DOCKET NO. 453-03-0938.M5
[MDR TRACKING NO. M5-02-2254-01]

CENTRAL DALLAS REHABILITATION AND DIAGNOSTIC CENTER, ***Petitioner***	§	**BEFORE THE STATE OFFICE**
	§	
V.	§	**OF**
	§	**ADMINISTRATIVE HEARINGS**
TEXAS MUTUAL INSURANCE COMPANY, ***Respondent***	§	

DECISION AND ORDER

This case involves a dispute over $9,941.40 in chiropractic and work hardening services provided by Central Dallas Rehabilitation and Diagnostic Center (Petitioner or Provider) to injured worker ____ (Claimant).[1] The Administrative Law Judge (ALJ) concludes that Provider failed to meet its burden of proving it is entitled to reimbursement, except for services totaling $93.00.

I. Background Facts

Claimant was injured on_____, while moving furniture up a staircase. Two days later, Provider diagnosed Claimant with a lumbar disc displacement, lumbar nerve root compression, muscle spasm, and pain; Provider began treating Claimant that day. Overall, Provider performed range of motion and muscle testing and treated Claimant with joint mobilization and manual traction. Claimant began a work hardening program on or about September 14, 2001, and continued through November 16, 2001.

Texas Mutual Insurance Company (Respondent or Carrier) denied payment for disputed services on dates July 12, 2001 though November 13, 2001, claiming they were either not medically necessary, global (such services were included in the office visit), or not documented.[2] The Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) agreed and Provider appealed, requesting a hearing before the State Office of Administrative Hearings.

---

[1] The ALJ calculates this amount by subtracting the billings (totaling $1820.00) for the CPT code 97110, which are not in dispute, from the total amount in dispute ($11,761.40) set out in Petitioner's Ex. 1 at 10.

[2] As stated in the preceding footnote, Carrier does not dispute any treatments billed with CPT code 97110 (these are consistently misidentified as CPT code 97710 on Petitioner's Ex. 1).

II. Discussion

At issue are the following disputed services:

CPT Codes/Description	Carrier Denial	Dates of Service
97265 joint mobilization	unnecessary medical treatment	7/12/01, 8/14/01,
95851 range of motion measurements	performed during a re-evaluation by a physical and occupational therapist should not be reimbursed separately	7/13/01, 7/27/01, 8/10/01
97750-MT muscle testing	integral component of another service, procedure, or program	7/16/01, 8/14/01, 9/4/01
99213 office visit	level, type, extent, or frequency not supported by documentation; unnecessary medical treatment	8/14/01, 9/19/01, 11/09/01, 11/13/01
97122 manual traction	level, type, extent, or frequency not supported by documentation; unnecessary medical treatment	8/14/01
99080 initial medical report	work status report not properly completed or in excess of filing requirements	7/17/01
97545-WH 97546-WH	documentation does not substantiate the service billed	9/18/01-9/21/01; 9/24/01-9/28/01; 10/1/01-10/5/01; 10/8/01-10/10/01; 10/23/01-10/25/01; 11/05/01/11/07/01

Joint Mobilization

Joint mobilization is billed at CPT code 97265. The Commission's Medical Fee Guideline (MFG) describes this therapeutic treatment as: Joint mobilization, one or more areas (peripheral or spinal).[3]

Laurent Pelletier, D.C.,[4] testified on behalf of Provider that joint mobilization is necessary especially when there is a problem in the joint. He stated that Claimant had a severe lumbar injury with disk displacement in the lumbar spine, which puts pressure on nerve roots. In his opinion, joint mobilization increases vascularization.

Respondent witness William D. Defoyd, D.C., testified that joint mobilization involves taking the joint through a passive range of motion but less than a chiropractic manipulation. In his opinion, it is incorrect to bill separately for mobilization and manipulation without documentation showing which joints are being mobilized. He further stated that it was not medically necessary to perform a manipulation and mobilization on the same day.

On July 12, 2001, the day that Provider began treating Claimant, Provider billed Carrier for a new office visit, X-ray exam, joint mobilization, myofascial release, manual traction therapy, and three therapeutic exercises.[5] The treatment notes do not indicate why the Provider needed to mobilize and manipulate the same area (the lumbar spinal region), billing separately for both services. More importantly, the treatment notes fail to list that joint mobilization was performed (there are other days that this procedure is listed separately, but not on July 12, 2001). The ALJ finds that Provider failed to document that a joint mobilization was either performed or was medically necessary on July 12, 2001.

---

[3] TWCC 1996 Medical Fee Guideline, p. 59.

[4] The treating doctor, Dean Allen, D.C., no longer works for Provider. Dr. Pelletier currently runs and operates the treating clinic.

[5] Petitioner Ex. 1 at 33. The ALJ notes that Petitioner's Ex. 1 does not contain the full 313 Bates-stamped pages noted on the affidavit/cover page.

The billing for August 14, 2001, is similar to that of July 12, 2001. Provider billed Carrier for an office visit, joint mobilization, myofascial release, manual traction therapy, four therapeutic exercises, and computer data analysis.[6] However, on this day, the treatment notes specify that joint mobilization was applied to the lumbar spinal region. That same day, Dr. Allen also performed a spinal manipulation to TEX. ADMIN. CODE the "areas of the lumbar spine," but there is no separate charge for this procedure.[7] Provider may have manipulated and mobilized the same area but didn't charge for both treatments. The ALJ concludes that Provider put forth sufficient evidence showing the joint mobilization treatment on August 14, 2001, was performed on Claimant and was medically necessary.

Range of Motion

Provider billed Carrier under CPT Code 95851, range of motion. The MFG lists such testing as "range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)."[8] Provider conducted range of motion tests on July 13, July 27, and August 10, 2001; Carrier denied these tests because they were global or included in another service.

Provider witness Dr. Pelletier testified that such testing compares or measures what movements an injured patient can perform against what is normal. He states such tests are medically necessary to monitor progress and develop a treatment plan. Carrier witness Dr. Defoyd testified that such tests are a component of the office visit.

On the same dates in question, Provider billed Carrier for an office visit CPT code 99213, which requires at least two of three key components: an expanded problem focused history, an expanded problem focused examination; and/or a medical decision making of low complexity.[9] The MFG states that physicians typically spend 15 minutes with the patient.[10] There is no evidence that the range of motion measurements required more time than the usual 15 minute visit and there is no indication in the treatment notes that the treating doctor spent additional time with the patient for any other reason. The ALJ also observes that the treatment notes do not contain the results of the tests; therefore, it is impossible to determine the extent of the testing. Accordingly, the ALJ finds that Provider failed to rebut Carrier's assertion that the tests could have been performed during the office visit. The ALJ concludes that billing for the range of motion measurements should have been included in the office visits on July 13, July 27, and August 10, 2001.

---

[6] Petitioner Ex. 1 at 53.

[7] Petitioner Ex. 1 at 53, 271.

[8] TWCC 1996 Medical Fee Guideline, p. 57.

[9] TWCC 1996 Medical Fee Guideline, p. 19.

[10] TWCC 1996 Medical Fee Guideline, p. 19; Petitioner's Ex. 1 at 39.

Muscle Testing

Muscle testing, CPT code 97750, requires a report identifying the service provided, results, and test interpretation and shall be reimbursed per body area.[11] Provider billed Carrier for performing muscle testing on Claimant on July 16, July 30, August 14, and September 4, 2001. Carrier witness Dr. Defoyd testified that muscle testing should be part of the office visit CPT code 99213. In particular, for the muscle testing performed on Claimant on July 16, Dr. Defoyd questioned the need and rationale for requiring Claimant to undertake this difficult test days after Claimant sustained the compensable injury.

As Dr. Defoyd noted, Provider billed Carrier for an office visit CPT code 99213 on the same days that Dr. Allen performed muscle testing. There are no reports in the treatment notes for these tests.[12] Although Provider supplied a hand written report titled "Functional Abilities evaluation" for the date July 30, 2001, there is no indication that the notes were a result of the muscle testing.[13] The ALJ finds that Provider failed to make an evidentiary showing that a separate service was performed on the dates in question: there is no report identifying the service provided, results, and test interpretation.

Office Visits

On August 14, September 19, November 9 and 13, 2001, Provider billed Carrier under CPT Code 99213, an office visit. Dr. Pelletier testified that this CPT code entails an updated patient history and a review of any reports and future treatment options. For the August 14, 2001 billing, Carrier questions why such an office visit was medically necessary as Claimant had received treatment the day before. Although Dr. Pelletier testified that the office visit included hands-on service and any new inquiry needed to be addressed, the treatment notes indicate no difference in subjective or objective findings as to pain, soreness, motion, or weakness and no difference in the future plans or therapy from August 13 to 14, 2001. In order to bill for such an office visit, the MFG requires that a provider meet two of three components: an expanded problem focused history; an expanded problem focused examination; or a medical decision making of low complexity.[14] Provider's witness testified that an updated patient history was necessary–but failed to show any additional key component was part of the examination on August 14, 2001. Carrier denied payment for the office visits on September 19, November 9 and 13, 2001, because the fees were global, or included in another service. Again, a review of the treatment notes from the preceding visits as compared to the dates of service reveal no differences in findings and no indication that any additional evaluation was performed, as required by the MFG. Although the notes state that the patient will be returning to "evaluate progress in Work Hardening program," this language is standard for most days during the work hardening program.[15] There is no evidence in the treatment

---

[11] TWCC 1996 Medical Fee Guideline, p. 35.

[12] *See* Petitioner's Ex. 1 240 through 306.

[13] Petitioner's Ex. 3.

[14] TWCC 1996 Medical Fee Guideline, p. 19.

[15] Petitioner Ex. 1 at 2940303, treatment notes for September 19 through November 13, 2001.

notes showing why Provider billed using CPT Code 99213 on September 19, November 9 and 13, 2001.

Manual Traction

Provider billed Carrier for manual traction performed on Claimant on August 14, 2001, under CPT code 97122. Carrier witness Dr. Defoyd testified that the technique is not documented properly because the treatment notes fail to state the length of time the procedure was performed. Although the treatment notes do not state how long the treatment was performed, Dr. Allen's notes state that he administrated this treatment to the lumbar spinal region on that date and the MFG does not appear to have a time/length requirement. The notes indicate the procedure was performed on the injured area and the ALJ finds Provider met its burden of proof that the treatment was medically necessary and sufficiently documented.

Work Status Report

On July 17, 2001, Provider billed Carrier for a work status report or special report under CPT code 99080. Carrier denied reimbursement on the grounds that the report (TWCC 73) was not properly completed or submitted in excess of the filing requirements. Carrier argues that there is no reason why this was filed because there was no change in work status. However, the records indicate that this was the initial work status report filed for the patient, thus it appears to be necessary. The form appears to be adequately filled out and there was no specific evidence showing otherwise.[16] Accordingly, the ALJ finds Provider should be reimbursed $15.00 for this report.

Work Hardening

Claimant participated in work hardening services offered by Provider. The first few days of the work hardening treatment were reimbursed by Carrier; however, Carrier does dispute reimbursement for 23 days of services. Although Provider argues that Carrier paid for the beginning of the work hardening treatment and such action indicates the need for the entire work hardening program, the ALJ finds this fact carries little probative weight.

Carrier witness Dr. Defoyd testified that the Functional Capacity Evaluation (FCE) performed on September 11, 2001, was incomplete: it was missing static positional tolerance and cardiovascular fitness indications; a definition of Claimant's work position; a written treatment plan, and psychological testing to see if Claimant had any psychological barriers that would make him an inappropriate candidate for work hardening. Dr. Defoyd also asserted that the daily progress notes are computer generated and Claimant's daily response to the work hardening treatment was not documented. He further stated the discharge summary was inadequate because it only concluded that Claimant can return to work; no other documentation is noted.

---

[16] Petitioner's Ex. 4.

Although Dr. Pelletier testified that an initial FCE was performed on September 11, 2001, and the September 10, 2001 treatment notes state that Claimant will be returning the next day to complete the five hour, initial examination,[17] there is no such analysis (i.e. the FCE) in the record evidence. A final FCE is also not in the record. Dr. Pelletier's testimony that the work hardening program was medically necessary and that Claimant improved as a result of the program fails to provide sufficient evidence to rebut Dr. Defoyd's testimony that the documentation for the program was inadequate and failed to meet the Commission's guidelines. The ALJ's evaluation of the evidence is limited to the documentation and testimony offered and admitted into evidence at the hearing (a *de novo* process). Because there is little to no documentary evidence showing that Claimant met the entrance criteria into the program and no documentary evidence showing objective, substantive, and continued improvement over time, Provider failed to show that the work hardening services met the MFG and were medically necessary. The ALJ concurs with Carrier that Provider failed to provide adequate documentation for the work hardening services in dispute.

III. Findings of Fact

1. Claimant, a furniture mover, sustained a compensable injury on_____.

2. At the time of the injury, Claimant's employer had its workers' compensation insurance through Texas Mutual Insurance Company (Carrier).

3. On July 12, 2001, Claimant received treatment for his injury with Dean Allen, D.C. at Central Dallas Rehabilitation and Diagnostic Center (Provider). Provider diagnosed Claimant with a lumbar disc displacement, lumbar nerve root compression, muscle spasm, and pain.

4. Provider submitted a claim to Carrier in the amount of $43.00 for joint mobilization performed on July 12, 2001, for which Carrier denied reimbursement.

5. Provider's treatment notes fail to list that any person performed joint mobilization on Claimant on July 12, 2001.

6. Provider submitted a claim to Carrier in the amount of $43.00 for joint mobilization performed on August 14, 2001, for which Carrier denied reimbursement.

7. Provider's notes demonstrate that such treatment was applied to the lumbar spinal region.

[17] Petitioner's Ex. 1 at 294.

8. Provider submitted claims to Carrier totaling $108.00 ($36.00 per visit) for range of motion testing performed on July 13, July 27, and August 10, 2001. On those dates, Provider also billed Carrier for an office visit, CPT code 99213. Carrier denied reimbursement for these claims.

9. Provider failed to document that the treating doctor spent additional time beyond the 99213 office visit in order to perform range of motion testing.

10. Provider submitted claims to Carrier totaling $129.00 ($43.00 per visit) for muscle testing performed on Claimant on July 16, August 14, and September 4, 2001. On those same days, Provider billed Carrier for an office visit CPT code 99213. Carrier denied reimbursement for these claims.

11. Muscle testing may be part of the office visit CPT code 99213.

12. Provider did not demonstrate that it provided a report identifying the service provided, results, and test interpretation for the muscle testing performed on July 16, August 14, and September 4, 2001.

13. Provider submitted claims to Carrier totaling $192.00 ($48.00 per visit) for office visits on August 14, September 19, November 9, and November 13, 2001. Carrier denied reimbursement for these claims.

14. The treatment notes do not demonstrate that there was a need for additional history, an expanded problem, or a medical decision. The treatment notes showed little difference in observation or treatment from the previous office visit and/or treatment.

15. Provider submitted a claim to Carrier of $35.00 for manual traction on August 14, 2001. Carrier denied reimbursement for this claim.

16. The treatment notes indicate that Dr. Allen administered this treatment to the Claimant's lumbar spinal region, which was injured on July 10, 2001.

17. Provider submitted a claim of $15.00 for a work status report; Carrier denied reimbursement for this claim.

18. The work status report was completed to notify the Texas Workers' Compensation Commission (Commission) of the change in work status.

19. The work status report provided sufficient information of the Claimant's work status and follow-up treatment.

20. Provider treated Claimant with 23 days of work hardening sessions totaling $9,318.40 from September 19, 2001, through November 7, 2001. Carrier denied reimbursement for these claims.

21. There is no documentary evidence that Provider performed a complete initial evaluation on Claimant, which should have included certain fitness indications, a definition of Claimant's work position, a written treatment plan, and psychological testing to determine whether Claimant was an appropriate candidate for work hardening.

22. Provider timely appealed Carrier's reimbursement denials to the Commission's Medical Review Division (MRD).

23. Provider filed a request for medical dispute resolution.

24. On September 18, 2002, the MRD reviewed the decision of the Independent Review Organization (IRO) and concluded that Carrier prevailed on the issue of medical necessity.

25. Provider timely filed a request for a hearing before the State Office of Administrative Hearings (SOAH).

26. The Commission sent notice of the hearing to the parties on November 4, 2002. The hearing notice informed the parties of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the statutes and rules involved; and the matters asserted.

27. SOAH Administrative Law Judge Lilo D. Pomerleau convened the hearing on April 2, 2003, at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared and was represented by Scott C. Hilliard, an attorney. Carrier appeared and was represented by Patricia Eads, an attorney. The Commission did not appear. The hearing adjourned, and the record closed that same day.

IV. Conclusions of Law

28. The Commission has jurisdiction to decide the issue presented, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 413.031.

29. SOAH 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.

30. Provider timely filed a notice of appeal of the MRD decision, as specified in 28 TEX. ADMIN. CODE § 148.3.

31. Proper and timely notice of the hearing was effected upon the parties according to TEX. GOV'T CODE ANN. ch. 2001.052 and 28 TEX. ADMIN. CODE § 148.4.

32. Provider had the burden of proving the case by a preponderance of the evidence, pursuant to 28 TEX. ADMIN. CODE § 148.21(h) and (i).

33. The disputed services referenced in Finding of Fact Nos. 4, 5, 13, 14, 20, and 21 (joint

mobilization on July 12, 2001, office visits using CPT code 99213, and work hardening) were not shown to be medically necessary health care for Claimant.

34. The disputed services referenced in Finding of Fact Nos. 6, 7, 15, and 16 were shown to be medically necessary health care for Claimant.

35. The work status report referenced in Finding of Fact Nos. 17 through 19 was shown to be properly completed.

36. The disputed services referenced in Finding of Fact Nos. 8 through 12 were not shown to be a necessary separate component of another service, procedure, or program.

37. Provider failed to show that Claimant met the criteria for admission into a work hardening program, as set forth in the Medical Fee Guideline.

38. Based on the foregoing findings of fact and conclusions of law, Provider's request for reimbursement should be denied for the services referenced in Finding of Fact Nos. 4, 5, 8 through 14, 19, and 20. Provider's request for reimbursement should be granted for the services referenced in Finding of Fact Nos. 6, 7, and 15 though 18.

ORDER

IT IS ORDERED that Central Dallas Rehabilitation and Diagnostic Center is entitled to reimbursement by Texas Mutual Insurance Company for certain services totaling $93.00.

SIGNED this 30th day of May 2003.

LILO D. POMERLEAU
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING