SOAH DOCKET NO. 453-04-8177.M5

MARSHA MILLER, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
ST. PAUL MERCURY	§	
INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

Marsha Miller, D.C., (Provider) appealed the decision of Envoy Medical Systems, LP, an independent review organization (IRO) certified by the Texas Department of Insurance, in Texas Workers' Compensation Commission (TWCC) Medical Review Division (MRD) tracking number M5-04-2466-01, denying reimbursement for medical services provided to the Claimant. This decision orders that St. Paul Mercury Insurance Company (Carrier) is not required to reimburse the Provider for the services in dispute.

The Administrative Law Judge (ALJ) convened a hearing on April 6, 2005. The hearing was concluded and the record closed that date. The Provider appeared *pro se* by telephone. The Carrier appeared through Steven M. Tipton, attorney.

II. EVIDENCE AND BASIS FOR DECISION

The issue presented in this proceeding is whether the Carrier should reimburse the Provider $1,977 plus interest for medical services provided between February 21, 2003, and July 8, 2003, and billed under CPT Codes 97124 (massage), 97250 (myofascial release), 97750-MT (muscle testing), 99070 (supplies and materials), 99211 (office visit), 99213 (office visit), 99358 (prolonged evaluation), and 99361 (medical conference). The Carrier argued that the medical services provided to the Claimant were not medically necessary or reasonably required to treat the compensable injury.

The documentary record in this case consisted of five packets of medical records (Prov. Exh. 1 - 244 pages, and Car. Exhs. 1, 2, 3, and 4 - 87 pages). Also, the Provider testified in her own

behalf.

The record revealed that on ___, the Claimant, a 37-year-old man, suffered an injury to his lower back while lifting 80-pound bags of cement. The Claimant began treatment with the Provider on August 5, 2002. On the initial narrative report, the Provider noted that the Claimant suffered from pain and stiffness in the lower back, and he was diagnosed with suspect displacement of the lumbar intervertebral disc without myelopathy, lumbar radiculitis, low back syndrome (pain, lumbago, or lumbagia), and muscle spasms. Treatment consisted of heat therapy, interferential current, intersegmental traction, and massage.[1]

Radiographs of the lumbar spine taken on August 12, 2002, revealed no evidence of acute fracture, but mild degenerative disc narrowing and facet tropism at the L5-S1 level was detected.[2] A lumbar spine CT performed on August 26, 2002, showed no vertebral body compression, spondylolisthesis, or spondylolysis. Mild degenerative disc narrowing without evidence of compression or displacement and a 2-3 mm protrusion were found at the L5-S1 level.[3]

R. Frank Morrison, M.D., examined the Claimant on September 9, 2002, and reported an abnormal EMG showing L5 radiculopathy on the right side. Dr. Morrison did not recommend any change in treatment unless the Claimant's progress slowed and his symptoms persisted.[4]

On November 12, 2002, Hooman Sedighi, M.D., completed an independent medical examination of the Claimant. Dr. Sedighi noted that the Provider had treated the Claimant with continuous chiropractic measures and passive modalities without any lasting benefit reported by the patient. He also indicated that the disc protrusion seen on the CT scan did not affect the L5 nerve root. Dr. Sedighi diagnosed the Claimant with a soft tissue injury consistent with lumbar strain and with no evidence of disc herniation. His only finding on physical examination was minimal muscle tightness. According to Dr. Sedighi, appropriate treatment for such an injury was physical therapy for two months with no more than two weeks of passive modalities included, which had been exceeded by the extensive amount of passive therapy delivered by the Provider with only transient benefit. Dr. Sedighi concluded by stating that no further formal intervention is deemed medically

1 Car. Exh. 3, pages 48 - 52.

appropriate and the patient should have been discharged to an active home exercise program already.[5]

Frank Schneider, D.C., reviewed the Claimant's medical records and issued his report dated December 23, 2002. Dr. Schneider agreed with Dr. Sedighi that an . . . active, patient-driven program is medically necessary and warranted in this case if the patient shows qualifying factors in an FCE. Additionally, he stated that further unidisciplinary passive therapeutic applications that include but are not limited to manipulation, myofascial release, and interferential are no longer appropriate to treat this patient's condition.[6]

The ALJ concludes that the Provider failed to prove that the medical services delivered from February 21, 2003, to July 8, 2003, were medically necessary and reasonably required to treat the Claimant's compensable injury. Both Dr. Sedighi and Dr. Schneider concluded that the Claimant was treated with more than adequate passive treatment with little success. Additionally, Dr. Sedighi stated that the Claimant suffered from a soft tissue injury and would have benefitted from an active home exercise program and non-steroidal anti-inflammatory medication. Therefore, the Provider should not be reimbursed for the contested services delivered to the Claimant.

III. FINDINGS OF FACT

1. On ___, the Claimant suffered a compensable injury to his lower back.

2. The Claimant's injury is covered by workers' compensation insurance written for the Claimant's employer by St. Paul Mercury Insurance Company (Carrier).

3. The Claimant was treated with passive chiropractic care beginning August 5, 2002, by Marsha Miller, D.C. (Provider) following a diagnosis of suspect displacement of the lumbar intervertebral disc without myelopathy, lumbar radiculitis, low back syndrome (pain, lumbago, or lumbagia), and muscle spasms.

4. The Provider's treatment of the Claimant's injury was billed under CPT Codes 97124 (massage), 97250 (myofascial release), 97750-MT (muscle testing), 99070 (supplies and materials), 99211 (office visit), 99213 (office visit), 99358 (prolonged evaluation), and 99361 (medical conference) .

5. The medical services in dispute were provided from February 21, 2003, and July 8, 2003, and reimbursement in the amount of $1,977.00 was denied on the basis that the treatment was not medically necessary or reasonably required to treat the compensable injury.

6. Hooman Sedighi, M.D., diagnosed the Claimant with a soft tissue injury consistent with lumbar strain and with no evidence of disc herniation. His only finding on physical examination was minimal muscle tightness.

7. The Claimant was treated with more than adequate passive treatment with little success.

8. The Claimant suffered from a soft tissue injury and would have benefitted from an active home exercise program and non-steroidal anti-inflammatory medication.

9. The Provider timely requested dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC).

10. On June 2, 2004, the IRO issued its decision concluding that the disputed expenses should not be paid, and the Provider timely appealed this decision.

11. TWCC sent notice of the hearing to the parties on August 3, 2004. The hearing notice informed the parties of the matter to be determined, the right to appear and be represented by counsel, the time and place of the hearing, and the statutes and rules involved.

12. The hearing on the merits convened April 6, 2005, before Michael J. Borkland, Administrative Law Judge. The Provider appeared *pro se* by telephone. The Carrier appeared through Steven M. Tipton, attorney.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (TWCC) has jurisdiction to decide the issues presented 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 and TEX. GOV'T CODE ANN. ch. 2003.

3. Based on Finding of Fact No. 11, the Notice of Hearing issued by TWCC conformed to the requirements of TEX. GOV'T CODE ANN. §2001.052.

4. The Provider has the burden of proving by a preponderance of the evidence that she should prevail in this matter. TEX. LAB. CODE ANN. §413.031.

5. Based on Findings of Fact Nos. 6 - 8, the Provider failed to prove that reimbursement for treatment provided from February 21, 2003, and July 8, 2003, should be ordered.

ORDER

IT IS, THEREFORE, ORDERED that St. Paul Mercury Insurance Company is not required to reimburse Marsha Miller, D.C. for the disputed services provided in treating the Claimant.

SIGNED May 18, 2005.

MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS