SOACH DOCKET NO. 453-04-3615M5R

PRIMARY HEALTH CARE, P.C.	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ACE USA / ESIS,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This dispute arises out of services Petitioner Primary Health Care, P.C. (Petitioner) provided to Claimant ___ (Claimant) on 49 separate occasions between January 16, 2002, and June 26, 2002.[1] Petitioner's services included ultrasound, electrical stimulation, mechanical traction, massage, office visits, x-rays, hot and cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and team conferences to discuss Claimant's progress.[2] Respondent Ace USA/ESIS (the Carrier) denied reimbursement on the basis that the services were not medically necessary. An independent review organization (IRO) chiropractor determined that services provided on eight dates of service between January 16, 2002, and January 28, 2002, were medically necessary, but that the services provided thereafter were not medically necessary. Additionally, the Medical Review Division of the Texas Workers Compensation Commission (the MRD, the Commission) reviewed certain services provided between May 1, 2002, and June 26, 2002, that were not addressed by the IRO; the MRD ordered reimbursement totaling $365.88 for four physical medicine modalities but denied reimbursement for certain others.[3]

The dispute here is over whether Petitioner is entitled to reimbursement totaling $6,543.49 for services provided on 41 separate occasions between January 30, 2002, and June 26, 2002. Essentially, the Carrier argues this is a case of overutilization. In this Decision and Order, the Administrative Law Judge (ALJ) finds that Petitioner failed to establish that the services at issue were medically necessary. Therefore, Petitioner is not entitled to reimbursement for the services.

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[1] In an opening statement at the hearing, Petitioner's representative stated that the dates of service at issue are January 16, 17, 18, 21, 23, 24, 25, 28, and 30; February 2, 4, 6, 7, 8, 11, 13, 15, 20, 22, 25; March 1, 4, 8, 11, 15, 22, and 27; April 1, 5, 8, 12, 15, 19, 26, and 29; May 1, 3, 13, 17, 20, 24, 29, and 31; and June 3, 10, 12, 14, 24, and 26, 2002. However, the Carrier's representative stated that the Carrier has reimbursed, or is in the process of reimbursing, Petitioner for dates of service January 16 - 28, 2002. In a telephonic post-hearing conference on June 10, 2004, representatives of both Petitioner and the Carrier agreed that dates of service January 16 - 28, 2002, are not at issue in this proceeding, because the IRO reviewer determined those services to be medically necessary, the Carrier did not appeal that determination, and the Carrier has already agreed to reimburse Petitioner for those services.

The IRO report also referenced (but does not recommend reimbursement for) services provided on July 1, 2002; however, Petitioner's representative did not include those services in Petitioner's claim at the hearing.

[2] According to Petitioner, the electrocardiogram and pulmonary function test were necessary to assess Claimant's heart and lung function before he was placed on an exercise program.

[3] The services for which the MRD ordered reimbursement are not at issue in this proceeding, as the Carrier paid Petitioner for those services following the MRD's issuance of its Decision and Order.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

No one contested jurisdiction, notice, or venue. Therefore, those issues are addressed in the Findings of Fact and Conclusions of Law without further discussion here.

A hearing in this matter was convened on May 4, 2004, at 9:00 a.m., at the hearings facility of the State Office of Administrative Hearings, William P. Clements Building, 300 West 15th Street, Austin, Texas, with ALJ Renee M. Rusch presiding. Petitioner appeared *pro se* through its employee administrator Barry McAlpine, D.C., who appeared by telephone.[4] Claimant was present with Dr. McAlpine at Petitioner's office during the hearing and testified by telephone. Adjuster J. Javier Gonzalez represented the Carrier. After the taking of argument and evidence, the hearing was adjourned and the record closed the same day.

II. REASONS FOR DECISION

1. Factual Background

Claimant's medical records reflect his "date of injury" as ___, though it appears Claimant suffered repetitive motion injuries to his neck, shoulders, arms, wrists, fingers, and back over an extended period of time. According to Claimant, his injuries occurred while he worked as an industrial sewing machine operator, a job that required him to sit for lonacg periods of time, sew waist bands on Levi jeans, move his left arm, and place almost-finished pants into a buggy that was located in front of him.[5] Initially, Claimant complained of pain in his neck, shoulders, arms, and wrists, with some numbness. He received conservative treatment, which included physical therapy with ultrasound, hot packs, massage, and exercises, as well as nonsteroidal and anti-inflammatory drug therapy, but his pain continued.

In October 1997, Claimant underwent a diskectomy, interbody fusion, and implantation of plates and steel screws at C4-5 and C5-6. In January 1998, Claimant underwent arthroscopic surgery of the left shoulder with debridement of the rotator cuff and glenoid labrum and decompression of the left shoulder. Claimant received extensive physical therapy both pre- and post-operatively and was instructed in how to perform home exercises. Claimant's shoulder surgery was followed by post-operative rehabilitation, including work hardening, but Claimant continued to experience pain, and he suffered from depression. As of September 16, 1998, Claimant had reached Maximum Medical Improvement (MMI) and was given an 18 percent whole body impairment rating. He was determined to be eligible for Social Security disability benefits in April 2000. (Pet. Ex. 2.)

The records of Ruben Pechero, M.D., who was Claimant's treating doctor in Texas, reflect that as early as October 1998, Claimant was physically able to perform light duty work; however,

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[4] According to Dr. McAlpine, Petitioner is a professional medical corporation certified and licensed in the State of Michigan.

[5] Claimant was employed by Levi Strauss in McAllen, Texas, during the approximately six years immediately preceding his injury; previously, he had worked in the construction industry for approximately 12 years.

claimant suffered from depression, and that depression interfered with his ability to return to work.[6] (Carrier Ex. 3.) In February 1999, Eduardo Elizondo, M.D., the doctor who set Claimant's impairment rating at 18 percent, reported that Claimant displayed symptom magnification during Dr. Elizondo's evaluation. (Carrier. Ex. 3.)

The Carrier hired a private investigator to conduct clandestine surveillance of Claimant. In July 1999, the investigator provided the Carrier with a surveillance videotape that the Carrier contended showed Claimant lifting large sheets of plywood and working on a roof. The videotape was not introduced into evidence in this proceeding, but the investigator's report was. The Carrier offered no evidence to authenticate the investigator's report, and Claimant testified that the man shown performing manual labor on the videotape was his brother-in-law, not he. Thus, the ALJ attached no weight to either the investigator's report or the testimony of the Carrier's expert witness, Melissa Tonn, M.D., about the surveillance videotape and the investigator's report.

Claimant appears to have stopped treatment in 2000. At a time not disclosed in the record, Claimant moved to Michigan. In January 2002, he presented at Dr. McAlpine's office in Holland, Michigan, complaining of neck and shoulder pain. According to Dr. McAlpine (who served as Petitioner's representative at the hearing), chiropractors do not like to treat patients who have plates and surgical screws in their necks; therefore, Dr. McAlpine referred Claimant to Petitioner. On January 16, 2002, Petitioner's medical director, Ivan Dale Carroll, M.D., examined Claimant at Petitioner's clinic.[7] Claimant reported a long history of neck and shoulder pain and left arm pain. Claimant told Dr. Carroll that he had experienced flare-ups of pain "ever since" his surgeries and was then experiencing such a flare-up. He characterized his pain as being at level 8 on a 1-to-10 scale. Dr. Carroll noted in Claimant's medical records that Claimant did not exercise regularly. (Pet. Ex. 1, pp. 72-73.)

The record does not reflect whether Dr. Carroll obtained copies of Claimant's Texas medical records before commencing treatment of Claimant; however, Dr. Carroll proceeded to perform multiple tests and prescribed physical therapy modalities and exercise. Dr. Carroll diagnosed Claimant as having discopathy, cervical neuritis, and myospasm. (Pet. Ex. 1, p. 17.) Dr. Carroll's treatment of Claimant included hot and cold packs, ultrasound, intersegmental traction, muscle massage, myofascial release, joint mobilization, electrical stimulation, testing, kinetic activities, functional activities, and home exercises. (Pet. Ex. 1, p. 73.) During the course of Petitioner's treatment of Claimant, Claimant reported he felt much better and his pain was reduced to level 4-5. Claimant discontinued treatment in June 2002 because the Carrier "cut off" his treatment.

The Carrier denied reimbursement for services Petitioner provided between January 16, 2002, and May 26, 2002, on the basis that the services were not medically necessary.

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[6] At the time of his shoulder surgery, Claimant was diagnosed with diabetes, he became insulin-dependent, and his eyesight began failing. He subsequently told doctors that his surgeries caused his diabetes. Dr. Pechero attributed much of Claimant's depression to his diabetes and other degenerative conditions. (Carrier Ex. 3.)

[7] Dr. Carroll subsequently became Claimant's treating doctor in Michigan. Dr. McAlpine testified that all of the services at issue in this proceeding were provided by Dr. Carroll or the staff at Petitioner's clinic; none of the services were provided by Dr. McAlpine. The ALJ notes, however, that Dr. McAlpine's name is listed on team conference worksheets dated February 7, 2002, and April 1, 2002. (Pet. Ex. 1, pp. 81 and 82.)

2. Review by the IRO and Commission's Medical Review Division (MRD)

The IRO chiropractor who reviewed Claimant's medical records assumed Dr. Carroll was a chiropractor. He concluded Claimant had suffered an exacerbation of his injury and made the following determination:

> [T]he patient was treated extensively with physical therapy in the past, and should be knowledgeable in home-based exercise and self-directed modalities. . . .[A] short course (6-9 visits) would be reasonable to treat an exacerbation and reinforce a home program. Therefore [the IRO doctor] concluded that the application of a modality, ultrasound, electrical stimulation, mechanical traction, massage office visit, C-rays, hot or cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and physical team conference from 1/16/02 through 1/28/02 were medically necessary to treat this patient's condition. However, the [IRO doctor] also concluded that [the services provided] from 1/30/02 through 5/1/02 and 5/3/02 through 5/24/02, 6/12/02 and 7/1/02 were not medically necessary to treat this patient's condition. (Carrier Ex. 1, p. 10.)

The MRD reviewed several disputed services that were not addressed by the IRO chiropractor, and ordered reimbursement totaling $365.88 for four physical medicine modalities. The MRD denied reimbursement for CPT Code 97110, therapeutic exercises to develop strength and endurance, range of motion and flexibility, on the basis that Petitioner failed to document (1) medical necessity for one-on-one therapy and (2) that individual services were provided as billed.

3. The Parties' Arguments and Evidence

Petitioner attached great significance to the fact that the IRO health care professional who reviewed the services at issue was a chiropractor, and the IRO chiropractor assumed Dr. Carroll too was a chiropractor. Petitioner argued that pursuant to 28 TEX. ADMIN. CODE ' 12.402, the services at issue should have been reviewed by a Tier One IRO reviewer (for medical doctors and doctors of osteopathy), not a chiropractor. In response, the Carrier's expert witness, Melissa Tonn, M.D., testified that, in Texas, IRO reviews of medical doctors, doctors of osteopathy, and chiropractors are "essentially equivalent." According to Dr. Tonn, the "match" between the reviewing and reviewed doctors should based on their practice areas, not the academic degree each doctor holds. The Carrier conceded that Petitioner may have been charged the wrong IRO fee, but argued that fact did not affect the validity of the IRO chiropractor's evaluation.

Although Dr. Carroll's records state Claimant reported having a "flare-up" and the IRO chiropractor believed Claimant had suffered an exacerbation, Petitioner's position was that Claimant had *not* suffered an exacerbation. Based on information Claimant provided and the fact that Claimant was taking strong pain medication, *e.g.,* Darvocet, Petitioner believed Claimant's symptoms stemmed from his original injury, were ongoing following Claimant's surgeries, and were not due to an exacerbation. (Pet. Ex. 1, p. 2.) Because Claimant reported that his pain continued after his surgeries, Petitioner concluded Claimant's surgeries had failed, although x-rays indicated that Claimant's fusions were in place. Petitioner argued that tests Dr. Carroll performed indicated nerve root involvement. Moreover, Claimant reported a 50 percent reduction in pain during the

course of treatment by Petitioner. In Dr. McAlpine's words, it would be "un-American" to discontinue care that gave Claimant "some relief" from pain.

The Carrier provided the opinions of three medical doctors who did not believe the services at issue were medically necessary. David H. Trotter, M.D., an orthopedic surgeon, performed a paper review; Patrick G. Ronan M.D., performed an independent medical evaluation (IME) of Claimant;[8] and Melissa Tonn, M.D., performed a paper review and testified at the hearing. Dr. Trotter's report focused primarily on the issue of whether Claimant's current symptoms were causally related to Claimant's 1996 injury, and he concluded they were not. However, Dr. Trotter was given incorrect information about Claimant's diagnosis did not even review Dr. Carroll's medical records. (Carrier Ex. 3.) Dr. Ronan reviewed Claimant's medical records, including Dr. Carroll's records, and examined Claimant in October 2002. Dr. Ronan noted that Claimant had symptoms related to left cervical radiculopathy dating back to the 1970s and made the objective finding that Claimant had somewhat limited overhead use of his left arm. Dr. Ronan did not believe Claimant would benefit from physical therapy or additional injections but recommended Claimant limit overhead activity with his left shoulder, learn home exercises, and pursue a more active lifestyle. (Carrier Ex. 2.)

The Carrier's expert witness, Dr. Tonn, is board-certified in occupational medicine and a Diplomat in the American Academy of Pain Management. She reviewed Claimant's medical records dating back to 1996, paying special attention to pre- and post-operative physical medicine entries. Relying on the investigator's 1996 surveillance report, Dr. Tonn questioned the credibility of Claimant's subjective complaints of pain. She testified that Claimant's medical records do not evidence any substantial progress toward recovery or employment though he has received conservative and surgical treatment totaling $183,979.00 since December 1996. She disagreed with the opinion of the IRO chiropractor that Claimant had suffered an exacerbation that justified the treatment between January 16 and 28, 2002.[9] According to Dr. Tonn, ongoing treatment is indicated where there is evidence of efficacy and where the treatment fits within treatment guidelines. She testified that national treatment guidelines suggest eight weeks of physical medicine intervention after an injury or surgery, but do not support the Petitioner's providing five and one-half months of physical medicine four to five years after Claimant's surgeries. Dr. Tonn acknowledged that Claimant may have felt better during the course of Petitioner's treatment but observed that within two months after the treatment, Claimant reverted to his previous condition.

4. ALJ's Analysis

An employee who has sustained 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 cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the employee's ability to return to or retain employment. TEX. LAB. CODE ANN. § 408.21(a). Workers' compensation insurance covers all medically necessary and reasonable health care, including examinations, treatments, diagnoses, evaluations, and services

[8] Dr. Ronan's IME report was on the letterhead of Orthopaedic & Spine Specialists of West Michigan. (Pet. Ex. 1, pp. 45-48.)

[9] As noted previously, however, the Carrier did not appeal the IRO reviewer's determination.

reasonably required by the nature of the compensable injury, and reasonably intended to cure or relieve the effects naturally resulting from the compensable injury. TEX. LAB. CODE ANN. § 401.011(19) and (31).

Normally, the opinion of the IRO reviewer is entitled to presumptive weight. 28 TEX. ADMIN. CODE § 133.308(w). Here, however, because a Tier Two IRO reviewer rather than a Tier One reviewer performed the review, the ALJ scrutinized Claimant's medical records more critically. The ALJ understands Petitioner's annoyance that it may have been charged a Tier One IRO reviewer fee but was apparently reviewed by a Tier Two IRO reviewer. However, the ALJ found nothing in the record, nor was she able to locate other authority, indicating that the term "medical necessity" has a different meaning when applied to the services of medical doctor than it does when applied to the services of a chiropractor. She does not believe the IRO reviewer or the reviewer's credentials affected the outcome of this case.[10]

Petitioner had the burden of establishing by a preponderance of the evidence that the services at issue were medically necessary and reasonable. The hearing lasted nearly three and one-half hours, and the voluminous documentary record consists of conflicting medical opinions. The Carrier introduced the opinions of three medical doctors who opined that the services Petitioner provided were not medically necessary. The ALJ discounted Dr. Trotter's opinion because he had been given incorrect information about Claimant's diagnosis and did not review Dr. Carroll's records. She did, however, consider the opinion of Dr. Ronan, who actually examined Claimant and who believed that Claimant would be best served by "a short course of physical therapy to learn a number of exercises for the patient to continue on a self-directed basis" and the use of analgesic and anti-inflammatory drugs.

The ALJ was not persuaded by Dr. Tonn's contention that a workers' compensation claimant is entitled only to services that will advance his progress toward recovery or employment; the law also entitles a claimant to treatment that is reasonably intended to *relieve the effects* of his injury. TEX. LAB. CODE ANN. § 408.21(a). Nor did the ALJ consider the sums the Carrier has already expended for Claimant's treatment to be determinative. Pursuant to TEX. LAB. CODE ANN. § 408.21(d), a carrier's liability for medical benefits may not be limited or terminated.

Unfortunately, Claimant's treating doctor, Dr. Carroll, chose not to testify at the hearing. Therefore, the ALJ did not have the benefit of hearing his explanation of the medical necessity for and reasonableness of approximately five and one-half months of conservative care-that brought Claimant only temporary pain relief-six years after his injury. This is especially true in light of evidence that Claimant had a tendency toward symptom magnification and had previously been taught home exercises to manage his pain, but chose instead to live a sedentary life without regular exercise. Although the ALJ believes Claimant sought relief from pain and is entitled to effective treatment that provides such relief, Petitioner did not show, by a preponderance of the evidence, that the services it provided were medically necessary and reasonable.

[10] Nor does she have the authority to here determine what remedy, if any, Petitioner has if it was overcharged for the IRO review.

Finally, in its request for hearing, Petitioner argued that the MRD, in considering compensation rates for certain services provided between May 1 and June 26, 2002, was wrong in reasoning that a provider must, in his daily notes, show medical necessity for one-on-one therapy sessions under CPT Code 97110 (therapeutic exercises to develop strength and endurance, range of motion and flexibility). Because the ALJ has concluded that Petitioner failed to establish medical necessity for *any* services provided after January 28, 2002, the issue is moot and will not be addressed in this Decision and Order.

5. Conclusion

For the reasons summarized above, the ALJ concludes that Petitioner failed to show by a preponderance of the evidence that the services at issue were medically necessary, and thus, Petitioner is not entitled to be reimbursed for them.

IV. FINDINGS OF FACT

1. As of ___, Claimant ___ (Claimant) sustained compensable repetitive motion injuries to his back, neck, and shoulders, arms and wrists while working as an industrial sewing machine operator for Levi Strauss in Texas.

2. At the time Claimant sustained the compensable injuries, Respondent, ACE USA / ESES (the Carrier), was the insurance carrier for Claimant's employer.

3. For approximately ten months following his date of injury, Claimant received conservative treatment, which included physical therapy with ultrasound, hot packs, massage, and exercises as well as nonsteroidal and anti-inflammatory drug therapy, but his pain continued.

4. In October 1997, Claimant underwent a diskectomy, interbody fusion, and implantation of plates and steel screws at C4-5 and C5-6.

5. In January 1998, Claimant underwent arthroscopic surgery of the left shoulder with debridement of the rotator cuff and glenoid labrum and decompression of the left shoulder.

6. Claimant received extensive physical therapy both pre- and post-operatively and was instructed in how to perform home exercises. Claimant's shoulder surgery was followed by post-operative rehabilitation, including work hardening.

7. Following his surgeries, Claimant experienced exacerbations of his pain from time to time.
8. On or about September 16, 1998, Claimant reached Maximum Medical Improvement and received an 18 percent whole body impairment rating.

9. In January 2002, Claimant presented at the offices of Barry McAlpine, D.C., in Holland, Michigan, complaining of neck and shoulder pain.

10. Dr. McAlpine referred Claimant to Primary Health Care, P.C. (Petitioner) for evaluation and treatment.

11. On or about January 16, 2002, Petitioner's medical director, Ivan Dale Carroll, M.D., examined Claimant and prescribed a course of treatment that included ultrasound, electrical stimulation, mechanical traction, massage, office visits, x-rays, hot and cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and team conferences to discuss Claimant's progress.

12. Claimant was not exercising regularly when he commenced treatment with Dr. Carroll.

13. Neither of Claimant's surgeries was a "failed surgery" in the sense that the fusions did not hold.

14. In or about January 2002, Claimant suffered an exacerbation of his condition that warranted Petitioner's providing the services it did between January 16, 2002, and January 28, 2002.

15. Claimant received relief from his pain during Petitioner's course of treatment; however, he reverted to his previous condition within two months after the treatment.

16. Petitioner presented insufficient evidence to establish the medical necessity for and reasonableness of approximately five-and-one-half months of conservative careBthat brought Claimant only temporary pain reliefBsix years after his injury.

17. The services Petitioner provided to Claimant between January 20, 2002, and June 26, 2002, were not medically necessary or reasonable.

18. Petitioner timely filed a request for medical dispute resolution with the Texas Workers' Compensation Commission.

19. An independent review organization (IRO) chiropractor reviewed the medical dispute and found the services Petitioner provided to Claimant between January 16, 2002, and January 28, 2002, were medically necessary to treat an exacerbation of Claimant's condition.

20. The Commission's Medical Review Division (MRD) reviewed certain disputed services that were not addressed by the IRO. The MRD issued its Findings and Decision on January 12, 2004, partially granting and partially denying reimbursement.

21. Petitioner requested a hearing on February 2, 2004, and the Commission issued its Notice of Hearing on March 4, 2004.

22. The hearing in this matter was held on May 4, 2004, at 9:00 a.m., at the hearings facility of the State Office of Administrative Hearings, William P. Clements Building, 300 West 15th Street, Austin, Texas, with ALJ Renee M. Rusch presiding. Petitioner appeared *pro se* through its employee administrator, Barry McAlpine, D.C., who appeared by telephone. Claims adjuster J. Xavier Gonzalez represented the Carrier. The hearing concluded and the record closed that same day.

V. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings 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.

3. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN §§ 2001.051 and 2001.052.

4. Petitioner had the burden of proving by a preponderance of the evidence in this matter. 28 TEX. ADMIN. CODE §148.21(h).

5. Petitioner failed to carry his burden of proving that the services provided between January 30, 2002, and June 26, 2002, were medically necessary and reasonable. TEX. LAB. CODE ANN. §§ 408.021(a); 401.011(19) and (31).

6. Petitioner's request for reimbursement for the services at issue should be denied.

ORDER

IT IS ORDERED that Petitioner's request for payment for services it provided to Claimant ___ between January 30, 2002, and June 26, 2002, be, and the same is hereby, denied.

SIGNED June 16, 2004.

RENEE M. RUSCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS