SOAH DOCKET NOS. 453-04-2032.M5 and 453-04-3027.M5
TWCC DOCKET NO. 03-1497 and 03-3294

CENTRAL DALLAS REHAB,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ZURICH AMERICAN	§	
INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case involves appeals by Central Dallas Rehab ("Petitioner") from decisions of independent review organizations ("IROs") on behalf of the Texas Workers' Compensation Commission ("Commission") in a dispute primarily regarding the medical necessity for chiropractic treatment. The IROs found that the insurer, Zurich American Insurance Company ("Respondent"), properly denied reimbursement for physical therapy and a work-hardening program that Petitioner provided to a claimant suffering from back and knee injuries.

Petitioner challenged the decisions on the principal 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 agrees with those of the IROs, finding that reimbursement of Petitioner for disputed services should be denied. However, it also disagrees in part with corresponding decisions of the Commission's Medical Review Division ("MRD"), which, while confirming the IRO decisions, made additional determinations respecting those services provided to the claimant that were disputed for reasons other than medical necessity.

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.

STATEMENT OF THE CASE

Petitioner moved to consolidate the captioned dockets, on grounds that both actions involve the same insurer, health care provider, claimant, and date of injury. SOAH Administrative Law Judge ("ALJ") Gary Elkins granted the motion on March 12, 2004, and consolidated the two actions under Docket No. 453___.

The hearing in this docket was convened and adjourned on May 26, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. ALJ Mike Rogan presided.

Petitioner was represented by Scott Hilliard, Attorney, who appeared by telephone. Respondent was represented by James Sheffield, Attorney. Both parties presented evidence and argument. The record remained open until June 9, 2004, to allow the parties to submit closing arguments and briefing.[1]

The record revealed that on ___, the claimant suffered compensable injury to her right knee and lower back, when she tripped and fell. In consequence, she ultimately underwent arthroscopic knee surgery on September 26, 2002. Prior to the surgery, Petitioner provided the claimant a variety of chiropractic therapies and related medical services, commencing on May 28, 2002. After the surgery, Petitioner administered a work hardening program for the claimant, in addition to other therapy. When Respondent (the insurer for the claimant's employer) subsequently denied reimbursement for some of the services provided by Petitioner, the pre-surgery care and the post-surgery care became the subjects of separate proceedings before the Commission's MRD.

The IRO to which the MRD referred the dispute over pre-surgery matters issued a decision on July 10, 2003, concluding that none of the services it considered (*i.e.*, for dates of service June 28 and July 1 through 24, 2002) had been medically necessary. The IRO stated its rationale as follows:

> Guidelines recommend two-week trials of care to assess the effectiveness of the treatment protocol. This patient's knee injury would eventually be a surgical case. According to the subjective and objective notes, there were no reports of improvement by [June 28, 2002]. Additional muscle tests and range of motion tests were conducted, but these tests would not significantly modify treatment. No changes in treatment were tried. This chiropractic care was not moving the patient toward resolution of her symptoms.

The MRD confirmed the IRO's decision in a separate decision dated November 25, 2003, which also addressed a number of other pre-surgery services that had been disputed on some basis other than lack of medical necessity. For these other services, which the IRO had not considered, the MRD recommended reimbursement of $2,335.30, out of some $7,584.00 billed by Petitioner.

As to Petitioner's post-surgery services, the IRO reviewing those matters issued a decision on September 25, 2003, finding that the work hardening and ancillary services provided to claimant from May 16 through June 17, 2003, had not been medically necessary. The IRO's basic rationale for decision was that Athe work hardening performed during the time frame in question failed to provide cure or relief for the condition, and did not progress toward recovery or enhancement of employability."

The MRD confirmed this IRO decision on January 6, 2004, again also addressing other services not considered by the IRO. With respect to the $328.00 in billings for such other services, the MRD recommended no reimbursement.

Petitioner made a timely request for review of the IRO and MRD decisions before SOAH, seeking reimbursement for all services billed but not approved in this case. (Petitioner calculated

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

these unpaid billings as $13,205.50.) The claimant remained out of work during the entire period encompassing the disputed dates of service.

THE PARTIES' EVIDENCE AND ARGUMENTS

A. Petitioner

Ted Krejci, D.C., a licensed chiropractor who practices with the Petitioner's organization, testified as the claimant's treating physician. Dr. Krejci contended that the claimant's pre-surgery therapy achieved its goal of increasing strength and range of motion ("ROM") in the injured parts of the body. He added that, even after Petitioner referred the claimant for orthopedic consultation and learned that surgery would be necessary to fully correct problems with the claimant's knee, extended therapy served the valuable function of conditioning the patient so that she would respond better to the surgery.

According to Dr. Krejci, fairly frequent testing of the claimant was required for continuing assessment of her progress in response to therapy. In particular, he cited mechanically generated results showing quantified increases in strength and ROM for the lumbar area and the right knee between June 28 and July 15, 2002.

As to the disputed work hardening program, Dr. Krejci testified that the reasons for prescribing work hardening in this case were stated in a letter seeking preauthorization for such services, dated January 22, 2003, from Crawford Sloan, M.D., and Lewis Cone, D.C. (doctors also associated with Petitioner).[2] The letter noted that, as of a functional capacity evaluation ("FCE") on January 6, 2003, the claimant was performing at a level consistent with "light" physical demands, whereas her occupation as a housekeeper imposed "medium" level demands. It added that the multi-disciplinary approach of work hardening was especially appropriate in this case because the claimant exhibited a "significant psychosocial overlay," reflected in anxiety that she might not be able to handle the strenuous demands of her job.

In comparing the claimant's performance on an FCE prior to the disputed work hardening program (March 10, 2003) with that on an FCE at the end of the program (June 17, 2003), Dr. Krejci acknowledged that the claimant did more poorly on a number of the individual tasks in the later evaluation. This, he stated, was the result of her being ill and hospitalized (for conditions unrelated to the compensable injury) during a couple of weeks between the two FCEs. On the whole, though, he concluded, the FCEs did not show a retrogression in the claimant's ability to return to work.

B. Respondent

Respondent presented the testimony of Kevin Tomsic, D.C., who, after reviewing case records, concluded that the pre-surgery therapy prescribed by Petitioner in this case was excessive and ineffective. According to a number of recognized medical-service guidelines, Dr. Tomsic

[2] Preauthorization was not approved but was not required, since Petitioner is CARF-accredited.

asserted, such chiropractic therapy is justifiable on a trial basis for up to four weeks.[3] If the patient does not respond to such conservative treatment in that time, therapy normally must be considered inefficacious in the case, dictating a reassessment of treatment. On this basis, Respondent agreed to pay for 30 days of the claimant's therapy B *i.e.*, from its commencement on May 28, 2002, through June 27, 2002, but not thereafter.

The claimant failed to make discernible progress during this initial 30 days, Dr. Tomsic declared. This was reflected in her performance on the Oswestry Pain Questionnaire, a methodology for assessing levels of disability based upon patients' perceptions of their own impairment. The claimant's responses indicated a 44 percent disability[4] on June 13, 2002. After undergoing therapy for a month, she underwent the assessment again on July 12, 2002, and demonstrated a 71 percent disability, a clear suggestion that her condition was worsening with treatment. Her levels of perceived pain remained the same on both assessments.

Although the orthopedic surgeon to whom Petitioner referred the claimant for consultation reported, on July 1, 2002, that the claimant's injured knee would require surgery, Petitioner apparently continued for weeks with the same extensive regimen of modalities that had been initiated before the claimant became a surgical candidate. In Dr. Tomsic's view, such failure to reassess and readjust treatment to changing circumstances undermines arguments that the care in this case was realistically aimed at relieving the effects of injury or returning the patient to work.

Dr. Tomsic also dismissed many results of testing and examination that Petitioner cited as objective evidence of the claimant's physical improvement in response to chiropractic therapy. He particularly questioned records indicating that the claimant gained sizeable, quantified increments of strength in injured parts of her body during the program. By contrast, his own review of the record showed no significant improvement in *real* strength B that is, in the claimant's functional abilities. He concluded that the computerized test results relied upon by Petitioner represented, at best, an imbalanced increase in the latent strength of isolated muscles B that is, a manifestation of improper rehabilitation rather than of progress toward recovery.

In questioning the claimant's need to participate in the disputed work hardening program, Dr. Tomsic criticized the FCE performed on the claimant in January of 2003, which served as a baseline for measuring her response to subsequent treatment. According to Dr. Tomsic, the FCE's static-lift testing indicated that the claimant could only lift about 10 pounds on an "occasional" basis, while its dynamic-lift testing B a much more demanding test B indicated that she could lift 25 pounds on a "frequent" basis. He concluded that these discrepancies in results reflected sub-maximal, inconsistent efforts by the claimant, casting the validity of the FCE in doubt.

If, however, the claimant could lift 25 pounds repetitively, as the FCE indicated, she thus satisfied the main criterion for an occupation in the "heavy" physical-demand category (which equals or exceeds the category of her own occupation prior to injury). Dr. Tomsic reasoned, therefore, that

[3] Dr. Tomsic cited in particular the "Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters" and the similar guidelines from the Mercy Center Consensus Conference.

[4] In terms of impact upon "activities of daily living."

the claimant "should have been returned to work without any significant difficulties"- and without any need for work hardening.

Moreover, he asserted, the claimant never met a work hardening program's entrance criteria, which demand objective evidence that a prospective participant might benefit from a supervised rehabilitation program. Because the claimant had already undergone post-surgical supervised rehabilitation (along with a home exercise program) since the end of September, 2002, with little or no significant benefit, such evidence of likely benefit from work hardening was distinctly lacking. Retrospectively, too, the claimant failed to show benefit from the work hardening program that the Petitioner provided her from May 16 through June 17, 2003, Dr. Tomsic said. An FCE performed after the program indicated that her physical capacity remained essentially unchanged (and in some ways had diminished).

In a peer review addendum dated November 26, 2002, David Sims, D.O., stated that the "claimant has had an exhaustive regimen of physical therapy both pre and post surgery to her knee without any significant relief whatsoever." He concluded that such conservative care should not be continued.

ANALYSIS

Both parties presented credible expert testimony, reflecting undoubtedly honest differences of opinion about the propriety of the services in dispute. However, Petitioner bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. It has not discharged that burden, in the ALJ's view. On the whole, the Petitioner's witness presented broad generalizations about the case, while the Respondent's witness provided a more reasoned explanation and citations to authority in support of his position.

On the other hand, with respect to the MRD's ancillary determinations in the case, the ALJ finds, as matter of law, that the MRD improperly denied reimbursement for $2,477.00 in services on the basis of rationales that were not identified before the medical dispute resolution process began.

Pre-surgery services addressed by IRO decision:

Petitioner failed to rebut the basic conclusion of the IRO (and Respondent), which applied to this case standards of practice calling for the suspension of chiropractic modalities when they fail to produce significant improvement after a maximum trial period of about four weeks. That principle seems particularly valid when a decision to address an injury through surgery has foreclosed any realistic possibility that conservative chiropractic treatment can itself resolve the condition.

Petitioner has presented what seems to be an alternate premise - *i.e.*, that much of the disputed therapy, at least after July 1, 2004, was intended to improve strength and ROM to "condition" the patient for knee surgery and its aftermath. The ALJ can find nothing in the extensive medical records submitted in this case to indicate that such conditioning was, in fact, the objective of the disputed therapy. If it was, the effectiveness of the effort seems doubtful, since it did not prevent the claimant from undergoing an unusually extensive amount of post-surgical rehabilitation. Moreover, Dr. James Laughlin, who made the initial orthopedic examination of the claimant on July 1, 2002, reported at that time that the injured knee's ROM was already "normal," although the patient informed him that the knee was "not improving" with the conservative care prescribed by Petitioner.

As Respondent asserts in closing argument, the provider's SOAP[5] notes from May 28 through August 6, 2002, remain almost identical, day after day - reflecting consistent levels of pain in the patient and unchanged findings and assessments. What periodic testing the provider did perform to assess the patient's progress does not appear to be consistent or systematic. The ALJ must conclude that Petitioner has failed to demonstrate the medical necessity of the disputed services, under the criteria of § 408.021 of the Act.

Post-surgery services addressed by IRO decision:

Evidentiary support is at best equivocal for Petitioner's contentions that the claimant was a legitimate candidate for work hardening and that her return to work was significantly facilitated by Petitioner's specific program. As noted in Respondent's closing argument, an FCE on January 6, 2003, showed the claimant performing at a level consistent with "light" demands, while an FCE at the end of the work hardening program, on June 17, 2003, showed her performing at only a "sedentary" level. Perhaps, as Petitioner contends, the claimant's progress was impeded by extraneous factors - primarily, her hospitalization for problems unrelated to the compensable injury. However, Petitioner has failed to provide even a brief, specific description of these extraneous factors or to explain how they negated progress that the claimant had made (or otherwise would have made) through work hardening.

Again, Petitioner clearly has failed to demonstrate the medical necessity of the work hardening services in dispute.

Services addressed only by MRD decisions: Previous SOAH decisions in disputes over fees or medical necessity have firmly established the general principle that a reason for denying reimbursement may not be considered in a proceeding at either the MRD or at SOAH unless that reason was previously asserted in the case on a TWCC-62 (or like form) before the request for medical dispute resolution was filed.[6]

In the ALJ's view, the MRD has ignored this principle without justification in recommending denial of reimbursement for a number of services provided to this claimant. With respect to those services considered by the MRD in conjunction with the IRO's decision on work hardening services, the MRD cryptically notes, as the carrier's basis for denial, "no EOB." Thus, as far as the ALJ can determine from the record, no reason for denial was officially conveyed to the requestor. Therefore, consistent with SOAH precedent on this subject, no basis for such denial exists. Under Commission regulations, the total maximum allowable reimbursement ("MAR") for the services in this category is $328.00.

In the initial proceeding that encompassed the IRO's assessment of pre-surgery chiropractic services, the MRD considered a number of services denied by the carrier through "E" or "R" codes (which dispute the compensability of the injury or the relationship of the service to a compensable injury, respectively), but the MRD based its own finding against reimbursement on other rationales.

---

[5] "Subjective/objective/assessment/plan."

[6] See, *e.g.*, SOAH Docket No. 453-01-0309.M5 (Feb. 7, 2001, ALJ Doherty), which stated,"A reason for carrier denial of a payment to a health care provider which is not properly before the MRD is not to be considered by SOAH on appeal of the MRD's decision."

In a few instances the carrier denied reimbursement with an "F" code (indicating reduction of reimbursement to MAR levels), while the MRD upheld denial upon wholly different reasons. In one instance, the MRD noted that the carrier had based denial on an obsolete, invalid "T" code, then found its own, unrelated reason to uphold denial. And again, as in the proceeding on work hardening, the MRD denied some reimbursements where the record indicated a total lack of EOBs. The total MAR for services in these categories is $2,149.00.

Accordingly, Petitioner should receive total reimbursement of $2,477.00 for the services noted above, which the MRD denied for reasons that were not identified prior to the dispute resolution process. On the other hand, where the MRD has presented a rationale for denying reimbursement that is consistent with the carrier's initial rationale, the ALJ finds nothing persuasive in the record to reverse the MRD's determination.

CONCLUSION

The ALJ finds that, under the record provided in this case, those disputed medical services that have been reviewed by IROs were not been shown to be medically necessary. Reimbursement for these services should be denied, accordingly, as initially determined by the IROs. However, Petitioner should receive reimbursement of $2,477.00 for services that the MRD denied for reasons that were not identified prior to this dispute resolution process.

FINDINGS OF FACT

1. On ___, claimant suffered an injury to her right knee and lower back that was a compensable injury under the Texas Worker's Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. The claimant's injury ultimately necessitated arthroscopic knee surgery on September 26, 2002.

3. Prior to the claimant's surgery, Central Dallas Rehab ("Petitioner") provided the claimant a variety of chiropractic therapies and related medical services, on dates of service including June 28 and July 1 through 24, 2002.

4. After the claimant's surgery, Petitioner administered a work hardening program for the claimant, along with ancillary services, from May 16 through June 17, 2003.

5. Petitioner sought reimbursement for services noted in Findings of Fact Nos. 3 and 4 from Zurich American Insurance Co. ("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. Subsequently the pre-surgery care (as noted in Finding of Fact No. 3) and the post-surgery care (as noted in Finding of Fact No. 4) became the subjects of separate proceedings before the Commission's Medical Review Division ("MRD").

8. The independent review organization ("IRO") to which the Commission referred the dispute over pre-surgery care (as noted in Finding of Fact No. 3) issued a decision on July 10, 2003, concluding that none of the services it considered had been medically necessary.

9. The MRD reviewed and concurred with the IRO determination noted in Finding of Fact No. 8, in a decision dated November 25, 2003 (dispute resolution docket No. M5___). The MRD decision also addressed a number of other pre-surgery services that had been disputed on some basis other than lack of medical necessity. For these other services, which the IRO had not considered, the MRD recommended reimbursement of $2,335.30, out of some $7,584.00 billed by Petitioner.

10. The IRO to which the Commission referred the dispute over post-surgery care (as noted in Finding of Fact No. 4) issued a decision on September 25, 2003, concluding that the work hardening and ancillary services provided to claimant had not been medically necessary, since they failed to contribute to claimant's progress toward recovery or enhancement of employability.

11. The MRD reviewed and concurred with the IRO determination noted in Finding of Fact No. 10, in a decision dated January 6, 2004 (dispute resolution docket No. M5___). The MRD decision also addressed other post-surgery services that had been disputed on some basis other than lack of medical necessity. For these other services, which the IRO had not considered, the MRD recommended no reimbursement, out of $328.00 billed by Petitioner.

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

13. The Commission mailed notice of the setting of hearings to the parties at their addresses on January 14 and February 18, 2004. The two originally separate proceedings B one upon the services noted in Findings of Fact Nos. 3 and 9, the other upon those noted in Findings of Fact Nos. 4 and 11 B were subsequently consolidated, with hearing continued to a later date, after proper notice to the parties.

14. A one-day hearing in this consolidated matter was convened before SOAH on May 26, 2004. Petitioner and Respondent were represented. The record remained open until June 9, 2004, to allow the parties to submit closing arguments and briefing.

15. The services noted in Finding of Fact No. 3 were preceded by approximately 30 days of similar chiropractic therapy to the claimant. This previous therapy had failed to provide significant improvement in the claimant's compensable injury.

16. Under recognized guidelines for chiropractic care, conservative therapy is justifiable on a trial basis for two to four weeks. If the patient does not respond to such treatment in that time, therapy normally must be considered inefficacious in the case, dictating a reassessment of treatment.

17. Although the claimant became a candidate for knee surgery on July 1, 2003, Petitioner continued to administer chiropractic therapy for that knee through July 24, 2003.

18. Contemporaneous medical records do not indicate that conditioning claimant's knee for anticipated surgery and its aftermath was the objective of the therapy noted in Finding of Fact No. 17.

19. Following knee surgery, the claimant underwent an unusually extensive amount of knee therapy and rehabilitation.

20. The claimant never met a work hardening program's entrance criteria (which demand objective evidence that a prospective participant might benefit from a supervised rehabilitation program), because the claimant had already undergone post-surgical supervised rehabilitation (along with a home exercise program) since the end of September, 2002, with little or no significant benefit

21. The work hardening program was not shown to contribute to claimant's progress toward recovery or enhancement of employability; a functional capacity evaluation ("FCE") on January 6, 2003, showed the claimant performing at a level consistent with "light" demands, while an FCE at the end of the work hardening program, on June 17, 2003, showed her performing at only a lower, "sedentary" level.

22. Among those services noted in Finding of Fact No. 9 that had been disputed on some basis other than lack of medical necessity, services with a maximum allowable reimbursement ("MAR") of $2,149.00 were denied by the MRD for reasons that had not been identified by the Respondent before the request for medical dispute resolution was filed in the case.

23. Those services noted in Finding of Fact No. 11 that had been disputed on some basis other than lack of medical necessity (*i.e.*, services with a MAR of $328.00) were denied by the MRD for reasons that had not been identified by the Respondent before the request for medical dispute resolution was filed in the case.

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 Findings of Fact Nos. 15 through 19, the disputed treatments for the claimant noted in Finding of Fact No. 3 do not represent elements of health care medically necessary under § 408.021of the Act.

7. Based upon Findings of Fact Nos. 20 and 21, the disputed treatments for the claimant noted in Finding of Fact No. 4 do not represent elements of health care medically necessary under § 408.021of the Act.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, the IROs' findings and decisions in this matter, issued on July 10 and September 25, 2003, were correct; Petitioner's request of reimbursement for services noted in Findings of Fact Nos. 3 and 4 should be denied.

9. Based upon Findings of Fact Nos. 22 and 23, the MRD B in decisions issued on November 25, 2003, and January 6, 2004 B improperly considered and invoked reasons for denying reimbursement that had not previously been asserted in the case on a TWCC-62 (or like form) before the relevant request for medical dispute resolution was filed. Denial of services with a total MAR of $2,477.00 was based upon such improper consideration.

10. Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's request of reimbursement for services noted in Findings of Fact Nos. 9 and 11 should be granted, to the extent of $2,477.00.

ORDER

IT IS THEREFORE, ORDERED that the appeal of Central Dallas Rehab, seeking reimbursement for chiropractic and related services, be denied, in part - in accordance with the findings and decisions of independent review organizations issued in this matter on July 10 and September 25, 2003, which concluded that the disputed services had not been shown to be medically necessary - and granted, in part - to the extent of $2,477.00, contrary to the decisions of the Texas Workers' Compensation Commission's Medical Review Division issued in this matter on November 25, 2003, and January 6, 2004, addressing services that had been disputed on some basis other than lack of medical necessity.

SIGNED July 2, 2004.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS