SOAH DOCKET NO. 453-04-8233.M5
MDR NO. M5-03-2056-01

ATLANTIS HEALTHCARE CLINIC	**§**	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	**§**	**OF**
	§	
ZURICH AMERICAN	**§**	
INSURANCE COMPANY	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Atlantis Healthcare Clinic (Provider) has challenged a decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) in a dispute regarding the medical necessity of chiropractic services provided to an injured claimant between August 20 and October 10, 2002. The MRD's decision was based on the findings of an independent review organization (IRO), which concluded that the insurer, Zurich American Insurance Company (Carrier), properly denied reimbursement for all of the services in dispute.[1] Provider challenged the decision on the basis that the treatment at issue was, in fact, medically necessary within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act, TEX. LABOR CODE ANN. ch. 401 *et seq.* The amount in controversy is $6,206.00.

The Administrative Law Judge (ALJ) concludes that the services in dispute were not medically necessary, and Provider is not entitled to any additional reimbursement.

I. JURISDICTION, NOTICE AND PROCEDURAL HISTORY

The hearing in this matter was convened June 9, 2005, at the State Office of Administrative Hearings with ALJ Carol S. Birch presiding. Provider was represented by its designated representative, Todd Peterson, D.C., who appeared by telephone. Carrier was represented by its

[1] Although the IRO addressed additional dates of service, they were not listed on the Table of Disputed Services (Provider's ex. 1, pp. 17-21), and, therefore, are not at issue in this proceeding. The MRD also found other services not reimbursable based on the Medical Fee Guidelines, but those findings were not appealed, and are likewise not at issue here.

attorney, Steven M. Tipton. After presentation of evidence and argument by the parties, the hearing was adjourned the same day. The record closed on July 15, 2005, after the filing of the final written closing arguments. The evidence on the issue of medical necessity consisted of medical records submitted by Provider, peer reviews submitted by Carrier, and the testimony of Dr. Peterson and Kellie Timberlake, D.C.

There were no contested issues of jurisdiction or notice. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

II. DISCUSSION

1. Background Facts

The record revealed the claimant suffered a compensable injury to his cervical and lumbar spine on ___, while pulling on a wire at work. He began chiropractic care with Provider on May 29, 2002, and it appears that the initial diagnosis was cervical and lumbar sprain/strain.

Over the three-month period between the claimant's initial visit and the dates of service in question in this proceeding, Provider provided approximately 44 sessions of chiropractic treatment to the claimant. The treatment provided at each session appears to have been generally the same and included office visits with and without manipulation, joint mobilization, one-to-one therapeutic exercises, myofascial release, range of motion measurements, muscle testing, and electrical stimulation.

Despite all of this treatment, the records reflect little improvement in the claimant's condition, and Provider continued to treat him, providing essentially the same basic protocols for at least another seven months. When Provider billed Carrier for the 23 dates of service disputed in this proceeding, Carrier denied payment for all treatments and office visits during that period of time on the basis that they were not medically necessary, with peer review.

B. IRO Decision

Based on a review of the medical records, the IRO physician found that prior to the disputed dates of service, the claimant had undergone an exhaustive course of chiropractic care and had made no significant progress. The reviewer noted that the objective findings and the subjective pain levels reported in the records varied greatly from exam to exam. The reviewer further noted that it was obvious from the record that psychological intervention or a work-hardening program would have been appropriate by the time of the first date of disputed service, rather than continuing the same course of treatment.

The reviewer also concluded that although the claimant eventually made progress, it was not clear that same result would not have been reached in the same time frame without any additional treatment. Therefore, the reviewer determined that all of the services provided on the disputed dates of service were not medically necessary.

C. Applicable Law

Under Texas law, an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. TEX. LABOR CODE § 408.021. The statute provides that the purposes for which health care is to be rendered to a claimant include any that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The types of health care to which an employee is entitled are similarly broad, including "all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services." TEX. LABOR CODE § 401.11(19).

Although the law describes few limitations on a claimant's entitlement to care, the law places upon the treating physician an obligation to maintain efficient utilization of health care. TEX. LABOR CODE § 408.025(c).

D. Burden of Proof

Under the Commission's rules, an IRO decision is deemed a Commission decision and order.[2] The burden of proof in this case is on Provider to prove by a preponderance of the evidence that the disputed services were reasonable and necessary medical treatments.[3]

E. Argument and Analysis

The basic facts are not in dispute in this case, although the parties' interpretations of the medical evidence differ significantly. Provider argued generally that the treatment at issue was medically necessary as follows:

- The claimant's injury was more serious than the diagnosis of a simple sprain/strain would suggest, and therefore required more treatment.
- Because the claimant did not reach maximum medical improvement (MMI) until sometime after the disputed dates of service, there was still potential for improvement of his condition, and Provider was entitled to rely on this finding to justify continued treatments.
- The claimant's physician instructed the claimant to continue chiropractic care during the dates in question, and Provider was entitled to rely on those instructions.
- The results of the range of motion and muscle testing done regularly by Provider demonstrate improvement in the claimant's condition.

Carrier responded by pointing out the following:

- Before even reaching the dates of service in dispute, Provider had exceeded the parameters of even the most difficult case, with little improvement and no change in approach.
- The MRI reports of normal, pre-existing anatomical conditions of the claimant's spine cannot be used to justify the amount of treatment provided.
- The testing relied on by Provider to demonstrate improvement is easily manipulated by the patient, and provides no cross-validation measures. Furthermore, the test results do not reveal any consistent or lasting improvement in the claimant's

[2] 28 TEX. ADMIN. CODE § 133.308(p)(5).

[3] 28 TEX. ADMIN. CODE §§ 133.308(p)(5), 148.14(a).

condition.

- The progress in the claimant's condition claimed by Provider reflects nothing more than an increase in function one would expect with the natural history of any injury, even without treatment.

- Provider completely ignores the fact that the claimant was observed by the designated doctor to exhibit seven out of seven positive signs of symptom exaggeration.

- There is nothing in the record to indicate Provider's particular treatments were warranted to treat the claimant.

Provider 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 met that burden. Dr. Peterson's testimony at the hearing - which consisted principally of generalities rather than any focused explanation of the medical need for the disputed care in this case - did not make Provider's case any more convincing than did the information apparently provided to the IRO. As Dr. Timberlake's testimony was more persuasive than that of Dr. Peterson, Provider clearly has not demonstrated by a preponderance of the evidence that the prior decisions of the IRO and MRD in this case should be overturned.

Based on the evidence in this case as discussed above, and as set forth in the findings of fact, the ALJ concludes Provider failed to meet its burden of proof to show that chiropractic care was reasonable and necessary for the disputed dates of service to treat the claimant's injuries. Although all of the evidence presented was not discussed in this decision, it was considered. The findings of fact and conclusions of law are based on all of the evidence in the record.

III. FINDINGS OF FACT

1. An injured worker, the claimant, suffered compensable injuries on ___, while pulling on a wire at work.

2. At the time of the claimant's injury, his employer had workers' compensation insurance with Zurich American Insurance Company (Carrier).

3. The claimant began treatment with Atlantis Healthcare Clinic (Provider) on May 29, 2002.

4. The claimant was diagnosed with cervical and lumbar sprain/strain.
5. Over the three-month period between the claimant's initial visit and the dates of service in question in this proceeding, Provider provided approximately 44 sessions of chiropractic

treatment to the claimant that included office visits with and without manipulation, joint mobilization, one-to-one therapeutic exercises, myofascial release, range of motion measurements, muscle testing, and electrical stimulation.

6. On 23 dates between August 20 and October 10, 2002, Provider performed or provided chiropractic services to the claimant that included the same basic protocols as the previous 44 visits.

7. Carrier denied the requested reimbursement for those 23 dates of service.

8. Provider made a timely request to the Texas Workers' Compensation Commission (the Commission) for medical dispute resolution with respect to the services provided between August 20 and October 10, 2002.

9. The Commission referred the dispute to an independent review organization (IRO), which concluded that the services in dispute were not medically necessary.

10. The Commission's Medical Review Division (MRD) reviewed and concurred with the IRO's decision.

11. Provider timely requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.

12. The Commission mailed notice of the hearing setting to the parties on August 11, 2004.

13. A hearing in this matter was convened on June 9, 2005, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Carol S. Birch, an Administrative Law Judge with SOAH. Provider and Carrier were represented and participated in the hearing.

14. The chiropractic services provided to the claimant did not result in any improvement in his condition that would not have occurred naturally with the passage of time.

15. Provider failed to substantiate the need for treatment after more than 40 previous treatment sessions.

16. The duration of treatment was not reasonable or medically necessary.

IV. CONCLUSIONS OF LAW

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

2. 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.

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. ADMINISTRATIVE 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, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.14(a).

6. Based upon the foregoing Findings of Fact, the treatments for the claimant from August 20 through October 10, 2002, do not represent elements of health care medically necessary under § 408.021 of the Act.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions of the IRO and of the MRD were correct.

ORDER

IT IS THEREFORE, ORDERED that the appeal of Atlantis Healthcare Clinic, seeking reimbursement for chiropractic services performed from August 20 through October 10, 2002, be denied.

SIGNED on September 13, 2005.

CAROL S. BIRCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS