DOCKET NO. 453-05-3363.M5
MDR NO. M5-05-0153-01

JAMES TANNER., D.C.,	'	**BEFORE THE STATE OFFICE**
Petitioner	'	
	'	
VS.	'	**OF**
	'	
AMERICAN HOME ASSURANCE CO.	'	
Respondent	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

James Tanner, D.C. (Provider) challenges an Independent Review Organization (IRO) decision concluding that chiropractic services he provided to an injured worker (Claimant) were not medically necessary. Based on the evidence presented at hearing, the Administrative Law Judge (ALJ) also concludes the disputed services were not shown to be medically necessary for the treatment of Claimant's injury. Consequently, Provider is not entitled to reimbursement from American Home Assurance Company (Carrier).

I. PROCEDURAL HISTORY

ALJ Gary Elkins convened the hearing in this case on July 26, 2005. Provider appeared *pro se*. Attorney Peter Macaulay appeared on behalf of Carrier. Notice and jurisdiction, which were not disputed, are addressed in the Findings of Fact and Conclusions of Law.

At the hearing, Carrier argued that because Provider failed to respond to requests for admission that were properly served on him, the requests were deemed admitted pursuant to 1 TEX. ADMIN. CODE § 155.31(d)(2)(A). In response to a question by the ALJ, Carrier argued that a request for admission may address the ultimate issue in a case, as did one of the requests served on Provider: whether the services in dispute were medically necessary. Although Provider acknowledged the

correctness of the telephone number to which Carrier asserted the requests were faxed, he stated he was not aware they were ever received by his office. He also expressed some misunderstanding regarding the nature of requests for admission, but he indicated a willingness to accommodate Carrier's discovery requests.

The ALJ rejected Carrier's position on the propriety of a request for admission on the ultimate issue being litigated, ruling instead that the ultimate issue was not a proper subject for such a request. Nonetheless, the ALJ gave Carrier the opportunity to submit a brief supporting its position. The ALJ also informed the parties that he would reconsider his ruling once briefs were reviewed.

Notwithstanding the ALJ's ruling, Carrier requested that the hearing move forward through the full presentation of evidence and argument. Provider did not object, the ALJ granted Carrier's request, and the hearing proceeded. Carrier submitted the requested brief on July 27, 2005, but Provider did not file a brief. The hearing closed on that date.

Having considered Carrier's brief, the ALJ withdraws his ruling at hearing that rejected the request for admission on the ultimate issue in the case. Having considered Carrier's arguments in support of the request being deemed admitted, the ALJ concludes the requests for admission should not be deemed admitted because Carrier failed to prove they were properly served on Provider. Based on this ruling, the ALJ does not rule on the propriety of requests for admission addressing the ultimate issue in dispute.

II. DISCUSSION

A. Background.

Claimant suffered a compensable injury to her lower back on ___. She was initially diagnosed with a sprain/strain to her lumbar spine and returned to light-duty work. Upon seeing Provider during an initial visit on December 12, 2003, he diagnosed her with intra-vertebral disc disorder-lumbar spine; lumbar segmental dysfunction; muscle spasms; and inflammation. In addition to formulating an initial plan of passive care, Provider took her off work.

Provider proceeded with a treatment plan consisting variously of electrical stimulation, spinal traction, neuromuscular re-education, manual therapy, and therapeutic exercise. He also provided two spinal adjustments. Carrier reimbursed Provider for services rendered on approximately 17 occasions from December 12, 2003, through January 23, 2004, but denied reimbursement for substantially the same services provided on 14 dates from January 27, 2004 through March 3, 2004.

After being denied reimbursement, Provider sought medical dispute resolution. In denying Provider's reimbursement claim, the Independent Review Organization included a detailed rationale supporting its conclusion. Among its findings were the following:

- There was no evidence supporting the need for the continued monitored care rendered by Provider, and services not requiring hands-on care or supervision by a health care provider are not considered medically necessary even if performed by a health care provider.
- Continuation of an unchanging treatment plan and performance of activities that could be performed as a home exercise program were not indicated in light of Claimant's diagnosis.
- A home exercise program is least costly and is preferable because the exercises can be performed on a daily basis. Nevertheless, Provider failed to demonstrate the continued need for one-on-one therapeutic exercises during the disputed dates of service.
- The medical necessity of Provider's continued use of electrical stimulation, manual therapy, and mechanical traction nearly eight weeks after Claimant's injury was not supported because the repeated use of such an approach

promotes physician dependency and chronicity.

- Although Provider administered chiropractic manipulations on only two occasions, such manipulations were the only treatment the AHCPR[1] guidelines recommend for relieving symptoms, increase function, and hasten recovery for persons suffering from acute low back pain.
- A December 30, 2003 MRI report Provider relied on as the basis for his ongoing treatment contained contradictory findings, on the one hand finding small anterior disc bulges at L2-3 and L3-4 with no protrusional abnormalities or evidence of neural compromise, while on the other hand finding a posterior disc bulge impinging on the thecal sac. Absent other documentation justifying prolonged care, therefore, the medical necessity of the treatment provided was not supported.

B. Summary of Evidence and Argument

Provider asserted the following in support of his position that the disputed services were medically necessary:

- The December 30, 2003, MRI revealed a two-level disc bulge at levels L2-3 and L3-4 of Claimant's lumbar spine, with thecal sac impingement.
- Although peer reviews found that Claimant was suffering from a sprain/strain, the reviews were very generic. Many sprains/strains resolve in as little as two weeks, but Claimant's did not.
- Every doctor who saw Claimant, including Provider and three medical doctors, concluded she had a disc injury instead of just a sprain/strain.
- The disputed treatments resulted in positive improvements to Claimant that ultimately allowed her to return to work.

As reflected in the testimony of its expert witness, Michael Hamby, D.C., Carrier's case presentation focused on the following assertions:

- Overall, there was no significant diagnostic evidence establishing the nature and extent of Claimant's injury. The December 30, 2003, MRI both contradicted itself and was of such poor quality as to be useless in a diagnosis.

- The check marks used by Provider in his Treatment Notes to indicate which

[1] Bigos S., Bowyer O., Braen G., *et al.* Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December 1994.

services were rendered and how Claimant was responding to the treatment provided no insight into the nature of the services provided or Claimant's response to them. They fell far below the standard of care for record-keeping.

- Neither Functional Capacity Evaluation (FCE) of Claimant, both of which were performed by Provider, reflected base-line measures such as heart rate, which would be necessary in order to establish that Claimant was exerting maximum effort during the FCEs.
- Claimant's records reflect no improvement in Claimant's condition during the period of disputed services.

C. Analysis and Conclusion

Provider failed to demonstrate by a preponderance of the evidence that the disputed services were reasonable and necessary based on the nature of Claimant's injury. Instead, the evidence indicates reimbursement should be denied. Provider seemed to rely heavily on an MRI report, but the report contained inconsistent findings. The reviewing radiologist found small anterior disc bulges at levels L2-3 and L3-4 with no protrusional abnormalities or evidence of neural compromise. However, the radiologist's conclusion under the "Impression" portion of his report-that of a posterior disc bulge impinging on the thecal sac-was different from and inconsistent with his findings. The effectiveness of the MRI as a diagnostic tool was further questioned by orthopaedic surgeon John Borkowski, M.D., who, on Provider's recommendation, evaluated Claimant on August 6, 2004:

> I have an MRI report and the films that were sent to me. I do not know how the inferences of disc bulges were made, because the MRI is of such poor quality and such [sic] limited in terms of cuts, both sagittal and axial, that I would not treat a patient based on this MRI with any invasive procedures.

Dr. Borkowski recommended another MRI be performed.

Interestingly, not only did Provider rely heavily on the MRI, but, apparently, he also chose to ignore the results of the test as they related to the finding of anterior bulges without protrusions or evidence of neural compromise. Instead, throughout the several months Provider treated Claimant

he opted to limit his focus to the radiologist's impression of posterior disc bulge with impingement.[2]

Also persuasive was Carrier's argument that Claimant was in worse shape after having been under Provider's care for approximately six weeks. On January 28, 2004, at the beginning of the dates of service in dispute, Claimant had already undergone approximately 17 sessions of treatment with Provider. With the exception of two instances where Provider performed spinal adjustments and neuro-muscular re-education on Claimant during those sessions, the treatments were the same as the disputed treatments that followed. Although Claimant experienced improvements in strength and in the length of time she could walk, squat, and kneel following the disputed services, her flexion had decreased from 65 degrees to 25 degrees; her extension had declined from 20 degrees to 15 degrees; and her left-lateral flexion and right-lateral flexion had decreased from 20 degrees to 10 degrees and 20 degrees to 15 degrees, respectively. By March 11, 2004, Claimant still had not reached the level of flexion she had enjoyed on her first visit to Provider in December 2003, although she had improved over the January 28, 2004, visit.

Additionally, the ALJ was persuaded that Provider's Daily Patient Notes, as noted by Dr. Hamby, contained little more than check marks to indicate the services performed and Claimant's response to them. They offered neither detail on how the treatments were administered nor substantive observations made during the treatment sessions.

Also convincing was Dr. Hamby's testimony that neither of the FCEs performed by Provider reflected base-line measures, such as heart rate, that would be necessary in order to establish that Claimant was exerting maximum effort during the FCEs.

Ultimately, in light of an MRI of questionable quality that produced inconsistent findings

[2] Ex. 1, p. 16-January 14, 2004 Progress Report; Ex. 1, p. 18-January 28, 2004 FCE; Ex. 1, p. 28-February 17, 2004 Progress Report; Ex. 1, p. 33-March 3, 2004 letter commenting on a peer review; Ex. 1, p. 36-March 11, 2004 FCE; Ex. 1, p. 64-June 23, 2004 Request for Reconsideration.

upon which Provider seemed to selectively rely, together with an inadequately reported chiropractic and physical therapy treatment regimen that produced mixed results at best, Provider failed to prove his services were medically necessary to treat Claimant's injury. Consequently, his reimbursement claim should be denied.

III. FINDINGS OF FACT

1. An injured worker (Claimant) suffered a compensable injury to her lower back on ___.

2. At the time of Claimant's injury, her employer held workers' compensation insurance coverage with American Home Assurance Company (Carrier).

3. Provider began treating Claimant on December 12, 2003, with modalities that included electric stimulation, spinal traction, manual therapy, and therapeutic exercise.

4. Provider was reimbursed for services provided on approximately 17 occasions through January 23, 2004, but Carrier denied reimbursement for services provided from January 27, 2004 through March 3, 2004 as medically unnecessary.

5. Provider requested medical dispute resolution before the Texas Workers' Compensation Commission (Commission) based on Carrier's denial of reimbursement.

6. The reviewing IRO concluded the disputed services were not medically necessary.

7. In response to the IRO decision, Provider requested a hearing before the State Office of Administrative Hearings (SOAH).

8. Notice of the hearing was sent to the parties on February 3, 2005. The notice informed the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

9. The hearing convened July 26, 2005, before SOAH Administrative Law Judge Gary Elkins. The hearing closed upon the filing of a brief by Carrier on July 27, 2005.

10. A December 30, 2003, MRI report Provider relied on as the basis for his ongoing treatment contained contradictory findings, on the one hand reflecting the existence of small anterior disc bulges at the L2-3 and L3-4 spinal levels with no protrusional abnormalities or evidence

of neural compromise, while on the other hand concluding Claimant suffered from a posterior disc bulge impinging on the thecal sac.

11. Provider disregarded the MRI results as they related to the finding of small anterior bulges with no protrusions or evidence of neural compromise.

12. Two doctors Provider relied on as backing his conclusion that Claimant had disc problems failed to acknowledge the inconsistency of the MRI report referred to in Finding 10.

13. Provider's Treatment Notes provided no detailed insight into the nature of the services provided or the level of improvement experienced by Claimant.

14. After six weeks under Provider's care, Claimant's flexion decreased from 65 degrees to 25 degrees; her extension had declined from 20 degrees to 15 degrees; and her left-lateral flexion and right-lateral flexion had decreased from 20 degrees to 10 degrees and 20 degrees to 15 degrees, respectively.

15. By March 11, 2004, Claimant still had not reached the level of flexion she had enjoyed on her first visit to Provider in December 2003.

16. Neither of Provider's Functional Capacity Evaluations reflected base-line measures such as heart rate, which would be necessary to establish that Claimant was exerting maximum effort during the evaluations.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. Provider had the burden of proof.

4. The disputed services were not shown to be reasonably required by the nature of Claimant's injury. TEX. LAB. CODE ANN. § 408.021.

5. Provider failed to prove the disputed services either promoted Claimant's recovery or enhanced her ability to return to employment. TEX. LAB. CODE ANN. § 408.021.

6. The disputed services were not medically necessary.

7. Provider is not entitled to reimbursement for any of the disputed services.

ORDER

IT IS ORDERED that the reimbursement claim of James Tanner, D.C., for chiropractic services provided from January 27, 2004 through March 3, 2004 is denied.

Signed September 26, 2005.

GARY W. ELKINS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS