SOAH DOCKET NOS. 453-05-1228.M5 and 453-05-4352.M5
MR NO. M5-04-3509-01 and M5-05-888-01

SCD BACK & JOINT CLINIC, LTD., Petitioner	§	**BEFORE THE STATE OFFICE**
	§	
	§	
	§	**OF**
AMERICAN HOME ASSURANCE, Respondent	§	
	§	
	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

SCD Back & Joint Clinic, Ltd., ("Petitioner") seeks review of two decisions by the Texas Workers' Compensation Commission ("Commission"[1]), acting in each case through an independent review organization ("IRO", in disputes regarding the medical necessity of chiropractic treatment. The Commission found that the insurer, American Home Assurance ("Respondent") properly denied reimbursement for physical therapy and related treatment that Petitioner administered from August 5 through December 18, 2003, to a claimant suffering from injury to the back, shoulder, hip, and neck.

Petitioner challenged the decision on the basis that the treatment at issue was, in fact, medically necessary, within the meaning of Sections 408.021 and 401.011(19) of the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ch. 401 *et seq.*, and that Respondent had failed to properly place the medical necessity of the treatment at issue in the medical dispute resolution process.

This decision finds that reimbursement should be denied, as the Commission previously determined.

I. JURISDICTION AND VENUE

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the newly created Division of Workers' Compensation within the Texas Department of Insurance.

The Commission (or its successor agency) has jurisdiction over this matter pursuant to §413.031 of the Act. 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. No party challenged jurisdiction or venue.

II. STATEMENT OF THE CASE

The hearing in this docket was convened on March 27, 2006, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge ("ALJ") Mike Rogan presided. Petitioner and its legal counsel (William Maxwell, attorney) appeared by telephone. Respondent did not appear and did not provide SOAH any explanation of its failure to appear. Petitioner presented evidence and argument, and the hearing was adjourned on the same date. Petitioner was given the opportunity to submit copies of the medical-care guidelines applicable to this case by April 10, 2006, on which date the record in the case was closed.[2]

The record revealed that on____, the claimant suffered a compensable injury to the neck, back, right shoulder, and right hip. After initial medical treatment that left her still experiencing persistent pain, the claimant began a course of chiropractic treatment with Petitioner, extending from August 5 through October 29, 2003, which included mechanical traction, electrical stimulation, massage, therapeutic exercise, chiropractic manipulation, diathermy, muscle-testing, and office visits.

From November 2 through December 18, 2003, the claimant underwent another round of treatment with Petitioner, including mechanical traction, massage, therapeutic exercise, chiropractic manipulation, diathermy, muscle-testing, office visits, group therapy, other physical medicine procedures, and range-of-motion measurements.

[2] The staff of the Commission formally elected not to participate in this proceeding, although it filed a general "Statement of Matters Asserted" with the notice of the hearing for each docketed cause of action.

When Petitioner submitted to Respondent (the insurer for the claimant's employer) bills for the August-October and November-December courses of treatment, Respondent denied reimbursement on the grounds that the treatment had been medically unnecessary. Petitioner then sought medical dispute resolution through the Commission.

The IROs to which the Commission referred the dispute issued decisions concluding that the chiropractic care and physical therapy administered through the Petitioner during the disputed dates of service had not been medically necessary. In a decision dated August 24, 2004, one IRO concluded that the August-October treatment was inordinately extensive for the patient's documented symptoms. The IRO also noted that the patient had shown "no positive findings on MRI" and had undergone "extensive treatment with different modalities without documented improvement."

In a decision dated January 19, 2005, another IRO found that the November-December treatments were inappropriate, because the patient had received "an intensive trial of conservative therapy prior to the dates in dispute with no relief of symptoms or improved function." The IRO then continued:

> Repeated Dynation and DeLorme testing were not necessary. These tests are usually done to determine the effect of treatment on strength and ROM. The D.C.'s treatment was failing and he continued to perform these expensive tests, yet based on the records provided for this review, the D.C. never changed his treatment protocol based on findings from these tests. . . . The services in this dispute took place some five months after treatment was initiated by the D.C. The records provided for review do not support any functional improvement, pain relief, progression of rehabilitation program, or a move toward self-directed care. There had been no improvement in strength, range of motion, or function that justified continued treatment for the dates in dispute. . . .

The Commission's Medical Review Division ("MRD") reviewed the IROs' decisions and, on September 7, 2004, and January 20, 2005, issued its own decisions confirming that the disputed services were not medically necessary and should not be reimbursed. Petitioner then made timely requests for review of the MRD decisions. After referral to SOAH, separate disputes relating to the August-October and November-December treatments were joined for hearing.

III. PETITIONER'S EVIDENCE AND ARGUMENT

Petitioner argued primarily that the medical necessity of the disputed treatments is not legitimately within the scope of these administrative actions, because while Respondent identified the basis for its denial of reimbursement with the code "U-777" - "unnecessary, based upon peer review"- Respondent failed to make timely submission of the relevant peer review report to Petitioner.

Dr. David Bailey (a chiropractor and principal owner of SCD Back & Joint Clinic) testified for Petitioner at the hearing.[3] He stated, very generally, that the disputed treatment provided to the claimant was consistent with medical guidelines applicable to such cases. With Petitioner's post-hearing submission of authorities relevant to this case, Dr. Bailey provided a further written statement about the disputed treatment. It, too, consisted of very general observations about the relationship of the treatment to the applicable guidelines, such as the following:

> The treatment plans proposed included treatment services that were appropriate for musculo-skeletal injuries such as sustained by the patient.
>
> There was sufficient evidence available at the time the treatment plans were prescribed, to support a reasonable belief that those treatment plans would have a significant likelihood of providing a positive health outcome for this patient.

IV. ANALYSIS

Petitioner bears the burden of proving that the disputed services are medically necessary. In the ALJ's view, it has not discharged that burden.

Dr. Bailey's testimony was wholly conclusory and provided no significant, meaningfully specific support for Petitioner's contention that the disputed treatment was consistent with applicable guidelines and thus medically necessary. Given the general context of this type of case and the amorphous diagnosis of the claimant in this particular instance, the IROs' conclusions that the disputed treatment was excessive seem, on the surface, quite convincing. Petitioner has submitted

[3] The record indicates, however, that the treating doctor, at least for most of the disputed dates of service, was John R. Wyatt, D.C., who was practicing through Petitioner's clinic.

hundreds of pages of medical records in an effort to rebut those conclusions. However, those records are typically rather cryptic, and Petitioner has offered little or no analysis, in either evidence or argument, to logically link the disputed treatments to legitimate medical imperatives in the claimant's case.

As for Petitioner's technical argument that Respondent has precluded a proper consideration of the issue of medical necessity by failing to submit sufficient information to Petitioner, the ALJ regards it an insubstantial afterthought. A number of SOAH decisions hold that because medical necessity is such a fundamental element in the statutory and regulatory scheme for workers' compensation, it may be raised at any stage in a medical dispute resolution process. While this is justly characterized as a "minority position" at SOAH, it nonetheless illuminates the more universally accepted principle that the issue of medical necessity should not readily be regarded as waived or otherwise negated in such an administrative action.

In this case, Petitioner's requests to the Commission for medical dispute resolution make no mention of Respondent's subsequently alleged failure to provide peer review reports or other information sufficient to explain the basis for carrier's denying reimbursement. Rather, they explicitly assert the medical necessity of the disputed services - seemingly acknowledging the fundamental relevance of this issue in this patient's case - and, indeed, include brief explanations of why Petitioner alleges that specific categories of treatment were medically necessary.

In the ALJ's view, therefore, the record makes it more plausible to conclude that Petitioner has waived any complaint it had about Respondent's adherence to rules governing the initial stages of the dispute-resolution process -including failure to timely provide Petitioner with a copy of the relevant peer review - than to conclude that Respondent's actions have waived the issue of medical necessity and (without the IRO, MRD, or other participants in the process previously noticing it) have essentially negated the entire process up to this point.

The situation in this case seems clearly analogous to that addressed in SOAH Docket No. 453-02-1881.M4,[4] in which the ALJ concluded:

[4] Issued October 10, 2002, ALJ Newchurch.

> As the provider notes, several SOAH ALJs have held that an objection to a claim that was not raised in the Carrier's EOB is beyond the scope of the subsequent SOAH proceeding. Those decisions noted that Labor Code § 408.027(d) and 28 TAC §133.304(a) require a Carrier within 45 days of receiving a medical bill to take final action on it and, if denying it, send the Provider a report that sufficiently explains the reason for denial. In this case, there is no direct evidence that the Provider complied with those provisions.[5] However, the Carrier somehow communicated to the Provider that it was denying the claims as unreasonable or unnecessary. The Provider admitted that in its own dispute-resolution request. Given that admission, the ALJ concludes that the Provider may not now argue to the contrary. The ALJ concludes that Carrier timely raised the medical-necessity objection and that it is within the scope of this case.

In summary, the preponderance of the evidence does not demonstrate that the IROs erred in finding the disputed services to be medically unnecessary. Rather, under the circumstances, the ALJ must conclude that Petitioner (or each treating physician practicing through Petitioner in the case) has failed to provide efficient management of the claimant's health care, as required by 28 TEX. ADMIN. CODE § 180.22(c).

V. CONCLUSION

The ALJ finds that, under the record provided in this case, the medical services at issue have not been shown to be medically necessary. The issue of medical necessity has not been waived or precluded by any action of Respondent. Accordingly, reimbursement for these services should be denied.

VI. FINDINGS OF FACT

1. On___, the claimant suffered an injury to the neck, back, right shoulder, and right hip that was a compensable injury under the Texas Worker's Compensation Act ("the Act", TEX. LABOR CODE ANN. §401.001 *et seq*.

[5] In the present case, there is also little definitive evidence that the carrier did not comply with those provisions.

2. After initial medical treatment that left her still experiencing persistent pain, the claimant began a course of chiropractic treatment with SCD Back & Joint Clinic, Ltd. ("Petitioner"), extending from August 5 through October 29, 2003, which included mechanical traction, electrical stimulation, massage, therapeutic exercise, chiropractic manipulation, diathermy, muscle-testing, and office visits.

3. From November 2 through December 18, 2003, the claimant underwent another round of treatment with Petitioner, including mechanical traction, massage, therapeutic exercise, chiropractic manipulation, diathermy, muscle-testing, office visits, group therapy, other physical medicine procedures, and range-of-motion measurements.

4. The treatment noted in Findings of Fact Nos. 2 and 3 was based upon ongoing diagnoses of "sprain/strain" to the affected regions of the body.

5. Petitioner sought reimbursement for the services noted in Findings of Fact Nos. 2 and 3 from American Home Assurance ("Respondent"), the insurer for the claimant's employer.

6. Respondent denied the requested reimbursement on grounds that the disputed treatment had been medically unnecessary, based upon peer reviews.

7. Petitioner made timely requests to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

8. The independent review organizations ("IROs") to which the Commission referred the disputed issues concluded that the treatment in question was not medically necessary, as follows:

    a. With respect to the treatment noted in Finding of Fact No. 2, an IRO in dispute resolution docket No. M5-04-3509-01 found (in a decision dated August 24, 2004) that such treatment was inordinately extensive for the patient's documented symptoms and that the patient had undergone "extensive treatment with different modalities without documented improvement."

    b. With respect to the treatment noted in Finding of Fact No. 3, an IRO in dispute resolution docket No. M5-05-0888-01 found (in a decision dated January 19, 2005) that such treatment was inappropriate, because the patient had already received "an intensive trial of conservative therapy prior to the dates in dispute with no relief of symptoms or improved function"

9. The Commission's Medical Review Division reviewed and concurred with the IROs' decisions in separate decisions dated September 7, 2004, and January 20, 2005, in dispute resolution docket Nos. M5-04-3501-01 and M5-05-0888-01, respectively.

10. Petitioner requested in a timely manner hearings with the State Office of Administrative Hearings ("SOAH"), seeking review of the MRD decisions.

11. The Commission mailed notice of the hearings' settings to the parties at their addresses on November 8, 2004, (for dispute resolution docket No. M5-04-3509-01) and March 2, 2005 (for dispute resolution docket No. M5-05-0888-01). The hearings were subsequently continued upon motion of the parties, with proper notice of rescheduling.

12. Upon party motion and by orders dated May 11, 2005, separate proceedings before SOAH with respect to the two dispute resolution docket numbers were joined for a single hearing on the merits.

13. A hearing in the joined matters was convened before SOAH on March 27, 2006, in Austin, Texas. Petitioner was represented and appeared by telephone. Respondent did not appear and did not provide SOAH any explanation of its failure to appear.

14. Petitioner was given the opportunity to submit copies of the medical-care guidelines applicable to this case by April 10, 2006, on which date the record in the case was closed.

15. Petitioner failed to offer sufficiently probative evidence to logically link the disputed treatments to legitimate medical imperatives in the claimant's case or to adherence with the applicable medical guidelines.

VII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (or its successor agency, 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) of the Act; TEX. GOV'T CODE ANN. ch. 2003; and Acts 2005, 79th Leg., ch. 265§8.013, eff. Sept. 1, 2005..

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMINISTRATIVE CODE ("TAC") §133.305(g) and §§148.001-148.028.

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

5. Petitioner, the party seeking relief, bore the burden of proof with respect to all facts necessary to support such relief in this case, pursuant to 28 TAC §148.21(h).

6. Based upon the foregoing Findings of Fact, the treatments for the claimant provided by Petitioner from August 5 through December 18, 2003, as noted in Findings of Fact Nos. 2 and 3, do not represent elements of health care medically necessary under §408.021of the Act.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's request for reimbursement for the services noted in Findings of Fact Nos. 2 and 3 should be denied.

ORDER

IT IS THEREFORE, ORDERED that the claim of SCD Back & Joint Clinic, Ltd., for reimbursement of chiropractic treatment provided from August 5 through December 18, 2003, is **DENIED**.

SIGNED June 9, 2006.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS