

DOCKET NO. 453-03-1485.M5
[TWCC Docket No. M5-02-2946-01]

STEVEN M. BROOKS, D.C.,	§	BEFORE THE STATE OFFICE
<i>Petitioner</i>	§	
VS.	§	OF
TEXAS WORKERS' COMPENSATION	§	
COMMISSION	§	
and CONTINENTAL CASUALTY	§	
COMPANY, <i>Respondents</i>	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

Steven M. Brooks, D.C., (Petitioner) appealed the independent review organization (IRO) reviewer's denial of his request for reimbursement for chiropractic services. Continental Casualty Company (Carrier) argued the treatment exceeded what was medically reasonable and necessary. The Petitioner's chief witness, the workers' compensation claimant, testified how much the treatment has improved his ability to function. In this Decision and Order, the administrative law judge (ALJ) allows reimbursement of \$468 for active treatments but denies reimbursement for more passive treatments.

I. Procedural History

The hearing on this appeal convened on February 19, 2003, before the undersigned ALJ. Attorney Jane Stone represented the Carrier, and Petitioner represented himself. All other matters concerning notice and jurisdiction are addressed in the findings of fact and conclusions of law.

II. Evidence

1. Background

This decision focuses on the dates of service listed in the request for dispute resolution, October 2, 2001, through April 11, 2002.¹ The request's table of disputed services shows the amount in dispute is \$1,996.00.² However, Petitioner introduced evidence that, of those charges, \$433.20 had been paid, leaving the remaining amount of \$1,562.80.

¹As the Carrier noted, payment for services on other dates may still be appealable, but because those services were not reviewed by the IRO, it would inappropriate for the ALJ to review them.

²P. Ex. 4, pp. 3-4.

The claimant was injured on _____. Surgeon Stanley Jones, M.D., the claimant's treating doctor, performed surgery on him on November 4, 1997. The surgery consisted of multiple procedures -- lumbar laminectomies at L4 through S1, facetectomies and foraminotomies, and disc fragment excision at L4/5 and L5/S1. The claimant was given a 13% whole-person impairment rating in February 1998. A few days later, he told Dr. Jones he had severe low back pain and could not stand from a seated position without pain. On September 22, 1998, Dr. Jones did a revision of his prior lumbar surgery.

In addition to the lumbar laminectomy, the claimant suffered loss of normal lordosis and disc heights, decreased IVF spaces, and aberrant movement of the vertebral bodies.³ Even though the claimant did the back exercises his physical therapist recommended, he continued to experience significant pain. By January 2001, his treating physician said he would need a third surgery, a spinal fusion. Nevertheless, his doctor advised him to wait as long as possible before having the fusion because a fusion would negatively impact his ability to work.

At the time, the claimant was taking Lodine, Vioxx, and another anti-inflammatory medication for pain. Nothing helped him significantly. He could not walk without sitting to rest every two or three minutes. Discouraged by the pain, the claimant began taking Celebrex. Beginning in September 19, 2001, Dr. Jones prescribed chiropractic care for him.

2. The Claimant

The claimant attended the Austin hearing and testified that the chiropractic care he received made it possible for him to work. Impressed by the claimant's progress, Dr. Jones has continued to prescribe this treatment. The claimant works full time, and since April 2002, has not needed to take Celebrex. In the mornings and with weather changes, he is not pain-free, but much of the time, he is without pain for the first time in years. At home, the claimant exercises with Therabands and a big ball every night for fifteen to twenty minutes. When he is tired, he uses a heating pad, and when his back feel inflamed, he uses ice packs.

After the claimant began receiving chiropractic treatment, the claimant was "up and down" for a while, sometimes better and sometimes not, he testified. His primary improvement was after January 2002, and then he changed from three to two treatments a week. At the time of the hearing, the claimant was receiving one treatment a week. He can now stand and walk more. The treatments are so important to him that he began paying Petitioner for treatments beginning in January 2003.

³P. Ex. 4, p. 26.

Because of his significant improvement, the claimant wondered what more he needed to do in order to show medical necessity.

3. Petitioner's Records

In a typical office visit, Petitioner charged for between four and eight CPT codes, such as:

97032 - electric muscle stimulation (usually billed at two units per day);

97110 - therapeutic exercises used to develop strength and endurance, range of motion, and flexibility (usually billed as four units). Examples include the use of graded resistance ranging from manual resistance to a variety of equipment including isokinetic, isometric, or isoinertial in one or more places;

97112 - use of other exercise equipment, also described as neuromuscular re-education (usually billed at two units);

99213-25 B Code 99213 is the code for an office visit. The modifier -25 indicates that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable evaluation/management service above and beyond the other service provided. Documentation of procedure is required. Any office visit exceeding 99213 on established patients and performed for reevaluation is limited to once every 30 days and must include the first manipulation; and

97530 - direct patient contact by the provider with the use of dynamic activities to improve foundational performance, including activator and Jeannie Rub/thumper (usually billed at two units).⁴

Treatment did not vary significantly based on the claimant's pain. For example, the claimant, using a scale of one to ten, rated his pain as:

⁴These explanations are taken from Petitioner's records, the 1996 Medical Fee Guideline(MFG), and the Spine Treatment Guideline (STG), 28 TEX. ADMIN. CODE §§ 134.1001 and 134.201.

severe (five) on January 31, 2002;
extreme (eight) on February 5, 2002;
four on April 2, 2002;
moderate (four) on April 4, 2002;
three on April 9, 2002; and
two on April 11, 2002

Treatment for these dates was similar with multiple CPT codes listed.

Service dates, as reflected on Petitioner's exhibit 3, were

2001:

September 27 and 29;
October 2, 4, 6, 9, 11, 13, 16, 18, 20, 23, 25, 27, 30, 31;
November 3, 6, 10, 12, 15, 17, 21, 24, 27, 29; and
December 1, 4, 6, 15, 18.

2002:

January 29 and 31;
February 5, 9, 12, 19, 21, 26, 28;
March 5, 12, 14, 19, 21, 26, 28; and
April 2, 4, 10, 11.

4. IRO

The IRO reviewer said it was unrealistic to attempt to make the claimant pain-free. "Treatment should be aimed at exacerbations that would not normally resolve on their own. The patient has been taught self-help exercises and has a transcutaneous electrical nerve stimulator [TENS unit] that may be utilized at home for mild irritations," he wrote. Care for exacerbations does not usually last beyond three-to-four weeks, and an exacerbation to require treatment was not documented for the dates in dispute, the reviewer also noted.

5. Carrier

1. **Bryan Glenn, D.C.**

Dr. Glenn, a peer-reviewing chiropractor, is familiar with spinal trauma and treats injured workers. Based on his review of the claimant's medical records, he found some chiropractic care was necessary for the claimant and had enhanced his life to a great degree. Nevertheless, Dr. Glenn

noted that the claimant had been able to work even before beginning chiropractic care, and he criticized Petitioner's failure to transition the claimant to a more independent type of program.

Based on the number and type of modalities billed, each visit appeared to be a two-hour session and included passive modalities. Passive modalities five years after an injury were not reasonable, and passive treatments do not necessarily made active treatments more effective and longer-lasting, he stated. Prior to April 2, 2002, when the Carrier began to deny payment, the claimant already had received significant treatment. Moreover, Dr. Glenn found it objectionable that the claimant sometimes had treatment even when he was not experiencing pain. He conceded that chiropractic treatment, even over a year, was less expensive than spinal fusion surgery.

Of the CPT codes for which Petitioner billed on the service dates in question, Dr. Glenn characterized only codes 97110 and 97530 as active and requiring a chiropractor's presence. He did not comment on code 99213-25, the extended-office-visit code. Dr. Glenn said code 97032, electric stimulation, was not necessary when a patient had a TENS unit at home.⁵ Neuromuscular re-education, code 97112, is primarily a central nervous system rehabilitation code. Some chiropractors use this code for kinetic activities; if Petitioner did so, the treatment was unnecessary because the claimant should have been able to do kinetic activities at home by this phase of treatment, Dr. Glenn testified.

1. **Arguments**

The Carrier recognized the claimant as someone who is eager to manage his own health care, stay better, and work. The Carrier also conceded that some chiropractic care, such as check ups, and when there are flare ups, active exercises, is medically necessary. Even so, the Carrier argued that any passive care was not medically necessary after six months of treatment. Further, the Carrier faulted Petitioner for not decreasing care to a maintenance level.

III. Applicable Law

⁵According to Dr. Glenn, some CPT codes have been changed, and he was not entirely certain that Petitioner billed for the same kinds of procedures in the way Dr. Glenn would have billed them.

An employee who sustains 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: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the employee's ability to return to or retain employment.⁶

The Commission's STG Ground Rules require manipulation to be performed for the minimum appropriate duration, *i.e.*, the time from initiation of treatment that will result in continued improvement, and beyond which additional treatment will not further benefit the injured employee. The frequency of treatment should be consistent with the phase of the injured employee's disease or dysfunctional process, as determined by ongoing evaluation and management of the injured employee's conditioning.⁷ Treatments must be:

1. Adequately documented;
2. Evaluated for effectiveness and modified based on clinical changes;
3. Provided in the most appropriate, least intensive setting;
4. Cost effective;
5. Consistent with [the STG] which may include providing a documented clinical rationale for deviation from the guideline;
6. Objectively measured and demonstrate functional gains; and
7. Consistent in demonstrating ongoing progress in the recovery process by appropriate re-evaluation of the treatment.⁸

⁶TEX. LAB. CODE ANN. §408.021. "Health care" includes "all reasonable and necessary medical . . . services." TEX. LAB. CODE ANN. §401.011(19).

⁷STG at (4)(e)(2)(E).

⁸STG at (4)(e).

IV. Analysis

The claimant's testimony was convincing, and the ALJ has no reason to doubt that his pain has decreased and his functional ability has increased significantly as a result of Petitioner's care. After such intense treatment for so long a period of time, the real issue is whether, even if care was gradually lessened, the claimant would have experienced the same relief. As stated above, the STG requires cost-effective treatment provided in the least intensive setting. While it is true that the number of office visits decreased over time, there was no movement to decrease the types of care provided at each visit. Further, the claimant was treated in much the same way, even when his pain level varied greatly. Therefore, the ALJ agrees with the Carrier that additional payment is not warranted for more passive treatment.

Petitioner provided care for many months after the dates shown on the table of disputed services, but only a few treatment dates are listed on the table and within the scope of this appeal. For treatments listed prior to April 2, 2002, the Carrier paid for some of the services, and the Petitioner did not address why additional payment is warranted. The Carrier denied payment for CPT code 99213-25 on January 31, 2002, and the same code had been billed two days earlier. It is possible that with CPT code revisions, the code can now be used more frequently than once a month. The version of the STG available to the ALJ permits billing for this code only once a month. Petitioner bore the burden of proof and did not introduce evidence to the contrary. Therefore, the ALJ agrees that he should be paid once under this code for April 2002, even though he billed it four times.

For the treatment dates of April 2, 4, 10, and 11, two of the CPT codes listed are for treatments specifically identified as active by Dr. Glenn, CPT codes 97110 and 97530. The remaining codes are 97112 (use of other exercise equipment) and 97032 (electrical stimulation). Dr. Glenn's testimony was essentially uncontroverted, and the ALJ agrees with his assessment that those passive treatments were not necessary.

In summary, Petitioner is entitled to recover once for CPT code 99213-25 (\$48, according to the MFG) and four times each for codes 97110 and 97530 (\$70 and \$35 respectively) for a total of \$468.

V. Findings of Fact

1. All parties received not less than ten-days notice of the hearing.
2. 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 would be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

3. Both Petitioner, Steven M. Brooks, D.C., and the Carrier, Continental Casualty Company, were represented at the February 19, 2003, hearing.
4. After a _____, workers' compensation injury, the claimant had surgery on November 4, 1997.
5. The surgery consisted of multiple procedures -- lumbar laminectomies at L4 through S1, facetectomies and foraminotomies, and disc fragment excision at L4/5 and L5/S1.
6. The claimant was given a 13% whole-person impairment rating in February 1998.
7. Because the surgery was not successful, the claimant underwent a revision of the prior surgery on September 22, 1998.
8. In addition to the lumbar laminectomy, the claimant suffered loss of normal lordosis and disc heights, decreased IVF spaces, and aberrant movement of the vertebral bodies.
9. Even though the claimant did the back exercises his physical therapist recommended, he continued to experience significant pain.
10. The claimant could not walk without sitting to rest every two or three minutes.
11. By January 2001, the claimant was taking Lodine, Vioxx, and another anti-inflammatory medication for pain, but nothing helped him significantly.
12. Discouraged by the pain, the claimant also began taking Celebrex.
13. The claimant's treating physician said he would need a third surgery, a spinal fusion; nevertheless, his doctor advised him to wait as long as possible before having the fusion because a fusion would negatively impact his ability to work.
14. The claimant began receiving chiropractic care from the Petitioner in September 2001.
15. Since receiving chiropractic care:
 - a. The claimant works full time, as he did before beginning treatment, but he is now more able to move freely and work better;
 2. He no longer needs to take Celebrex;
 3. He can now stand and walk more.

4. In the mornings and with weather changes, he is not pain-free, but much of the time, he is without pain for the first time in years.
15. The number of the claimant's treatments has decreased over time from three a week to two a week by December 2001, and to one a week at the time of the hearing.
16. In a typical office visit, Petitioner charged for between four and eight CPT codes, such as:
 - 97032 - electric muscle stimulation;
 - 97110 - therapeutic exercises;
 - 97112 - use of other exercise equipment;
 - 99213-25 - extended office visit limited to once every 30 days; and
 - 97530 - direct patient contact by the provider with the use of dynamic activities.
17. Treatment did not vary significantly based on the claimant's pain. For example, the claimant, using a scale of one to ten, rated his pain as:
 - severe (five) on January 31, 2002;
 - extreme (eight) on February 5, 2002;
 - four on April 2, 2002;
 - moderate (four) on April 4, 2002;
 - three on April 9, 2002; and
 - and two on April 11, 2002
18. Treatment for the above dates was similar with multiple CPT codes listed.
19. Based on the number and type of modalities billed, each visit appeared to be a two-hour visit and included passive modalities.
20. Even though the number of office visits decreased over time, Petitioner did not attempt to transition the claimant to a more independent type of program.
21. The Spine Treatment Guideline (STG) requires cost-effective treatment provided in the least intensive setting.
22. After six months of initial treatment, passive modalities were not a reasonable treatment option for the claimant.

23. CPT code 97032, electric stimulation, was not necessary for the claimant because he had a TENS unit at home.
24. Neuromuscular re-education, code 97112, is sometimes used to bill for kinetic activities.
25. Treatment with kinetic activities was not necessary after six months of treatment.
26. Even after receiving chiropractic treatment for six months, the claimant continued to benefit from active chiropractic care.
27. Chiropractic care, even for a year, is generally less expensive than spinal fusion surgery.
28. For treatments listed prior to April 2, 2002, the Carrier paid for some of the services, and the Petitioner did not address why additional payment is warranted.
29. The Carrier denied payment for CPT code 99213-25 on January 31, 2002, and the same code had been billed two days earlier.
30. The STG permits billing for CPT code 99213-25 only once per month.
31. Petitioner billed for CPT code 99213-25 four times in April 2002, but should be reimbursed for only one office visit under that code.
32. The maximum allowable reimbursement for CPT code 99213-25 is \$48.
33. CPT codes 97110 and 97530 are for active treatment and require a chiropractor's presence.
34. The maximum allowable reimbursement for CPT code 97110 is \$70, and Petitioner billed this code four times in April 2002, for a total of \$280.
35. The maximum allowable reimbursement for CPT code 97530 is \$35, and Petitioner billed this code four times in April 2002, for a total of \$140.

VI. Conclusions of Law

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §2001.052.
3. Petitioner had the burden of proof in this matter. 28 TEX. ADMIN. CODE § 148.21(h).
4. Petitioner is entitled to recover once for CPT code 99213-25 and four times each for codes 97110 and 97530, for a total of \$468.

ORDER

IT IS, THEREFORE, ORDERED that Continental Casualty Company pay Steven M. Brooks, D.C., the sum of \$468 for services provided October 2, 2001, through April 11, 2002.

Signed this 22nd day of April, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

SARAH G. RAMOS
Administrative Law Judge