DOCKET NO. 453-03-3462.M5
MDR TRACKING NO. M5-03-1324-01

CENTRAL DALLAS REHAB	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	**OF**
	§	
LIBERTY MUTUAL FIRE	§	
INSURANCE COMPANY	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is a dispute over whether reimbursement is appropriate for treatment rendered to ___ (Claimant) at Central Dallas Rehab (Provider), between February 18, 2002, and August 16, 2002. Provider sought reimbursement from Liberty Mutual Fire Insurance Company (Carrier) for treatment rendered to Claimant, which Carrier denied. The Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) adopted the findings of an Independent Review Organization (IRO) that held Provider was not entitled to reimbursement. In this Order, the Administrative Law Judge (ALJ) concludes Provider is entitled to $4,199.99 reimbursement.

I. JURISDICTION, NOTICE AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those matters will be addressed in the findings of facts and conclusions of law without further discussion here.

A hearing convened and closed on August 6, 2003, before the State Office of Administrative Hearings (SOAH) with Steven M. Rivas, ALJ, presiding. Provider appeared and was represented by Scott Hilliard, attorney. Carrier appeared and was represented by Kevin Franta, attorney.

II. DISCUSSION

1. Background Facts

Claimant sustained a compensable injury to her little toe on her left foot when a machine rolled over it on. Claimant immediately underwent conservative care and later had surgery on ___. After her surgery, Claimant began a course of physical therapy with Provider between February 18, 2002, through August 16, 2002. Carrier denied reimbursement for the physical therapy as not medically necessary.

B. Applicable Law

The Texas Labor Code contains the Texas Workers' Compensation Act (the Act) and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims. In particular, the Act, as noted in § 408.021, provides 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. Under the same statute, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

3. Evidence and Arguments

Carrier argued the 18 physical therapy sessions Claimant underwent to treat her little toe was a classic case of "over-treatment." Provider responded the treatment was medically necessary because Claimant needed physical therapy following her surgery and, the evidence suggests she derived some benefit from the therapy.

Ted Krejci, D.C., who treated Claimant at Provider's facility, asserted that Claimant needed to undergo physical therapy in order to receive the necessary conditioning that would prepare her to return to work. Dr. Krejci pointed out that Lonnie Schwartz, D.P.M., the surgeon who performed Claimant's surgery, prescribed Claimant to undergo four weeks of post-surgery therapy, five times a week with Provider.[1] The program was to include myofascial release, joint mobilizations, ultrasound, and hot/cold packs.

Dr. Krejci testified the first five sessions consisted of office visits to assess Claimant's condition following surgery. According to Dr. Krejci, the five office visits were necessary to evaluate Claimant before the actual therapy sessions commenced, so that he could make sure Claimant had completely healed from the surgery and had not contracted any post-surgical infections. Carrier argued Claimant should have visited Provider only if she experienced a "significant change" in her condition.

The first session during which Claimant participated in actual physical therapy exercises was on May 15, 2002. On that date, Claimant complained of pain and swelling in her toe. The record indicates Claimant complained of pain and swelling of her toe on each visit. Furthermore, Claimant received the same type of joint mobilization and traction exercise treatment on each visit as well. Dr. Krejci testified he decided to forego the prescribed ultrasound and hot/cold packs in an attempt to reduce costs.

Carrier argued Provider is not entitled to reimbursement because the therapy program was not followed as prescribed. Claimant's actual program consisted of 18 visits over a four-month period, in contrast to the original prescription of five visits a week for four weeks. Under normal circumstances, such a program would seem sporadic in nature and draw scrutiny about Claimant's genuine need for therapy. However, the record reflects Claimant became pregnant early in the program, and her treatment plan had to be prolonged and tailored to fit her needs. Thomas Sato, D.C., who testified on behalf of Carrier, stated that if he had been treating Claimant, he would have prescribed home therapy in order to prevent her from traveling back and forth from therapy sessions in her condition.

Carrier also argued that because the notes of each visit were relatively similar, there was no indication that Claimant was benefitting from the therapy. Furthermore, Dr. Sato asserted it was difficult to measure Claimant's progress because an initial physical evaluation was not performed to document baseline findings like range of motion, and other physical limitations.

[1] See page 71 of Carrier's exhibit, prescription for physical therapy issued on April 25, 2002, by Lonnie Schwartz, DPM.

Dr. Sato also asserted Provider is not entitled to reimbursement because there were no objective findings contained in the therapy records. A review of the records, however, reflects differently. The therapy records indicate Claimant had "red, warm, and swollen" joints in the area ofher surgery on almost every visit. The reports for each visit also state Claimant "is improving in this area." This seemed to support Carrier's position, but on cross-examination, Dr. Sato admitted he would not "expect" the objective findings to change, but rather he would "want" the objective findings to reflect that a patient undergoing physical therapy was improving.

4. Analysis and Conclusion

On the surface, it appears $4,199.99 is an exorbitant amount to charge for therapy of Claimant's little toe. Carrier's position that home exercise would have been more appropriate in this matter is persuasive. However, Carrier did not provide compelling evidence that the treatment in question was not medically necessary.

Because Dr. Schwartz prescribed the therapy program, the ALJ can reasonably infer that he deemed it medically necessary. Dr. Krejci, the chiropractor who administered the therapy program also argued it was medically necessary. The only evidence to the contrary was Dr. Sato's testimony that home exercise would have been a better option.

In this matter, the ALJ is asked to render a decision on the appropriateness of a four week therapy program for Claimant's little toe. Without more substantial evidence from the Carrier, the ALJ must rely on the opinions of the medical practitioners who treated the Claimant, or reviewed her records.

A report from a medical journal that concluded home-based therapy was more appropriate than office-based therapy would have supported Carrier's argument. If Dr. Sato had testified that he treated numerous patients in Claimant's condition,that would have been compelling as well.

Both parties made valid arguments and presented good evidence to support their respective positions. However, in balancing the evidence presented by both sides, the ALJ concludes more weight falls in favor of deeming the physical therapy medically necessary.

III. FINDINGS OF FACT

1. Claimant suffered a compensable injury to her little toe on her left foot on.

2. Claimant was initially treated conservatively and later had surgery on her little toe on ___.

3. Lonnie Schwartz, D.P.M., performed the surgery and prescribed four weeks of physical therapy for Claimant.

4. On February 18, 2002, Claimant began a physical therapy program under Ted Krejci, D.C., at Central Dallas Rehab (Provider). Claimant attended a total of 18 therapy sessions through August 16, 2002.

5. Provider billed Liberty Mutual Fire Insurance Company (Carrier) for the physical therapy program it rendered to Claimant, which was denied as not medically necessary.

6. Provider filed a Request for Medical Review Dispute Resolution with the Texas Workers' Compensation Commission (the Commission), seeking reimbursement for the physical therapy program rendered to Claimant.

7. The dispute was referred to an Independent Review Organization (IRO), which found Provider was not entitled to reimbursement.

8. Provider timely appealed the IRO decision and filed a request for hearing before the State Office of Administrative Hearings (SOAH).

9. Notice of the hearing was sent June 18, 2003.

10. 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. The hearing convened and closed on August 6, 2003, with Steven M. Rivas, Administrative Law Judge (ALJ) presiding. Provider appeared and was represented by Scott Hilliard, attorney. Carrier appeared and was represented by Kevin Franta, attorney.

12. The objective findings contained in Claimant's medical records indicate Claimant had a red, warm, and swollen little toe, and that it had improved after each visit.

13. Carrier presented insufficient evidence that the physical therapy program rendered to Claimant was not medically necessary.

IV. 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(k) and TEX. GOV'T CODE ANN. ch. 2003.

3. Provider timely filed its request for hearing as specified by 28 TEX. ADMIN. CODE § 148.3.

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

5. The Provider, as Petitioner, has the burden of proof in this matter under 28 TEX. ADMIN. CODE § 148.21(h).

6. Under TEX. LAB. CODE ANN. § 408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury 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.

7. Provider has met its burden of showing, by a preponderance of the evidence, that the physical therapy program Provider rendered to Claimant was medically necessary.

8. Pursuant to the foregoing Findings of Fact and Conclusions of Law, Provider is entitled to $4,199.99 reimbursement for the physical therapy program it rendered to Claimant.

ORDER

IT IS, THEREFORE, ORDERED that Provider, Central Dallas Rehab, is entitled to receive reimbursement from the Carrier, Liberty Mutual Fire Insurance Company, in the amount of $4,199.99, for the treatment it rendered to Claimant.

Signed September 15, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE