SOAH DOCKET NO. 453-05-2972.M5
[TWCC MDR NO. M5-04-4184-01]

CODY B. DOYLE, D.C., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
CITY OF WACO, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

Cody B. Doyle, D.C., (Petitioner) requested a hearing to contest the November 4, 2004 Findings and Decision of the Texas Workers' Compensation Commission (Commission). The Commission relied upon an October 5, 2004 decision of Medical Review Institute of America, an Independent Review Organization (IRO), and denied reimbursement for services provided by Petitioner to injured worker ___(Claimant) from August 11, 2003, through September 11, 2003.

After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that the disputed services provided by Petitioner were not reasonable and medically necessary.

The hearing convened on August 25, 2005, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Amber E. Morgan represented Petitioner, and Janice Menzies represented the City of Waco (Respondent). Craig Cernosek, D.C., testified for Petitioner, and William Culver, M.D., testified for Respondent. The hearing concluded and the record closed that day. Neither party objected to notice or jurisdiction.

Claimant suffered a work-related injury to his left shoulder on___. On October 8, 2002, Brett Miller, M.D., an orthopedic surgeon, performed an arthroscopy of Claimant's left shoulder, an open

Bankart repair of the left shoulder and excision of loose bone fragments of the left shoulder with an open capsular shaft. Between November 2002 and January 2003, Claimant received approximately 24 sessions of post-operative physical therapy. On December 23, 2002, Claimant returned to work with restrictions. On March 17, 2003, Dr. Miller noted Claimant's shoulder was doing well, that the range of motion (ROM) was improved, and that Claimant experienced some discomfort with heavy lifting. Both Dr. Miller and William E. Blair, M.D., the physician who performed the Designated Doctor Evaluation (DDE), determined Claimant had reached Maximum Medical Improvement (MME) as of March 2003. Dr. Blair's July 23, 2003 DDE reported that Claimant demonstrated some left shoulder motion deficiencies in flexion, extension, abduction and internal rotation. Based upon the loss in ROM, Dr. Blair assigned Claimant a 4% whole person impairment rating.

On May 20, 2003, Claimant changed treating doctors, moving from Dr. Miller to Petitioner. On May 22, 2003, Claimant exacerbated his left shoulder injury while lifting an object at work. Petitioner's diagnosis was a grade II sprain strain and myofacial pain syndrome. The treatment plan involved home exercise and 12-15 sessions of both active and passive physical therapy. Claimant received approximately 36 sessions between May 22, 2003, and September 11, 2003. Respondent reimbursed Claimant for treatments prior to August 11, 2003, and denied reimbursement for all treatments thereafter.

The only issue in this proceeding is whether the services provided by Petitioner to Claimant from August 11, 2003, through September 11, 2003, were reasonable and medically necessary. Petitioner had the burden of proof. Petitioner failed to prove that the services were reasonable and medically necessary. Although Petitioner initially contended otherwise, Claimant did receive post-surgical physical therapy prior to treating with Petitioner. The evidence in the record does not

establish Claimant's perceived pain levels in May, June or July of 2002, but Petitioner's notes do show that Claimant's perceived pain levels during the first week of August were moderate to low (3-5).[1] On August 8, 2003, Claimant arrived for treatment with a perceived pain level of five and left, following treatment, with a perceived pain level of three. On August 11, 2003, the first disputed treatment, Claimant arrived for treatment with a perceived pain level of four,[2] and following treatment he had a perceived pain level of three. On August 11, 2003, Petitioner noted that Claimant could "look after himself without extra pain."

Petitioner's description of Claimant's condition on September 5, 2003, the next to last treatment date, is not substantially different from Petitioner's description of Claimant's condition on August 8, 2003, the last undisputed visit. Some descriptions have changed from "mild to moderate" to "mild" and Claimant's perceived pain level of five on August 8, 2003, has diminished to two by September 11, 2003. These differences do not demonstrate significant improvement between August 11 and September 11. Comparisons between Claimant's test results in May 2003 and September 2003 are not helpful in quantitatively measuring any improvement between August and September 2003. There is no quantitative measure of improvement during the disputed time period.

The active therapy provided during the dates in dispute did not differ from the active therapy provided prior to the dates in dispute. The passive therapy provided during the dates in dispute did not differ from the passive therapy provided prior to the dates in dispute. Petitioner's explanation as to why Claimant could not accomplish the necessary conditioning with a home exercise program was conclusory and unpersuasive.

Simply showing some improvement in the Claimant's actual or perceived condition is not sufficient. The treatment must be reasonable as well as medically indicated. The credible evidence

[1] On the 10-point scale, 10 is extreme pain and 1 is very low pain.

[2] This level of pain was described as "mild."

demonstrates a slight, but not significant, change in the Claimant's condition. His perceived level of pain diminished from four to two between August 11 and the last treatment in September. The decrease in Claimant's perceived level of pain is not significant. Claimant's change of ROM is unmeasured and the subjective description shows only minimal improvement. Prior to and during the disputed treatment dates, Claimant was fully capable of performing his job functions and his activities of daily living.

Petitioner's September 11, 2003 notations state the Claimant has "a 50% to 80% chance of continued residual pain, which will interfere with or limit to some extent the patient's daily activities."[3] Claimant was already at that condition by August 11, 2003, and the evidence shows no substantive improvement during the next 30 days.

Consequently, Petitioner failed to demonstrate by a preponderance of the evidence that the services provided Claimant between August 11, 2003, and September 11, 2003, were reasonable and medically necessary. Petitioner is not entitled to reimbursement for services provided Claimant between August 11, 2003, and September 11, 2003.

II. FINDINGS OF FACT

1. __ (Claimant) suffered a work related injury on___.

2. On October 8, 2002, Brett Miller, M.D., an orthopedic surgeon, performed an arthroscopy of Claimant's left shoulder, an open Bankart repair of the left shoulder and excision of loose bone fragments of the left shoulder with an open capsular shaft.

3. Between November 2002 and January 2003, Claimant received approximately 24 sessions of post-operative physical therapy.

[3] Petitioner's Exhibit No. 1 at 50.

4. On December 23, 2002, Claimant returned to work with restrictions.

5. By March 17, 2003, Claimant's shoulder was doing well and the range of motion (ROM) was improved.

6. Both Dr. Miller and William E. Blair, M.D., the physician who performed the Designated Doctor Evaluation (DDE), determined Claimant had reached Maximum Medical Improvement (MME) as of March 2003.

7. Dr. Blair's July 23, 2003 DDE reported that Claimant demonstrated some left shoulder motion deficiencies in flexion, extension, abduction and internal rotation. Based upon the loss in ROM, Dr. Blair assigned Claimant a 4% whole person impairment rating.

8. On May 20, 2003, Claimant changed treating doctors, moving from Dr. Miller to Cody B. Doyle, D.C. (Petitioner).

9. On May 22, 2003, Claimant exacerbated his left shoulder injury while lifting an object at work. Petitioner's diagnosis was a grade II sprain strain and myofacial pain syndrome.

10. The treatment plan involved home exercise and 12-15 sessions of both active and passive physical therapy.

11. Claimant received approximately 36 sessions between May 22, 2003, and September 11, 2003.

12. Respondent reimbursed Claimant for treatments prior to August 11, 2003, and denied reimbursement for all treatments thereafter.

13. Claimant received post-surgical physical therapy prior to treating with Petitioner.

14. The evidence in the record does not establish Claimant's perceived pain levels in May, June or July of 2002.

15. Claimant's perceived pain levels during the first week of August were moderate to low (3-5).

16. On August 8, 2003, Claimant arrived for treatment with a perceived pain level of 5 and left, following treatment, with a perceived pain level of 3.

17. On August 11, 2003, the first disputed treatment, Claimant arrived for treatment with a

perceived pain level of four, and following treatment he had a perceived pain level of three.

18. By August 11, 2003, Claimant was able to undertake his activities of daily living without incurring additional pain.

19. Petitioner's description of Claimant's condition on September 5, 2003, the next to last treatment date, is not substantially different from Petitioner's description of Claimant's condition on August 8, 2003, the last undisputed visit.

20. The differences in Claimant's condition, as described by Petitioner, do not demonstrate significant improvement between August 11 and September 11.

21. Comparison's between Claimant's test results in May 2003 and September 2003, do not measure improvement between August 2003 and September 2003.

22. There is no quantitative measure of improvement during the disputed time period.

23. The active therapy provided during the dates in dispute did not differ from the active therapy provided prior to the dates in dispute.

24. The passive therapy provided during the dates in dispute did not differ from the passive therapy provided prior to the dates in dispute.

25. Claimant could have accomplished the necessary conditioning with a home exercise program.

26. Claimant's condition did not significantly improve.

27. Prior to and during the disputed treatment dates, Claimant was fully capable of performing his job functions and his activities of daily living.

28. Claimant's ROM did not significantly improve during the disputed treatment period.

29. Claimant's perceived level of pain did not show any significant decrease between August 11, 2003, and September 11, 2003.

30. As of September 11, 2003, Claimant had a 50% to 80% chance of continued residual pain interfering with or limiting, to some extent, Claimant's daily activities.

31. Claimant was already at that condition by August 11, 2003.

32. Claimant's condition did not substantively improve between August 11, 2003, and September 11, 2003.

33. The treatment dates in issue are August 11, 2003, through September 11, 2003.

34. The City of Waco (Respondent) denied Petitioner reimbursement for the services provided Claimant between August 11, 2003, and September 11, 2003, as not medically necessary.

35. On November 4, 2004, the Texas Workers' Compensation Commission (Commission), acting through an Independent Review Organization (IRO), the Medical Review Institute of America, denied reimbursement for services provided by Petitioner to Claimant from August 11, 2003, through September 11, 2003.

36. On November 12, 2004, Petitioner requested a hearing before the State Office of Administrative Hearings (SOAH).

37. The Commission issued a notice of hearing on December 27, 2004.

38. The notice of hearing contained: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held; (3) a reference to the particular sections of the statutes and rules involved; and (4) a short, plain statement of the matters asserted.

39. The hearing convened on August 25, 2005, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Amber E. Morgan represented Petitioner and Janice Menzies represented Respondent. The hearing concluded and the record closed that day.

III. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. The party requesting the contested case hearing has the burden of proof.

6. Petitioner failed to prove by a preponderance of the evidence that the services provided to Claimant between August 11, 2003, and September 11, 2003, were reasonable and medically necessary.

ORDER

THEREFORE IT IS ORDERED that Cody B. Doyle, D.C., is not entitled to reimbursement from the City of Waco for charges associated with services provided to injured worker ___(Claimant) from August 11, 2003, through September 11, 2003.

SIGNED October 6, 2005.

_____

HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS