SOAH DOCKET NO. 453-04-3029.M5
TWCC NO. M5-03-1925-01

CURTIS ADAMS CHIROPRACTIC	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
V.	**§**	**OF**
	§	
LIBERTY MUTUAL FIRE INSURANCE COMPANY	**§**	
	§	
Respondent		**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is a dispute over whether reimbursement is appropriate for post-surgical therapy rendered to Claimant by Curtis Adams, D.C. (Provider), between September 11, 2002, and January 28, 2003. Provider sought reimbursement from Liberty Mutual Fire Insurance Company (Carrier) for the treatment rendered to Claimant, which Carrier denied as not medically necessary. The Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) adopted the findings of an Independent Review Organization (IRO) that held Provider was not entitled to reimbursement. In this Order, the Administrative Law Judge (ALJ) concludes Provider is not entitled to reimbursement.

I. JURISDICTION, NOTICE AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those matters will be addressed in the findings of facts and conclusions of law without further discussion here. The hearing convened and closed on April 8, 2004, before the State Office of Administrative Hearings (SOAH) with ALJ Steven M. Rivas presiding. Provider appeared and represented himself. Carrier appeared and was represented by Charlotte Salter, attorney.

II. DISCUSSION

1. Background Facts

Claimant sustained a compensable back injury on ___. Following her injury, Claimant underwent treatment, which ultimately led to back surgery on April 12, 2002. In August 2002, Claimant visited Provider and complained of lower back pain. Provider recommended a post-surgical therapy program and commenced treatment on September 11, 2002. The treatment included office visits, electromuscle stimulation, trigger point injections, traction, joint mobilizations, and cryo packs. Carrier paid for some services but denied payment for most of the treatment rendered to

Claimant as not medically necessary. The amount in dispute is $16,450.00.[1]

B. Applicable Law

The Texas Labor Code contains the Texas Workers' Compensation Act (the Act) and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims. In particular, the Act, as noted in § 408.021, provides that 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. Under the same statute, the employee is entitled to 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.

2. Evidence and arguments

Provider's main argument stems from Carrier's approval of a work conditioning program near the conclusion of the disputed services. Claimant began treatment with Provider on September 11, 2002, and was approved for work conditioning on December 19, 2002, which was performed by Provider as well. Provider argued that the approval of the work conditioning program reflected the effectiveness of the treatment rendered in September through December. Provider further asserted that because the work conditioning program was approved, all treatment prior to that approval should be deemed medically necessary because in order for Claimant to be ready for work conditioning, she had to undergo the post-surgical therapy.

Carrier argued that regardless of the work conditioning approval, the records indicated Provider's post-surgical treatment was excessive and ineffective. Carrier presented two reports from Leighton B. Parker, M.D., the surgeon who performed Claimant's back surgery on April 12, 2002. Dr. Parker noted that Claimant "did quite well" after the surgery, but recommended an MRI exam to investigate Claimant's complaint of pain in July 2002. The MRI exam was performed on August 19, 2002, and revealed no recurrent or residual disc herniation. Dr. Parker reviewed the MRI results on August 22, 2002, and recommended nonsteroidal, anti-inflammatory medications for Claimant's pain. The record is unclear about any therapy rendered to Claimant following her surgery, however, Carrier pointed out that Dr. Parker did not recommend any further therapy as of August 2002.[2]

Carrier presented Kevin Tomsic, D.C., who testified that he regularly treats patients in the same condition as Claimant, and noted that Claimant's visits were too frequent for the type of care reasonably expected for a patient in Claimant's condition. At the outset of the post-operative therapy program, Provider rendered treatment four times-a-week. Later, Provider treated Claimant each day for five consecutive weeks and then reduced the visits back to four times-a-week. Dr. Tomsic asserted this type of "acute" treatment may be reasonable only if it was administered within days of

[1] Provider billed Carrier $20,975.00, of which Carrier paid $4,525.00.

[2] Provider argued that Claimant made repeated requests to her treating doctor for post-operative therapy, and that the treatment was never recommended. However, Provider did not offer any evidence to establish this was the case.

an injury or surgery. According to Dr. Tomsic, this type of treatment was not medically necessary considering it started five months after Claimant's surgery.

Additionally, Dr. Tomsic asserted the treatment rendered to Claimant was not medically necessary because Claimant showed no signs of improvement following the treatment administered by Provider. Dr. Tomsic pointed out Claimant had seven different subjective pain complaints during her first visit on September 11, 2002, including stiffness and soreness in her lower back. On September 26, 2002, after 12 visits, Provider noted that Claimant complained of the same lower back pain and two additional complaints: pain in her left shoulder and stiffness in her neck. Claimant now had nine subjective pain complaints, and throughout her entire treatment program with Provider, she continued to have all nine pain complaints. Provider argued this fact merely demonstrated how difficult this case was for Claimant. However, Dr. Tomsic testified he did not see any records that indicated any complications with the surgery or Claimant's condition. Additionally, Dr. Tomsic asserted he saw nothing in the records that would have warranted rehabilitation for more than six weeks following her surgery, which was a typical period according to Dr. Tomsic.

3. Analysis and Conclusion

Provider is not entitled to reimbursement because the treatment rendered to Claimant was not medically necessary. First, there is insufficient evidence in the record suggesting Claimant should have participated in any type of therapy program. Dr. Parker recommended Claimant take anti-inflammatory medications following his review of Claimant's MRI exam on August 22, 2002. Provider, as Petitioner in this matter, failed to provide sufficient evidence regarding any recommendation of the treatment he rendered. Additionally, the ALJ was persuaded by Dr. Tomsic's testimony that the treatment was not medically necessary because the record clearly reflected that Claimant not only failed to improve under Provider's care, but in fact got worse after four months of almost-daily treatment.

Provider argued that it should be reimbursed because the work conditioning program was approved. However, under Commission rules, treatment modalities are considered separately for purposes of medical necessity and preauthorization. It would seem unreasonable to "piggy-back" months of ineffective treatment on a subsequent preauthorization. The argument that the work conditioning preauthorization somehow deemed months of treatment as medically necessary was unpersuasive.

Carrier reimbursed Provider for all of the work conditioning, some of the therapy services, and some office visits. Considering the record in this case, the ALJ believes Provider was reimbursed a reasonable amount. Because Provider failed to establish the disputed dates of service were medically necessary, no further reimbursement is justified.

III. FINDINGS OF FACT

1. Claimant ___ suffered a compensable back injury on ___.

2. Claimant was treated for her injury, which included back surgery on April 12, 2002.

3. Claimant was treated at Curtis Adams Chiropractic (Provider) between September 11, 2002, and January 28, 2003.

4. Claimant's treatment included office visits, electromuscle stimulation, trigger point injections, traction, joint mobilizations, and cryo packs.

5. Provider billed Liberty Mutual Fire Marine Insurance Company (Carrier) $20, 975.00 for the treatment rendered, of which Carrier paid $4,525.00. Carrier denied the remaining $16,450.00, as not medically necessary.

6. Provider filed a Request for Medical Review Dispute Resolution with the Texas Workers' Compensation Commission (the Commission), seeking reimbursement for the treatment rendered to Claimant.

7. The dispute was referred to an Independent Review Organization (IRO), which found Provider was not entitled to reimbursement.

8. Provider timely appealed the IRO decision and filed a request for hearing before the State Office of Administrative Hearings (SOAH).

9. Notice of the hearing was sent February 18, 2004. 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.

10. The hearing convened and closed on April 8, 2004, with Steven M. Rivas, Administrative Law Judge (ALJ) presiding. Provider appeared and represented himself. Carrier appeared and was represented by Charlotte Salter, attorney.

11. Claimant's MRI exam on August 19, 2002, revealed no residual herniation.

12. No physician referred Claimant to Provider for post-operative therapy.

13. Authorization of a work conditioning program does not deem prior therapy medically necessary.

14. "Acute" treatment may be reasonable only if it is administered within days of an injury or surgery.

15. Claimant's condition did not warrant "acute" or prolonged treatment five months following surgery.

16. Claimant's condition worsened as a result of Provider's care.

17. Provider presented insufficient evidence that the treatment in dispute was medically necessary to treat Claimant's compensable injury.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely filed its request for hearing as specified by 28 TEX. ADMIN. CODE § 148.3.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051, 2001.052 and 28 TEX. ADMIN. CODE § 148.4.

4. The Provider, as Petitioner, has the burden of proof in this matter under 28 TEX. ADMIN. CODE § 148.21(h).

5. Under TEX. LAB. CODE ANN. § 408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery;

6. or (3) enhances the ability of the employee to return to or retain employment.

7. Provider did not meet its burden of showing, by a preponderance of the evidence, that the treatment rendered to Claimant was medically necessary.

8. Pursuant to the foregoing Findings of Fact and Conclusions of Law, Provider is not entitled to any further reimbursement for the treatment rendered to Claimant.

ORDER

IT IS, THEREFORE, ORDERED that Provider, Curtis Adams Chiropractic is not entitled to reimbursement from the Carrier, Liberty Mutual Fire Insurance Company, for the treatment rendered to Claimant from September 11, 2002, through January 28, 2003.

SIGNED May 12, 2004.

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS