SOAH DOCKET NO. 453-04-1809.M5
TWCC CASE NO. 03-1342

WACO ORTHO REHAB,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
AMERICAN HOME	§	
ASSURANCE COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

I. INTRODUCTION

This case presents a challenge by Waco Ortho Rehab (Petitioner) to a decision of an independent review organization (IRO) on behalf of the Texas Workers' Compensation Commission (Commission or TWCC) in a dispute regarding medical necessity for chiropractic treatment. The IRO found that the insurer, American Home Assurance Co. (Respondent), properly denied reimbursement for physical therapy that Petitioner administered to a claimant suffering from back and shoulder injuries.

Petitioner challenged the decision on the basis that the treatment at issue was, in fact, medically necessary, within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision disagrees with that of the IRO, finding that reimbursement of Petitioner for the disputed services is appropriate.

II. JURISDICTION AND VENUE

The Commission has jurisdiction over this matter pursuant to § 413.031 of the Act. The State Office of Administrative Hearings (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. No party challenged jurisdiction or venue.

III. STATEMENT OF THE CASE

The hearing in this docket was convened on August 16, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (AALJ) Mike Rogan presided. Petitioner was represented by William Maxwell, attorney. Respondent was represented by John Fundis, attorney, who appeared by telephone. Both parties presented evidence and argument. The record was left open to allow submission of additional briefing and closed on September 23, 2004.[1]

The record revealed that on ____, the claimant suffered a compensable injury to his neck, back, and right shoulder, resulting from an attempt to push a heavy cart. His condition subsequently necessitated cervical spine-fusion surgery on July 12, 2001. The claimant then received post-surgical therapy for only a handful of days during the rest of 2001. On January 31, 2002, Dennis Bullock, D.C., examined the claimant, determined him to be at maximum medical improvement (AMMI), and assigned him a permanent whole-body impairment rating of 15 percent.

On March 5, 2002, the claimant initially presented to Petitioner's clinic, complaining of severe pain in the parts of his body that had been injured the previous year. Under the treatment of Craig Cernosek, D.C., the claimant began a therapeutic regimen of supervised exercise and chiropractic modalities. Dr. Cernosek's supervising doctor during the treatment was David Bailey, D.C., a board-certified chiropractic orthopedist who practices with Petitioner.[2]

When Petitioner subsequently billed Respondent (the insurer for the claimant's employer) for

[1]The staff of the Commission formally elected not to participate in this proceeding, although it filed a general AStatement of Matters Asserted@ with the notice of the hearing.

[2] Dr. Bailey is presently the sole owner of Waco Ortho Rehab.

chiropractic services in the case from March 5 through May 9, 2002, Respondent denied reimbursement on the grounds that the treatment had been medically unnecessary. Petitioner sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on April 20, 2003, concluding that Petitioner should not receive reimbursement for the disputed services. The IRO presented the following rationale for its decision:

> The patient received extensive post surgical chiropractic treatment that resulted in little, if any, documented relief of his post surgical symptoms. He was evaluated at MMI 1/31/02, indicating that no additional treatment would result in furthering therapeutic benefit. . . . A continued actively supervised rehabilitation program past MMI is not reasonable or necessary, as the patient had reached a point where improvement is not considered likely. After MMI has been reached, all further treatment must be reasonable and necessary in relieving symptoms or improving function.

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and, on November 3, 2003, issued its own decision confirming that the disputed services were not medically necessary and should not be reimbursed. Petitioner then made a timely request for review of the IRO and MRD decisions before SOAH.

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Petitioner

Although the IRO decision in this case addressed Chiropractic treatments 3/5/02 - 5/9/02, Petitioner now seeks reimbursement only for services provided from March 27 through April 17, 2002.[3] According to Petitioner, Respondent has already reimbursed those previously disputed services that Petitioner provided before March 27 (beginning with March 5, 2002) and after April 17

[3] The dates and CPTs for the disputed services include:
March 27, 2002: 97110,97150, 97250, 97265, 99213
March 28, 2002: 97110,97150, 97250, 97265, 99213
April 3, 2002: 97750-MT
April 4, 2002: 97110,97150, 97250, 97265, 99213
April 10, 2002: 97110,97150, 97250, 97265, 99213

(concluding on May 9, 2002). Respondent did not challenge Petitioner's assertion that such payments have been made. (Because these previously reimbursed services, bracketing the disputed dates of service, are very similar to the disputed services, Petitioner argues that their reimbursement provides some evidence that allowance of the disputed services would also be appropriate.)

Petitioner presented the testimony of Dr. Bailey, who took issue with the IRO's conclusions, particularly with respect to the initial MMI determination in this case. According to Dr. Bailey, a determination of MMI is significant in indemnifying a patient for a current (and presumably permanent) loss of physical functioning, but it has little or nothing to do with defining appropriate future medical treatment for such a patient. He stated, there's a significant chance that a person can improve in their function, and improve in their physical capacity, and improve in their pain level@ after being judged at MMI.

Moreover, Dr. Bailey noted that the physician who designated this claimant at MMI on January 31, 2002, (with an impairment rating of 15 percent) failed to indicate in his report (and thus seemingly failed to realize) that the claimant had undergone spine-fusion surgery only about five and a half months earlier. The claimant received a more realistic determination of MMI, Dr. Bailey suggested, when he underwent a TWCC Required Medical Examination (ARME@) in mid-April of 2002 and received an impairment rating of 11 percent. The principal reason for difference in the two ratings, Dr. Bailey concluded, was that during the RME the claimant (who was then halfway through his program of therapy with Petitioner) exhibited significantly greater range of motion in the cervical spine.

According to Dr. Bailey, the functional capacity evaluations (FCEs) performed at the beginning and end of the claimant's physical therapy program demonstrated significant overall improvement in the claimant's condition over the period - particularly in range of motion for the cervical spine, which initially was the area causing the patient's greatest complaint. During the program, the claimant's perception of chronic pain subsided from a typical 6 (on an increasing scale

of 1 to 10) to 4. At the end of the therapy, noted Dr. Bailey, the patient was able to return to full-time work without restrictions.

B. Respondent

David Niekamp, D.C., testified for Respondent. He examined medical records and performed a peer review in the case B but only with respect to two dates of service, March 20 and 21, 2002 (dates for which Petitioner is not now seeking recovery). In Dr. Niekamp's view, the FCEs relied upon by Petitioner in this case failed to reflect proper validity testing, which calls into question the significance of the FCE results. He conceded, though, that the FCEs showed no evidence of malingering on the patient's part during the testing.

Dr. Niekamp acknowledged that the disputed care apparently relieved the effects of the claimant's injury and promoted recovery, at least to some extent. He also found the Petitioner's clinical notes on the claimant's treatment to be quite coherent and comprehensive.

In closing argument, Respondent noted that Dr. Bailey, upon cross examination, had described as fair the 15 percent impairment rating assigned the claimant after the MMI determination on January 31, 2002. Respondent extrapolated from this statement the conclusion that, because the impairment rating was based largely on the claimant's decreased range of motion at that time, Dr. Bailey was logically acknowledging that subsequent efforts to improve the patient's condition would have been expected to be unproductive.

V. ANALYSIS

While both parties provided credible expert testimony in this case, Dr. Bailey presented a considerably more comprehensive factual justification for Petitioner's position than did Dr. Niekamp for the Respondent. Indeed, Dr. Niekamp agreed that the disputed treatment contributed to the improvement of the claimant's medical condition.

Both Respondent and the IRO suggest (without citing any definitive authority) that a finding of MMI in a case represents an effective stopping point for most reimbursable medical care. The IRO seeks to emphasize its position with the concluding statement that after MMI has been reached, all further treatment must be reasonable and necessary. However, this statement, in context, is essentially meaningless, since it is equally true of all treatment at all times, whether or not MMI has been declared. Specifically, § 408.021 of the Act entitles workers to all health care reasonably required to cure or relieve the effects naturally resulting from the compensable injury. Such relief need not be permanent or absolute and certainly may include the reasonable relief of chronic pain, which may continue long after a patient reaches MMI.

The legal position on this issue taken by Respondent and the IRO also fails to account for instances in which a determination of MMI is flawed (as seems to have been true in this case). When a later evaluation (based on fuller information) supersedes a previous MMI rating and when the

results of therapy actually demonstrate that a patient was capable of greater rehabilitation than a previous rating contemplated, no valid reason exists for limiting treatment on the basis of such a questionable determination of MMI. This is particularly true where, as here, the evaluation invoked by the IRO apparently failed to take into account the claimant's lack of routine rehabilitative therapy between his surgery in July of 2001 and the initial declaration of MMI on January 31, 2002.

The record in this case indicates that the patient benefitted from the treatment at issue, both in overcoming pain and in improving physiological functioning. It also seriously calls into question the rationale offered by the IRO for denying reimbursement of the treatment. The ALJ thus finds that the Petitioner has met its burden of proof to establish that it is entitled to such reimbursement.

The "Table of Disputed Services"[4] from the Commission's review process in this case indicates that the services for which Petitioner currently seeks payment are subject to a total

[4] See Exhibit No. 1, pp. 211-212.

maximum allowable reimbursement ("MAR") of $1,941.00, under the Commission's applicable Medical Fee Guidelines.

VI. CONCLUSION

The ALJ finds that, under the record provided in this case, the medical services at issue have been shown to be medically necessary and reasonable. Reimbursement of $1,941.00 for these services is therefore appropriate, contrary to the prior determination of the IRO.

VII. FINDINGS OF FACT

1. On ____, a claimant suffered injury to his neck, back, and right shoulder, which constituted compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. The claimant's condition subsequently necessitated cervical spine-fusion surgery on July 12, 2001.

3. On January 31, 2002, Dennis Bullock, D.C., examined the claimant, determined him to be at maximum medical improvement ("MMI"), and assigned him a permanent whole-body impairment rating of 15 percent.

4. On March 5, 2002, the claimant initially presented to the clinic of Waco Ortho Rehab (Petitioner), complaining of severe pain in the parts of his body that had been injured the previous year; the claimant began a therapeutic regimen of supervised exercise and chiropractic modalities that extended through May 9, 2002.

5. Petitioner sought reimbursement for services noted in Finding of Fact No. 4 from American Home Assurance Company ("Respondent"), the insurer for claimant's employer.

6. The Respondent denied the requested reimbursement.

7. Petitioner made a timely request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

8. The independent review organization ("IRO") to which the Commission referred the dispute issued a decision on April 20, 2003, treatment at issue had not been medically necessary, primarily upon grounds that "continued actively supervised rehabilitation program past MMI is not reasonable or necessary".

9. The Commission's Medical Review Division reviewed and concurred with the IRO's decision in a decision dated November 3, 2003, in dispute resolution docket No. M5-03-1342-01.

10. Petitioner requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the MRD decision regarding reimbursement.

11. The Commission mailed notice of the hearing's setting (originally for March 4, 2004) to the parties at their addresses on December 31, 2003. The hearing was subsequently continued to August 16, 2004, with proper notice to parties.

12. A hearing in this matter was convened on August 16, 2004, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Mike Rogan, an Administrative Law Judge with SOAH. Petitioner and Respondent were represented.

13. The record in this administrative proceeding remained open until September 23, 2004, to allow the parties to submit argument and briefing.

14. The claimant underwent a Required Medical Examination ("RME") under Commission auspices in mid-April of 2002 and received a second determination of MMI with an impairment rating of 11 percent; the improved rating (over that found in the examination noted in Finding of Fact No. 3) largely resulted from the fact that the claimant (who was then half way through his program of therapy with Petitioner) exhibited significantly greater range of motion in the cervical spine.

15. The functional capacity evaluations performed at the beginning and end of the claimant's physical therapy program demonstrated significant overall improvement in the claimant's condition over the period - including markedly increased performance on four of six measures for range of motion in the injured shoulder (with slight decreases on two measures) and markedly increased performance on four of six measures for range of motion in the cervical spine (with two measures essentially unchanged).

16. Over the course of Petitioner's therapy program, the claimant's perception of chronic pain subsided from a 6 (on an increasing scale of 1 to 10) for a typical day to a consistent 4.

17. The claimant was released to full-time work without restrictions on May 9, 2002.

18. During the hearing process, Petitioner sought reimbursement only for service provided to the claimant on the following dates: March 27 and 28 and April 3, 4, 10, and 17, 2002.

19. The Commission's applicable Medical Fee Guidelines restrict Petitioner to a total maximum allowable reimbursement of $1,941.00 for the treatment noted in Finding of Fact No. 18.

VIII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 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 § 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. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC ' 148.21(h).

6. Based upon the foregoing Findings of Fact, the treatments for the claimant noted in Findings of Fact Nos. 4 and 18 represent elements of health care medically necessary under §408.021of the Act.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decision of the IRO issued on April 20, 2003, were incorrect; rather, reimbursement of $1,941.00 for the services noted in Finding of Fact No. 18 is appropriate.

ORDER

IT IS THEREFORE ORDERED that, based upon Waco Ortho Rehab's successful challenge of an IRO decision dated April 20, 2003, Respondent, American Home Assurance Company, shall reimburse Petitioner, Waco Ortho Rehab, $1,941.00 for medical services provided from March 27 through April 17, 2002.

SIGNED October 25, 2004.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS