SOAH DOCKET NO. 453-05-5313.M5
MRD NO. M5-05-0691-01

TRACE ALEXANDER, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
LIBERTY MUTUAL FIRE	§	
INSURANCE COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

I. INTRODUCTION

This case presents a challenge by Trace Alexander, D.C. (Provider) to a decision of an independent review organization (IRO) on behalf of the Texas Department of Insurance, Division of Worker's Compensation, in a dispute regarding medical necessity for chiropractic treatment. The IRO found that the insurer, Texas Mutual Insurance Company (Carrier), properly denied reimbursement for chiropractic services that Provider administered to a claimant suffering from neck pain, left arm pain, and left shoulder pain due to repetitive stress injuries from work.

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 agrees with the IRO, finding that no reimbursement to Provider is required.

II. JURISDICTION AND VENUE

The hearing in this docket was convened on November 14, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Bill Zukauckas presided. Provider represented himself. Carrier was represented by Charlotte Salter, attorney. 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 sprain/strain injury to her neck and left arm and shoulder while working at a keyboard on ___. She sought treatment originally from Vincent Paul, M.D., who prescribed medications and physical therapy. She had 24 sessions of physical therapy from October 28, 2003 to January 30, 2004 and was released to return to work with light duty restrictions as of December 18, 2003. Claimant subsequently sought a change of treating doctor and began treating with Provider on February 13, 2004. Provider treated Claimant with both active and passive modalities at each visit.

When Provider billed Carrier (the insurer for the claimant's employer) for chiropractic services from March 10 through May 1, 2004, Carrier denied reimbursement on the grounds that the treatment had been medically unnecessary.[1] Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on February 28, 2005, concluding that Provider should not receive reimbursement for the disputed services. The IRO presented the following rationale for its decision:

> The guidelines for chiropractic quality assurance and practice parameters recommend that a patient definitely should not be placed on passive modalities or passive treatment 5 months post-injury. This patient can easily develop an adverse reaction and dependency on the treatment based on the passive treatment and can easily lead to physician over-utilization.
>
> Even with the Mercy Guidelines, the diagnoses given for these injuries, sprain/strain, would resolve anywhere at the longest 8 to 12 weeks. This patient reverted backwards in care doing the physical therapy first, and then after change of treating doctors, reverting backwards into a passive treatment. The dates of treatment were also done as an acute injury 3 times per week. The therapy procedures in this area would have been redundant from the 25 sessions that the physical therapist had done which would include the therapeutic exercises to develop strength and endurance,

[1] The record is unclear whether services rendered prior to March 10, 2004, were reimbursed by Carrier, but those dates are at least not at issue in this appeal.

range of motion, and flexibility. These would all be accomplished throughout the physical therapy procedure and treatment schedule outlined by the medical doctor.

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and, on March 15, 2005, issued its own decision confirming that the disputed services were not medically necessary. 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. Specifically, he argued that the physical therapy provided to Claimant before he saw her consisted of "putting her in a corner with hot packs", according to Claimant. He testified that he refused to discuss this matter with the IRO peer reviewing doctor because the doctor, John Brow, D.C., is licensed only in New Jersey and not Texas. Provider's letter to the MRD also indicated that he refused to talk to anyone from the IRO company, Professional Reviews, Inc., because their phone calls typically can take up to an hour and he does not have time during his day for that sort of questioning.

Alternatively, Dr. Alexander believes the treatments he provided were for re-exacerbation of her original injury.

B. Carrier

Gilbert Andrew Pratt, P.T., testified for Carrier. He examined medical records and performed a peer review in the case. He testified there is nothing in Provider's notes that even acknowledged the previous 24 visits of physical therapy before he began seeing the Claimant. He testified that the acute care phase of Claimant's treatment had been exhausted with the previous physical therapy and there was no evidence to support Provider's contention that the previous physical therapy was merely Claimant sitting in a corner with hot packs. In fact, Mr. Pratt noted

that the physical therapy notes indicated that Claimant had been put through a series of progressive exercises, much like those subsequently provided by Provider.

Specifically, Mr. Pratt noted that the records show Provider provided acute care to Claimant at a time when all recognized guidelines call for chronic care. Consequently, Pratt argued Provider used passive modalities well after the time they could reasonably be expected to help a sprain/strain situation. He also agreed with the IRO doctor that the active modalities provided by Provider were excessive this far after the injury.

Finally, Mr. Pratt testified that Provider's objective observations and assessment sections for many of his notes seemed completely disjointed. For instance, on Carrier's Ex.1, p. A 86, Provider lists a whole series of subjective complaints, some of which are moderately severe in intensity and note objective findings of severe pain at the C2-C7 levels on the left upon palpation. Yet the first line of Provider's assessment notes states that Claimant's condition is resolving and improving with care. Mr. Pratt believes Provider's assessment of improvement is inconsistent with Claimant's observed overall pain complaints.

V. ANALYSIS

The ALJ agrees with the IRO and Carrier that the services were not shown to be medically necessary. Provider did not document anything about the previous physical therapy services which were rendered closer to the time of injury. His position at hearing that Claimant had reported that her past physical therapy consisted of merely sitting in a corner with hot packs is not supported by his notes or the detailed notes from the physical therapist. Additionally, there was no documentation that Claimant's complaints to Provider represented some re-exacerbation of her original injury.

Also, the ALJ notes that Provider was admittedly uncooperative in communicating with the IRO reviewer when that individual gave him a call to discuss the services he had performed. While the ALJ does not know whether this helps or hurts Provider's overall chances of prevailing in TDI/DWC reviews in general, the ALJ notes that it does hurt his ability to review a fully developed IRO analysis as contemplated by statute. If Provider believes there is something inherently unfair,

inadequate, or biased about an IRO reviewer's qualifications, the Provider should bring it to the attention of the TDI/DWC.

VI. CONCLUSION

For the reasons discussed above, the ALJ agrees with the Carrier and the IRO that Provider failed to show that his acute-type care for Claimant was appropriate for the reasons discussed above or effective, based on the progress noted. The ALJ finds that, under the record provided in this case, the medical services at issue are not shown to be medically necessary and reasonable.

VII. FINDINGS OF FACT

1. In early___, Claimant first noticed pain to her neck, left arm, and left shoulder, from repetitive stress injuries, which constituted compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. Between October 28, 2003, and January 30, 2004, Claimant initially presented to a medical doctor and was prescribed and underwent physical therapy from October 28, 2003, to January 30, 2004.

3. On February 13, 2004, after requesting a change of physician, Claimant presented to Trace Alexander, D.C. (Provider), and began a therapeutic regimen of supervised exercise and chiropractic modalities that extended through May 1, 2004.

3. Provider sought reimbursement for services noted in Finding of Fact No. 3, limited to dates between March 10 and May 1, 2004, from Liberty Mutual Fire 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 February 28, 2005, finding that the treatment at issue had not been medically necessary.

7. The Commission's Medical Review Division (MRD) reviewed and concurred with the IRO's findings in a decision dated March 15, 2005.

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 November 14, 2005, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Bill Zukauckas, an Administrative Law Judge with SOAH.

11. Provider was unable to show that the chiropractic services provided for this claimant were reasonable and necessary for an ordinary sprain/strain injury to her neck and left arm and shoulder from using a keyboard.

    a. The chiropractic services were redundant to the 24 sessions of physical therapy received before transferring to Provider in that Provider treated her as if she were a newly injured patient, using both active and passive modalities, on an acute frequency, well beyond 16 weeks from the original injury.

    b. There was no documentation of a new injury or a re-exacerbation of an old injury and no documentation or credible explanation as to why the past 24 sessions of physical therapy should be discounted as effective acute care.

VIII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission 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 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, 28 TEX. ADMIN. 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. 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 failed to prove that services rendered were medically necessary for the dates of services at issue.

ORDER

IT IS THEREFORE ORDERED that Trace Alexander, D.C., should have no reimbursement for chiropractic modalities provided Claimant in this matter for dates of service between March 10 and May 1, 2004.

SIGNED January 12, 2006.

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS