SOAH DOCKET NO. 453-05-3218.M5
MR NO. M5-04-4155-01

SOUTH COAST SPINE AND REHAB CENTER,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
TEXAS WORKERS' COMPENSATION, SOLUTIONS	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

This case is an appeal by South Coast Spine and Rehab Center (Provider) from a decision of an independent review organization (IRO) on behalf of the Texas Workers' Compensation Commission (Commission) in a dispute regarding medical necessity for chiropractic treatment. The IRO found that Texas Workers' Compensation Solutions (Carrier) properly denied reimbursement for office visits, massage, and aquatic therapy. Provider appealed on the basis that these services were medically necessary, within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq*.

The Administrative Law Judge (ALJ) finds that reimbursement to Provider for the disputed services should be denied.

I. STATEMENT OF THE CASE

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 § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2005. No party challenged jurisdiction or venue. ALJ Lilo D. Pomerleau convened the hearing in this docket on June 30, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th Street, Austin, Texas. Provider was represented *pro se* by Robert S. Howell, D.C., and Carrier was represented by Steven Tipton, attorney. The record closed July 7, 2005.

Claimant was injured on the job at Brownsville ISD on ___. She was sitting on the bottom of a bleacher while taking a class picture when some students above her fell, pushing Claimant to the floor. Claimant injured her left middle finger and wrist, neck, and middle and lower back. Claimant sought care from Oliver Achleitner, MD, on November 7, 2002, and received some physical therapy from November 12 through November 25, 2002. Claimant sought no additional treatment for approximately three months and then requested a change of treating doctors, from Dr. Achleitner to Dr. Howell,[1] Provider. On April 9, 2003, Dr. Howell diagnosed Claimant as suffering from carpal tunnel syndrome and sprain/strain of left hand. Claimant received chiropractic treatment from Provider beginning April 9, 2003, completing a course of care that included aquatic therapy, massage, and physical medicine. On March 23, 2004, Claimant returned to Provider complaining that her neck, low back, and left arm pain was exacerbated because of rainy weather.[2]

At issue are office visits, massage, and aquatic therapy, provided from March 23 through March 29, 2004.[3] The amount in question is $1,046.84.

III. THE EVIDENCE AND ARGUMENTS

A. Provider

Provider submitted into evidence medical records and argument previously submitted to the IRO and the testimony of Dr. Howell. The services in dispute began on March 23, 2004, when Claimant visited Provider, complaining of moderate and constant neck and low back pain (both at a level of seven out of ten, with ten as the highest level of pain). According to Dr. Howell, Claimant stated that rainy weather exacerbated her injury.[4] Based on his evaluation and citing previous MRIs of Claimant taken May 6, 2003, (left wrist) and December 10, 2003, (lumbar spine) and her 10 percent impairment rating (December 20, 2003), Dr. Howell recommended physical therapy for

[1] Dr. Howell is a Doctor of Chiropractic medicine.

[2] Provider's Ex. 13 at 218 (IRO decision); Ex. 6 at 26.

[3] Provider notes that Carrier paid for one of the four treatments rendered to Claimant during this time period. According to Provider, this action is an admission by Carrier that the treatments were reasonable and necessary. Carrier responds that the payment of medical benefits is not an admission. The ALJ agrees with Carrier: the services at issue will be evaluated based on the evidence admitted at the hearing.

[4] Dr. Howell testified that when barometric pressure drops, joints swell.

six sessions, each consisting of 30 minutes of massage and 90 minutes of aquatic therapy.[5] Treatment began the next day.[6]

Dr. Howell reevaluated Claimant on April 6, 2004, after the treatments. He testified that Claimant's pain decreased from a seven to a three and her range of motion improved significantly in five days of actual treatment -- in half the time of the recommended guideline of 10 to 14 days. Further, Claimant was given a home exercise kit with instructions to use and, to date, has not returned for more treatments.

Provider argues that Carrier's denial of the treatments were based on a peer review completed before the dates of service. Provider contends that Commission rules require peer reviews to be retrospective -- thus, Carrier's denial based on a peer review conducted over one year ago is not a proper denial.

Provider also argues that the IRO decision was based on faulty premises. First, the IRO questioned whether six treatments were medically necessary, but Claimant only had four treatments.[7] Second, the IRO reviewer failed to state that the results of Claimant's MRIs were taken into consideration. Third, the IRO found that Claimant failed to respond to conservative care in the past and additional care was not warranted -- yet Claimant did show improvement from the treatments. Dr. Howell also took issue with the IRO's reliance on Chapter 8 of the Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists for denial of the services. The IRO cited to those guidelines for the opinion that "the mechanism of exacerbation, rainy weather, does not appear to be a complicating factor which would warrant additional treatment in this case."[8] Dr. Howell argues that the guidelines clearly note that a patient may need specialized care after experiencing acute exacerbation of chronic spine pain. And he pointed out that Claimant improved in five days, well within the guidelines.

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[5] Provider's Ex. 4 at 9-12.

[6] Claimant only came in for four treatments.

[7] This is a non-issue, because while Provider scheduled Claimant for six treatments, she simply chose to attend only four sessions.

[8] Provider's Ex. 13 at 218 (IRO decision).

In response to Carrier's argument that, on October 27, 2003, Terry W. Fuller, M.D., found that Claimant had no neurological compromise and should begin a home exercise program of walking,[9] Provider contends that certain treatments such as electrical stimulation cannot be provided at home and that therapeutic massage by a licensed physical therapist is expensive and not paid for by workers' compensation. He also took issue with Dr. Fuller's recommendation that walking will alleviate neck pain. In closing argument, Dr. Howell contended the care was reasonable because, by receiving therapeutic exercise, she avoided taking aspirin and other drugs, and that it was cheaper for her to get a therapeutic massage (paid for by Carrier) than for her to pay a massage therapist.

B. Carrier

Carrier did not submit evidence into the record. Rather, Carrier argued that:

- Under the Medicare Guidelines and Local Medical Review Policies, in effect since May 2000, (1) physical therapy should last no longer than 30 to 45 minutes, and billing for longer treatments must clearly be documented for medical necessity, and (2) Provider cannot bill for extended office visits (under CPT code 99213) and treatment on the same day.
- Provider failed to show why extended office visits were necessary for an established patient.
- Common sense informs one that ups and downs in pain due to weather changes does not require thousands of dollars of treatment.
- Claimant "got better" in this case not based on her treatment but due to time after the weather and barometric pressure changed.
- Provider's own records show positive changes in cervical and lumbar spine flexion and extension overnight, from the date of Claimant's first visit on March 23, 2004, to the next day, before Claimant had received any treatment at all. Moreover, Claimant's flexion, extension, and rotation of the cervical and lumbar spine has not changed since January 2004.
- On January 26, 2004, Claimant's pain was reduced from a level eight to a level seven -- the same level as when she had came in on March 24, 2004, complaining of an exacerbation.

Finally, Carrier argues that the creation of the exacerbation is a fiction to allow Provider to bill for treatment -- in this particular case, for massage and expensive aquatic therapy.

[9] Provider's Ex. 12 at 202-203.

II. ANALYSIS

At issue is whether Provider showed by a preponderance of evidence that Claimant, more than one-year after her initial injury, was entitled to over $1,000 of further conservative treatment after joint swelling caused by rainy weather. Provider failed to meet that burden.

Dr. Howell lost credibility in this matter when he testified during cross-examination. He was unable to testify as to whether he previously treated Claimant in 2003 and 2004, stating he did not have those records.[10] Also, citing his lack of records, he was unable to state whether he had given Claimant a home exercise program at the end of her earlier treatment or even whether he provides a home exercise program as a standard practice. He admitted that Claimant could have more exacerbations of her condition with future weather changes, but testified that the home exercise program provided to Claimant at the end of the sessions at issue decreased that possibility. Dr. Howell further indicated that "there will be no more bills from me because the patient has changed doctors." Dr. Howell's comments appear to acknowledge that additional treatments as a result of future exacerbations cannot continue indefinitely. Further, his position that giving Claimant a home exercise program in March 2004 will likely preclude further treatment is questionable. First, during three extensive office visits (CPT code 99213), Provider did not address whether Claimant followed the passive range of motion exercises Dr. Fuller demonstrated and recommended, or the exercise plan (walking). Second, no documentary evidence corroborates Dr. Howell's testimony that a home treatment program was given to Claimant during the disputed dates in question. The evidence concerning a home treatment program fails to support Dr. Howell's conviction that Claimant will not be seeking future treatment.

The ALJ also takes note of another opinion by Paul Strube, D.C., written April 2, 2003, after a paper review of Claimant's medical history. Claimant had reported no complaints to the physical therapist after initial therapy treatments provided post-injury. Dr. Strube found it unlikely that Claimant would need additional treatments.[11]

[10] Provider's own records, admitted into evidence, suggest she was examined by Provider on December 29 and 30, 2003, and January 26, 2004.

[11] Provider's Ex. 12 at 212.

The evidence also indicates that as late as October 27, 2003, five months before the treatment at issue in this case, Dr. Fuller found Claimant's condition "reassuringly benign in nature."[12] Dr. Fuller further reported that:

> Conservative management was reviewed at length with the patient. It would begin with a diet with adequate calcium, vitamin K. and protein. She then should go through a four times per day passive range of motion exercise program, including cervical, lumbosacral, shoulder, left finger, and bilateral hip regions. I have reviewed this with the patient at length. She then should start a conservative exercise regime to include walking . . . .
>
> A good overall prognoses would be anticipated. No particular restrictions from activity are suggested.[13]

Based on the March 24, 2004 office visit notes, Claimant's subjective complaints concerning pain showed only a change from "soreness" on January 26, 2004, to a "dull ache" on March 24 and March 25, 2004. Pain levels were actually *decreased* from those in January. Range of motion for Claimant's left wrist had improved over time, reaching normal on March 23, 2004.[14] The office visit notes for the next day indicate improvement -- reaching levels dating back to December 16, 2003. The chart below shows the measurements (in degrees):[15]

Cervical Spine	12/16/03	03/23/04	3/24/04
Flexion	52	48	55
Extension	72	60	70
Left Lateral	40	35	40
Right Lateral	40	30	40

[12] Provider's Ex. 12 at 203.

[13] Provider's Ex. 12 at 203.

[14] Provider's Ex. 4 at 10.

[15] Numbers from Provider's Ex. 10 at 176 and Ex. 4 at 10.

Cervical Spine	12/16/03	03/23/04	3/24/04
Left Rotation	75	65	75
Right Rotation	75	62	75
Lumbar Spine			
Flexion	52	48	55
Extension	20	15	20
Left Lateral	20	15	20
Right Lateral	20	12	20

It is unclear from the record if the March 24 testing was performed before or after that day's treatment. Either way, these numbers suggest a high probability that Claimant's aches and symptoms from swelling due to rainy weather would likely have improved without the prescribed six sessions of massage and aquatic therapy. In fact, the numbers show little need for any treatment in March 2004. Also troubling, the diagnosis in both the March 24 and March 25 notes indicates only carpal tunnel syndrome and sprains and strains of the wrist and hand, which appeared cured by March 2004. The diagnosis of cervical and lumbar HNP only appears on the March 29 notes, the last day of treatment.

In whole, the ALJ finds more persuasive Dr. Fuller's earlier findings and that of the IRO provider, a chiropractor, who opined that "the mechanism of exacerbation, rainy weather, does not appear to be a complicating factor which would warrant additional treatment in this case."[16]

Dr. Howell argues that the rules (the Spine Care Guidelines) provide for health care due to exacerbation. Dr. Howell is ignoring the intent of the rules and the law, which is primary to any adopted Commission guideline or rule. Under § 408.021 of the Act, an injured worker is entitled to "health care reasonably required" to relieve the effects of the injury or to enhance the ability to continue working. However, care that provides only superficial or illusory improvement or relief at

[16] Provider's Ex. 13 at 218, IRO opinion.

inordinate cost is not "reasonably" required. Pursuant to the Code Construction Act:

> In enacting a statute, it is presumed that: (1) compliance with the constitutions of this state and the United States is intended; (2) the entire statute is intended to be effective; (3) a just and reasonable result is intended; (4) a result feasible of execution is intended; and (5) public interest is favored over any private interest.[17]

The Carrier argues that common sense precludes costly treatment for hundreds of thousands of injured workers every time the weather changes. The ALJ agrees and further finds that the statute requires a just and reasonable result. Accordingly, an injured worker and a treating doctor must show a clear basis for an exacerbation of a compensable injury other than "rainy weather." The statute and Code Construction Act also require a judge to keep in mind the public interest. Here, public interest, sound public policy, and the Act's mandate to be reasonable dictate that the requested care was not necessary. Provider should not be reimbursed for the disputed services.

The ALJ further finds persuasive two arguments proffered by Carrier. The extended office visits under CPT code 99214 failed to meet both the Fee Schedule for Physician's Services and the Local Medical Review Policies, the former of which states that if a doctor bills for an office visit on the same day as physical therapy, he or she must document that the office visit was unrelated to the physical therapy service. Under the Medicare Guidelines and Local Medical Review Policies, in effect since May 2000, physical therapy should last no longer than 30-45 minutes unless the reason for a longer period is clearly documented.

IV. FINDINGS OF FACT

1. Claimant was injured on the job at Brownsville ISD on ___. She was sitting on the bottom of a bleacher while taking a class picture when some students above her fell and landed on top of her, pushing Claimant to the floor. Claimant injured her left middle finger and wrist, neck, and middle and lower back. The injury was a compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. Claimant sought care from Oliver Achleitner, MD, on November 7, 2002, and received some physical therapy from November 12 through 25, 2002.

3. Claimant sought no additional treatment for approximately three months and then requested a change of treating doctors, from Oliver Achleitner, M.D. to Robert S Howell, D.C. (Provider).

[17] Code Construction Act, TEX. GOV'T CODE, § 311.021.

4. In an initial diagnosis, Provider indicated Claimant had carpal tunnel syndrome and sprain/strain of left hand.

5. Claimant received chiropractic treatment from Provider beginning April 9, 2003, completing a course of care that included aquatic therapy, massage, and physical medicine.

6. On March 23, 2004, Claimant returned to Provider complaining that her neck, low back, and left arm pain was exacerbated because of rainy weather.

7. From March 23 through 29, 2004, Claimant received massage and aquatic therapy with office visits for a complaint of an exacerbation of the injury noted in Finding of Fact No. 1.

8. Provider sought reimbursement for therapeutic treatment and office visits from Texas Workers' Compensation Solutions (Carrier), the insurer for Claimant's employer.

9. Carrier denied the requested reimbursement.

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

11. The independent review organization (IRO) to which the Commission referred the dispute issued a decision on September 10, 2004, and concluded office visits, massage, and aquatic therapy for dates of service March 23 through 29, 2004, were not medically necessary.

12. The Commission's Medical Review Division reviewed and concurred with the IRO's decision in a decision dated November 19, 2004, in dispute resolution Docket No. M5-04-4155-01.

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

14. The Commission mailed notice of the hearing's setting to the parties at their addresses on January 31, 2005.

15. On June 30, 2005, Lilo D. Pomerleau, an Administrative Law Judge with SOAH, convened a hearing in this matter at the William P. Clements Building, 300 W. 15th Street, Austin, Texas. Provider was represented by Dr. Howell, *pro se*, and Carrier was represented by Steven Tipton, attorney. The record closed July 7, 2005.

16. Claimant's condition as of October 27, 2003, was benign and required only conservative management: good diet, home exercise, and no particular restrictions from activity.

17. Claimant's pain level at the time she sought further treatment due to rainy weather in March 2004 was reduced from her pain level on January 26, 2004.

18. Claimant's cervical and lumbar spine ranges of motion improved significantly from March 23 to March 24, 2004, without any treatment given.

19. Claimant's cervical and lumbar spine ranges of motion on March 24, 2004, were similar to those on December 16, 2003.

20. Exacerbation due to rainy weather is not a complicating factor that warranted additional treatment to Claimant in March 2004.

VII. CONCLUSIONS OF LAW

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

2. 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 § 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 SOAH's rules, 1TEX. ADMIN. CODE (TAC) § 155.1 *et seq*.

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 bore the burden of proof as to whether office visits, massage, and aquatic therapy for dates of service March 23 through 29, 2004, were medically necessary pursuant to 28 TAC § 148.14 and 1 TAC § 155.41(b).

6. Under the Code Construction Act, TEX. GOV'T CODE ch. 311, it is presumed that a just and reasonable result is intended and the public interest is favored over any private interest.

7. Based upon the foregoing Findings of Fact, the office visits, massage, and aquatic therapy for dates of service March 23 through 29, 2004, do not represent elements of health care medically necessary under § 408.021of the Act.

8. 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 South Coast Spine and Rehab, seeking reimbursement for office visits, massage, and aquatic therapy provided on March 23 through 29, 2004, be denied.

SIGNED August 29, 2005.

LILO D. POMERLEAU
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS