SOAH DOCKET NO. 453-04-4570.M5
MRD TRACKING NO. M5-04-0735-01

KEVIN STRATHDEE, D.C., **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
LIBERTY MUTUAL INSURANCE COMPANY, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Kevin Strathdee, D.C. (Provider) appeals from a decision by an independent review organization (IRO) regarding medical necessity for chiropractic treatment. The IRO found that Liberty Mutual Insurance Company (Carrier) properly denied reimbursement based on lack of medical necessity for therapy administered by Provider during February 10B28, 2003, to a claimant suffering from a right shoulder injury. Provider argues that the treatment was medically necessary while Carrier argues that it was not. This decision finds that the treatment was not medically necessary and that reimbursement for the disputed services should be denied.

I. JURISDICTION AND PROCEDURAL HISTORY

The Commission has jurisdiction over this matter pursuant to TEX. LAB. CODE ' 413.031. 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 TEX. LAB. CODE ' 413.031(k) and TEX. GOV'T CODE ch. 2003. No party challenged jurisdiction or venue.

Administrative Law Judge (ALJ) Thomas H. Walston convened a hearing in this matter on August 19, 2004, at the SOAH hearing facilities in Austin, Texas. Dr. Kevin Strathdee appeared by telephone, and attorney Kevin Franta represented Carrier. The hearing concluded and the record closed the same day.

II. DISCUSSION

A. Introduction

Claimant is a 75-year-old female who injured her right shoulder on ____, while lifting a bag of clothes over her head during the course of her employment with ____. Claimant received chiropractic care from Provider but her pain persisted. On October 16, 2002, Linden Dillin, M.D., performed surgery on Claimant's shoulder. The surgery included right shoulder arthroscopy, arthroscopic acromioplasty, A-C joint resection, labral debridement, and rotator cuff debridement. The surgery also revealed a large tear of the undersurface of the rotator cuff, but this was not repaired.

After the surgery, Claimant returned to Provider for a post-surgery physical medicine and rehabilitation program. These services were recommended by her surgeon, and Provider initially planned four weeks of daily treatment following the Wilk and Andrews protocol, which provides a treatment plan following rotator cuff surgery. Provider followed this protocol but it extended well beyond four weeks and continued until late February 2003.

In December 2002, Carrier hired Professional Reviews, Inc. to conduct a peer review of Provider's services. Thomas B. Sato, D.C., performed the review. He concluded that twelve additional rehabilitation sessions through January 31, 2003, would be appropriate, but any additional treatment would require additional documentation to support medical necessity. Provider continued to provide these services through the end of February 2003, and the services between February 10B28, 2003, are at issue in this case. Carrier has paid for all of Provider's services provided prior to February 10, 2003.

On March 4, 2003, Dr. Dillin reexamined Claimant He noted that she continued to have impairment in range of motion and tenderness over the A-C joint. She could place her arm on her buttock but could not reach all the way behind her back. He diagnosed her condition as right shoulder pain secondary to AC joint arthropathy and rotator cuff tearing. Claimant elected to go

forward with surgery and on May 21, 2003, Dr. Dillin performed a right rotator cuff repair and AC joint debridement. After this second surgery, Provider administered additional post-surgery rehabilitation services, but those services are not at issue in this case.[1]

Carrier denied payment for the services provided by Provider during February 10B28, 2004. The total amount in dispute is $2,465.00. Provider appealed Carrier's denial to TWCC, which assigned the matter the Envoy Medical Systems IRO. The IRO agreed with Carrier and stated the following rationale:

> The patient received excessive postoperative rehabilitation and because of her age she progressed very slowly. However, physical therapy treatment beyond the treatment that had been approved appears to have been excessive, based on the records provided for this review. The patient should have been easily transferred to a home exercise program. Based on the patient's age and the level of pathology found at surgery, it could be anticipated that the patient would take greater than one year to achieve maximal rehabilitation from surgical intervention. In addition, she will most likely suffer from permanent loss of motion or strength because of her age and the amount of pathology. However, chiropractic or physical therapy is not indicated during this long, extended course after surgical procedure. The records provided for this review failed to demonstrate the necessity for physical therapy or chiropractic treatment with modalities during the period in dispute.

B. Parties' Evidence and Arguments

1. Provider

Provider argues that the services were medically reasonable an necessary and should be reimbursed. Dr. Strathdee testified and offered Claimant's records into evidence. He is a chiropractor and was Claimant's treating doctor. Dr. Strathdee stated that he followed directions from Claimant's surgeon and that Claimant showed good improvement in her shoulder as a result of his therapy. Her abduction strength, extension, and flexion all increased, and her overall weakness decreased as the therapy progressed. Dr. Strathdee also explained that each patient must be

[1] Claimant also had a third shoulder surgery on January 28, 2004, to remove a recurring right inferior acromial spur, followed by additional therapy from Provider. Again, however, those services are not at issue in this proceeding.

considered individually and that Claimant required more therapy due to her age. He stated that because of her age, Claimant also needed close supervision and one-on-one assistance to ensure that she did the exercises properly.

At the time the disputed services were provided, Dr. Strathdee did not think Claimant would need additional surgery, and he provided the therapy in order to avoid surgery. However, Claimant decided to undergo additional surgery for a rotator cuff repair because she wanted even more improvement. Dr. Strathdee argued that his services met the criteria of the Workers' Compensation Act because it improved her condition and ability to return to work and reduced her pain. In his opinion, the services were medically reasonable and necessary and should be reimbursed.

2. Carrier

Carrier also offered Claimant's records into evidence and called Neal Blauzvern, D.O., as a witness. Dr. Blauzvern is board certified in anesthesiology and pain management. He reviewed Claimant's records but did not examine or treat her. Dr. Blauzvern summarized Claimant's course of treatment. He emphasized that Claimant's arthroscopic surgery in October 2002 revealed a significant rotator cuff tear, but the tear was not repaired at that time. Dr. Blauzvern stated that a typical post-arthroscopic surgery protocol would include eight to sixteen weeks of physical therapy that gradually moved to unsupervised home exercises. In this case, however, he argued that the rehabilitation efforts would never meet with success because Claimant's rotator cuff was not repaired. In other words, the therapy would show some initial improvement from the effects of surgery, but it could never return Claimant to normal due to her unrepaired, torn rotator cuff.

Dr. Blauzvern also testified that the Wilk and Andrews protocol followed by Dr. Strathdee was inappropriate because it is designed for athletes with stable rotator cuffs, which Claimant did not have. He also pointed out that this protocol has four progressive phases. Phases three and four require full, painless range of motion, which Claimant never reached and could not reach due to her torn rotator cuff. But Dr. Strathdee placed Claimant into those phases even without her reaching the specified criteria.

Finally, Dr. Blauzvern noted that Claimant subsequently had a full rotator cuff repair in May 2003 and had further therapy for several months after that surgery. He stated that this shows the therapy in dispute was not medically reasonable or necessary because it did not cure or relieve the effects of Claimant's injury, it did not promote recovery, and it did not enhance her ability to return to work. In his view, the therapy was futile with Claimant's torn rotator cuff, which Dr. Strathdee knew about at the time of his services.

C. ALJ's Analysis

The ALJ finds that Provider did not meet his burden of proof to show that the services he provided between February 10B28, 2004, were medically reasonable and necessary. Testimony was presented on both sides of this dispute, but Provider bears the burden of proving that the services were reasonable and necessary. In the ALJ's view, Provider has not discharged that burden.

The IRO examiner stated that Provider's treatment of Claimant was excessive, particularly considering Claimant's age and the pathology of her shoulder observed in the initial surgery. In her view, Claimant should have been moved into a home exercise program, and chiropractic therapy was not appropriate for such a long period of time. Dr. Blauzvern also explained that the extended therapy provided by Provider was futile due to Claimant's unrepaired rotator cuff. And he pointed out that even the Wilk and Andrews protocol followed by Provider states that it is designed for patients with a stable rotator cuff, which Claimant did not have. This was born out by subsequent events, as Claimant made only limited progress and eventually had to undergo surgery for rotator cuff repair. Provider knew about Claimant's rotator cuff tear when he provided the services in dispute, and the ALJ believes that the services were not medically reasonable and necessary under these circumstances.

In summary, the ALJ finds that, under the record in this case, Provider did not establish that the services at issue were medically necessary. Accordingly, reimbursement for these services should be denied.

III. FINDINGS OF FACT

1. On ____, Claimant suffered an injury to her right shoulder during the course of her employment with ____. The injury was compensable under the Texas Worker's Compensation Act (the Act), TEX. LAB. CODE § 401.001 *et seq*.

2. At the time of Claimant's injury, Respondent Liberty Mutual Insurance Company (Carrier) provided workers' compensation insurance coverage for her employer.

3. Claimant underwent arthroscopic shoulder surgery (decompression and debridement) on October 16, 2002. The surgery revealed a large rotator cuff tear, but the tear was not repaired at that time.

4. Provider Kevin Strathdee, D.C., provided post-surgical rehabilitation therapy for Claimant. This treatment included office visits, joint mobilization, myofascial trigger point massage, hot packs, various exercises, and other therapeutic procedures.

5. Provider sought reimbursement from Carrier for services noted in Finding of Fact No. 4, including care provided on dates of service during February 10-28, 2003. The amount in dispute for these dates of service is $2,465.00.

6. Provider's treatment of Claimant during the period in dispute was ineffective because Claimant had a torn rotator cuff. The treatment protocol used by Provider is designed for patient's with stable rotator cuffs.

7. When Claimant received the services in dispute from Provider, her rotator cuff was torn, unrepaired, and not stable.

8. Based on Finding of Fact Nos. 6 and 7, Provider's treatment of Claimant during the period in dispute was not medically reasonable or necessary.

9. On May 21, 2003, Claimant had surgery for a rotator cuff repair in her right shoulder.

10. Carrier denied the requested reimbursement for dates of service February 10-28, 2003.

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

12. The independent review organization (IRO) to which the Commission referred the dispute issued a decision on February 16, 2004, and concluded that the disputed services were not medically reasonable or necessary.

13. The Commission's Medical Review Division reviewed and concurred with the IRO's determination in a decision dated February 24, 2004, in dispute resolution docket No. M5-04-0735-01.

14. Provider timely requested a contested case hearing with the State Office of Administrative Hearings (SOAH), seeking reimbursement for the services in dispute.

15. The Commission mailed notice of the hearing's setting to the parties at their addresses on April 26, 2004. The hearing was subsequently continued to a later date, with proper notice to the parties.

16. A hearing in this matter convened before SOAH on August 19, 2004. Provider and Carrier appeared and participated in the hearing. The hearing concluded and the record closed the same day.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to TEX. LAB. 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 TEX. LAB. CODE ANN. § 413.031(k) 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. Provider, as the party seeking relief, bore the burden of proof in this case pursuant to 28 TAC §148.21(h).

6. The disputed treatments for Claimant, noted in Findings of Fact Nos. 4 and 5, were not reasonable and necessary health care under TEX. LAB. CODE ANN. § 408.021.

7. Provider's request of reimbursement for the services noted in Findings of Fact Nos. 4 and 5 should be denied.

ORDER

IT IS THEREFORE, ORDERED that Dr. Kevin Strathdee's request for reimbursement for therapeutic services provided to Claimant during February 10-28, 2003, is denied, and that Dr. Strathdee shall have and recover nothing from Liberty Mutual Insurance Company for the services in dispute in this proceeding.

Signed October 15, 2004.

THOMAS H. WALSTON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS