**DOCKET NO. 453-03-2722.M5**
**MDR TRACKING NUMBER: M5-03-0656-01**

| | | |
|---|---|---|
| **AMERICAN CASUALTY COMPANY OF READING, PA.** | § | **BEFORE THE STATE OFFICE** |
| ***Petitioner*** | § | |
| **VS.** | § | **OF** |
| | § | |
| **ALAN BERG, D.O.** | § | |
| ***Respondent.*** | § | **ADMINISTRATIVE HEARINGS** |

# DECISION AND ORDER

American Casualty Company of Reading, PA. (Petitioner or Carrier) has appealed an Independent Review Organization's (IRO's) conclusion authorizing reimbursement to physician Alan Berg, D.O. (Dr. Berg or Respondent) for $3,933.00 of therapeutic services he provided to ___. (Claimant). The Administrative Law Judge (ALJ) finds that Respondent should be reimbursed for 1) two electrical stimulation treatments provided under CPT Code 97032; 2) the three 15-minute units Dr. Berg provided to Claimant on November 5 and November 7, 2001, for therapeutic activities under CPT Code 97530; and 3) eight 15-minute units of therapeutic procedures and exercises under CPT Code 97110 in the total amount of $429.00. The Carrier proved that Respondent is not entitled reimbursement for the remaining treatments at issue because they were either not medically necessary, not sufficiently documented or not provided.

## I. DISCUSSION

### A. Background

Claimant is a 31-year-old female who worked at Frito Lay Company packing bags of chips in boxes. On ___, she manifested symptoms of a repetitive motion injury affecting her shoulder, an injury found compensable under her employer's workers' compensation insurance. Claimant sought treatment for her shoulder at the Wol+Med Clinic on October 12, 2001, and she was first examined by Nick Padron, M.D., who diagnosed her with a shoulder sprain.[1]

Claimant was later diagnosed with bursitis, internal derangement, and impingement syndrome. On October 16, 2001, Claimant requested that Dr. Berg, a doctor of osteopathy, be designated as her treating doctor. Dr. Berg began treating Claimant on October 29, 2001, with physical medicine and therapy modalities. In dispute is the reimbursement of $3,933.00 for 53 treatments Dr. Berg provided Claimant from November 2, 2001, to February 13, 2002, for the following physical medicine and therapy modalities and assessments:[2]

| CPT Code | Description |
|---|---|
| 97032 | Electrical stimulation (manual) - 15 minutes each |
| 97139-PH | Phonophoresis |

[1] Carrier's Ex. 1 at 10-11. The Commission's Upper Extremities Treatment Guideline defines a sprain as "an injury to a ligament" and a strain as "an injury to a muscle." Carrier's Closing Brief at p. 2.`

[2] Provider's Ex. 1 at 8-11.

| | |
|---|---|
| 99070 | Phonophoresis supplies |
| 97139-SS | Spray and stretch |
| 97110 | Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility |
| 97530 | Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance) - 15 minutes each[3] |
| 97799-JA | Job Site Assessment |

B. Claims and Procedural History

According to the explanations of benefits (EOBs) in evidence, Carrier denied payment for all of the services under Code F: *Reduced according to fee guideline for unnecessary treatment based on peer review*, with the exception of CPT Code 97799-JA, the Job Site Assessment, which Carrier denied under Code U as *Unnecessary medical treatment or service, denied per nurse auditor - employer has complete job analysis on every position in plant*.[4]

Wolfgang Gilliar, D.O., a physical medicine and rehabilitation specialist, performed the January 7, 2002 peer review evaluation that served as the basis for the denials. After reviewing Dr. Berg's treatment notes, Dr. Gilliar concluded in his review that:

> ...based on the submitted information, and despite the information provided by the AP [attending physician], there is insufficient information that would substantiate the medical necessity for the ongoing need or passive physical therapeutic interventions and exercise training for the given diagnosis, five to six months after the alleged injury. Specifically, the submitted records lack the objectively verifiable and functional information that would substantiate ongoing treatment, specifically:
>
> 1. Detailed documentation of neuro-musculo-skeletal examination and functional status. . .
>
> 2. Definition and rational analysis of functional limitations as a result of the reported symptomatology.
>
> 3. Meaningful recommendations regarding improvement, elimination, or accommodation of potential residual disability.
>
> 4. Functional results expected as a result of contemplated management and based on what kind of objective indicators.
>
> 5. . . . The record does not indicate what kind, and if any, treatment the patient

[3] *See* Table of Disputed Services in Provider's Ex. 1 at 8-11; *see also*, Appendix A to this Decision.

[4] Provider's Ex. 1 at 32-35.

received prior to starting a physical therapeutic regimen on 11/02/2001 for

reported shoulder and thoracic sprain.

6. The submitted records do not reflect sufficient information as to substantial evidence and functional progress, as the treatment notes are limited to insufficient information, such as: [u]nder "S" (subjective) there is either no record entry (11/10/2001 note) or only a pain rating; there is no functional information in the treatment notes.

7. The goals are vague and general rather than patient-specific. The information provided by the AP in discussion indicates that the patient was seen by such therapists as kinesiologists, massage therapists, and others.[5]

Dr. Berg requested reconsideration which resulted in the same denials. He then appealed to the Texas Workers' Compensation Commission (Commission)and his appeal was submitted to an approved IRO. On February 10, 2003, the IRO disagreed with Carrier's denials, stating that:

> [Carrier based its denial on] Dr. Cillar's [sic] Peer Review, dated 1/7/02. [Dr. Cillar] found fault with the documentation provided by Dr. Berg for the services rendered. Though the Ziroc reviewer also finds the documentation to be rather scant, it is certainly well within range of normal with comparison to the medical practices of other providers. Upon review of Dr. Berg's documentation and his rationale, the Ziroc reviewer finds that he met the standard of documentation that is necessary for providing the services that were provided to this patient.

The Medical Review Division (MRD) accepted the IRO recommendation and issued a report on February 14, 2003, finding the disputed services reasonable, necessary, and sufficiently documented. The MRD ordered the Carrier to reimburse Dr. Berg. Carrier appealed the MRD's order to the State Office of Administrative Hearings (SOAH) on March 7, 2003. A contested hearing was convened on June 24, 2003, before ALJ Deborah L. Ingraham. Attorney H. Douglas Pruett represented Respondent. Attorney James M. Loughlin represented the Carrier. The parties submitted written closing arguments and the record closed July 29, 2003.

## II. REASONS FOR DECISION

Under the Texas Workers' Compensation Act (Act), Claimant is entitled to all health care reasonably required by the nature of the compensable injury as and when needed, specifically health care that (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.[6] According to the Act, health care includes all reasonable and necessary medical aid, medical examinations, medical treatment, medical diagnoses, medical evaluations, and medical services.

An IRO decision is deemed a Commission decision and order under Commission Rule 133.308 (p)(5)**.** Commission Rule 133.308(w) provides that, in all appeals from reviews of

[5] Carrier's Ex. 1 at p. 40.

[6] TEX. LAB. CODE ANN. §§ 401.011(19), 408.021.

prospective or retrospective [medical] necessity disputes, an IRO decision has presumptive weight.[7]

In this case, Carrier has the burden of proof and must show by a preponderance of the evidence that the treatments and services were not medically necessary.[8]

A. CPT Code 97032: Electrical stimulation.

1. Parties' Arguments

Carrier challenges the medical necessity of the electrical stimulation treatments Claimant received in combination with ultrasound or phonophoresis. Carrier argues that Dr. Berg's Workers' Compensation Physical Medicine Treatment Plan form indicates that electrical stimulation is "always combine[d] with ultrasound or phono."[9] Dr. Samuel M. Bierner, M.D., a board-certified physical medicine and rehabilitation specialist testified for the Carrier that there is no medical justification for always performing electrical stimulation with ultrasound or phonophoresis. Dr. Bierner further testified that the electrical stimulation in dispute was not medically necessary to treat the claimant given the nature of her injury and the length of time from the date of the injury. According to Dr. Bierner, electrical stimulation is not very useful five months after the injury occurred.[10]

Dr. Berg maintains that his own testimony and IRO decision carry greater weight than the report of Carrier's peer reviewer, Dr. Gilliar. In his brief, Dr. Berg argued that all of the active therapy he provided Claimant was medically necessary based on his examinations. Claimant began treatment with decreased strength and decreased range of motion. When she returned to work after being injured, her pain increased. Dr. Berg relies on his documentation of Claimant's progress, which shows decreased pain and improved range of motion resulting from the active therapy.[11]

2. ALJ's Decision

The ALJ has reviewed Dr. Berg's treatment notes and his testimony. She agrees with Carrier that the notes are minimal and do not describe adequate functional results or treatment plans. She rejects Dr. Berg's argument that the IRO decision carriers greater weight than the opinion of Carrier's expert. The IRO decision comments only on the sufficiency of Dr. Berg's documentation and does not, as Carrier points out, contain the specific reasons, including clinical bases, for its decision or the source of screening criteria as required by Commission Rule 133.308(n)(1).[12] Therefore, the IRO decision is not helpful in determining the medical necessity of these treatments.

That leaves the ALJ with the weight of the testimonies of Dr. Berg and Dr. Bierner. Dr. Berg testified that these treatments repeatedly contract the muscle to relax it. Dr. Bierner testified that

---

[7] *See* 28 TEX. ADMIN. CODE § 133.308 **(p)(5), (w).**

[8] *See* 28 TEXAS ADMIN. CODE § 148.21(h), (i).

[9] Provider's Ex. 1at p. 65.

[10] Carrier's Closing Brief at p. 5.

[11] Provider's Closing Brief at pp. 2-3.

[12] Carrier's Reply at pp. 2-3.

electrical stimulation should only be done one to two times. Dr. Berg disagrees. The ALJ is persuaded by Dr. Bierner's testimony. She also finds that Dr. Berg conceded that phonophoresis treatments can be done alone without electrical stimulation. The ALJ, therefore, concludes that two treatments of electrical stimulation were medically necessary and Carrier should reimburse Dr. Berg for two electrical stimulation treatments at the $22.00 per treatment or the maximum reimbursement allowed by the Commission.

B. CPT Code 97139-PH: Phonophoresis and CPT Code 99070: Phonophoresis Supplies

1. Parties' Arguments

Dr. Berg billed Carrier for several treatments of phonophoresis. First, Carrier challenges the medical necessity of the treatments because phonophoresis does not have a therapeutic effect for deep tissue injuries like the one Claimant suffered. Dr. Bierner explained that phonophoresis involves the delivery of topical medications with the use of an ultrasound wand on the theory that the ultrasound is supposed to drive the medication into the tissues. This might work for superficial injuries, Dr. Bierner testified, but would not work for something deeper, such as the claimant's diagnoses of bursitis, internal derangement, and impingement syndrome, because the medication would not penetrate deeply enough to be of benefit. Phonophoresis was not medically necessary in Dr. Bierner's opinion.

Second, Carrier opposes reimbursing the provider $46.00 for the phonophoresis supplies Dr. Berg billed for each treatment because the Medicine Ground Rules state that phonophoresis supplies shall be reimbursed at $7.00.[13]

Third, Carrier opposes any reimbursement for these treatments because Dr. Berg's office notes indicate that Claimant received this treatment with 2% Hydrocortisone cream for 30 minutes each date of service;[14] however, the provider's Physical Medicine Calendar, which records the actual number of minutes for treatment or testing, shows only 16 minutes for each date of service.[15] Because the provider billed for administering two 15-minute units of phonophoresis for each date of phonophoresis service, but provided only 16 minutes, he is not entitled to reimbursement for 30 minutes of treatment.[16]

Contrary to the opinion of Carrier's expert, Dr. Berg argues that the treatments were medically necessary because, as he testified, phonophoresis can properly be used to treat shoulder injuries and penetrates from five centimeters to two inches based on a study he could not identify. Dr. Berg emphasizes that Dr. Bierner admitted his opinion of phonophoresis' effectiveness is not based on clinical studies or medical literature. He further argues that Dr. Bierner's testimony is inconsistent with the relief Claimant experienced from the treatments. Because Claimant experienced decreased pain after the treatments, Dr. Berg maintains that they were medically necessary.

---

[13] Provider's Ex. 1at pp. 8-11

[14] Carrier's Ex. 1 at pp. 13, 17, 20, 23, 24, 26, 28, 30, 33.

[15] Carrier's Ex. 1 at pp. 15, 19.

[16] Provider's Exhibit 1 at pp. 15-31 (Provider's HCFA-1500 billing forms).

2. ALJ's Decision

The office notes for each date of service state that "[p]honophoresis with 2% Hydrocortisone cream was given to the patient for 30 minutes."[17] While neither Dr. Berg nor Dr. Bierner cited

medical literature about the effectiveness of phonophoresis, the ALJ finds Dr. Bierner's testimony more persuasive. In addition to his board certification, the record reflects that Dr. Bierner has extensive experience in physical medicine and rehabilitation, including a residency in physical medicine and rehabilitation at Baylor University Medical Center and a residency in physical medicine and rehabilitation at the University of Washington Hospital in Seattle where he was Chief Resident in the Department of Rehabilitation. Therefore, the ALJ concludes that the phonophoresis treatments were not medically necessary and Dr. Berg is not entitled to reimbursement.[18]

C. CPT Code 97139-SS: Spray and Stretch

1. Parties' Arguments

Carrier further challenges the medical necessity of the spray and stretch treatments because the record includes no reports indicating that Claimant suffered myofascial pain or spasms. Dr. Bierner explained that spray and stretch is a type of myofascial release treatment involving spraying a cooling agent then stretching the muscle. The spray and stretch treatment was discontinued after the Claimant complained that it made her neck stiff and gave her headaches.[19] Dr. Bierner would not have treated the claimant with this modality.

Dr. Berg relies on his previous argument that all of the active therapy he provided Claimant was medically necessary based on his examinations. He also urges the ALJ to give Dr. Bierner's testimony less weight or credibility because Dr. Bierner has never examined Claimant and has a financial interest in the case, that is, the $500.00 per hour fee Carrier has paid him to serve as its expert.

2. ALJ's Decision

Dr. Berg testified that the spray and stretch treatment was used to stop Claimant's pain in the super-scapula area. He described it as "rebooting" the muscle. Dr. Berg's testimony is some evidence that Claimant had pain, but the pain was not described as myofascial or as muscle spasms. Dr. Berg referred the ALJ to nothing in the record that supports the necessity of these treatments and she finds his arguments unpersuasive. Because the record contains insufficient evidence of the medical necessity of the spray and stretch treatments, the ALJ concludes that Dr. Berg is not entitled to reimbursement for these treatments.

D. CPT Code 97110: Therapeutic Procedures and Exercises

1. Medical Necessity

---

[17] Carrier's Ex. 1 at pp. 13, 17, 20, 23, 24, 26, 28, 30, 33.

[18] The ALJ further notes that had she found the phonophoresis treatments reimbursable, Dr. Berg would not have been entitled to reimbursement for 30 minutes per treatment since he actually provided only 16-minutes. She also finds that Dr. Berg would have only been entitled to the MAR for the phonophoresis supplies at $7.00, not $46.00.

[19] Carrier's Ex. 1 at p. 28.

Carrier opposes reimbursement for the therapeutic procedures billed under CPT Code 97110 because Dr. Berg's documentation does not contain sufficient information to establish the medical necessity of the procedures as found by Dr. Gilliar in his peer review.[20] Although Dr. Bierner testified that this physical medicine modality would generally be appropriate for a condition like a shoulder impingement syndrome, Carrier insists that there is no way to determine medical necessity because there is no documentation of what was actually performed under that code or whether the Claimant was making progress in those exercises, which would substantiate ongoing treatment.

Dr. Berg testified that Claimant performed therapeutic exercises to improve her mobility and range of motion and to decrease her pain. Dr. Berg did not refer the ALJ to specific evidence in the record identifying exactly what procedures and exercises were performed.

2. Improper Billing

Carrier challenges the billing practice Dr. Berg used to for these treatments because Claimant did not actually receive 30 minutes of one-on-one therapeutic exercises for each date of service. Rather, she received only 16 minutes. Nonetheless, the provider billed for two units, or 30 minutes, on each date of service. Carrier asked Dr. Berg whether it is common practice in his office to provide only 16 minutes of a physical medicine modality but bill for two units, but Dr. Berg could not provide a satisfactory answer to the question and would not agree hypothetically that it was an inappropriate practice to provide only 16 minutes of these codes but bill for thirty minutes.[21]

Carrier argues that nowhere do the Commission rules state that a provider can provide one extra minute of a physical medicine modality, then bill two units. The evidence demonstrates that, at least in this case, the provider and/or his office were engaged in a pattern or practice of providing 16 minutes of a physical medicine modality and then billing for two units. There is no evidence whatsoever to suggest that Claimant was physically unable to perform two units each of 97110 or 97530 or that on each date of service she became physically exhausted after exactly 16 minutes and had to stop the exercises or activities. Carrier stresses that it is this type of billing conduct that helps explain the current state of the Texas Workers' Compensation System. In fact, the Commission recognized the problem when it said in the preamble to its recently adopted amendments to rule 134.600 for *Treatments and Services Requiring Preauthorization*, that:

> Research studies commissioned by the ROC [Research and Oversight Council on Workers' Compensation] pursuant to HB-3697 confirm perceptions that Texas workers' compensation medical costs are higher than those in other states and other health care delivery systems. The ROC has concluded that, "These cost differences result primarily from more medical testing and treatment provided to Texas injured workers for longer periods of time than for workers with similar injuries in other state workers' compensation systems and in group health plans."[22]

* * *

For those reasons, Carrier insists reimbursement should be denied completely or that reimbursement be limited to the care actually provided to Claimant.

---

[20] Carrier's Closing Brief at 10; Carrier's Ex. 1 at p. 41.

[21] Carrier's Closing Brief at 7-9.

[22] 26 Tex. Reg. 9874, 9875 (2001).

Dr. Berg argues that the ALJ does not have jurisdiction to consider this billing issue because the Carrier failed to raise the issue in its EOBs. He relies on prior SOAH decisions in Commission hearings that prohibited a Carrier from raising a new reason for denying payment at the hearing.[23]

3. ALJ's Analysis

Addressing first the billing issue Carrier raised at the hearing, the ALJ concludes that SOAH has jurisdiction to consider a provider's alleged billing irregularities for the first time during the contested hearing even though Carrier did not deny payment on the ground that the provider over billed for the services for the reasons argued by Carrier. The ALJ is further persuaded that, where there is a billing question, reimbursement should be limited to the care actually provided the Claimant. Although the procedures and exercises were not clearly specified, the ALJ finds that some services were provided by Dr. Berg's personnel. The problem, however, is with the on-going nature of the treatments and the ALJ agrees with Carrier that the record contains insufficient evidence to justify repeating these treatments week after week and month after month.

After reviewing the notes and Dr. Berg's testimony, the ALJ concludes that Dr. Berg should be reimbursed for providing these treatments from November 2, 2001, through and including the treatment on November 23, 2001. The notes indicate that her pain decreased and these were appropriate procedures for her medical problem. But the ALJ finds that Dr. Berg is not entitled to reimbursement for the treatments that continued after November 23, 2001, because the notes show Claimant's pain the increased and the treatment plan should have been reevaluated at that point.

As for the units Dr. Berg's office billed for those treatments, Carrier insists that Dr. Berg is not entitled to reimbursement for the second 15-minute unit when only one minute was actually provided. It does appear to the ALJ that Dr. Berg's staff provided one additional minute of service beyond the 15-minutes, then billed Carrier for two 15-minute units.

The evidence in the record demonstrates a serious billing problem with respect to these treatments. As Carrier noted, the evidence shows that for each date of service Dr. Berg billed two units of CPT Code 97110 at 15 minutes for each unit or 30 minutes.[24] The office notes for each date contain the exact same statement: "Therapeutic exercises, 1-on-1, for 2 15-minute intervals were used to develop strength, endurance, range of motion, and flexibility." Neither the daily office notes, the physical medicine calendar, nor the Multi-Set Conditioning Program notes indicate what specific exercises Claimant did each day; the number of repetitions; or how much weight she lifted. But Dr. Berg's Physical Medicine Calendar, on which the actual number of minutes for treatment or testing are recorded, shows 16 minutes of therapeutic exercises for each of the nine documented dates.[25] In fact, the number 16 appears 43 times on the provider's physical medicine calendar.[26]

The ALJ cannot conclude from the evidence that overbilling is a routine practice in Dr. Berg's office, but she can and does conclude that his office improperly billed Carrier in this case. Dr. Berg argued in his closing that if a provider worked for 14 minutes, he would, under Carrier's

---

[23] Provider's Closing Brief at 7-8.

[24] Provider's Ex. 1at pp. 15-31 (Provider's HCFA-1500).

[25] Provider's Ex. 1 at pp. 13, 17, 20, 23, 24, 26, 28, 30, 33.

[26] Carrier's Ex. 1 at p. 19, 70. (Two of the dates of service on which 97110 was billed, 11/16/01 and 11/19/01, are not documented on the Physical Medicine Calendar); *see also* Provider's Ex. 1 at p. 70 (Multi-Set Conditioning Program notes).

logic, be deprived payment for a 15-minute unit. The ALJ finds this argument unpersuasive to support reimbursement at 15-minutes for one minute of service. If the argument was meant to defend a common practice of billing 16 minutes and charging for 30, the ALJ considers such a practice inappropriate. It is hard for the ALJ to see that any provider could think this billing method

is proper, unless the provider documents specific and acceptable circumstances each time showing that a significant portion of a 15-minute unit was provided, but not completed due to those specific circumstances.[27]

Because the second 15-minute unit of therapeutic procedures and exercises was improperly billed and insufficiently documented, reimbursement for those treatments from November 2, 2001, through and including the treatment on November 23, 2001, is limited to one 15- minute unit each treatment. The parties stipulated that the MAR is $35.00 for each 15 minute unit. Therefore, Carrier should reimburse Dr. Berg for eight units in the amount of $280.00.[28]

E. CPT Code 97530: Therapeutic Activities

1. Parties' Arguments

Carrier also disputes Dr. Berg's billing for therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance) under CPT Code 97530. Like CPT code 97110, Carrier argues that the provider also billed two units, or thirty minutes, under CPT Code 97530 for each date of service, even though his office provided only 16 minutes on each service date. Because Dr. Berg is not entitled to reimbursement for services that were not actually provided, Carrier opposes reimbursement.

Moreover, Carrier questions what specific therapeutic activities were performed by Claimant on each date because neither the daily office notes, nor the physical medicine calendar show the activities.[29] Dr. Berg was unsure what activities were performed, but testified that the one-on-one, direct patient contact therapeutic activities were the activities marked on the Progressive Exercise Prescription Pad for Cervical/Scapular and Shoulder Stretching. Carrier faults these bills because a separate exercise prescription was not filled out for each date of service, and also because the form indicates prescription is intended to prescribe and instruct the claimant in exercises to be performed at home. Even if it is not just a prescription pad for home exercises, it was not medically necessary to perform these activities in the office in a one-on-one setting Dr. Bierner's in view.

Dr. Berg argues that the on-on-one sessions were necessary because Claimant needed instruction and assistance in practicing and maintaining good form during the exercises.

2. ALJ's Analysis

The ALJ agrees that the evidence shows that Claimant was to use these exercises to complement her in office therapy treatments. While she agrees with Dr. Bierner's testimony that Claimant should have been performed these activities on her own as an adjunct to treatment in the clinic, she is persuaded by Dr. Berg's testimony that preliminary instruction and some follow-up guidance on her form was necessary. Maintaining proper form is extremely important when

[27] The Commission's new partial billing rule does not apply to this case.

[28] The dates of service are 11-5-01; 11-10-01; 11-12-01; 11-15-01; 11-16-01; 11-19-01; 11-21-01; 11-23-01. Provider's Ex. 1 at 8.

[29] Carrier's Ex. 1 at pp. 13, 17, 19, 20, 23, 24, 26, 28, 30, 33.

performing any exercise and the ALJ finds it reasonable and medically necessary to provide this instruction and guidance in the office for a limited duration. Thereafter, Claimant should have mastered the exercises and done them on her own.

Because, as Dr. Bierner testified, there is no evidence in the records that Claimant was incapable of performing the home exercises on her own and required constant one-on-one supervision to do them, the ALJ finds that Dr. Berg should only be reimbursed for the first three 15-minute units billed under CPT Code 97530, two on November 5, 2001, and one unit on November 7, 2001. Parties stipulated that the MAR is $35.00 for each 15 minute unit, so the Carrier must reimburse Dr. Berg in the total amount of $105.00.

F. CPT Code 97799-JA: Job-Site Assessment

1. Parties' Arguments

Dr. Berg ordered an assessment of Claimant's job-site on December 21, 2001, and requests reimbursement of $780.00 for the assessment.[30] Carrier opposes reimbursement because Frito Lay has a complete job analysis on every position in their plant and the service was not necessary or approved by Carrier.[31] Moreover, an assessment was not medically necessary to determine job requirements for setting treatment goal.[32]

The job-site assessment was unnecessary, Carrier asserts, because the Frito Lay ___ First Report of Incident states under "Corrective Action," that a packer trainer and a physical therapist were to observe Claimant's packing practices and make recommendation.[33] Dr. Berg's records provide no documented treatment goals that were established based on the job-site assessment and Dr. Berg admitted at the hearing that he made no changes to Claimant's workstation or her job execution based on the assessment. Dr. Bierner testified for the Carrier that, in his opinion, Claimant had a fairly uncomplicated injury and one rarely needing a job-site assessment unless the employer is not sure it can accommodate a claimant.

Dr. Berg defines a job-site assessment as a test used by a provider to help determine if a patient is able to return to work. To make this determination, he needs to know exactly what the patient's job duties are and he requested this assessment after being informed that, after 90 days of light duty Frito Lay requires its employees to either be excused from work completely or be given a full-duty restriction.[34] As a result of the job-site assessment, Dr. Berg concluded that Claimant was not yet ready to return to full work duty.[35] Although Petitioner claims there is a job description for Claimant, Dr. Berg notes that no document was ever produced at the hearing.

Carrier argued in its reply brief that the IRO did not address the job-site assessment, so the case should be remanded or Dr. Berg should have the burden of proof on this issue. Dr. Berg did not file a response to this position. The ALJ notes that this argument could have been made for many of the services already considered in this case given the IRO's brief report. Therefore, she has

[30] Provider Ex. 1 at 11; Carrier's Ex. 1 at 36.

[31] Provider's Ex. 1 at p. 35.

[32] Provider's Ex.1 at p. 11.

[33] Carrier's Ex. 1 at p. 9.

[34] Provider's Ex. 1 at p. 53.

[35] Provider's Closing Argument at 4.

determined that this issue should be considered here.

2. ALJ's Decision

The evidence shows that Claimant did not return to work after Dr. Berg's job-site assessment, but eventually returned to work six months later through her employer's ramp-in program.[36] Dr. Berg's documentation contains notes on December 21, 2001, stating only that a three-hour job site assessment was performed. Notes on December 31, 2001, January 14, 2002, and February 13, 2002, then reference Claimant's return to work on limited duty and her understanding of her employer's policy 90-day policy. Dr. Berg discusses sending Claimant to a work hardening program and then for a physical performance test (PPT), which showed that she could only perform sedentary to light work. His notes conclude that based on the PPT, she cannot perform her regular job.[37]

The ALJ finds that Dr. Berg's notes contain absolutely no details about the job-site assessment. This documentation is insufficient to support a finding of medical necessity. Moreover, Dr. Berg failed to explain why he made no specific recommendations after the job-site assessment. Therefore, Dr. Berg's request for reimbursement is denied.

## III. FINDINGS OF FACT

5. ___.(Claimant) developed a compensable repetitive motion injury on ___, during the course of her employment packing bags of chips in boxes at the Frito Lay Company.

6. Claimant was first examined by Nick Padron, M.D. at the Wol+Med Clinic on October 12, 2001, who diagnosed Claimant with a shoulder sprain.

7. Dr. Alan Berg, D.O., who is with Wol+Med Clinic, became Claimant's treating doctor on October 29, 2001, and prescribed physical medicine/therapy modalities, including electrical stimulation and phonophoresis for her.

8. At the time of Claimant's injury, American Casualty Company of Reading, PA (Carrier) provided workers' compensation insurance to her employer.

9. Carrier denied Dr. Berg reimbursement in the amount of $3,933.00 for the following physical medicine/therapy modalities he provided from November 2, 2001, through February 13, 2002, on the grounds that they were not properly documented or medically necessary:

    1. CPT Code 97032: Electrical Stimulation;
    2. CPT Code 97139-PH: Phonophoresis;
    3. CPT Code 99070: Phonophoresis supplies;
    4. CPT Code 97139-SS: Spray and stretch;
    5. CPT Code 97110: Therapeutic procedures;
    f. CPT Code 97530: Therapeutic activities;
    7. CPT Code 97799-JA: Job Site Assessment.

[36] Carrier's Ex. 1 at p. 111-112.

[37] Provider's Ex. 1 at 53-56.

6. Respondent requested medical dispute resolution on April 26, 2002, through an Independent Review Organization (IRO), to review whether Carrier properly denied the claims.

7. The IRO concluded that the documentation Dr. Berg submitted was adequate to support the medical necessity of the treatments and services he provided.

8. Based on the IRO conclusion, the Medical Review Division (MRD) found the disputed services reasonable and necessary and on February 14, 2003, ordered the Carrier to reimburse Dr. Berg.

9. On March 7, 2003, Carrier requested a hearing and appealed the IRO determination and MRD order to the State Office of Administrative Hearings (SOAH).

10. Notice of the hearing was mailed to the parties on April 9, 2003. 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.

11. Two electrical stimulation treatments provided under CPT Code 97032 at $22.00 per treatment were medically necessary to treat Claimant's injury.

12. The three 15-minute units Dr. Berg provided to Claimant on November 5 and November 7, 2001, for therapeutic activities under CPT Code 97530 billed at the maximum allowed reimbursement (MAR) of $35.00 per unit were medically necessary.

13. Reimbursement for the therapeutic procedures and exercises provided from November 2, 2001, through and including the treatment on November 23, 2001, is limited to one 15- minute unit each treatment because the second 15-minute unit was improperly billed and insufficiently documented. Carrier should reimburse Dr. Berg for eight units at $35.00 per unit or $280.00.

14. All other treatments set forth in the Table of Services attached as Appendix A were not adequately documented; not medically necessary; or not provided; and the Carrier properly denied reimbursement for those charges.

## IV. CONCLUSIONS OF LAW

1 The Texas Workers' Compensation Commission has jurisdiction over this matter pursuant to TEX. LAB. CODE § 413.031.

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. Petitioner timely filed notice of appeal as specified in 28 TEX. ADMIN. CODE § 148.3.

4. Proper and timely notice of the hearing was effected in accordance with TEX. GOV'T CODE § 2001.052 and 28 TEX. ADMIN. CODE §148.4.

5. Under TEX. LABOR CODE § 408.021(a)(1), 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
that cures or relieves the effects naturally resulting from the compensable injury.

**6.** Under 28 TEX. ADMIN. CODE § 133.308(v), in all appeals from reviews of prospective or retrospective necessity disputes, the IRO decision has presumptive weight.

7. Petitioner failed to carry its burden of proof to show that the treatments or services identified in Finding of Fact Nos. 11 and 12 were unreasonable and medically unnecessary for the treatment of Claimant's injury and Dr. Berg is entitled to reimbursement in the amount of $149.00.

8. Based on Finding of Fact No. 13, reimbursement for the therapeutic procedures and exercises provided from November 2, 2001, through and including the treatment on November 23, 2001, is limited to one 15- minute unit each treatment on eight dates at $35.00 per unit or a total reimbursement of $280.00.

9. Petitioner proved by a preponderance of the evidence that all treatments and services identified in Finding of Fact No. 14 were either unreasonable and medically unnecessary for Claimant's injury; not sufficiently documented; or not fully provided.

10. Based on the above Findings of Facts and Conclusions of Law, Carrier shall reimburse Dr. Berg as ordered below.

## ORDER

IT IS HEREBY ORDERED THAT Carrier reimburse Dr. Berg in the total amount of $429.00. Reimbursement for all other services is denied based on the Findings of Fact and Conclusions of Law.

**ISSUED this 15th day of January 2004.**

**DEBORAH L. INGRAHAM**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**
**ADMINISTRATIVE LAW JUDGE**