DOCKET NO. 453-05-7479.M5
M5-05-2152-01

CORNERSTONE CLINIC, INC.	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
DALLAS ISD,	§	
Respondent	§	
	§	**ADMINISTRATIVE HEARINGS**
	§	

DECISION AND ORDER

Petitioner Cornerstone Clinic, Inc. (Provider) disagrees with the decision of an independent review organization (IRO) issued on behalf of the Texas Workers' Compensation Commission (Commission)/Medical Review Division (MRD)[1] finding that the medical services provided Claimant from June 14, 2004, to December 17, 2004, were not medically necessary. The amount in dispute is $39,235.27. Provider contends that all the medical services provided Claimant during these six months were medically necessary.

After considering the evidence and arguments presented, the Administrative Law Judge (ALJ) finds that Provider failed to prove by a preponderance of the evidence that the disputed medical services provided to Claimant from June 14, 2004, through December 17, 2004, were medically necessary. Therefore, Carrier is not required to reimburse Provider for these disputed medical services.

[1] Effective September 1, 2005, the functions of TWCC have been transferred to the newly created Division of Worker's Compensation at the Texas Department of Insurance.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

The State Office of Administrative Hearings (SOAH) has jurisdiction over matters related to the hearing in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031 (k) and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction or notice.

ALJ Catherine C. Egan convened the hearing on the merits on July 11, 2006, at the SOAH hearing facilities in, Austin, Texas. Laurence N. Smith, D.C. appeared telephonically on behalf of Provider. Attorney Mark Sickles represented Dallas Independent School District (Carrier). The record closed the same day.

II. BACKGROUND

On___, Claimant, a sixty-seven-year-old male, injured his lower back while working for the Dallas Independent School District. Claimant was initially treated at Accident and Injury Clinic with physical therapy and rehabilitation.[2] In early June 2003, Claimant had an MRI of his lumbar spine taken, which showed a flattening of the lumbar lordosis secondary to muscle spasms or possible patient positioning, and degenerative disc disease at L5, with posterior bulging of L5 annulus by 2-3 mm which contacts, but does not displace, the thecal sac.[3] Claimant also underwent a nerve conduction study revealing bilateral L5 nerve irritation.

[2] Ex. 2 at 8.

[3] *Id.*

On June 14, 2004, Claimant changed his treating physician to Laurence N. Smith, D. C., a member of Provider's facility, claiming that he still had pain and was not improving.[4] According to Dr. Smith, Claimant told him that Claimant's prior treating physician required him to carry "70 lbs around an indoor track for seven hours a day" as part of a work hardening program.[5] Provider began treating Claimant with stretching exercises, recumbent biking, and simple ball exercises to reduce Claimant's pain, to improve his range of motion, and to improve his functional ability so he could return to work.[6]

Provider continued providing aggressive and intense medical services to Claimant for six months. The disputed services included extended office visits, (CPT 99205/99213), x-ray of the lower spine (CPT 72110), manual therapy (CPT 97140-59), electrical stimulation - manual (CPT 97032), mechanical traction (CPT 97012), one-on-one therapeutic exercises (CPT 97110), functional capacity examination (CPT 97750-FC), therapeutic activities (CPT 97530), and neuromuscular re-education (CPT 97112).

Dr. Smith diagnosed Claimant as suffering with sciatica, lumbosacral spondylosis without myelopathy, and displacement of intervertebral disc without myelopathy. On August 13, 2004, Anthony Giola, M.D., reviewed Claimant's medical records and physically examined Claimant. Dr. Giola noted that Claimant was treated for a year and three months with chiropractic care almost five days per week. Yet, Claimant still reported feeling no different and not making any progress.[7] On September 28, 2004, Claimant underwent another lumbar MRI. This MRI showed the following:

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[4] Ex. 2 at 14.

[5] The ALJ is not sure what weight Claimant carried, if any, because the prior treating doctor's records were not introduced into evidence and Dr. Smith provided an inconsistent weight in his letter requesting reconsideration. Ex. 2 at 1.

[6] Ex. 2 at 54.

[7] Ex. 2 at 430.

1. Minimal generalized disc bulge at L5-S1 combined with facet hypertrophy causing mild to moderate spinal stenosis and mild bilateral foraminal narrowing.

2. Diffuse annular bulge at L4-5 combined with facet hypertrophy causing mild spinal stenosis.

3. Diffuse annular bulge at L3-4 combined with facet hypertrophy causing mild spinal stenosis.

4. Diffuse annular bulge at L2-3. No spinal stenosis or foraminal narrowing is noted.

5. Desiccation involving all lumbar lordosis which is a non-specific finding. This can be due to muscle spasm or patient positioning. Clinical correlation is recommended.[8]

On December 20, 2004, Dr. Smith found Claimant had reached maximum medical improvement with a ten percent whole body impairment rating.

III. DISCUSSION

Provider had the burden of proof. Provider's expert and the treating physician, Dr. Smith, testified that Claimant's age and his reinjury to his lower back justified the intensity of the medical services provided Claimant. According to Dr. Smith, Claimant reinjured his lower back while carrying the 70 pounds mentioned above as part of a work hardening program. Other than this statement, little information is documented in Provider's records to substantiate that Claimant reinjured his compensable injury, how he reinjured it, and the extent of the reinjury. Likewise, little information is documented in the medical records to explain why Claimant had to undergo extended office visits each time he came in for therapy or why he could not engage in a home-based exercise program.

[8] Ex. 2 at 410.

Carrier called an expert witness, Richard T. Champlin, Jr., D.C., to testify. Dr. Champlin testified that while it is permissible to provide more treatment than specified in the treatment guidelines to a patient whose condition justifies it, the medical record most support the need for this additional treatment. After reviewing Provider's medical record, Dr. Champlin opined that Provider's treatment of Claimant's condition was excessive and medically unnecessary particularly thirteen months after the compensable injury.

Dr. Champlin noted that when Claimant presented to Provider, Claimant had already received passive modalities, active therapy, and work-hardening. Nothing in Provider's records justified providing Claimant with more than a hundred sessions of additional treatment. Moreover, Dr. Champlin argues Provider's treatments did not appear to be goal-oriented or monitored for effectiveness, and showed no objective overall orthopedic improvement. Dr. Champlin agrees that Provider's records did show some subjective improvement in his complaints of pain, but that could have been a function of time rather than the treatment provided.

Although Dr. Champlin maintains none of the dispute services were medically necessary, Dr. Champlin addressed the lack of medical necessity for the disputed CPT codes. The following is a brief summary of his opinion regarding these disputed CPT code:

- CPT Code 99205 (new patient, highest level examination) and CPT Code 99213 (detailed established patient examination) were billed excessively (done on every visit) and were not supported by Provider's medical records.
- CPT Code 97140-59 (manual manipulation) was not documented adequately in the medical records to show where, how, or the reason for the manipulations.
- CPT Code 97032-manual (electrical stimulation) requires one-on-one contact between the Provider and Claimant. The record does not support that one-on-one electrical stimulation was given Claimant.
- CPT Code 97012 (mechanical traction) is not supported by documentation.

- $ CPT Code 97110 and 97530 deal with physical therapy, but the medical records do not show that Claimant could not do these exercises at home.

- $ CPT 97112 (neuromuscular re-education) was not medically necessary because Provider did not describe why the service was needed or what technique was used.

The IRO issued a report on May 18, 2005, that was adopted by the MRD in its order dated May 20, 2005. The IRO found that the disputed services provided between June 14, 2004, and December 17, 2004, were not medically necessary. According to the IRO, the disputed services were provided 13 months after the injury and were provided after Claimant had already received physical therapy. The IRO reported that Claimant had approximately 108 chiropractic visits with Provider including a rehabilitation program, which far exceeded the Official Disability Guidelines.[9] The IRO opined that Claimant should have been "faded from active care and instructed with a home treatment exercise program of stretching and strengthening the lumbar spine."[10]

The ALJ finds that Provider failed to provide sufficient evidence to support the aggressive and intensive medical services provided to Claimant. The extent of Claimant's reinjury is not adequately documented in the medical record to explain the need for Provider's treatment plan. Furthermore, Provider failed to clearly identify the treatment goals, Claimant's progress, the area of Claimant's body treated, the effectiveness of the treatment, or why Claimant required the one-on-one treatment he was receiving. The medical records do not support a finding that Claimant could not participate in a home-based therapy program. Therefore, the ALJ finds that Provider is not entitled to additional payment for the disputed services.

[9] Ex. 2 at 9.

[10] *Id.*

IV. FINDINGS OF FACT

1. On___, Claimant sustained a work-related injury to his lower back as a result of his work activities (compensable injuries).

2. At the time of Claimant's compensable injuries, Claimant's employer's workers' compensation insurance carrier was Dallas Independent School District (Carrier).

3. As a result of the compensable injury, Claimant received treatment at Accident and Injury Clinic, which included physical therapy and rehabilitation.

4. Claimant progressed to work hardening prior to changing his treating physician on June 14, 2004, to Laurence N. Smith, D.C., a member of Cornerstone Clinic, Inc. (Provider).

5. Claimant's reason for changing his treating physician was that he was not improving.

6. Provider did not obtain the medical records from Claimant's prior treating physician to determine what medical treatment Claimant was receiving prior to coming to Dr. Smith for treatment.

7. Claimant did not reinjure his lower spine.

8. Dr. Smith diagnosis of Claimant's condition included sciatica, lumbosacral spondylosis without myelopathy, and displacement of intervertebral disc without myelopathy.

9. Provider treated Claimant with an aggressive and intensive program between June 14, 2004, and December 17, 2004, which included extended office visits, (CPT 99205/99213), x-ray of the lower spine (CPT 72110), manual therapy (CPT 97140-59), electrical stimulation manual (CPT 97032), mechanical traction (CPT 97012) one-on-one therapeutic exercises (CPT 97110), functional capacity examination (CPT 97750-FC), therapeutic activities (CPT 97530), and neuromuscular re-education (CPT 97112) (the disputed medical services).

10. Provider requested reimbursement from Carrier for the disputed medical services.

11. Carrier refused to pay for the disputed medical services asserting that the treatment was not medically reasonable or necessary.

12. On May 18, 2005, an independent review organization (IRO) reviewed the medical dispute and found that the disputed medications were not medically necessary.

13. Based on the IRO's findings, the Texas Workers' Compensation Commission's Medical Review Division (MRD) denied Provider's request for additional reimbursement from the Carrier.

14. After the MRD order was issued, Provider requested a contested-case hearing by a State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ).

15. Required notice of a contested-case hearing concerning the dispute was mailed to the parties.

16. On July 11, 2006, SOAH ALJ Catherine C. Egan held a contested-case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Laurence N. Smith, D.C. appeared telephonically on behalf of Provider. Attorney Mark Sickles represented Carrier. The hearing concluded and the record closed on that same day.

17. The disputed medical services were excessive and far exceeded established medical treatment guidelines.

18. Claimant's condition did not require the disputed services because Claimant could have participated in a home treatment exercise program.

19. The disputed medical services were not reasonable or medically necessary to treat Claimant's compensable injury.

V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. (Labor Code)§§ 402.073(b) and 413.031(k) and TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

3. Based on the above Findings of Fact and Gov't Code § 2003.050 (a) and (b), 1 TEX. ADMIN. CODE (TAC) § 155.41(b) (2004), and 28 TAC§§ 133.308(v) and 148.21(h) (2004), Provider had the burden of proof in this case, which was the preponderance of evidence standard.

4. An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. Labor Code § 408.021 (a).

5. Based on the above Findings of Fact and Conclusions of Law, the disputed medical services

provided by Provider to Claimant between June 14, 2004, and December 17, 2004, were not medically necessary to treat Claimant's compensable injury.

ORDER

IT IS ORDERED THAT Cornerstone Clinic, Inc., is not entitled to additional reimbursement from Dallas Independent School District for the disputed medical services provided to Claimant from June 14, 2004, to December 17, 2004.

Signed September 11, 2006.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS