DOCKET NO. 453-03-1483.M5
[MDR TRACKING NO. M5-02-2521-01]

CENTRAL DALLAS REHAB,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
LUMBERMEN'S	§	
UNDERWRITING ALLIANCE,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

I. INTRODUCTION

This case involves an appeal by Central Dallas Rehab (Provider) from the findings and decision of the Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) ordering payment of $760, out of $5,328 sought by Provider, for services provided to Claimant _____ (Claimant) between May 3, 2001, and October 29, 2001. The services at issue comprised office visits with manipulation, joint mobilization, myofascial release, traction, therapeutic exercises, range of motion (ROM) studies, and electrodiagnostic studies. Respondent Lumbermen's Underwriting Alliance (the Carrier) denied payment on the basis that the services and tests were not medically necessary.[1] An independent review organization (IRO) chiropractor partially agreed and partially disagreed with the Carrier's determinations.[2] The amount in dispute in

[1]Though the MRD stated the Carrier's only basis for denial was lack of medical necessity, the Carrier pointed out, in its closing brief, that many Explanations of Benefits (EOBs) also reflected "lack of documentation" as a basis for denial, and one office visit (on May 11, 2001) was also denied on the basis that it allegedly was not in accordance with the "Treatment Guidelines." (Ex. 2 , p. 69.) The parties submitted approximately 550 pages of documentary evidence at the hearing (approximately 100 pages of which consisted of EOBs), but neither offered any live testimony to explain Claimant's medical records or the Carrier's peer reviewers' opinions. In the debate among the health care providers whose opinions are reflected in the documentary evidence, the issues of medical necessity and lack of documentation were intertwined. Thus, in evaluating the medical necessity of the disputed services, the ALJ, of necessity, also considered whether the record contained documentation to support the services.

[2]It is unclear what the IRO's recommendation actually was, as the record contains two IRO "reports." One, a letter dated September 26, 2002, signed by someone purporting to be the secretary and general counsel of the IRO, states, without analysis, that all disputed office visits with manipulations were medically necessary, as were joint mobilizations, therapeutic exercises, and range of motion studies, but traction and myofascial release (May 3, 2001 - May 30, 2001) and May 16, 2001electrodiagnostic studies were not medically necessary. The other IRO report, dated September 23, 2003 and entitled "Medical Case Review," appears to have been prepared by an IRO chiropractor. In it, the IRO chiropractor recommended Provider be reimbursed for fewer services than the IRO's secretary and general counsel recommended in the September 26, 2002 letter; however, the document contains numerous handwritten notations that could reasonably be interpreted as "correcting" or modifying various portions of the typed report. No evidence was introduced to explain the

this proceeding is $4,568.00. In this Decision and Order, the ALJ finds Provider is entitled to reimbursement totaling $1,199.00, in addition to the amounts previously ordered by the MRD, which amounts are not in dispute.

II. REASONS FOR DECISION

Summary of the Evidence and Issues

Claimant suffered a compensable injury in a motor vehicle accident on_____. Claimant injured his neck, left shoulder, lower back, and left hip in the accident. He first sought treatment on April 3, 2001, at which time Kenneth Lustick, D.C., of Lonestar Radiology, took x-rays that revealed multiple chiropractic anomalies. (Ex. 2, p. 150.) On April 6, 2001, Claimant first saw Dean L. Allen, D.C., who became Claimant's treating doctor.[3] Dr. Allen diagnosed Claimant as having lumbar spine disc disorder, thoracic spine disc disorder, rotator cuff sprain/strain, and whiplash syndrome/cervical spine hyperflexion.

Claimant was already on light duty before his injury; therefore, Dr. Allen did not take Claimant off work. However, Dr. Allen recommended Claimant begin physical therapy on a daily basis. For two weeks, Claimant daily received passive modalities to relieve pain, adjustments of his

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handwritten notations or the discrepancy between the two IRO "reports." The Commission's MRD, also without explanation, appears to have disregarded the September 26, 2002 IRO letter "report" and adopted most, but not all, of the recommendations contained in the September 23, 2001 IRO chiropractor report, without regard to the handwritten notations on it. Given this muddled record, the Administrative Law Judge (ALJ) was unable to determine what the IRO's recommendations actually were on various issues.

[3]Provider is the entity that billed the Carrier for Dr. Allen's services, but no evidence was presented as to the nature of Dr. Allen's legal relationship with Provider.

lower back and other injured areas, and light active stretching to relieve muscle spasms. (Ex. 1, p. 118.) According to Dr. Allen, Claimant "made great progress" with this treatment: his cervical pain decreased significantly, his lower back pain lessened, and his shoulder and hip became stronger and more flexible. As ROM studies and muscle strength studies showed Claimant making progress, Dr. Allen reduced Claimant's physical therapy treatments to three times per week for six weeks and transitioned Claimant to active therapeutic exercises with strengthening as the main goal. (Ex. 2, pp. 298-359.)

On April 11, 2002, and again on April 26, 2001, Dr. Allen performed temperature gradient studies on Claimant. Dr. Allen described temperature gradient studies as noninvasive procedures during which the provider measures the skin surface temperature of a specific sensory dermatome. According to Dr. Allen, decreased temperature (2.4 degrees Fahrenheit) over one dermatome, as compared to the temperature over the same location on the opposite limb, usually indicates disk involvement on the cold side (due to vasoconstriction). (Ex. 2, pp. 177-178.) Dr. Allen routinely performs temperature gradient studies on patients with symptoms of radiculopathy in order to ascertain whether the radicular symptoms are due to a condition in the extremity or due to a disk bulge or herniation.

The Carrier questioned the appropriateness of the temperature gradient studies as diagnostic tools, and as a result, it appears, came to question many, if not most, of the tests and services Dr. Allen recommended or performed.[4] Between May 21, 2001, and October 9, 2001, the Carrier submitted Dr. Allen's statements to four peer reviews by three separate doctors: Joel Brandon Brock, D.C., May 21 and May 30, 2001; R. David Bauer, M.D., an orthopedist, July 12, 2001; and David W. Strausser, M.D., an orthopedist, October 9, 2001. (Ex. 2, pp. 139-156.) Though reimbursement for temperature gradient studies was not an issue in this case, the Carrier maintained that Dr. Allen's use of temperature gradient studies undermined his credibility and supported its contention that Dr. Allen provided Claimant with medically unnecessary services.

According to Dr. Allen, Claimants neck and lower back responded well to conservative care, but his hip and shoulder remained "very symptomatic and did not respond as favorably." (Ex. 2, p. 239.) Therefore, Dr. Allen referred Claimant for an MRI of the left hip and shoulder. The MRIs were performed on May 9, 2001; the MRI of Claimant's left hip was within normal limits but the MRI of Claimant's left shoulder revealed some anomalies. (Ex. 1, p. 178; Ex. 2, pp. 220-221.) Dr. Allen reported that the MRI results enabled him to alter Claimant's treatment plan to focus on the affected areas and that Claimant responded "favorably" to the new treatment. (Ex. 2, p. 239.)

The services and tests at issue in this proceeding are the following:

- Office visits with manipulation, CPT Code 99213, MAR $48, on May 11, 16, 23, 30, June 29, July 27, October 12, 15, and 29, 2001;

[4]The Carrier argued that, as early as 1987, the Texas Industrial Accident Board (the predecessor of the Commission) determined that temperature gradient studies did not constitute reasonable and necessary health care.

- Myofascial release, CPT Code 97250, MAR $43, on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001;

- Traction, CPT Code 97122, MAR $35, on May 8, 16, and 30, 2001;

- Therapeutic exercises, CPT Code 97110, MAR $70, on May 3, 7, 11, 15, 18, 21, 23, and 30, 2001, with a balance of $60 in dispute for May 8 and 16, 2001 each;

- Range of Motion (ROM) studies, CPT Code 95851, MAR $72, on May 8, 2001;

- Electrodiagnostic studies: CPT Codes 95900-27, MAR $512; 99904-27, MAR $512; 95925-27, MAR $1,400; 95935-27, MAR $530, on June 13, 2001; and

- Preparation of TWCC-73 Report, CPT Code 90080-73, MAR $15, October 15, 2001.

Provider contends that the services and tests were medically necessary and appropriately documented. The Carrier argues that Provider over-treated Claimant and subjected Claimant to medically unnecessary tests.

B. Analysis

As the petitioner, Provider had the burden of proof in this matter. The Carrier's arguments regarding the invalidity of temperature gradient studies notwithstanding, the ALJ need not, in this proceeding, make findings as to whether temperature gradient studies are valid diagnostic tools. Nor does she believe that Dr. Allen's use of them necessarily casts suspicion over all of his other treatments of Claimant. Therefore, she has considered each disputed service individually in light of the evidence relating to the service and Provider's overall treatment plan for Claimant.

1. Office visits with manipulation, CPT Code 99213, MAR $48, on May 11, 16, 23, 30, June 29, July 27, October 12, 15, and 29, 2001

Dr. Allen's treatment plan consisted of two weeks of daily care followed by six weeks of active therapy three times per week. Joel Brandon Brock, D.C., who performed peer reviews for the Carrier on May 21 and again on May 30, 2001, opined that his treatment plan for Claimant would have consisted of one week of daily care followed by approximately seven weeks of active therapy three times a week. Thus, Dr. Allen's and Dr. Brocks recommendations were quite similar.

The IRO chiropractor who prepared the September 23, 2001 report believed that Dr. Allen's judgment on this issue should carry greater weight, as Dr. Allen actually examined Claimant and observed his progress. Moreover, according to the IRO chiropractor, Dr. Allen's office visit schedule appeared to be "in line" with what would be "usual and customary for an individual with this number of problems." (Ex. 1, p. 8.) Thus, the ALJ finds that the nine office visits with manipulation at issue were medically necessary and Provider is entitled to reimbursement totaling

$432.00 for those services.

2. Myofascial release, CPT Code 97250, MAR $43, on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001

   Traction, CPT Code 97122, MAR $ 35, on May 8, 16, and 30, 2001

According to the IRO chiropractor who prepared the September 23, 2001 report, the intended therapeutic outcomes of joint mobilization (CPT Code 97265), myofascial release (CPT Code 97250), and traction (CPT Code 97122) are similar; therefore, only one should be reimbursed. The IRO chiropractor concluded, without explanation, that joint mobilization was the service that should be reimbursed and that myofascial release and traction were duplicative services that were not medically necessary. Provider's only argument to the contrary was contained in correspondence dated October 1, 2001, written by Leanne Goolsby (apparently a non-doctor), in which Ms. Goolsby contended that traction is a distinct service with a different therapeutic purpose, and that an employee in the Commission's MRD had supplied Provider with correspondence supporting that position.[5] The MRD, however, ordered reimbursement for joint mobilization only. Thus, the issue before the ALJ was whether myofascial release and traction should also be reimbursed. The ALJ was unable to find, in the sizable record, any explanation from a health care provider as to why myofascial release and traction were medically necessary, given that Claimant received joint mobilization on ten occasions. Thus, the ALJ concludes that Provider is not entitled to reimbursement for these services.

3. Therapeutic exercise, CPT Code 97110, MAR $70, on May 3, 7, 11, 15, 18, 21, 23, and 30, 2001, with a balance of $60 in dispute for May 8 and 16, 2001 each

Dr. Allen had Claimant perform three supervised 15-minute units of therapeutic exercises per day. The record contains a description of the various exercises that were included in Claimant's exercise program. (Ex. 1, pp. 192-200.) According to Dr. Allen, the exercises Claimant was instructed to perform varied from day to day, depending on Claimant's symptoms and stage of recovery. (Ex. 1, p. 172.) Dr. Allen maintained Claimant made such significant, measurable progress on this treatment plan, that Claimant was given a complete release to full-duty work prior to the eight weeks recommended by Dr. Brock (one of the Carrier's peer reviewers). (Ex. 1, pp. 179-

[5]In correspondence dated October 1, 2001, Ms. Goolsby stated she was providing the Carrier with correspondence from the MRD to this effect; however, the MRD correspondence was not offered into evidence in this proceeding.

180.)

Dr. Brock believed Claimant should have been prescribed one, rather than three, 15-minute units of therapeutic exercises per day. The IRO chiropractor who prepared the September 23, 2001 report appeared to agree, but provided no rationale for his conclusion, other than to say the documentation provided to him or her did not support the medical necessity for "all modalities listed." (Ex. 1, p. 8.)

Thus, the ALJ must decide whom to believe: Claimant's treating doctor, who examined Claimant on a regular basis, or the Carrier's peer reviewer, who examined only paper and whose opinion, in a nutshell, amounted to the view that he would have treated Claimant somewhat differently, but not radically differently. The ALJ found Dr. Allen's explanation for his treatment plan to be credible, and thus, finds Provider is entitled to additional compensation totaling $680.00 for therapeutic exercises performed on the dates at issue.

4. Range of Motion (ROM) studies, CPT Code 95851, MAR $72, on May 8, 2001

The IRO chiropractor concluded that the ROM studies at issue was necessary in order to evaluate Claimant's progress. Though the Carrier complained that Provider performed too many ROM studies, the ALJ was persuaded by Provider's contention that, had Dr. Allen not conducted numerous ROM studies during the course of Claimant's treatment, Dr. Allen would not have been able to objectively assess and document Claimant's progress. Therefore, the ALJ concludes Provider is entitled to reimbursement of $72.00 for the ROM studies conducted on May 8, 2001.

5. Electrodiagnostic studies: CPT Codes 95900-27, MAR $512; CPT Codes 99904-27, MAR $512; CPT Codes 95925-27, MAR $1,400; CPT Codes 95935-27, MAR $530, on June 13, 2001

Dr. Allen ordered that Claimant undergo certain electrodiagnostic studies: an EMG, motor nerve conduction, F wave and H reflex, somatosensory evoked potential, and dermatosensory evoked potential studies. These tests were administered by Charles Tuen, M.D. of Neuromed, on June 13, 2001. (Ex. 1, pp. 160-172.) Provider's charges in connection with these services, $2,954.00, reflect Dr. Allen's charges for reading the test results, not Neuromed's charges for administering the tests. The test results were within normal limits, except they indicated a conduction block of the left Ulnar nerve at the elbow and nerve root dysfunction at the bilateral L5 level, worse on the left side. (Ex. 1, pp. 160, 163.)

In criticizing Dr. Allen's use of temperature gradient studies, two of the Carrier's peer reviewers, Drs. Brock and Bauer, stated that, if radicular injury was suspected, the appropriate tests would have been a needle EMG, H and F wave studies, and possibly an evoked potential study. (Ex. 2, pp. 142-156.) Thus, it appears Dr. Allen ordered the precise tests the Carrier's peer reviewers opined might be appropriate if a radicular injury was suspected. Dr. Bauer reported, however, that there was no indication that Claimant had a cervical injury nor documentation that Claimant had a "lumbar problem," except the "discredited temperature gradient studies." (Ex. 2, p. 143.) He concluded, therefore, that the electrodiagnostic tests were not medically necessary.

The ALJ finds that Provider did not carry its burden of proof on this issue because the record does not reflect either the need for the tests or what use, if any, Dr. Allen made of the test results in treating Claimant. In connection with his referral of Claimant for MRIs on May 9, 2001, Dr. Allen prepared a "Letter of Medical Necessity," as well as a follow-up letter explaining how the MRI results affected his treatment plan for Claimant. (Ex. 1, pp. 274, 239.) The ALJ was unable to find similar documentation regarding the electrodiagnostic tests. Numerous documents in the record indicate that Claimant had made substantial progress in his recovery as of June 13, 2001. Dr. Allen's SOAP notes for June 6, 2001 and June 13, 2001, reflect Claimant had pain at only level 2 in the left shoulder and level 1 in the lumbar and left hip areas, *i.e.,* a *decrease* in pain levels from those reported in earlier SOAP notes. (Ex. 1, pp. 142-144.) By Dr. Allen's own admission, the April 26, 2001 temperature gradient studies "showed improvement from the previous testing and that the interference on the nerves at those levels had decreased." (Ex. 1 p. 179.) In correspondence supporting his request for payment, dated October 1, 2001, Dr. Allen wrote that, as a result of his treatment,

> "[C]laimant's pain went down remarkably that [sic] after 3 weeks of this more intensive therapy he was completely pain free. The only area of slight complaint was his left hip and anterior thigh with radiating pain intermittently down his left leg...." (Ex. 1, pp. 178-179.)

Provider did not offer any explanation as to why a "slight complaint" constituted medical necessity for the electrodiagnostic studies performed on June 13, 2001, a time when, Dr. Allen contended, Claimant was virtually pain-free or had very little pain. Nor did Provider offer evidence of what use, if any, Dr. Allen made of the electrodiagnostic test results in treating Claimant. For these reasons, the ALJ finds Provider failed to establish that the tests were medically necessary.

6. Preparation of TWCC-73 Report, CPT Code 90080-73, MAR $15, October 15, 2001

The IRO and MRD denied reimbursement for CPT Code 99080-73, which covers a $15.00 charge for preparation of a TWCC-73 report on October 15, 2001, on the basis that the file did not contain a copy of the report. Pursuant to Commission Rule 129.5(d)(2), a provider is required to complete and submit the TWCC-73 when a patient□s work status changes. 28 TEX. ADMIN. CODE (TAC) § 129.5(d)(2). The evidence here reflects that Claimant experienced a flare up of pain in his left shoulder, for which he saw Dr. Allen on October 12, 2001 (after approximately two months without office visits), and Dr. Allen restricted Claimant's work activities as a result. The record includes at least two copies of the TWCC-73 that Dr. Allen prepared on October 15, 2001, reporting the flare-up and work restrictions. (Ex. 1, pp. 173 and 174.) Accordingly, the ALJ concludes Provider is entitled to $15.00 reimbursement for preparation and submission of the report.

III. FINDINGS OF FACT

1. On_____, Claimant ____ (Claimant) was involved in a motor vehicle accident in which he sustained an injury compensable under the Texas Workers' Compensation Act (the Act).

2. Claimant injured his neck, left shoulder, lower back, and left hip in the accident.

3. At the time Claimant sustained the compensable injury, Respondent Lumbermen's Underwriting Alliance (Carrier) provided workers' compensation insurance to Claimant's employer.

4. Petitioner, Central Dallas Rehab (Provider), is the entity that billed the Carrier for Dr. Allen's services.

5. Claimant's treating doctor, Dean L. Allen, D.C., diagnosed Claimant as having lumbar spine disc disorder, thoracic spine disc disorder, rotator cuff sprain/strain, and whiplash syndrome/cervical spine hyperflexion.

6. In dispute in this proceeding are the following services:

> Office visits with manipulation, CPT Code 99213, MAR $48, on May 11, 16, 23, 30, June 29, July 27, October 12, 15, and 29, 2001;
>
> Myofascial release, CPT Code 97250, MAR $43, on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001;
>
> Traction, CPT Code 97122, MAR $ 35, on May 8, 16, and 30, 2001;
>
> Therapeutic exercises, CPT Code 97110, MAR $70, on May 3, 7, 11, 15, 18, 21, 23, and 30, 2001, with a balance of $60 in dispute for May 8 and 16, 2001 each;
>
> Range of Motion (ROM) studies, CPT Code 95851, MAR $72, on May 8, 2001;
>
> Electrodiagnostic studies: CPT Codes 95900-27, MAR $512; 99904-27, MAR $512; 95925-27, MAR $1,400; 95935-27, MAR $530, on June 13, 2001; and
>
> Preparation of TWCC-73 Report, CPT Code 90080-73, MAR $15, on October 15, 2001.

7. The Carrier declined to reimburse Provider for the services listed in Finding No. 6, on the basis that the services were not medically necessary and, in some instances, not properly documented.

8. The intervals at which Dr. Allen scheduled office visits with manipulations for Claimant were appropriate given the nature and number of Claimant's injuries.

9. Office visits with manipulation on May 11, 16, 23, 30, June 29, July 27, October 12, 15, and 29, 2001, billed to CPT Code 99213, were medically necessary and properly documented.

10. Based on Findings Nos. 8 and 9, Provider is entitled to reimbursement for nine office visits with manipulation, at the MAR rate of $48.00, for a total of $432.00.

11. The intended therapeutic outcomes of joint mobilization (CPT Code 97265), myofascial release (CPT Code 97250), and traction (CPT Code 97122) are similar, and therefore, only one of these treatments was medically necessary.

12. Provider failed to prove that myofascial release, performed on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001, and billed to CPT Code 97250, was medically necessary.

13. Provider failed to prove that traction performed on May 8, 16, and 30, 2001, and billed to CPT Code 97122, was medically necessary.

14. Dr. Allen had Claimant perform three 15-minute units of therapeutic exercises per day on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001. The exercises performed varied from day to day, depending on Claimant's symptoms and stage of recovery.

15. Claimant made significant, measurable progress on the treatment plan described in Finding No. 14.

16. Based on Findings Nos. 14 and 15, all units of therapeutic exercise performed on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001, were medically necessary.

17. Based on Finding No. 16, Provider is entitled to reimbursement at the MAR rate of $70.00 for therapeutic exercise performed on May 3, 7, 11, 15, 18, 21, 23, and 30, 2001, and reimbursement at the rate of $60.00 for May 8 and 16, 2001, for a total of $680.00.

18. Range of Motion (ROM) testing performed on May 8, 2001, was medically necessary to evaluate Claimant's progress.

19. Based on Finding No. 18, Provider is entitled to reimbursement at the MAR rate of $72.00 for ROM studies performed on May 8, 2001, and billed to CPT Code 95851.

20. Dr. Allen ordered an EMG, motor nerve conduction, F wave and H reflex, somatosensory evoked potential, and dermatosensory evoked potential studies (collectively, electrodiagnostic studies), which were administered to Claimant by Charles Tuen, M.D. of Neuromed, on June 13, 2001.

21. Dr. Allen's SOAP notes for June 6, 2001 and June 13, 2001, reflect Claimant had pain at level 2 in the left shoulder and level 1 in the lumbar and left hip areas, *i.e.,* a *decrease* in pain levels from those reported in earlier SOAP notes.

22. As of June 13, 2001, Claimant had made substantial progress in his recovery, and his pain levels in his left shoulder, lumbar, and left hip areas had decreased.

23. There was no evidence as to how Dr. Allen interpreted the results of the electrodiagnostic studies or what use he made of them in his treatment of Claimant.

24. Based on Findings Nos. 20-23, Provider failed to prove that the electrodiagnostic studies performed on June 13, 2001, and billed to CPT Codes 95900-27, 99904-27, 95925-27, 95935-27, were medically necessary.

25. Claimant experienced a flare-up of pain in his left shoulder, for which he saw Dr. Allen on October 12, 2001, and Dr. Allen restricted Claimant's work activities as a result.

26. Dr. Allen prepared a TWCC-73 report on or about October 15, 2001, reporting the flare-up and Claimant's work restrictions.

27. Provider timely filed a request for medical dispute resolution with the Texas Workers' Compensation Commission (the Commission).

28. An independent review organization (IRO) chiropractor reviewed the medical dispute.

29. The record in this proceeding contains insufficient evidence to determine what the IRO chiropractor's recommendations were with respect to all of the services at issue.

30. On October 28, 2002, the Commission's Medical Review Division (MRD) ordered the Carrier to pay Provider a total of $760.00 for CPT codes 99213 (one day), 97110 (two days–one unit), 97265 (ten days), and 95851 (one day).

31. The Provider filed its request for hearing on November 19, 2002.

32. Notice of the hearing was sent to the parties on December 13, 2002.

33. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

34. The hearing was held February 19, 2003, at the hearings facility of the State Office of Administrative Hearings (SOAH), with Administrative Law Judge (ALJ) Renee M. Rusch presiding and representatives of the Carrier and the Provider participating. The Commission did not participate in the hearing. The record closed on March 5, 2003, after the submission of argument and citations relating to a limited issue.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas

Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. ch. 401 *et seq*.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

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

4. The Provider had the burden of proof by a preponderance of the evidence in this matter. 28 TEX. ADMIN. CODE (TAC) §148.21(h); 1 TAC § 155.41.

5. Provider timely filed its request for hearing, as provided in 28 TAC §148.3.

6. Based on Findings Nos. 8-10, 14-19, Provider met its burden of proving that the following services were medically necessary, pursuant to TEX. LABOR CODE ANN. § 408.021(a):

> Office visits with manipulation, CPT Code 99213, MAR $48, on May 11, 16, 23, 30, June 29, July 27, October 12, 15, and 29, 2001;
>
> Therapeutic exercises, CPT Code 97110, MAR $70, on May 3, 7, 11, 15, 18, 21, 23, and 30, 2001, with a balance of $60 in dispute for May 8 and 16, 2001 each;
>
> Range of Motion (ROM) studies, CPT Code 95851, MAR $72, on May 8, 2001; and
>
> Preparation of TWCC-73 Report, CPT Code 90080-73, MAR $15, October 15, 2001.

7. Based on Findings No. 25 and 26, Provider is entitled to reimbursement of $15.00 for preparation and submission of the TWCC-73 as required by 28 TAC § 129.5(d)(2).

8. Based on Findings Nos. 11-13 and 20-24, Provider did not meet met its burden of proving that the following services were medically necessary, pursuant to TEX. LABOR CODE ANN. § 408.021(a):

> Myofascial release, CPT Code 97250, MAR $43, on May 3, 7, 8, 11, 15, 16, 18, 21, 23, and 30, 2001;
>
> Traction, CPT Code 97122, MAR $ 35, on May 8, 16, and 30, 2001; and
>
> Electrodiagnostic studies: CPT Codes 95900-27, MAR $512; 99904-27, MAR $512; 95925-27, MAR $1,400; 95935-27, MAR $530, on

June 13, 2001.

9. The Carrier is obligated to reimburse Provider for the services listed in Conclusion No. 6, pursuant to TEX. LABOR CODE ANN. § 408.021(a).

10. Based on the foregoing findings and conclusions, Provider is entitled to additional reimbursement in the sum of $1,199.00.

ORDER

IT IS, THEREFORE, ORDERED that Respondent Lumbermen's Underwriting Alliance shall reimburse Petitioner Central Dallas Rehab the sum of $1,199.00. Petitioner is not entitled to recover any additional portion of the disputed fees.

SIGNED this 22nd day of April, 2003.

RENEE M. RUSCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS