DOCKET NO. 453-05-4087.M5
TWCC MRD NO. M5-04-1222-01

DR. MARSHA MILLER,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE CO.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Marsha Miller, D.C. (Provider) appealed the decision of the Independent Review Organization (IRO) on behalf of the Texas Workers' Compensation Commission (TWCC) denying reimbursement for services provided to an injured worker (Claimant). The IRO did not find that the disputed services were medically necessary due to Claimant's compensable injury, and based on that determination the TWCC medical Review Division (MRD) denied Provider's request to be reimbursed. After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that Provider failed to show by a preponderance of the evidence that the services in issue were medically necessary. Therefore, Provider is not entitled to reimbursement for the amounts in controversy.[1]

I. BACKGROUND

Claimant suffered compensable, work-related injuries to his lower back on___, __, after bending over to pick something up off the floor. Claimant underwent numerous treatments or services, including therapeutic exercises, electrical stimulations, manipulations, and massage therapy beginning in September 2002, and at least for purposes of this hearing, ending in September 26, 2003. Texas Mutual Insurance Co. (Carrier) declined to reimburse the treatments and services provided after January 2, 2003, contending they were not medically necessary. Based on Carrier's denial of reimbursement, Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission). The matter was referred to an IRO designated by the Commission for the review process. The IRO determined that the disputed services were not medically necessary treatment for Claimant's compensable injury. Provider then requested a hearing

[1] Carrier stipulated to payment for one office visit per month during the time of the disputed services. The maximum allowable reimbursement for the office visits was $48.00 per visit over nine months, for a total of $432.00.

before the State Office of Administrative Hearings (SOAH). The hearing convened on June 27, 2006, with ALJ Bill Zukauckas presiding, but with the understanding that ALJ Tommy Broyles would review the record and issue the Decision and Order. Provider and Carrier appeared at the hearing which concluded on the same day with the record closed. No party objected to notice or jurisdiction.

II. DISCUSSION AND ANALYSIS

Provider maintains that the disputed treatments were medically necessary. Sean Kilgore, D.C., testified that at a minimum, treatment was reasonable and necessary up to the designated doctor's report of March 24, 2003, and then again from July 16, 2003, until September 26, 2003. Prior to March 24, 2003, Dr. Kilgore opined that the disputed services were reasonable because: 1) a neurologist who examined Claimant on January 7, 2003, indicated conservative treatment was the best course of action; 2) an examination and FCE in January suggested deficits continued; and 3) a January 20, 2003 progress report evaluation suggested chronic pain continued, that slight improvement had been seen, and that Claimant needed further therapeutic exercises in a supervised environment. As to the services provided after July 16, 2003, Dr. Kilgore found the treatments were reasonable because Claimant had became deconditioned while waiting for referral to an orthopedic surgeon. For these reasons, Dr. Kilgore requests reimbursement be ordered for all services between January 1 and March 24, 2003, and from July 16 until September 26, 2003.

Carrier relied on the testimony of David Alvarado, D.C., who opined that only one office visit per month was reasonable and necessary medical care during the time in dispute. Dr. Alvarado testified that by the end of 2002, it should have been clear to Provider that Claimant was not seeing any improvement from the therapy and care provided. Moreover, Dr. Alvarado explained that while one-on-one exercises may have been necessary to instruct Claimant on how to perform them and to watch Claimant and make sure he was doing them correctly, they were not reasonable after the same or similar exercises had been performed in group therapy. He continued that once exercises are understood by a patient, they should be performed in group sessions in order to encourage the patient to become more functionally independent. In this case, and to Dr. Alvarado's dismay, the opposite occurred. Claimant began with two months of group exercises but then was moved to one-on-one exercises. Dr. Alvarado found no justification for this in the medical records and stated that he had never before seen such a case. Turning to the services performed after July 16, 2003, Dr Alvarado opined that since conditioning was the issue, a home program would have sufficed. He stated that

walking is one of the best exercises for someone overweight and with low back pain. Yet, he found no evidence in the medical records that any home exercise program was prescribed.

After considering the arguments and evidence presented, the ALJ concludes that the disputed services provided to Claimant were not medically necessary for treatment of Claimant's compensable injury. Therefore, the ALJ finds that Provider is not entitled to reimbursement, other than those amounts stipulated to by Carrier. In reaching this decision, the ALJ gives great weight to the testimony of Dr. Alvarado, who suggested that at a minimum, care in 2003 should not have been one-on-one. The ALJ agrees and further finds that the lack of improvement indicated by the medical records suggest that after several months of therapy in 2002, continuing this or similar care in any fashion was not reasonably expected to improve Claimant's condition. Rather, the evidence indicates that Claimant should have been enrolled in a multi-disciplined program, such as work hardening with a psychiatric component, or immediately referred to an orthopedic surgeon.

The ALJ does not give great weight to the neurologist's opinion cited by Dr. Kilgore, suggesting that continued conservative care was reasonable in 2003. The neurologist's notes indicate that his opinion was rendered under the mistaken belief that Claimant was improving with conservative care. In fact, the evidence establishes Claimant was not improving, as indicated by the FCEs performed on November 6, 2002 and March 3, 2003, and revealing no improvement.

Finally, the ALJ finds that after July 16, 2003, a home program was reasonable and sufficient to provide for conditioning. The extensive care provided was unnecessary. The deconditioning could have been avoided had Provider prescribed a home program at the beginning of 2003, or could have at least been minimized, had the Provider/treating physician helped expedited the referral to an orthopaedic surgeon once it became obvious this course of action was necessary. The four month delay is unreasonable.

In considering the totality of the record, the ALJ concludes that the preponderance of the evidence shows that the treatments in issue were not medically necessary. Therefore, Provider is not entitled to reimbursement for the treatments. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant suffered a compensable, work-related injury on___.

2. Texas Mutual Insurance Co. (Carrier) is the provider of workers' compensation insurance covering Claimant for his compensable injury.

3. Claimant underwent numerous treatments and services for his injuries, including those presently in dispute: therapeutic exercises and office visits from January 2, 2003 to September 26, 2003 (disputed services).

4. After providing weeks of rehabilitation in October, November and December, Carrier denied reimbursement for the disputed services, contending they were not medically necessary.

5. Marsha Miller, D.C. (Provider) requested medical dispute resolution by the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD), which referred the matter to an Independent Review Organization (IRO).

6. MRD declined to order reimbursement on December 21, 2004, based on the IRO physician reviewer's determination that the services in issue were not medically necessary.

7. On February 4, 2005, Provider requested a hearing and the case was referred to the State Office of Administrative Hearings (SOAH).

8. Notice of the hearing was sent by the Commission to all parties on February 10, 2005.

9. All parties received not less than ten days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statues and rules involved; and a short, plain statement of the matters asserted.

10. On June 27, 2006, a hearing was convened. Provider appeared through Sean Kilgore, D.C. Carrier appeared through its attorney, Katie Kidd. The hearing concluded and the record closed on that same day.

11. Carrier stipulated to payment for one office visit per month during the time of the disputed services.

12. The maximum allowable reimbursement for the office visits was $48.00 per visit over nine months, for a total of $432.00.

13. Claimant's condition did not improve after several months of therapy in 2002.

14. Continuing the same or similar care after January 1, 2003, was not reasonably expected to improve Claimant's condition.

15. At the time of the disputed services, Claimant should have been enrolled in a multi-disciplined program such as work hardening or referred immediately to an orthopedic surgeon.

16. One-on-one exercises are necessary to instruct a patient on how to perform exercises and to watch the patient and make sure they are doing the exercises correctly.

17. Once the exercises are understood, a patient may move to group exercises or even home exercises in order to become more functionally independent

18. One-on-one exercises were prescribed for Claimant after he had already performed the same or similar exercises in group therapy.

19. One-on-one exercises, prescribed after group exercises, were not reasonable or necessary in this instance.

20. For disputed services after July 16, 2003, a home program was reasonable and sufficient to provide for conditioning.

21. The disputed services were not medically necessary.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

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

5. Provider has the burden of proof. 28 TEX. ADMIN. CODE §§148.21(h) and 133.308(w).

6. Provider has not shown, by a preponderance of the evidence, that the services in issue provided to Claimant between January 2, 2003 to September 26, 2003, were medically necessary for treatment of Claimant's compensable injury.

7. Carrier is not liable to reimburse Provider for the treatments and services provided to Claimant between January 2, 2003, to September 26, 2003, other than the monthly office visits stipulated to in the total amount of $432.00.

ORDER

IT IS, THEREFORE, ORDERED that Marsha Miller, D.C., take nothing from Texas Mutual Insurance Co. for the treatments provided to Claimant between January 2, 2003, to September 26, 2003, other than the monthly office visits stipulated to in the total amount of $432.00.

SIGNED August 25, 2006.

_____

TOMMY L. BROYLES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS