SOAH DOCKET NO: 453-04-3674.M5

EAST TEXAS CHIROPRACTIC, **Petitioner**	**BEFORE THE STATE OFFICE**
V.	**OF**
ACE USA/ESIS, **Respondent**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Petitioner, East Texas Chiropractic (Provider), appealed the Findings and Decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC) denying reimbursement from ACE USA/ESIS (Carrier) for medical services provided to ___., (Claimant). Provider disputes the IRO's conclusion that these services were not medically necessary. The Administrative Law Judge (ALJ) concludes that Provider has not met its burden of proof with respect to the services in dispute provided to Claimant between November 5, 2002, and June 6, 2003. Thus, Provider should not be reimbursed.

I. PROCEDURAL HISTORY

ALJ Penny Wilkov convened a hearing in this case on May 11, 2004, at the State Office of Administrative Hearings, Austin, Texas. Attorney William Maxwell represented Provider. Attorney David A. Lawson represented Carrier. The record closed on May 11, 2004.

The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

1. Background

Claimant, a ___-year old male, sustained a work-related back injury on ___, while employed as a stacker at___, when he repeatedly stacked forty to fifty pound bags of material within a ten to twelve hour day. Claimant is not currently working.

Claimant has been generally diagnosed with facet syndrome, sciatica neuralgia or neuritis of sciatica nerve, muscle spasms, and lumbar region segmental dysfunction. An MRI revealed some bulges at the L3-4 and L5-S1 levels of Claimant's spine, and a small 2-3 mm posterior herniation. Claimant describes symptoms of constant pain, predominately in his back but also in his left leg. He reports a subjective level of pain ranging from six on a scale of one to ten.[1] The medical records indicate that he has been primarily under the care of Michael T. Fleck, D.C.

[1] Petitioner's Exhibit 1, page 191, (October 4, 2002, Examination by G. Peter Foox, M.D.).

Carrier denied payment, using denial code V[2] for the following treatments administered between November 5, 2002, and June 6, 2003**:**

X office visits on twenty five occasions.[3]

X therapeutic activities (direct patient contact by the provider) performed on twenty two occasions.[4]

$ manual traction services performed on eighteen occasions.[5]
$ joint mobilization conducted on fifteen occasions.[6]

$ preparation of a special report performed on a single occasion.[7]

$ diagnostic radiology (spine and pelvis) performed on a single occasion.[8]

$ diagnostic ultrasound (spinal canal) performed on a single occasion.[9]

$ analysis of information data stored in a computer performed on a single occasion.[10]

$ team conferences performed on two occasions.[11]

2. Evidence and Argument

1. Provider

Provider did not call any witnesses to testify but instead introduced into evidence a compilation of medical evaluations, assessments, follow-ups, reviews, and test results, all of which were considered as part of the IRO's decision process.

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[2] Denial Code V is used when the insurance carrier is denying payment because the treatment or service is medically unreasonable and unnecessary based on a peer review.

[3] CPT Code 99213, 99215, and 99219.

[4] CPT Code 97530.

[5] CPT Code 97122.

[6] CPT Code 97265.

[7] CPT Code 99080.

[8] CPT Code 72110.

[9] CPT Code 76800.

[10] CPT Code 99090.

[11] CPT Code 99362.

Provider argues that the Carrier's denial is essentially a decision made prior to the rendering of any of the disputed chiropractic services, that operates to circumvent Claimant's recovery. Specifically, on November 6, 2002, a peer review conducted by Timothy J. Fahey, D.C., concluded that, *in the absence of a surgical finding*, the exhaustion of non-surgical treatment had occurred.[12] The peer review, relied on by Carrier as the basis for denial, coincides with the initial date of disputed services, and recommends a self-directed personalized home exercise program as the best course of action. Therefore, Provider argues that the peer review result impermissibly and unfairly bars any prospective Providers from administering medically necessary treatment.

The issue then becomes whether there was a legitimate expectation that surgery was necessary but possibly preventable with treatment or whether the treatments just continued a fruitless course of action that had begun after the initial injury on March 29, 2002, and which could have been resolved with a home exercise program.

To address this issue, Provider contends Claimant was fearful of surgery, prompting his treating doctors to avoid surgical options such as steroid injections or a surgical fusion until conservative treatment proved futile. Provider points to the various medical reports and examinations that validate the services provided. One such physician, Charles R. Gordon, M.D., examined Claimant on November 4, 2002, shortly before the disputed treatments began, stating that he recommended trying conservative treatment prior to surgical intervention.[13] On December 5, 2002, Alexander Orlov, D.O., the designated doctor, examined Claimant and agreed that the course of treatment was working stating, AI do agree that all the (therapy and treatment) services so far performed has been very reasonable and necessary and in fact beneficial and had helped the patient quite a bit.@[14] On March 29, 2003, midway through the disputed services, Claimant was examined by Charles R. Gordon, M.D., who stated he wanted to try conservative management prior to surgical intervention. Five months after treatments concluded, on October 9, 2003, and on October 31, 2003, Uday Doctor, M.D., noted that he explained to Claimant that surgery would be the only other option.[15] Approximately one year after the injury, on March 24, 2003, Dr. Gordon notes that, Claimant continues to have pain and states that the conservative care has failed him, and at this point recommends surgery.[16] Thus, Provider argues that the peer review did not take into account that there was a recognition of the need for surgery by the treating physicians and that the therapy continued to aid in recovery.

Provider takes further issue with the conclusion of the peer review that a home based exercise program would be the best solution, noting that Dr. Fahey failed to state how this program would advance Claimant's recovery.

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[12] Respondent's Exhibit 1, page 51.

[13] Petitioner's Exhibit 1, page32 (Examination performed by Charles R. Gordon, M.D.).

[14] Respondent's Exhibit 1, page12 (Examination performed by Alexander Orlov, D.O.).

[15] Respondent's Exhibit 1, pages 145, 146 (Examination performed by Uday Doctor, M.D.).

[16] Petitioner's Exhibit 1, page 170 (Examination performed by Charles R. Gordon, M.D.).

2. Carrier

Carrier argues that it should not be required to reimburse Provider for all medical services provided between November 5, 2002 and June 6, 2003, since the treatments were unproductive and medically unnecessary.

Carrier argues that the reluctance to have surgery or injections should not be a reason to continue ineffective treatment and that Provider has distorted the medical findings to justify the disputed services. He points out that all of the doctors and chiropractors have consistently observed that the conservative treatments were not improving Claimant's condition. For instance, G. Peter Foox, M.D., who examined Claimant on October 4, 2002, prior to the disputed services, concluded that since there is no clinical indication for a surgical consideration and since ongoing conservative treatments have not been effective, there is no indication future structured treatment should continue.[17] He instead recommends a home exercise program of stretching and walking and a return to light-duty work. This opinion coincides with the peer review of fellow chiropractor, Timothy J. Fahey, D.C., who states that there is no indication that office modalities and procedures would have any benefit of equal to or better than a safe personalized home exercise program.[18] The Designated Doctor, Alexander Orlov, D.O., based on his December 12, 2002 examination, concluded that the patient had reached Maximum Medical Improvement (MMI) on December 5, 2002.[19] The practicing chiropractor on the Independent Review Organization's external review panel also concluded that most of the treatment rendered to the patient could have been performed at home and that the care rendered to Claimant did not cure or alleviate his pain, return the patient to work, or promote recovery.[20] Lastly, Carrier points to Claimant's statement, made in March 2003, that the conservative care has failed him as further proof of the ineffectiveness of treatment.[21]

3. Applicable Law

Under the workers' compensation system, an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment. TEX. LAB. CODE ANN. ' 408.021. "Health care" includes "all reasonable and necessary medical . . . services." TEX. LAB. CODE ANN.' 401.011(19).

4. Analysis

Provider has not met the burden of proof to establish entitlement to reimbursement for any services administered between November 5, 2002, and June 6, 2003**.** Although Claimant may have a fear of surgery, Carrier should not be required to continue to provide fruitless conservative treatments when no evidence has been presented that establishes the effectiveness or necessity of the

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[17] Petitioner's Exhibit 1, page 193.

[18] Respondent's Exhibit 1, page 53 (Case review performed on November 6, 2002).

[19] Respondent's Exhibit 1, page 12.

[20] Respondent's Exhibit 1, page 8 (Case review performed by Maximus).

[21] Petitioner's Exhibit 1, page 170.

services. Provider was aware that there were two medical opinions, from G. Peter Foox, M.D., who examined Claimant on October 4, 2002 and Timothy J. Fahey, D.C., who reviewed the records on November 6, 2002, that concurred that non-surgical treatment had been exhausted. Both recommenced a home exercise program based on the lack of indication that structured therapy was appropriate. With the concurrence of medical opinions, as has occurred in this case, Provider should have been on notice that continuing with the same course of treatment would not produce a favorable result. Assuming that there was a surgical indication, as argued by Provider, there has been no showing of the benefit of the continuous eight months of treatment in pain reduction, increase in range of motion, ability to return to work or alternatively, reduction in the necessity for surgery. Even Claimant concurred in the futility of the services when he stated in March, 2003, that conservative treatment had failed him.

5. Conclusion

Provider has not met the burden of proof to establish entitlement to reimbursement for any services administered between November 5, 2002, and June 6, 2003**.**

III. FINDINGS OF FACT

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

2. At the time of the injury, Claimant's employer had its workers= compensation insurance through ACE USA/ESIS (Carrier).

3. Claimant has been generally diagnosed with facet syndrome, sciatica neuralgia or neuritis of sciatica nerve, muscle spasms, and lumbar region segmental dysfunction.

4. Claimant describes symptoms of pain in his back and left leg.

5. Provider submitted a claim to Carrier for treatment rendered to Claimant from November 5, 2002, until June 6, 2003, including procedures billed under CPT codes 99213, 99215, and 99219 (office visits), 97530 (therapeutic activities), 97122 (manual traction), 97265 (joint mobilization), 99080 (preparation of special report), 72110 (diagnostic radiology), 76800 (diagnosis ultrasound), 99090 (analysis of computer data), and 99362 (team conferences).

6. Carrier denied Provider's request for reimbursement.

7. On December 15, 2003, Petitioner requested medical dispute resolution with the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD).

8. An Independent Review Organization concluded that chiropractic treatments rendered from November 5, 2002, until June 6, 2003, were not medically necessary.

9. Provider filed a request for a hearing before the State Office of Administrative Hearings on February 9, 2004.

10. The Commission sent notice of the hearing to the parties on March 9, 2004. The hearing notice informed the parties of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the statutes and rules involved; and the matters asserted.

11. The hearing convened on May 11, 2004 and the record closed on May 11, 2004. Provider appeared and was represented by William Maxwell, attorney. Carrier appeared and was represented by David A. Lawson, attorney.

12. Despite the services rendered to Claimant between November 5, 2002, until June 6, 2003, by Provider, there was no evidence that Claimant experienced either pain reduction, increase in range of motion, or ability to return to work or alternatively, that there was a reduction in the necessity for surgery.

13. As of the beginning date of disputed services, ongoing conservative treatments had not been effective in promoting Claimant's recovery and a home-based exercise program was the preferred method of treatment.

14. Provider was on notice, prior to and during the rendering of disputed services, that continuing conservative therapy was not producing favorable results for Claimant's recovery.

15. Provider has not shown the medical necessity of any of the disputed services rendered between November 5, 2002 until June 6, 2003.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings (SOAH) has jurisdiction over matters related to the hearing, 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 a request for hearing before SOAH, as specified in 28 TEX. ADMIN. CODE ' 148.3.

3. The parties received proper and timely notice of the hearing pursuant to TEX. GOV'T CODE ANN. ch. 2001 and 1 TEX. ADMIN. CODE ' 155.27.

4. Provider had the burden of proving the case by a preponderance of the evidence pursuant to 28 TEX. ADMIN. CODE ' 148.21.

5. 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 ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. ' 408.021(a).

6. Health care includes all reasonable and necessary medical services. TEX. LAB. CODE ANN. ' 401.011(19)(A).

7. Provider failed to establish that physical therapy modalities billed under CPT codes 99213,

99215, and 99219 (office visits), 97530 (therapeutic activities), 97122 (manual traction), 97265 (joint mobilization), 99080 (preparation of special report), 72110 (diagnostic radiology), 76800 (diagnosis ultrasound), 99090 (analysis of computer data), and 99362 (team conferences) are reimbursable under TEX. LAB. CODE ANN. §§ 401.011(19) and 408.021(a).

8. Provider's claim should be denied.

ORDER

IT IS **ORDERED** that East Texas Chiropractic is not entitled to reimbursement by ACE USA/ESIS for the physical therapy modalities billed under CPT codes 99213, 99215, and 99219 (office visits), 97530 (therapeutic activities), 97122 (manual traction), 97265 (joint mobilization), 99080 (preparation of special report), 72110 (diagnostic radiology), 76800 (diagnosis ultrasound), 99090 (analysis of computer data), and 99362 (team conferences) provided to Claimant between November 5, 2002, and June 6, 2003.

SIGNED July 6, 2004.

PENNY WILKOV
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS