution.

9. An independent review organization issued a decision on December 10, 2004, concluding that (i) there was no documentation of objective or functional improvement in the Claimant's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of a positive response to prior treatment; (ii) applicable treatment guidelines do not support continued treatment after a four-week time period without improvement; (iii) there was insufficient documentation to support the medical necessity of the treatments; (iv) an August 25, 2004, examination showed the Claimant's cervical range of motion had not materially improved; (v) there was nothing in the diagnosis or physical examination findings to support neuromuscular reeducation services (CPT code 97112); and (vi) the Petitioner failed to justify continued one-on-one treatment (CPT code 97110).

10. The disputed services, from March 15, 2004, through August 20, 2004, are shown generally in the table of disputed services entered into evidence at the hearing as part of Exhibit 3, the Petitioner's Request for Medical Dispute Resolution.

11. The Carrier disputed the compensability of the cervical spine injury in a TWCC-21 submitted to the Texas Workers' Compensation Commission.

12. The Carrier did not dispute the compensability of the left-shoulder sprain/strain.

13. A part of the services the Petitioner provided to theC were for her cervical spine, although the majority of the services were for her shoulder.

14. It is not clear from the evidence which portions of the services were for the cervical spine and which were for her left-shoulder injury.

15. With certain exceptions, the disputed services on and after March 15, 2004, were reasonably required by the nature of the Claimant's injury.

    a. The Claimant suffered a relatively severe left-shoulder sprain/strain and a milder cervical spine injury.

    b. The pain levels greatly improved during treatment.

    c. The Claimant was returned to work less than two months after her injury.

    d. The Claimant was returned to work without undergoing more invasive treatments such as epidural steroid injections.

e. Gradual improvement over time indicates that treatment is reasonably required by the nature of a compensable injury.

16. Approximately forty-nine treatments of one-on-one physical therapy provided to the on each visit over a five-month period were not shown to be reasonably required by the nature of the Claimant's injury.

a. Many of the exercises were the same stretching exercises the Petitioner prescribes for home-exercise.

b. The Petitioner did not provide evidence, expressly based on his observations of the condition, to justify prolonged one-on-one therapeutic exercise.

17. The neuromuscular reeducation services (CPT code 97112) the Petitioner provided were not shown to be reasonably required by the nature of the injury.

a. This service is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception, and can be used for impairments that affect the body's neuromuscular system, if the documentation clearly shows the need for the treatment.

b. Nothing in the Claimant's diagnosis or physical examination findings to demonstrated the type of neuropathy that would support the provision of this service.

c. This service is generally not provided for a shoulder injury.

d. The also used a wobble board under Petitioner's care.

e. A wobble board is a device to help improve balance and is not generally useful for shoulder injuries.

18. MRD ordered the Carrier to pay $333.45 for certain CPT code 97112 services on February 20, 2004; March 10, 2004; and March 11, 2004, as encompassed within the dispute.

19. The Carrier did not appeal the MRD decision described in Finding of Fact No. 18.

20. MRD determined that the Petitioner should not receive reimbursement for services under CPT codes 98941, 97140-59, 97110, 97112 and 97530 performed on May 7, 2004, and services under CPT code 97140-59 on June 11, 2004, because neither party presented EOBs for those services.

21. There was no evidence to prove that the MRD decision described in Finding of Fact No. 20 was erroneous.

22. MRD found that a March 26, 2004, CPT code 99080-73 work status report was paid in full.

23. There was no evidence to disprove the MRD finding described in Finding of Fact No. 22.

24. The Petitioner agreed with an MRD finding that the following services were not in dispute and should not be paid: CPT code 98941 services that are listed on the table of disputed services for March 17, 2004; April 2, 5, 7, 9, 16, 28, and 30, 2004; May 3, 5, 10, 14, 19, and 28, 2004; June 7, 9, and 24, 2004; and July 12, 2004; a CPT code 97530 service that was listed on the table of disputed services for April 9, 2004; a CPT code 97530 service on April 12, 2004, that was listed on the table of disputed services; and CPT codes 98941 and 97140-59 on April 14, 2004, that are included on the table of disputed services.

25. ceived not less than 10 days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

26. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

V. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings (SOAH) has jurisdiction over 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.

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

3. The Petitioner has the burden of proof in this proceeding. 1 TEX. ADMIN. CODE (TAC) 155.41(b); 28 TAC§148.14(a).

4. 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, including health care that cures or relieves the effects naturally resulting from the compensable injury; promotes recovery; or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. §408.021.

5. The MRD decision stands for the services described in Finding of Fact No. 18.

6. The Carrier is not liable for the services described in Findings of Fact Nos. 20, 22, and 24.

7. Except as stated in Conclusion of Law No. 6 and except for one-on-one physical therapy (CPT code 97110) and neuromuscular reeducation (CPT code 97112), the treatments provided on and after March 15, 2004, were medically necessary.

8. SOAH is not authorized to determine whether an injury is compensable. TEX. LAB. CODE ANN. chs. 410 and 413.

9. The Carrier should pay for the services stated to be medically necessary in Conclusion of Law No. 7 that were provided only for the shoulder.

10. The Carrier should pay for services for the Claimant's cervical spine that were stated to be medically necessary in Conclusion of Law No. 7, if the injury to the Claimant's cervical spine is found to be a compensable injury.

ORDER

IT IS THEREFORE, ORDERED that American Home Assurance Company pay Lawrence N. Smith, D.C., for the services found to be medically necessary in Conclusion of Law No. 7 that were to treat the Claimant's left shoulder.

IT IS ORDERED FURTHER that Lawrence N. Smith may request that the record be reopened for the purpose of receiving evidence on whether the injury to the Claimant's cervical spine is found to be a compensable injury and to order the Carrier to pay for medically necessary services provided to treat the Claimant's cervical spine.

IT IS ORDERED FURTHER that the parties attempt in good faith to determine which services were for the shoulder and which for the cervical spine.

IT IS ORDERED FURTHER that this order will remain open for two weeks from the date of its issuance for the parties to request any necessary clarification.

IT IS ORDERED FURTHER that the MRD decision stands with regard to the services referred to in Conclusions of Law Nos. 5 and 6.

SIGNED November 28, 2006.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS