DOCKET NO. 453-05-3066.M5
TWCC MRD NO. M5-04-3453-01

TEXAS MUTUAL INSURANCE COMPANY, Petitioner	**§**	**BEFORE THE STATE OFFICE**
V.	**§**	**OF**
JACK BARNETT, D.C., Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) appealed the decision of the Texas Workers' Compensation Commission (Commission)[1] designee, an Independent Review Organization (IRO), which granted reimbursement to Jack Barnett, D.C. (Provider) for chiropractic care provided to Claimant __(Claimant) from June 2, 2003, through October 22, 2003, and the office visit on January 29, 2004. The Administrative Law Judge (ALJ) finds that the chiropractic care provided from June 2, 2003, through October 22, 2003, was medically necessary but the office visit on January 29, 2004, was not medically necessary. Accordingly, Carrier shall reimburse Provider for the chiropractic care provided from June 2, 2003, through October 22, 2003.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

On November 9, 2005, ALJ Michael J. O'Malley convened the hearing on the merits at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared and was represented by attorney Larry Trimble. Carrier appeared and was represented by its attorney, Katie Kidd. On December 12, 2005, the parties filed closing arguments, and the record closed the same day. There were no contested issues regarding notice or jurisdiction; therefore, those issues are presented in the findings of fact and conclusions of law.

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

II. BACKGROUND, EVIDENCE, AND DISCUSSION

1. Background

On____, Claimant sustained a compensable lumbar spine injury while working as a ___ for ___. His injury occurred while unloading a pallet of produce using a pallet jack. He slipped and fell backwards, landing on his back. With symptoms of pain and stiffness in the lower back, he first sought treatment from Clark D. McKeever, M.D., who ordered an MRI and lumbar discogram. The MRI and lumbar discogram had significant findings, showing Claimant had extensive chronic degenerative pain in the Claimant's L5-S1 vertebrae, stenosis, radiculopathy, and a large tear in the annulus. Claimant was in severe pain, typically 10/10 or 9/10.

On January 3, 2001, Claimant was examined by Henry Small, M.D., who became his treating physician. Claimant had various medical tests during the year 2000, and on April 6, 2001, Dr. Small recommended surgery for Claimant. Claimant opted to try non-surgical care before committing to major surgery. Dr. Small referred Claimant to Dr. Barnett for one month of work hardening. However, Claimant participated in the program for only one week. A functional capacity evaluation was performed, which showed Claimant had decreased range of motion, poor flexibility, and radiculopathy.

On October 8, 2001, Claimant had to have a five-vessel coronary artery bypass. When he recovered from the bypass surgery, Claimant returned to Dr. Small on January 3, 2002, stating that he was ready for lumbar spine surgery. Dr. Small needed to get a coronary clearance before the spinal surgery could be performed. As a result, he was not referred to a neurosurgeon, David MacDougall, D.O., until March 5, 2003. Dr. MacDougall wanted more updated imaging studies and a more current cardiology clearance before performing the surgery. Dr. MacDougall performed a microdiscectomy at L4-5 on June 12, 2003. On July 16, 2003, he prescribed an active, post-operative rehabilitation program and referred Claimant to Provider, who had been treating

Claimant since July 5, 2002. On the disputed dates of service, Claimant received treatment from Provider, which included office visits, electrical stimulation, ultrasound, hot/cold pack therapy, myofascial release, chiropractic manipulations, therapeutic exercises, massage, and a functional capacity evaluation (collectively, chiropractic care).

B. Legal Standards

Carrier has the burden of proof in this proceeding. 28 TEX. ADMIN CODE §148.14(a). An employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care 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. TEX. LABOR CODE ANN. § 408.021(a).

C. Parties' Positions and Evidence

1. Provider's Position and Evidence

Provider generally argues that the treatments he provided to Claimant before the surgery on June 2, 2003, through June 10, 2003, were medically necessary to relieve the effects of Claimant's compensable injury; that the treatments after the spinal surgery of June 12, 2003, were reasonably and medically necessary post-operative treatments for spinal surgery; that due to Claimant's cardiovascular history, he needed to be examined and monitored frequently by his doctors; that his long wait for spinal surgery resulted in severe deconditioning and the need for aggressive post-surgical rehabilitation; and that the dates of service after the surgery were medically necessary as Claimant awaited a request for work hardening.

John K. Connell, Jr., D.C.,[2] testified that Claimant's inactivity during the time he was waiting for spinal surgery resulted in Claimant becoming severely deconditioned. Provider maintains that Dr. Connell's testimony is supported by the functional capacity evaluation, which showed severe deconditioning and the need for post-operative rehabilitation.

Provider maintains that Carrier has provided insufficient evidence as to why it denied reimbursement for most of the post-operative spinal surgery rehabilitation. Provider, as the primary treating doctor since July 2002, was attempting to provide Claimant with supportive care while awaiting all the tests and medical clearance to undergo the spinal surgery.[3] He argues that the treatments he provided after the surgery were medically necessary to help Claimant recover from the surgery. Provider further contends that his goal all along has been to assist in curing or relieving the effects naturally resulting from Claimant's compensable injury, to promote recovery, and to enhance the ability of Claimant to return to work or retain employment. Provider points to the fact that after the surgery, Claimant was able to increase his range of motion and strength, even though still experiencing some pain, as evidence that his treatments were effective. In addition, according to Provider, as a result of the post-operative active rehabilitation, Claimant was able to function at a light to light/medium work demand level. Although Claimant will not likely be able to return to a heavy-work demand level, Provider argues that he will be able to safely return to gainful employment.

[2] Dr. Connell provided the chiropractic care to Claimant at Dr. Barnett's office.

[3] Services provided by Provider to this Claimant up until May 13, 2003, were the subject of another SOAH decision issued in Docket No. 453-04-2057.M5 on February 17, 2005.

2. Carrier's Position and Evidence

After submitting its documents in evidence, Carrier called William DeFoyd, D.O., to testify. Dr. DeFoyd testified generally that the pre-surgery treatments were not necessary and not helping. He testified that for the disputed dates of service of June 2, 2003, through June 10, 2003, Claimant was already in a chronic stage and awaiting surgery, and that the passive treatments provided by Dr. Barnett's office were ineffective. According to Carrier, the *Medicine Ground Rules* dictate that the patient shall have the potential for restoration of function through the treatments provided; however, the records indicate no improvement in Claimant. Furthermore, the same treatment had been provided since August 9, 2002, which exceeds the recommendation of the *Official Disability Guidelines*. The *Official Disability Guidelines* suggest ten visits over an eight-week period.

Dr. DeFoyd also claimed that the office visits on June 2 and 10, 2003, billed under CPT Code 99213, did not meet the requirements for billing under that code.[4] Provider's office visits did not include an expanded problem focused history, expanded problem focused examination, and medical decision making of low complexity. Neither did Provider check for vitals, general appearance, perform a lymphatic evaluation, gait assessment, musculoskeletal exam, skin inspection and neurological exam in all of the visits. According to Dr. DeFoyd, if a level of service was not provided as billed, then it certainly was not necessary and should not be reimbursed.

Concerning the post-surgery treatments by Provider, Carrier maintains that it reimbursed for all therapies begun on July 21, 2003, and up until August 1, 2003. On that date, Carrier denied reimbursement for electrical stimulation. Dr. DeFoyd stated that this was the sixth treatment date and in the second week of treatment post-surgery. On August 5, 2003, Carrier began denying payment on all passive modalities but continued reimbursement for one of four units of therapeutic exercise. By August 19, 2003, Carrier denied payment on all treatments. As of August 19, 2003,

[4] Carrier states same arguments apply for office visits on 8/20/03, 8/22/03, 8/27/03, 9/3/03, 9/10/03, 9/17/03, 10/15/03, and 10/21/03.

Claimant had received 13 treatments and was in the fifth week of treatment. Carrier asserts that denial of reimbursement after August 19, 2003, was appropriate, given the fact that the L4/5 micro-discectomy/laminotomy is a less invasive procedure than a discectomy/laminectomy or fusion. Four weeks of post-operative treatment for the procedure was reasonable in light of the fact that Claimant was experiencing no improvement, there was no focused rehabilitation plan, and there were no change to the plan or the type of exercises.

Carrier's position is that Claimant was not improving. It contends that treatments by Provider did not relieve the effects resulting from the injury; did not return the Claimant to employment; nor did they help Claimant to retain employment. The increase in his range of motion was more a direct result of the surgery than of Provider's treatments. Carrier asserts that Claimant's increase in strength was due to his learning how to operate the exercise machines. Carrier maintains that Claimant should have been provided a home exercise program as encouraged by the *Official Disability Guidelines*, and he should have been offered other treatment programs such as psychological counseling or a pain management program.

D. ALJ's Analysis

Claimant's injury presented Provider with a unique situation. Not only had Claimant suffered from a severe spinal injury, he also suffered from other health problems, specifically a cardiac condition. Claimant's delay in seeking his spinal surgery resulted in additional but medically necessary care. Carrier disputes the services provided, prior to surgery, from June 2 through June10, 2003, as not medically necessary. However, Dr. Connell adequately explained that Claimant's inactivity during the time he was waiting for surgery caused deconditioning. While waiting for surgery, it was medically necessary for Provider to provide passive/palliative care to Claimant to relieve his pain and maintain his functionality. Under the *Medicine Ground Rules*, to qualify for reimbursement, Claimant's condition must have the potential to return him to functionality, and the treatment must be specific to the injury and provide for the potential

improvement of Claimant's condition.[5] Furthermore, Claimant was entitled to health care to treat his injury as well as his pain, an effect naturally resulting from the injury. In this case, the passive care relieved Claimant's pain and allowed him to function and perform daily activities.

As Dr. Connell testified, safety was paramount with this patient, given Claimant's deconditioning and cardiac condition; therefore, one-on-one therapy would have been appropriate. Finally, the office visits, billed under CPT Code 99213 that occurred prior to and after surgery, satisfied the *Medical Fee Guideline* in that each office visit included an expanded problem focused examination and decision making of low complexity. Typically, the exams included range of motion testing, strength testing, endurance testing, and flexibility testing, and involved low complexity decisions on the type of continuing treatment and exercises.

On July 16, 2003, Dr. MacDougall released and referred Claimant to physical therapy following his surgery. Based on Dr. MacDougall's referral, Provider noted on July 21, 2003, that he would begin an active rehabilitation program, consisting of range of motion, stretching and strengthening exercises to focus on restoring function to the post-surgical region to allow safe return to work. The rehabilitation also was designed to prevent deconditioning following surgery. Under the *Official Disability Guidelines*, a patient should be treated with 34 visits over 16 weeks following spinal surgery.[6] In this case, given Claimant's medical history and severe deconditioning, an active rehabilitation program was medically necessary. The September 30, 2003, functional capacity evaluation demonstrated Claimant's severe deconditioning and need for an active program. The functional capacity evaluation showed reduced and painful range of motion, poor lifting tolerance, decreased work agility, decreased postural tolerances, and decreased cardiovascular fitness. Despite his deficiencies in the functional capacity evaluation, Claimant improved and was able to function at a light to light/medium performance demand level. Given Claimant's improvement, it was reasonable for Provider to continue treatment.

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[5] Adopted as part of the1996 *Medical Fee Guideline*, 28 TEX. ADMIN. CODE §134.201. *Medicine Ground Rules*, I.A. at 31.

[6] Although the *Official Disability Guidelines* refer to fusion surgery in a parenthetical, it is not clear whether the 34 visits relates only to fusion surgery or whether it includes other types of spinal surgeries.

On October 21, 2003, Provider noted that Claimant's condition had improved although he was still experiencing increased lumbar pain. Dr. Connell also testified that he witnessed improvement in Claimant's strength, flexibility, and endurance during the post-surgery rehabilitation. The ALJ agrees that this Claimant needed a post-surgical, active rehabilitation program. As Dr. Connell testified, a home program immediately following surgery would not have been beneficial for this Claimant given his severe deconditioning and heart condition. The ALJ finds that treatment provided through October 22, 2003, was medically necessary.[7] However, as of October 22, 2003, although Claimant had improved, he was still experiencing lumbar pain, and had not returned to work. By October 22, 2003, Provider should have successfully implemented a home program for Claimant and discontinued treatment.[8] Accordingly, the ALJ finds that the treatment provided from June 2, 2003, through October 22, 2003, was medically necessary and should be reimbursed. The office visit rendered on January 29, 2004, was not medically necessary and should not be reimbursed.

III. FINDINGS OF FACT

1. On___, ___(Claimant) sustained a compensable lumbar spine injury while working as a truck driver for First Quality Fruit. His injury occurred while unloading a pallet of produce using a pallet jack. He slipped and fell backwards, landing on his back.

2. With symptoms of pain and stiffness in the lower back, Claimant first sought treatment from Clark D. McKeever, M.D., who ordered an MRI and lumbar discogram.

3. The MRI and lumbar discogram had significant findings, showing Claimant had extensive chronic degenerative pain in the Claimant's L5-S1 vertebrae, stenosis, radiculopathy, and a large tear in the annulus.

4. On January 3, 2001, Claimant was examined by Henry Small, M.D., who became his treating physician.

[7] It reasonable to use the protocols under the *Official Disability Guidelines* as a tool to determine the appropriate number of visits. The ALJ's decision is consistent with the IRO decision. The ALJ realizes Carrier disputes which date of service was the 34th visit.

[8] The IRO denied reimbursement after October 22, 2003, and Provider did not appeal that decision.

5. Claimant had various medical tests during the year 2000, and on April 6, 2001, Dr. Small recommended surgery for Claimant.

6. Claimant opted to try non-surgical care before committing to major surgery.

7. Dr. Small referred Claimant to Jack Barnett, D.C., (Provider) for one month of work hardening. However, Claimant participated in the program for only one week.

8. A functional capacity evaluation showed Claimant had decreased range of motion, poor flexibility, and radiculopathy.

9. On October 8, 2001, Claimant had a five-vessel coronary artery bypass.

10. When Claimant recovered from the bypass surgery, Claimant returned to Dr. Small on January 3, 2002, stating that he was ready for the spinal surgery.

11. Dr. Small needed to get a coronary clearance before Claimant could be referred for spinal surgery.

12. Claimant was not referred to a neurosurgeon, David MacDougall, D.O., until March 5, 2003.

13. Dr. MacDougall wanted more updated imaging studies and a more current cardiology clearance before performing the surgery.

14. Dr. MacDougall performed a microdiscectomy at L4-5 on June 12, 2003.

15. On July 16, 2003, Dr. MacDougall prescribed an active, post-operative rehabilitation program and referred Claimant to Provider for treatment.

16. Provider had been Claimant's treating doctor since July 5, 2002.

17. Claimant received chiropractic care from Provider, which included office visits, electrical stimulation, ultrasound, hot/cold pack therapy, myofascial release, chiropractic manipulative, therapeutic exercises, massage, and a functional capacity evaluation (collectively, chiropractic care).

18. Not only did Claimant suffer from a severe spinal injury, he also suffered from other health problems, specifically a cardiac condition.

19. Claimant's inactivity during the time he was waiting for spinal surgery caused severe deconditioning.

20. While waiting for surgery, Provider provided passive/palliative care to Claimant to relieve his pain and maintain his functionality.

21. The passive care relieved Claimant's pain and allowed him to function and perform daily activities.

22. The exams performed by provider included range of motion testing, strength testing, endurance testing, and flexibility testing, and involved low complexity decisions on the type of continuing treatment and exercises.

23. On July 16, 2003, Dr. MacDougall released and referred Claimant to physical therapy following his surgery.

24. Provider began an active rehabilitation program, consisting of range of motion, stretching and strengthening exercises to focus on restoring function to the post-surgical region to allow safe return to work.

25. The September 30, 2003 functional capacity evaluation demonstrated Claimant's severe deconditioning and need for an active program.

26. The functional capacity evaluation showed reduced and painful range of motion, poor lifting tolerance, decreased work agility, decreased postural tolerances, and decreased cardiovascular fitness.

27. The rehabilitation also was designed to prevent further deconditioning following surgery.

28. The *Official Disability Guidelines* recommend a patient be treated with 34 visits over 16 weeks following spinal surgery.

29. Despite the deficiencies in the functional capacity evaluation, Claimant was able to function at a light to light/medium performance demand level.

30. On October 21, 2003, Provider noted that Claimant's condition had improved although he was still experiencing increased lumbar pain.

31. Claimant's strength, flexibility, and endurance improved during the post-surgery rehabilitation.

32. A home program immediately following surgery would not have been beneficial for this Claimant given his severe deconditioning and heart condition.

33. On September 7, 2004, an Independent Review Organization (IRO) granted reimbursement to Provider for chiropractic care provided to Claimant from June 2, 2003, through October 22, 2003, and for the office visit on January 29, 2004.

34. On November 28, 2004, Carrier appealed the decision of the IRO.

35. On January 7, 2005, the Texas Workers' Compensation Commission sent notice of the hearing to the parties. The hearing notice informed the parties of the matters to be determined, the right to appear and be represented, the time and place of the hearing, and the statutes and rules involved.

36. On November 9, 2005, Administrative Law Judge Michael J. O'Malley convened the hearing on the merits at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared and was represented by attorney Larry Trimble. Carrier appeared and was represented by its attorney, Katie Kidd.

37. On December 12, 2005, the parties filed closing arguments, and the record closed.

CONCLUSIONS OF LAW

1. 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 TEX. LAB. CODE ANN. §§ 402.073 and 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

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

3. Carrier timely requested a hearing in this matter pursuant to 28 TEX. ADMIN. CODE 148.3.

4. An employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care 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. TEX. LAB. CODE ANN. § 408.021(a).

5. Pursuant to 28 TEX. ADMIN. CODE §148.14(a), Carrier has the burden of proving by a preponderance of the evidence that the chiropractic provided to Claimant was not medically necessary.

6. Under the *Medicine Ground Rules*, to qualify for reimbursement, Claimant's condition must have the potential to return him to functionality and the treatment must be specific to the injury and provide for the potential improvement of Claimant's condition. Adopted as part of the1996 *Medical Fee Guideline,* 28 TEX. ADMIN. CODE §134.201. *Medicine Ground Rules,* I.A. at 31.

7. The office visits, billed under CPT Code 99213 that occurred prior to and after surgery, satisfied the *Medical Fee Guideline* in that each office visit included an expanded problem focused examination and decision making of low complexity.

8. Given Claimant's medical history and severe deconditioning, a post-surgery, active rehabilitation program was medically necessary.

9. Carrier did not prove by a preponderance of the evidence that the chiropractic care provided from June 2, 2003, through October 22, 2003, was not medically necessary for Claimant. Carrier proved that the January 29, 2004 office visit was not medically necessary.

10. Provider should be reimbursed for the services provided from June 2, 2003, through October 22, 2003, but not for the office visit of January 29, 2004.

ORDER

IT IS HEREBY ORDERED that Texas Mutual Insurance Company is required to reimburse Jack Barnett, D.C., for chiropractic care provided to Claimant ___from June 2, 2003, through October 22, 2003. Texas Mutual Insurance Company is not required to reimburse for the January 29, 2004 office visit.

SIGNED February 9, 2006.

MICHAEL J. O'MALLEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING