SOAH DOCKET NO. 453-05-6799.M5
MRD NO. M5-05-2191-01

CLEM C. MARTIN, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
LUMBERMEN'S MUTUAL INSURANCE	§	
COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

I. INTRODUCTION

This case presents a challenge by Clem C. Martin, D.C. (Provider) to a decision of an independent review organization (IRO) on behalf of the Texas Department of Insurance, Division of Workers'Compensation[1], in a dispute regarding medical necessity for chiropractic treatment. The IRO found that the insurer, Lumbermen's Mutual Insurance Company (Carrier), properly denied reimbursement for chiropractic services that Provider administered to a claimant suffering from lower back pain from a work injury.

Provider challenges 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 (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision disagrees with the IRO, finding that reimbursement to Provider is required.

[1] Formerly the Texas Workers' Compensation Commission.

II. JURISDICTION AND VENUE

The hearing in this docket was convened on January 24, 2006, at State Office of Administrative Hearings (SOAH) facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Bill Zukauckas presided. Provider represented himself with assistance of his son, who works as an office manager in Provider's office. Carrier was represented by attorney Tommy W. Lueders, II. Both parties presented evidence and argument and the record closed the same day.

No party challenged jurisdiction or venue. Therefore, those matters are set out in the findings and conclusions without further discussion here.

III. STATEMENT OF THE CASE

The record revealed that Claimant reported a lower back injury on____, from stooping under a counter and cleaning a glue pot. She initially began treatment with Petitioner and then was referred to Richard Dyer, M.D., on October 22, 1996, who recommended and performed a series of epidural steriod injections. She reported recurrent lower back and buttock symptoms with pain extending into the left lower extremity. A repeat MRI scan was performed with contrast, which revealed a broad-based herniated disc at L4/L5 on top of degenerative changes. The Claimant was reported to have reached maximum medical improvement, which was determined by designated doctor Benzel MacMaster, M.D., on June 19, 1997, and was assigned a 10% whole person impairment rating. On August 23, 2002, Dr. MacMaster, also performed a required medical evaluation (RME) and opined that Claimant's work-related injury had stabilized and she would no longer benefit from chiropractic care. The Carrier apparently relied on that report in denying subsequent care rendered by Provider. The Claimant continues to receive chiropractic services from Petitioner to date.

Provider billed Carrier for chiropractic services from January 16 through June 21, 2004, and Carrier denied reimbursement on the grounds that the treatment had been medically unnecessary. Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on May 5, 2005, concluding that Provider should not receive reimbursement for the disputed services. The IRO presented the following rationale for its decision:

> The clinical documentation does not support the medical necessity nor the performance of the level of service of a 99213 on each office visit. The CPT code book defines a 99213 E&M code as an expanded problem-focused history, problem-focused examination, and medical decision of low complexity. First, the clinical record does not support the need for this level of service at each office visit, as there is no necessity to perform this level of care. Regarding the billing of 92531, testing for spontaneous nystagmus, and 92532, positional nystagmus, the Reviewer sees absolutely no need whatsoever for the performance of these tests for a lumbar spine injury. The Reviewer is quite taken aback [sic] that these services are being billed for a lumbar spine injury. It is the Reviewers opinion that there is absolutely no necessity whatsoever for the performance for testing of spontaneous or positional nystagmus. This patient has also undergone a protracted course of chiropractic manipulation without documented long term therapeutic benefit. The reviewer sees no need for the performance or billing of 98941, spinal manipulation. Regarding the billing of 94760, noninvasive ear or pulse oximetry for oxygen saturation determination, the reviewer is also in complete agreement with the insurance carrier that this level of service billed is not medically necessary. This test in no way, shape, or form would be necessary for treatment of a lumbar spine injury by a chiropractor. There is also no necessity to support the billing of a 99214 E&M code

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and, on May 5, 2005, issued its own decision confirming that the disputed services were generally not medically necessary with the exception of $214.60 of services. Provider then made a timely request for review of the IRO and MRD decisions before SOAH.

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Provider

Provider presented his own testimony and took issue with the IRO's conclusions in this case. Provider addressed each of the issues addressed in the IRO decision by CPT code. Provider noted that CPT code 99213 and 99214 E&M require only two of the three elements discussed by the IRO; those being an expanded problem-focused history, problem-focused examination, and medical decision of low complexity. Provider noted that he was seeing Claimant only on an as-needed basis. He was not treating Claimant daily as do some of his other peers. He testified he was providing at least two of the three elements needed to bill for this code at each visit.

Regarding the billing of code 92531, testing for spontaneous nystagmus, and code 92532, for positional nystagmus, the Provider testified that he uses these diagnostic observations of the eyes both before and after his spinal manipulations to evaluate the effectiveness and needed intensity of the manipulations. His testimony indicated that Claimant's relentless pain shows up as nystagmus in her eyes and that his artful observation of this nystagmus, both before and after his manipulations, helps him to achieve the optimal degree of manipulation without harming Claimant. He noted that because his manipulative applications can exceed the metabolic capacity of Claimant, that force with feedback is needed to properly modulate those applications.

With regard to the performance or billing of code 98941, spinal manipulation, the Provider testified that this is the base treatment he provides. In Claimant's situation he agrees that because she has a ruptured disc, she will never be healed. But his goal with the manipulations is not to heal her, but to provide her with "as needed" pain relief. He argues that relieving her pain arising from Claimant's compensable injury for some period of time, although not permanent, is all that is required by the statute. To address the IRO doctor's contention that a home exercise program is sufficient to address Claimant's pain needs, Provider testified that the necessary manipulation of an individual disc cannot be achieved through exercise because exercise moves the entire spine. He testified that manipulation of the individual disc was necessary for Claimant's pain relief.

Regarding the billing of code 94760, noninvasive ear or pulse oximetry for oxygen saturation determination, the Provider testified that he uses this, bilaterally, as an evaluative tool, much like the nystagmus measurements, to measure the blood oxygen saturation. The measured blood saturation

difference on each side is sometimes an indicator of the body's pain response on one side versus the other.

The Provider disagreed that the opinions of Dr. MacMaster, who performed the August 23, 2002, RME, or the opinion of the IRO reviewer, also a medical doctor, were helpful in evaluating the medical necessity of his services. He argued that because they are both medical doctors, and not peer chiropractors, they are unable to objectively evaluate his chiropractic services.

B. Carrier

Carrier presented no expert testimony and relied on the record, including the IRO analysis and the RME dated August 23, 2002. The Carrier relies heavily on Dr. MacMaster's opinion that light medication and exercise are appropriate to treat Claimant's back pain resulting from ordinary degenerative conditions in her back. Carrier further notes that Dr. MacMaster's report indicated that Claimant's compensable injury had stabilized and that further chiropractic treatments would not be helpful.

Also, the Carrier argued that the IRO evidence from a medical doctor clearly stated that there was no possible medical benefit from the nystagmus codes 92531 and 92532 in the treatment of a spine injury by a chiropractor. Likewise, there is no possible medical use in measuring Claimant's oxygen saturation levels, CPT code 94760, to treat a spine injury. Finally, Carrier argues that even the manipulations provided under CPT code 98941, by Provider's own admission, do nothing to cure Claimant's back injury and at best provide only temporary pain relief. Carrier also argued that the evidence indicated Claimant's back pain was now from her degenerative disc condition as opposed to her compensable injury from 10 years ago.

V. ANALYSIS

The ALJ finds Provider has shown that his services were medically necessary for treatment of Claimant's back pain from her compensable injury. The ALJ is bound by the evidence in the record in determining whether Provider has met his burden. While the ALJ has some concern that

the nystagmus testing and oxygen saturation testing seem, at the very least, unconventional in his experience with these cases, the ALJ cannot make a decision on his own uneducated medical intuition. While the IRO reviewer makes clear that he believes the two nystagmus codes and one oximetry code billed by Carrier are unhelpful in treating a spine injury, the ALJ just does not have an educated frame of reference to weigh untested evidence against Provider's live testimony. Had any medical or chiropractic doctor testified that this was the case, the ALJ would have some weightier evidence to compare against Provider's testimony. In the absence of that, however, Provider's testimony meets his burden for these three codes.

With regard to the actual manipulations billed under code 98941, the evidence indicates that Claimant experienced some temporary pain relief from those manipulations. Despite the overall temporary nature of the pain relief, the evidence indicates it lasted from a few days to several weeks before the next exacerbation and did relieve the pain effects naturally resulting from the compensable injury. The ALJ believes Provider has shown this satisfies the requirements of ' 408.021(a)(1) of the Act.

To address and rebut the documentary evidence that Claimant's pain was likely the result of her ordinary disc degeneration, Provider testified that ordinary bilateral disc degeneration was not painful itself. Consequently, he argued that her pain was from her compensable injury that resulted in her ruptured disc rather than from some degenerative natural process.

VI. CONCLUSION

For the reasons discussed above, the ALJ finds Provider has shown that the services he provided Claimant, under the record in this case, are medically necessary and reasonable.

VII. FINDINGS OF FACT

1. Claimant suffered a lower back injury on____, from stooping under a counter and cleaning a glue pot, which constituted a compensable injury under the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. The Claimant received chiropractic services from Provider from soon after her injury

through the date of service in question.

3. Provider sought reimbursement for services limited to dates between January 16 and June 21, 2004, from Lumbermen's Mutual Insurance Company (Carrier), the insurer for Claimant's employer.

4. The Carrier denied the requested reimbursement.

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

6. The independent review organization (IRO), to which the Commission referred the dispute, issued a decision on May 5, 2005, finding that the treatment at issue was not medically necessary.

7. The Commission's Medical Review Division (MRD) reviewed and concurred with the IRO's findings in a decision dated May 5, 2005, with the exception of $214.60 of services.

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

9. The Commission mailed notice of the hearing to all parties.

10. A hearing in this matter was convened on January 24, 2006, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Bill Zukauckas, an Administrative Law Judge with SOAH.

11. The chiropractic services provided were reasonable and necessary to treat the Claimant's lower back pain.

    a. Code 92531, testing for spontaneous nystagmus, and code 92532, testing for positional nystagmus, were diagnostically necessary, both before and after spinal manipulations, to evaluate the effectiveness and needed intensity of the manipulations.

    b. Code 94760, noninvasive ear or pulse oximetry for oxygen saturation was necessary as an evaluative tool to measure the blood oxygen saturation and make a manipulation adjustment based on those readings.

    c. Code 99213 and 99214 E&M, for office visits, was necessary in that Provider performed, each visit, a problem-focused examination and medical decision of low complexity. That code was not excessive because Claimant appeared only on an "as needed" basis, rather than a daily basis.

    d. Code 98941, for spinal manipulation, was necessary because it provided "as needed"

pain relief for her compensable injury that lasted from several days to several weeks. That manipulation of an individual disc for pain relief cannot be achieved through exercise because movement of the individual disc is needed for proper treatment.

VIII. CONCLUSIONS OF LAW

1. The Division of Workers' Compensation of the Texas Department of Insurance 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 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) and 402.073(b) 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.

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 Finding of Fact No. 11, Provider proved that the services rendered were medically necessary for the dates of services at issue.

IT IS THEREFORE ORDERED that Clem C. Martin, D.C., should have full reimbursement from Lumbermen's Mutual Insurance Company (Carrier) for all chiropractic modalities provided Claimant in this matter for dates of service between January 16 and June 21, 2004.

SIGNED March 9, 2006.

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS