STATE OFFICE OF ADMINISTRATIVE HEARINGS
300 West Fifteenth Street, Suite 502
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GALAXY HEALTHCARE CENTERS	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE	§	
COMPANY	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Galaxy Healthcare Centers (Provider) appealed the findings of an Independent Review Organization (IRO), which found that Texas Mutual Insurance Company (Carrier) should reimburse Provider for outpatient services rendered by Provider from February 13, 2002 through February 25, 2002, but that treatments rendered between the dates of February 26, 2002 and May 24, 2002, were not medically necessary and not reimbursable. The Administrative Law Judge agrees with the IRO decision that Provider's services for the second set of dates was not shown to be medically necessary and Provider is not entitled to additional reimbursement.

I. PROCEDURAL HISTORY AND NOTICE

The hearing convened before Suzanne Marshall, Administrative Law Judge (ALJ) with the State Office of Administrative Hearings (SOAH), on June 23, 2003, 300 West 15th Street, Fourth Floor, Austin, Texas. Patricia Eads appeared on behalf of the Carrier. The Provider appeared via telephone and was represented by Dr. Alex Kurt Riley, D.C. ALJ Bill Zukauckas reviewed the record and has prepared the decision.

II. FACTUAL BACKGROUND

The injured worker, ____ sustained a compensable workers' compensation injury on ___, attempting to lift an incapacitated patient. On January 22, 2002,____. visited Provider's center with complaints of lower back pain and radicular pain patterns. On January 23, 2002, Claimant was evaluated by Shanti Pain and Wellness Clinic by Issan Shanti, M.D., who prescribed non steroidal anti-inflammatory medications. She continued care at Provider's facility. On February 12, 2002, she had an MRI of her lumber spine which revealed an L4-L5 disc herniation with indentation of the thecal sac on the left. On February 16, 2002, Claimant was evaluated by Jeffrey Reuben, M.D. Dr. Reuben's notes indicated motor strength sensation and reflexes to be normal in both extremities. On February 28, 2002, Claimant began active physical therapy under Kurt Thedford, P.T. On April 4, 2002, Claimant visited Dr. Edward Lewis, M.D. whose diagnosis included lumbar strain with chronic low back pain and a herniated nucleus pulposus with lumbar radiculitis, improving. Dr. Lewis' exam showed no sensory change, no muscular weakness and normal reflexes. Dr. Lewis noted that Claimant did not want to consider epidural steroid injections.

III. THE PARTIES' POSITIONS

1. The Carrier

The Carrier contends that the Provider inappropriately charged for "one-on-one" physical therapy for the Claimant because the Claimant did not need that kind of more expensive, close supervision. The Carrier argues Claimant had no trouble completing the recommended exercises once shown how to do them. The Carrier's expert witness, William A. DeFoyd, D. C., testified that Provider's one-on-one exercise supervision, and billing for one-on-one supervision[1], in this instance, was unnecessary. Dr. DeFoyd further notes that this particular Carrier testified that he has a blanket approach of providing this one-on-one supervision for each and every patient at his facility, and that it was entirely unwarranted for this patient. He noted that the Claimant had no difficulty completing the recommended exercises and could have well done them herself after being shown once what was required. Dr. DeFoyd testified that a home exercise program or a membership at a local health club would have been much more cost effective and that this patient did not need anyone supervising her when she walked on the treadmill. Dr. DeFoyd also noted that Provider had no individualized treatment plan for the Claimant, as the Commission's rules contemplate. Dr. DeFoyd testified that without some baseline measure, some intermediate measures of progress, and some overall treatment goal, it would be impossible to measure Claimant's progress.

2. The Provider

The Provider argues that it is medically necessary for the Claimant, and every other patient at his facility to receive "one-on-one" therapy at his facility. The Provider disputes the Carrier's contention that one-on-one therapy was not medically necessary for this patient specifically, and for each of his patients. He contends that all patients need this level of care.

IV. ALJ's ANALYSIS

The ALJ found the Carrier's arguments persuasive and agrees with the IRO that Provider has not shown that the active and passive modalities provided to Claimant between February 26, 2002, and May 24, 2002, were medically necessary. The Provider billed all of these modalities on a one-on-one basis. The Provider's testimony indicates that he provided one-on-one therapy not only to this patient, but to every patient in his facility. The Provider did not show, by a preponderance of credible evidence, that these intensive and expensive one-on-one active and passive therapies were medically necessary. Provider did little to support his position that this one-on-one therapy was medically necessary and simultaneously the most cost effective approach. While some portion of the treatment modalities might have been justified, the ALJ does not believe it is his responsibility to figure out how many of those would be reasonable. Thus, he concludes, the services as billed, were not medically necessary.

The Provider's practice of providing one-on-one treatment to every patient is excessive. For this particular patient, the practice was unwarranted. The ALJ also agrees with Dr. DeFoyd that an

[1] DeFoyd testified that this one-on-one billing was billed to the Carrier at a rate that is about 10 times higher than a group supervision rate.

articulated and measurable treatment plan should have been formulated, that measurements addressing treatment goals should have been documented, and that assessment of those objective should have been recorded. That was not adequately done.

The ALJ, therefore, concludes that the Provider is not entitled to additional reimbursement for active or passive treatment billings between February 26, 2002, and May 24, 2002 and that the previously ordered limited IRO reimbursement was appropriate.

V. FINDINGS OF FACT

1. The injured worker suffered a compensable injury on ___.

2. On December 12, 2002, an Independent Review Organization issued a decision finding that the outpatient services rendered by the Galaxy Health Care Center (Petitioner) between February 13, 2002 and February 25, 2002, were medically necessary and were to be paid by Texas Mutual Insurance Company (Carrier), but that those rendered from February 26, 2002, to May 24, 2002, were not.

3. The Petitioner filed a timely request for a hearing before the State Office of Administrative Hearings (SOAH).

4. The parties received notice of hearing containing 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.

5. The Carrier provided workers' compensation insurance coverage to the injured worker's employer on the date of the injury.

6. For dates of service occurring between February 26, 2002 and May 24, 2002, the Provider billed the Carrier for active and passive modalities under CPT codes 97110, 97112, 99213, and 97250.

7. For each of the dates of service in question, the patient received one-on-one physical therapy at Provider's clinic resulting billings that were substantially (as much as 10 times) more expensive than were warranted for Claimant___.

8. Provider failed to demonstrate that one-on-one therapy for Claimant was necessary for the dates in question. A self-administered home or health club exercise regime would have been sufficient for this Claimant's needs after February 25, 2002.

9. For each date of service where Provider rendered services to Claimant from February 26 through May 24, 2002, Provider billed the Carrier using one-on-one CPT codes. In light of the lack of sufficient treatment plan documentation and any other persuasive evidence that services on a one-on-one basis were appropriate, billed costs for at that one-on-one service level were not medically necessary.

VI. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to section 413.031 of the Texas Workers' Compensation 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(d) 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. §§ 2001.051 and 2001.052.

4. The Provider has the burden of proof in this matter. 28 TEX. ADMIN. CODE (TAC) § 148.21(h).

5. Office visits, therapeutic procedures, neuromuscular re-education, manipulations, myofacial release, ultrasound, and electrical stimulation rendered on any date between February 26, 2002 and May 24, 2002, were not medically necessary because CPT code 97150 (the less expensive group code) should have been billed in this situation for this patient. Medical Fee Guideline (MFG), *Medicine Ground Rule*, I.A.9.b. and I.C.9.

6. The limited reimbursement Carrier has previously been ordered to pay Provider, for services from February 13, 2002, through February 25, 2002, was medically necessary.

7. The Provider is not entitled to any additional reimbursement.

Order

IT IS, THEREFORE, ORDERED that the Texas Mutual Insurance Company is not required to reimburse Galaxy Health Care Centers, PA, any additional amounts.

SIGNED this 9th day of September 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

_____

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE