SOAH DOCKET NO. 453-04-4339.M5
TWCC CASE NO. 03-2688

TEXAS MUTUAL INSURANCE CO.,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
V.	**§**	**OF**
	§	
ERIC A. VANDERWERFF, D.C.,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Co. ("Carrier") has challenged a decision of an independent review organization ("IRO") on behalf of the Texas Workers' Compensation Commission ("Commission") in a dispute regarding the medical necessity of chiropractic therapy services. The IRO found that Carrier improperly denied reimbursement for care that Eric A. Vanderwerff, D.C., ("Provider") administered between October 28 and December 27, 2002, to a claimant suffering from hand and wrist injuries.

Carrier challenged the decision on the basis that the treatment at issue was not, 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 that of the IRO, finding that reimbursement of the disputed services should be approved.

I. JURISDICTION, NOTICE, 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, notice, or venue.

II. STATEMENT OF THE CASE

The hearing in this docket was convened on September 21, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge ("LJ") Mike Rogan presided. Carrier was represented by Scott Placek, Attorney. Provider was represented by William Maxwell, Attorney. Both parties presented evidence and argument. The record remained open until October 6, 2004, to allow the parties to submit briefing and argument.[1]

The record revealed that on___, the claimant suffered a compensable injury to

[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 the hearing.

His right hand and wrist. His subsequent rehabilitation included rather extensive chiropractic care, including passive and active modalities, manipulative treatments, and a work hardening program.

Carrier (the insurer for the claimant's employer) reimbursed Provider for much of the physical therapy provided to the claimant B including the claimant's first 22 visits to Provider, beginning on September 19, 2002. However, Carrier denied reimbursement for services (including office visits with manipulation, joint mobilization, therapeutic exercises, electrical stimulation, and myofascial release) that were provided between October 28 and December 27, 2002, on grounds that these services were not medically necessary.

Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on September 16, 2003, concluding that Carrier should have reimbursed Provider for the disputed services. The IRO noted:

> . . . The patient underwent an appropriate course of care that showed steady improvement of his condition and ultimate return to work without restrictions or pain. Therefore . . . the office visits with manipulations, joint mobilization, electrical stimulation, myofascial release, therapeutic exercises from 10/28/02 through 12/19/02 and 12/27/02 were medically necessary to treat this patient's condition at this time.

The Commission's Medical Review Division ("MRD") reviewed the IRO's decision and, on January 27, 2004, issued its own decision confirming that the disputed services were medically necessary and should be reimbursed. Carrier then made a timely request for review of the IRO and MRD decisions before SOAH.

III. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Carrier

Carrier presented the video deposition of Mark Miller, a practicing physical therapist who also frequently lectures on treating spinal and musculo-skeletal conditions. Mr. Miller found the disputed services to be medically unnecessary, on grounds that the claimant should have progressed beyond the use of passive modalities during his 22 earlier visits to the Provider and should have been able to learn the relevant active modalities (therapeutic exercises) during that time, as well B thus allowing him to perform them at home, rather than under one-on-one supervision. According to Mr. Miller, the records in the claimant's case presented none of the valid justifications for one-on-one supervision of therapeutic exercise after October 28, 2002. The claimant was not being initially introduced to the exercise program, the program was not being adjusted or modified in response to constant monitoring of the patient's performance, and the patient's condition did not raise questions as to the safety of his performing the exercises unsupervised.

Based on his knowledge of the general medical literature, Mr. Miller agreed with Provider's position that repetitive movement (through exercise) is vital to developing healthy scar tissue in the healing of joints in the bodily extremities. However, he also noted that the literature shows home exercise, performed throughout each day, to produce better results than limited exercise under one-on-one supervision.

Mr. Miller criticized Provider's clinical notes for their wholesale lack of detail as to what exercises were performed on any date of service, what parts of the patient's body received passive modalities, and how the patient responded to such treatment. Based upon what general information the notes did provide, though, Mr. Miller concluded that Provider's basic treatment of the claimant remained virtually unchanged from the first visit on September 19 through the last disputed date of service on December 27, 2002. Such a prolonged, static course of treatment was unjustifiable, he contended.

At the outset of treatment, Mr. Miller noted, the claimant described his typical pain from the injury at a level of 6 (on an ascending scale of 1-10). About five weeks later, on October 28, 2002, (the first disputed date of service) the claimant still reported his pain as 6, suggesting to Mr. Miller that the initial 22 visits with Provider had produced insufficient progress to justify continuing the same course of treatment. Mr. Miller also noted that the claimant's reported pain fell to 1 (a level synonymous, in practical terms, with complete lack of pain) a couple of weeks later, by mid-November of 2002, which, in his view, should have prompted some change in Provider's regimen of treatment. The records do not reflect any such change, however.

Finally, Mr. Miller asserted a logical inconsistency in Provider's use, throughout the claimant's treatment program, of both joint manipulation and Russian electrical stimulation. The electrical stimulation was designed, in large part, to cause contractions in the muscles surrounding the injured joint without moving the joint itself B thus exercising and strengthening the muscles without disturbing adjacent injured tissue. However, joint manipulation entails high-velocity thrusting movement of an affected joint B thereby negating the isolation of the joint from disturbance, which is the main benefit of electrical stimulation. If the claimant was able to withstand joint manipulation from the outset of his treatment with Provider, Mr. Miller concluded, he never needed electrical stimulation to substitute for his own voluntary movement in exercising his muscles.

B. Provider

Provider, a licensed chiropractor, presented his own written deposition testimony. In it, he stated that the claimant suffered a Grade II sprain/strain to his right wrist, including a fracture of the fourth metacarpal, subluxations in the carpal bones, and some apparent nerve damage. For the most part, Provider's deposition enumerated the general types of treatments administered to the claimant and discussed some of the principles underlying the use of such treatments. As to issues bearing more directly on the medical necessity of the specific services at issue in this case, Provider noted that the claimant was a very cooperative and motivated patient whose performance in therapy was excellent. He also agreed that the claimant was a person of at least average intelligence who should have been safe from reinjuring himself while performing the exercises prescribed in his program of therapy. Provider conceded that he administered more or less the same services during every day of that program, but he stated that the specific exercises performed by the claimant changed, becoming more intensive over the course of treatment.

In a summary of his position on this dispute submitted to the IRO (dated August 20, 2003), Provider stated that because the injury at issue was a Grade II sprain/strain, with significant compromise to the bony/ligamentous structure of the wrist, the duration of appropriate care was substantially longer than would be expected for an uncomplicated Grade I sprain/strain. He also noted that the patient's injured wrist was 52 percent weaker than his uninjured wrist during a functional capacity examination ("FCE") on October 28, 2002, but only 29 percent weaker during an

FCE on December 26, 2002. (And by January 15, 2003, the wrists exhibited equal strength.) Provider cited medical literature, including a study by Finnish trauma researcher Pekka Kannus, M.D., Ph.D., showing that the typical Grade II sprain/strain requires six months to a year for healing.

Concluding his summary, Provider asserted that the claimant showed continuous, steady, objective clinical improvement throughout his five months' treatment by Provider. He stated that his daily notes reflect a significant, gradual reduction in swelling of the claimant's hand and wrist, in lost range of motion ("ROM"), in spasms and adhesions of the wrist extensor muscles, and in the severity of subluxations of the carpals. During the treatment, the claimant's perception of pain fell from 8 to 0, and at the end, he was able to return to work without restrictions (functioning at the Very Heavy physical demand level).

Records of the claimant's successive FCEs on October 28 and December 26, 2002, reflect marked improvement during that period B which corresponds almost exactly with the disputed dates of service. On the earlier FCE, the injured wrist's ROM was 90 percent of normal (or barely above that mark) for all four measurement categories , flexion, extension, ulnar deviation, and radial deviation). By the latter FCE, the injured wrist's ROM ranged from 104 to 151 percent of normal for the same categories. Similarly, the claimant's exertion of force with the injured wrist on a standard hand grip test went from 52.1 lbs. to 70.1 lbs.; and on a maximum voluntary effort test, from 62.5 lbs. to 84.7 lbs. However, in various "pinch tests," generally measuring force exerted through the fingers, the claimant showed some loss of strength between the two FCEs.

Documenting another physical performance evaluation on January 15, 2003, Adrian Olivares, D.C., reported:

> ____currently tries to push himself beyond his limits. He is not able to identify the moment at which his limitation is maximal. During work hardening close attention should be placed on this to teach him to identify his limits so that he can prevent re-injuring himself or aggravating his injury by pushing beyond his limits.

Dr. Olivares also examined the claimant for an impairment rating on January 29, 2003. He concluded that the patient had not yet reached maximum medical improvement ("MMI"), because the patient was then still undergoing "medically necessary work hardening" and was continuing to demonstrate improvement in his condition.

The claimant did not reach MMI until January 31, 2003, more than a month after the last disputed date of service, when a Designated Doctor (Michele M. Doone, D.C.) made that determination.

In closing argument, Provider's counsel also contended that Carrier, by questioning whether Provider's documentation of services adequately demonstrates the necessity of those services, has raised issues beyond the jurisdiction of SOAH in this case. Noting that SOAH's jurisdiction is limited to the denial codes enumerated by a carrier at the outset of a medical dispute resolution process and that the Carrier in this case denied reimbursement only on the basis that the disputed services were medically unnecessary, Provider argues that Carrier's subsequent criticism of documentation represents an unacknowledged effort to establish some basis for denial besides lack of necessity.

IV. ANALYSIS

Carrier bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. In the ALJ's view, it has not discharged that burden. Both parties submitted into evidence credible expert evaluations of the claimant's case, and the difference in probative weight between the parties' presentations was insufficient to justify overturning the IRO's prior conclusion.

Mr. Miller provided a rather persuasive critique of Provider's treatment, but much of it was somewhat general, rather than focused on the particular facts of this case, and he identified no specific standards of practice supporting his views of what normally constitutes reasonable therapeutic treatment. Mr. Miller acknowledged that a fracture of the fourth metacarpal, which occurred in this case, is rather rare, implying that he had not treated an injury precisely like the claimant's. He also did not address the significance of the fact that the claimant suffered a more complex Grade II sprain/strain, rather than a standard Grade I injury. While Mr. Miller raised a trenchant question about whether administering electrical stimulation and joint manipulation together is self-contradictory, his comments about the significance of the claimant's changing levels of reported pain also seemed to create something of a contradiction: they suggested that both a change in such pain and a lack of change in such pain were circumstances drawing into question the validity of Provider's course of treatment.

Provider's documentation of the disputed treatment and claimant's response to it is unquestionably sketchy and conclusory. His clinical notes repeatedly sum up the patient's condition with the uninformative observation, "improving." Still, the claimant's condition certainly did improve during the disputed dates of service, as reflected in FCEs performed at the beginning and end of the period and in the diminution of the claimant's subjective pain levels. While Provider's deposition testimony was also quite general, on the whole, it nonetheless conveyed the concept that the claimant's unusual injury at the complicated juncture of joints making up the wrist required a somewhat delicate and changing combination of passive therapy and monitored exercise. The comments of Dr. Olivares upon the claimant's tendency to push beyond limits during testing and possibly to aggravate his injury B which were made after the disputed dates of service B also provide some support for Provider's judgment that supervision of the claimant's therapeutic exercise was needed.

The record's lack of peer reviews or other reports from physicians questioning the necessity of the disputed treatment is also notable.

Since the ALJ's decision is based upon the conclusion that Carrier has failed to sustain its burden of proof, further consideration of other legal issues raised by Provider's counsel is not necessary. However, the ALJ does feel impelled to reject Provider's rather specious contention that Carrier, merely by examining the extent to which medical documentation supports the necessity of the disputed treatment, has gone beyond the proper bounds of an action for determining whether services are medically necessary. As noted by Carrier's closing argument, the only practical way for retrospectively establishing or challenging the medical necessity of treatment is by reviewing the medical records in the case (unless, of course, the treating physician's declarations upon necessity are simply to be accepted as indisputable). Seeking to analyze what documents reveal about the necessity of treatment is not, as Provider attempts to reason, the same as basing a denial of reimbursement on a lack of proper or administrative required documentation.

V. CONCLUSION

The ALJ finds that, under the record provided in this case, the disputed medical services have not been shown to be medically unnecessary. Provider should accordingly be reimbursed for these services, as previous determined by the IRO.

VI. FINDINGS OF FACT

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

2. Claimant's subsequent rehabilitation included rather extensive chiropractic care, including passive and active modalities, manipulative treatments, and a work hardening program.

3. When Eric A. Vanderwerff, D.C., ("Provider") billed Texas Mutual Insurance Co. ("Carrier") B the insurer for the claimant's employer B for some of the services noted in Finding of Fact No. 2 (including office visits with manipulation, joint mobilization, therapeutic exercises, electrical stimulation, and myofascial release that were provided between October 28 and December 27, 2002), Carrier denied reimbursement on grounds that these services were not medically necessary.

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

5. The independent review organization ("IRO") to which the Commission referred the dispute issued a decision on September 16, 2003, and concluded that the services in dispute had been medically necessary, because claimant showed steady improvement of his condition during the program of therapy administered by Provider and ultimately returned to work without restrictions or pain.

6. The Commission's Medical Review Division ("MRD") reviewed and concurred with the IRO's determination in a decision dated January 27, 2004, in dispute resolution docket No. M5-03-2688-01.

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

8. The Commission mailed notice of the hearing's setting to the parties at their addresses on April 5, 2004. The hearing was subsequently continued to a later date, with proper notice to the parties.

9. A hearing in this matter was convened before SOAH on September 21, 2004. Carrier and Provider were represented. The record in the proceeding remained open until October 6, 2004, to allow submission of argument and documentation of authorities.

10. Claimant's compensable injury was a Grade II sprain/strain to his right wrist, including a fracture of the fourth metacarpal, subluxations in the carpal bones, and some nerve damage. Such an injury, with significant compromise to the bony/ligamentous structure of the wrist, entails a period of appropriate care substantially longer than would be expected for an uncomplicated Grade I sprain/strain.

11. During the period of the disputed dates of service, as noted in Finding of Fact No. 3, claimant experienced significant improvement in his objectively tested strength and range of motion of his injured wrist and in his subjectively reported levels of pain.

12. Claimant's injury required a changing combination of passive therapy and monitored exercise over a period that encompassed the disputed dates of service.

13. With respect to services noted in Finding of Fact No. 3, Carrier did not show that the IRO and MRD erred in finding such services to be medically necessary, as noted in Findings of Fact Nos. 5 and 7.

VII. 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. ADMIN. 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. Carrier, 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 disputed services for the claimant noted in Finding of Fact No. 3 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 decisions in this matter of the IRO, issued on September 16, 2003, and of the MRD, issued on January 27, 2004, were correct. Provider should be reimbursed by Carrier for such services.

ORDER

IT IS THEREFORE, ORDERED that Texas Mutual Insurance Co. shall be required to reimburse Eric A. Vanderwerff, D.C., for those disputed therapy services provided from October 28 through December 27, 2002, as previously addressed in dispute resolution docket No. M5-03-2688-01 of the Texas Workers' Compensation Commission's Medical Review Division.

SIGNED December 6, 2004.

_____

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS