SOAH DOCKET NOS. 453-05-1458.M5 and 453-05-3404.M5
TWCC MR. NOS. M5-04-3866-01 and M5-04-1939-01

J. P. M., D. C., **Petitioner**	**BEFORE THE STATE OFFICE**
V.	**OF**
LIBERTY MUTUAL FIRE INSURANCE COMPANY, **Respondent**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Jack P. Mitchell, D. C. (Provider), challenged the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC or Commission)[1] denying reimbursement to him for a variety of rehabilitation services and office visits provided to ___ (Claimant) between June 20, 2003, and December 29, 2003. The MRD determined that the services provided were not medically necessary. Provider also sought refund of the fee levied for initiation of an Independent Review Organization (IRO) review of one claim, asserting that he was the prevailing party in that matter.

Provider treated Claimant for low back injury throughout the period in dispute. However, separate requests for reimbursement resulted in two MRD decisions. The first claim covered services between June 20, 2003, and July 28, 2003 (first treatment period).[2] The second claim covered services between August 13, 2003, and December 29, 2003 (second treatment period).[3]

[1] The Commission was abolished effective September 1, 2005, and the functions of the Commission assigned to the Division of Workers' Compensation of the Texas Department of Insurance. The agency name as of the time of the claims is used here for clarity.

[2] Docket No. 453-05-3404.M5 (MR. No. M5-04-1939-01).

[3] Docket No. 453-05-1458.M5 (MR. No. M5-04-3866-01).

On November 10, 2004, the MRD ruled that some of the services provided to Claimant during the first treatment period were medically necessary, but that office visits with manipulations on six days within that period were not. The MRD also ruled that Liberty Mutual Fire Insurance Company (Carrier) prevailed on the issue of medical necessity so did not refund the IRO fee to Provider. On September 14, 2004, the MRD ruled that no spinal manipulation or other passive treatments administered to Claimant during the second treatment period were medically necessary. Provider sought a contested case hearing on all matters for which the MRD declined to order reimbursement for both treatment periods.

The Administrative Law Judge (ALJ) concludes that Provider is entitled to reimbursement for the services during the first treatment period, but not for services provided during the second treatment period. The refund issue is being dismissed because the State Office of Administrative Hearings (SOAH) has no authority to resolve disputes on that subject.

As both cases involved the same parties, claimant, and injury, the hearings for both were conducted together on August 4, 2005. One evidentiary record applicable to both cases was made. The hearing convened in Austin, Texas, with ALJ Cassandra Church presiding. The record-closing date was extended to September 2, 2005, to allow the parties to submit written argument. Carrier was represented by Charlotte Salter, attorney; Provider represented himself.

Notice was proper and jurisdiction was established in this case.

I. DISCUSSION

A. Applicable Standards and Rules

Most medical care in this case was provided after August 1, 2003, which is the date on which the terms of the 2002 *Medical Fee Guideline* (2002 MFG) went into effect.[4] The 2002 MFG adopted the guidelines of the Center for Medicare and Medicaid Services polices (CMS policies) as the guidelines for treating injured workers in Texas, augmenting them in some matters specific to worker rehabilitation. Care for dates before August 1, 2003, is governed by the 1996 *Medical Fee Guideline* (1996 MFG).[5] However, the parties used CPT codes appearing in the 1996 MFG for both periods. Neither the parties nor the MRD contended that the CMS polices applicable to this case differed from standards applied in the past. Both parties and the MRD applied the reimbursement values set forth in the 1996 MFG.

Under both guidelines, the medical necessity for treatment is the key determinant for reimbursement.[6] Here, both parties disputed whether the treatments comprised care needed to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

Rule 133.308 provides for the IRO review process including allocation of fees. Specifically, Rule 133.308(r)(1) provides that a requestor, in the case of a retrospective review, must pay the fee at the time an IRO reviewer is assigned, subject to a refund of the fee if the requestor prevails. The fee allocation provisions found in Rule 133.308(r)(2)(c) are as follows:

---

[4] *See Texas Medical Ass'n v. Texas Workers' Compensation Com'n*, 137 S.W.3d 342 (Tex. App.-Austin 2004, rehearing overruled June 24, 2004). This decision affirmed the District Court judgment and denied a permanent injunction to restrain implementation of the 2002 MFG. 28 TEX. ADMIN. CODE § 134.202(2). Further, it did not change the District Court Judge's determination that the effective date of the 2002 MFG would be August 1, 2003. Final Judgment, Cause No. GN 202203, June 1, 2003 (J. Dietz).

[5] 28 TEX. ADMIN. CODE § 134.201 (Eff. date April 1, 1996).

[6] Provider Exh. 2, TWCC Advisory 2003-11 (July 15, 2003).

(r) IRO Fees. IRO fees shall be paid as follows.

Y

(2) Upon receipt of an IRO decision in a retrospective necessity dispute other than an employee reimbursement dispute, and in a concurrent review prospective necessity dispute, the commission shall review the decision to determine the prevailing party and, if applicable, will order the nonprevailing party to refund the IRO fee to the party who prevailed by CCH or SOAH decision.

(A) If the IRO decision as to the main issue in dispute is a finding of medical necessity, the requestor is the prevailing party.

(B) If the IRO decision does not find medical necessity with respect to the main issue in dispute, the respondent is the prevailing party.

(C) If the IRO decision does not clearly determine the prevailing party, the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

B. History of the Claims

On ___, Claimant injured his low back while unloading 70-pound packages from a truck. Claimant's back pain increased to the point he could not work. Provider diagnosed Claimant as having lumbar disc displacement, lumbosacral neuritis, and lumbosacral disc degeneration.[7] An X-ray examination on May 28, 2003, showed suggestions of early degenerative disc changes but no other abnormality.[8] A MRI examination on May 5, 2003, showed that Claimant had posterior annular[9] radial tearing of the L4-L5 disc with mild associated posterior disc bulging and also some

[7] Provider Exh. 1, pp. 124-126.

[8] Carrier Exh. 1, p. 25.

[9] A ring of cartilage surrounding the soft portion of the spinal disc.

desiccation. There was no significant narrowing (stenosis) of the central or neural openings in the spine (foramina).[10] Other levels of the spine showed no injury.

Provider began treating Claimant three days after the injury, on ___, and was his treating doctor throughout 2003.[11]

Immediately after the injury, Provider administered conservative chiropractic care.[12] Claimant then underwent six weeks of work conditioning beginning on June 16, 2003, and ending on July 25, 2003.

Provider released Claimant to work on July 14, 2003, with restrictions and, on July 29, 2003, determined Claimant was ready to return to work without restrictions.[13] Claimant returned to his prior job with a parcel delivery firm and continued in that position during the remainder of the disputed period. On July 30, 2003, Provider determined Claimant to be at maximum medical improvement (MMI) and assigned an impairment rating of five per cent.[14]

(1) First Treatment Period

For services administered during the first treatment period, Provider requested dispute resolution on bills totaling $649.00, and paid the IRO fee. Before the MRD issued its decision, Carrier paid $72.00 on two claims so the total amount in dispute considered by the MRD was $577.00. The MRD ordered payment of a total of $289.00, on both medical necessity and fee grounds, which is $1.00 over half of the amount at issue. The MRD found that Provider did not

[10] Carrier Exh. 1, p. 45.

[11] Provider continued to treat Claimant at least through mid-July of 2004. Carrier Exh. 1, pp. 59-60.

[12] Carrier Exh. 1, pp. 29-75.

[13] Provider Exh. 1, pp. 128-133.

[14] Provider Exh. 1, pp. 123-127.

prevail on the majority of the *medical necessity* issues so did not order the IRO fee refunded to Provider.[15]

The MRD denied reimbursement for six expanded office visits with manipulations (CPT Code 99213-MP), but approved payment for two office visits with manipulation and a telephone conference.[16] Reimbursement was denied for visits on June 20, 2003, and on July 15, 18, 21, 23, and 25, 2003. All sessions denied fell within the dates of the work conditioning program. The IRO reviewer concluded that an expanded office visit with manipulation once every two weeks for continued monitoring, re-evaluation, and pain relief during the course of the work conditioning program was medically necessary but that spinal manipulations administered three times a week or more were not warranted. The reimbursement rate for an office visit with manipulations was $48.00, pursuant to the 1996 MFG.

The MRD also awarded reimbursement to Provider in the amount of $182.00 on three fee issues. Of that total, $167.00 was for office visits for which Carrier had denied payment on fee grounds rather than the medical necessity grounds it had used for denying similar office visits. Provider asserted that Carrier's grounds for denial appeared arbitrary, if not random. He argued that the appropriate grounds for determining which party prevailed, thus which party bears the cost of the IRO review, should be the total dollar amount of all claims referred to dispute resolution.

(2) Second Treatment Period

For services provided during the second treatment period, the MRD denied reimbursement for all passive modality treatments, all office visits with manipulations, and all manipulation sessions. Provider treated Claimant approximately once a week, a total of 13 times, during that period for the purpose of pain relief. The IRO reviewer in this case concluded there was no medical

[15] Provider Exh. 1, pp. 6-12.

[16] The MRD ordered reimbursement for expanded office visits with manipulations on June 18, 2003, and July 28, 2003, and also for a telephone conference on July 2, 2003. Provider Exh. 1, p. 7.

necessity for administering passive treatments to Claimant at such frequency long after the the acute phase of Claimant's injury had ended.[17]

Provider contended that all treatments were necessary to alleviate Claimant's ongoing pain arising from exacerbations of the compensable injury.

Provider also contended that Carrier had conducted an improper prospective review of the claims from this period because, in denying the claims, Carrier relied on a peer review performed before the dates of service at issue. Jason Watkins, D. C., performed a peer review on July 8, 2003, a date somewhat over a month before the first date of service in the second treatment period. He reviewed no records from the disputed treatment period.[18]

Carrier contended that Provider failed to establish any reason for the treatments and had not demonstrated that Claimant had experienced any exacerbating event other than the ongoing demands of his job. Carrier disputed that Dr. Watkins' review was an improper prospective review.

C. Medical Necessity Evidence

Provider testified on his own behalf in regard to the medical necessity for all treatments. In regard to the first treatment period, Provider contended that pain relief was a necessary adjunct to the work conditioning program. Provider stated the tears in the annular rings of the L4- L5 level of Claimant's spine, if irritated by overuse, would cause low back pain even if the disc itself were intact because there are nerves within the rings. Provider characterized Claimant as a person with a high tolerance for pain who would continue to work despite continuing pain. He said that the pain relief treatments were necessary to promptly return Claimant to work because they helped Claimant overcome his fear of re-injury. Claimant reported pain levels between 1 and 3 on 10-point scale

[17] Carrier Exh. 1, pp. 14-16.

[18] Provider Exh. 1, pp. 100, 103, 110, 114-117.

during this period. Immediately after the injury, Claimant had reported pain levels of 9 and 10 on a 10-point scale.

Carrier's expert, Andy Pratt, a licensed physical therapist and specialist in spine rehabilitation, viewed Claimant's behavior differently. He contended that Claimant's high scores on the Owestry test-a test designed to reveal symptom magnification behavior-suggested that Claimant perceived that he was experiencing more pain than was demonstrated by objective tests. He noted that Claimant's self-reported pain levels during the latter part of June and July were low to moderate, and said that excessive pain-relief treatment during work conditioning fostered dependence on the medical care system rather than independence from it. Mr. Pratt stated that a major component of work conditioning is teaching workers how to manage their own pain in future.[19] Mr. Pratt concluded that treatment for pain relief three or more times a week during a work conditioning program was not warranted.

He questioned whether some exercises in the work conditioning were actual job simulation activities and also stated there was some evidence Claimant did not always give full effort on functional capacity evaluations (FCE) administered to him. Notwithstanding those concerns, Mr. Pratt stated that Provider had done a commendable job in rapidly returning Claimant to work and moving him from the sedentary work capacity to the capacity to regain his former job which is at the medium-heavy physical demand level.[20] Mr. Pratt agreed with Provider that damage to the annular rings could cause back pain.

In regard to the second treatment period, Provider contended that the ongoing physical demands, primarily repeated lifting, of Claimant's job constituted exacerbations which required regular pain relief treatment. Provider stated such treatment was necessary to enable Claimant to

[19] The need to teach injured workers to manage their own pain in the course of the work conditioning program was also a key factor in the recommendation by the IRO reviewer to deny the six office visits at issue. Provider Exh. 1, p. 11.

[20] Provider Exh. 1, pp. 128-133, 136-141.

retain employment. However, during that time, Claimant did not experience a second injury or any specific exacerbating event. Provide contended that Claimant will need on-going pain treatment as long as he has a job involving repetitive lifting, and that the injury in May 2003 had permanently altered Claimant's biomechanics.

In contrast, Mr. Pratt noted that Claimant's pain levels during that period were at substantially the same pain levels as during the work conditioning program, *i.e.*, generally either 1, 2, or 3 on a 10-point scale. He stated pain at those levels, or at even higher levels, would be expected in a job requiring repetitive lifting. He also stated that a worker who had undergone a conditioning program should be capable of self-management of pain at those pain at those levels.

D. Analysis of Medical Necessity

Notwithstanding Mr. Pratt's considerable experience in the field of worker rehabilitation, he is not a health care provider licensed to diagnose or treat patients on his own. Thus, his comments, although helpful to the ALJ and credible, must be considered in that light and given less weight than those of a medical peer. The ALJ relied primarily on the comments and rationale provided by Provider, as well as the documents in support of that opinion, and the comments of the IRO reviewers who were Provider's peers.

The ALJ found Provider credible as to the treatments provided during the course of the work conditioning. As Claimant's treating doctor, Provider was in the best position to know whether Claimant had a significant fear of re-injury which needed to be addressed promptly in order to render the work conditioning effective for its intended purpose of returning Claimant to work. The IRO reviewer for the first treatment period acknowledged that some pain relief and monitoring would be appropriate during the work conditioning period, although he differed with Provider on the appropriate frequency. The ALJ found Provider's rationale for the level of treatment that he provided during the work conditioning program to be credible and so concluded that Provider met his burden of proof to show the treatments were medically necessary during that period.

However, Provider's testimony in regard to the extended series of manipulations and passive modalities from the second treatment period was not sufficient to meet his burden of proof. Provider did not dispute that a significant goal of work conditioning is to allow an injured worker to learn to manage his own pain. Provider's work conditioning program included instruction on stretching at home.[21] However, nearly-weekly treatment continuing for three and one-half additional months seems contradictory to that goal. Provider was unable to explain why such extensive treatment was needed for pain that was no greater than the same low to moderate levels that Claimant routinely reported during the work conditioning program.

Further, Provider failed to explain why passive modalities continued to be appropriate treatment long after both the acute care and rehabilitation stages of Claimant's recovery had passed. Provider's assertion that the ongoing, routine demands of Claimant's job constituted an exacerbation of his prior injury is without merit. Objective testing, the MRI and the X-ray examinations, demonstrated that Claimant was experiencing degenerative changes in his back as well as the immediate effects of the ___, injury. Provider failed to demonstrate that something more than those degenerative changes caused the moderate pain that Claimant was experiencing in the fall of 2003.

E. Analysis of Peer Review

Provider asserted that Carrier's reliance on a peer review that did not examine records from the time in question constituted a prohibited prospective review of those services. Carrier argued that the peer review did not a constitute prospective review and, in the alternative, that if were an improper review, Provider had ample opportunity to rebut the reviewer's conclusions in the course of the dispute resolution process.

A prospective review is a review and denial of benefits which occurs before the services are provided.[22] There is no evidence that Carrier denied payment for the services before Provider

[21] Carrier Exh. 1, pp. 136 and 147.

[22] *See* TEX. LABOR CODE ANN. § 413.014; 28 TEX. ADMIN. CODE §§ 113.300, 113.301, and 113.650.

administered them. Rather, Carrier denied them retrospectively, relying-at its risk-on a peer review from a prior date as authority to do so.

SOAH is charged with determining whether a provider is entitled to payment for the services rendered, not with determining whether the Commission's rules were violated.[23] That is, even if this were a case of an improper prospective review, that issue would not be determined in this proceeding. Thus, the ALJ will not rule on the question of a rule violation.

However, the concerns raised by Provider were considered by the ALJ in determining the weight to give Dr. Watkins' comment. A health care provider's review that did not encompass the records of the treatment period at issue is entitled to little, if any, weight and was given none here.

F. Request for Fee Refund

In raising the refund issue in the SOAH hearing, Provider assumed that this issue, like the claims for reimbursement themselves, would be subject to decision by the ALJ. However, the rule in regard to the IRO fees does not support Provider's position on this procedural point. Specifically, Rule 133.308(r)(10) provides that the Commission orders any refund in the event a SOAH ALJ reverses or decides differently those matters previously determined by the IRO. Specifically, that rules states in pertinent part as follows:

> (10) If the IRO decision is subsequently reversed or differently decided at a CCH or by a SOAH decision, *the Commission* shall order a refund of the IRO fee

[23] In its brief, Carrier contends that one role of the ALJ at the SOAH hearing is to determine whether the IRO's decision is supported by a preponderance of the evidence. As the evidentiary record at SOAH is routinely constructed anew by both carriers and providers, to suggest that the contested case amounts to something akin to a substantial evidence review does not accurately characterize this proceeding. *See* Carrier's Brief at p. 3.

> to be paid the party who prevailed by CCH or SOAH decision within 10 days of receipt of the order. (Emphasis supplied)

In short, SOAH has no subject-matter jurisdiction to hear this issue, so this portion of Provider's claim is hereby dismissed.[24]

G. Summary

The ALJ concludes that Carrier should reimburse Provider for office visits with manipulation during the first treatment period. Those treatments were rendered in support of the work conditioning program. The ALJ further concludes that Provider failed to carry his burden of proof to show that frequent treatment by passive modalities and by spinal manipulation-alone or in conjunction with office visits-was medically necessary to treat Claimant's compensable injury during the second treatment period.

The request for refund of the IRO fee is dismissed as being outside SOAH's subject-matter jurisdiction.

II. FINDINGS OF FACT

1. On ___, ___ (Claimant) injured his low back while lifting 70-pound objects.

2. Liberty Mutual Fire Insurance Company (Carrier) was the responsible insurer.

3. Claimant suffered lumbar disc displacement, lumbosacral neuritis, and posterier annular tearing of the L4-L5 disc; no other spine level was injured.

4. In May 2003, Claimant showed signs of some disc degeneration including some desiccation but no stenosis (narrowing) of any of the central or neural openings in the foramina (spine).

5. The annular ring of the disc, made of cartilage, has some nerve endings within it and injury to the ring can cause back pain.

[24] This conclusion is in accord with previous decisions on this issue. *See* SOAH Docket Nos. 453-03-3610.M5 (September 15, 2003) and 453-02-3525.M5 (October 12, 2002).

6. Beginning on March 28, 2003, Jack P. Mitchell, D.C. (Provider), was Claimant's treating doctor.

7. In the acute care phase, immediately after the injury, Provider administered conservative chiropractic care, including various passive modalities.

8. On June 9, 2003, Claimant was at the sedentary-light physical demand level of work capacity.

9. After the injury, Claimant reported pain levels of 9 and 10 on a 10-point level of pain severity.

10. During the work conditioning program, Claimant had pain levels between 1 and 3 on a 10-point scale of pain severity.

11. Claimant displayed some indications of pain magnification behavior, *i.e.*, perceiving that he was experiencing higher levels of pain than indicated by objective measures.

12. Between June 16, 2003, and July 25, 2003, Claimant completed a program of work conditioning conducted by Provider.

13. One of the major goals of work conditioning is to teach an injured worker how to manage pain that can be expected as part of returning to work and to reduce that worker's dependence on health care providers to manage that pain.

14. During the work conditioning program, Claimant demonstrated a fear of re-injury upon returning to his job.

15. Keeping Claimant's pain levels low during the work conditioning program helped Claimant complete that program despite his fears of re-injury when he returned to work.

16. Provider released Claimant to work with restrictions on July 14, 2003.

17. On July 29, 2003, Claimant was fit to return to his employment with a parcel-delivery firm without restrictions.

18. On July 30, 2003, Provider determined Claimant was at maximum medical improvement and assigned an impairment rating of five per cent.

19. In June and July 2003, during the course of the work conditioning program, Provider also conducted expanded office visits with manipulations on eleven dates to treat Claimant.

20. On December 1, 2004, the MRD of TWCC ordered reimbursement to Provider for five office visited conducted in June and July 2003. Three office visits were paid on fee grounds and two office visits were paid on medical necessity grounds.

21. On December 1, 2004, the MRD denied reimbursement to Provider for office visits with manipulations on six dates of service: June 20, 2003, and July 15, 18, 21, 23, and 25, 2003. Payment was denied on the grounds that those treatments were not medically necessary.

22. On 13 dates between August 13, 2003, and December 29, 2003, Provider treated Claimant's recurring low back pain either with manipulation administered during an office visit or with a combination of passive modalities and manipulation administered during a treatment session.

23. Between August 13, 2003, and December 29, 2003, Claimant did not suffer a second injury.

24. Between August 13, 2003, and December 29, 2003, Claimant did not suffer any exacerbating incidents that worsened his, injury other than repetitive lifting that was a routine part of his job.

25. Between August 13, 2003, and December 29, 2003, Claimant's pain levels were between 1 and 3 on a 10-point scale of pain severity.

26. Low to moderate levels of low back pain are likely to occur in the course of a job involving repetitious lifting.

27. Between August 13, 2003, and December 29, 2003, Claimant could reasonably be expected to manage the low to moderate pain that he was experiencing due to the routine lifting demands of his job.

28. On September 17, 2004, the MRD upheld Carrier's denial of reimbursement for all treatment between August 13, 2003, and December 29, 2003 (second treatment period), on the grounds it was not medically necessary.

29. On September 29, 2004, Provider requested a contested-case hearing on the MRD Decision issued on September 17, 2004.

30. On December 1, 2004, the MRD upheld Carrier's denial of reimbursement for expanded office visits with manipulation on June 20, 2003, and on July 15, 18, 21, 23, and 25, 2003 (first treatment period), on the grounds they were not medically necessary.

31. On December 22, 2004, Provider requested a contested-case hearing on the MRD Decision issued on December 1, 2004, and also requested that he be refunded the fee for initiation of a review of this dispute by an IRO.

32. For all claims, Provider requested reimbursement at the maximum allowable reimbursement (MAR) values as set in the 1996 *Medical Fee Guideline,* 28 TEX. ADMIN. CODE § 134.201; Carrier did not dispute the amounts requested.

33. On November 8, 2004, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted in regard to Provider's September 29, 2004, request for a hearing on the second treatment period.

34. On February 16, 2005, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted in regard to Provider's December 22, 2004, request for a hearing on the first treatment period.

35. On March 4, 2005, both cases were joined for purposes of hearing on merits and reset.

36. On August 4, 2005, the joined cases were convened in Austin, Texas, by ALJ Cassandra Church, and one evidentiary record made that was applicable to both cases.

37. The record closed on September 2, 2005, to permit the parties to submit written argument.

III. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearings 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.

2. Provider timely requested a hearing on both matters, as specified in 28 TEX. ADMIN. CODE §◦148.3.

3. Proper and timely notice of the hearings was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. SOAH lacks subject-matter jurisdiction in regard to the allocation or refund of the IRO fee, pursuant to 28 TEX. ADMIN. CODE § 133.308(r)(10).

5. Provider, as the petitioning party in both cases, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41(b), and 28 TEX. ADMIN. CODE § 148.14(a).

6. Provider met its burden of proof to show that his usual and customary fee for office visits with manipulations was equivalent to the MAR values set in the 1996 *Medical Fee Guideline,* 28 TEX. ADMIN. CODE § 134.201.

7. Provider met its burden of proof to show that office visits with manipulation on June 20, 2003, and on July 15, 18, 21, 23, and 25, 2003, were medically necessary to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

8. Provider failed to meet its burden of proof to show passive modalities, spine manipulations or office visits with manipulations between August 13, 2003, and December 29, 2003, were required to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§◦408.021 and 401.011(19).

ORDER

IT IS ORDERED that Liberty Mutual Insurance Company reimburse Jack P. Mitchell, D.C., for office visits with manipulation conducted to treat Claimant on June 20, 2003, and on July 15, 18, 21, 23, and 25, 2003. Reimbursement shall be at the MAR for that treatment set forth in the 1996 *Medical Fee Guideline*.

IT IS FURTHER ORDERED that all requests by Provider for reimbursement for services provided to Claimant between August 13, 2003, and December 29, 2003, are hereby denied.

IT IS FURTHER ORDERED that Provider's claim for refund of the IRO fee is hereby dismissed from this case as a matter not within the subject-matter jurisdiction of SOAH.

SIGNED November 1, 2005.

CASSANDRA J. CHURCH

ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS