SOAH DOCKET NO. 453-03-4035.M
MRD NO. M5-03-1609-01

TWIN CITY FIRE INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner,	§	
	§	
v.	§	**OF**
	§	
MAIN REHAB & DIAGNOSTIC,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Twin City Fire Insurance Company (Carrier) appealed a decision of the Medical Review Division (MRD) of the Texas Worker's Compensation Commission (Commission) which authorized reimbursement to Main Rehab & Diagnostic (Provider or Main Rehab) for physical therapy services and office visits from May 28 through June 19, 2002.[1] This decision finds that Provider is not entitled to reimbursement for the services and office visits because they were not medically necessary.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The Texas Worker's Compensation Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN. ch. 401 *et seq*. The State Office of Administrative Hearings (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. A hearing in this matter was convened on November 10, 2003, before Administrative Law Judge (ALJ) Suzanne Formby Marshall. James Laughlin, attorney, represented Carrier. Scott Hilliard, attorney, represented the Provider.[2] There are no issues of notice or jurisdiction; therefore, those matters are addressed in the findings of fact and conclusions of law without further discussion.

II. BACKGROUND

Claimant is a fifty-four year old housekeeper who suffered a compensable worker's compensation injury when she fainted, fell and broke her left wrist while working as a housekeeper in a federal building. She was treated at the local emergency room and referred to a doctor who took her off work for approximately four weeks. On May 24, 2002, approximately seven weeks post-injury, Claimant was examined by Dr. Osler Kamath (D.C.) at the Main Rehab and Diagnostic clinic. X-rays of Claimant's wrist revealed an unhealed fracture. A treatment plan was prepared for Claimant involving physical therapy on a daily basis for two weeks, after which the therapy would be reduced to four times a week for two weeks. Claimant began physical therapy at Main Rehab on May 28, 2002.

---

[1] Provider did not appeal the portion of the MRD decision that it was not entitled to reimbursement for a number of other services and office visits.

[2] Mr. Hilliard and Dr. Osler Kamath appeared by telephone.

III. LEGAL STANDARDS

The applicable legal standards are found in sections 408.021 and 401.011 of the Texas Labor Code. Section 408.021 states:

> (3) 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 compensable injury;
> 1. promotes recovery; or
> 2. enhances the ability of the employee to return to or retain employment.

Section 401.11(19) defines "health care" to include "all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services."

IV. EVIDENCE

The issue presented in this case is whether the Carrier should reimburse Provider $597 for three office visits billed under CPT Code 99213 and five sessions of physical therapy, billed under CPT Code 97110, from May 28 through June 19, 2002.[3] Carrier contends that the physical therapy sessions were not medically necessary because at the time they were provided, Claimant had an unhealed fracture and did not need active physical therapy. Further, Carrier contends a weekly office visit is not required for an established patient.

Provider argues that the services and office visits were medically necessary and disputes the findings of two peer reviewers and Carrier's expert witness, Dr. William DeFoyd (D.C.). Provider also asserts that because Carrier paid half the billed amounts for the office visits and physical therapy, it has agreed that the services were necessary. According to Provider, the MRD decision should be upheld.

A. Carrier's Evidence

Carrier introduced into evidence the medical records of Claimant which were marked as Carrier's Exhibit No. 2. Additionally, the testimony of Dr. William Defoyd, an expert witness was presented.

Dr. Defoyd is a board-certified chiropractic orthopedist who works for the Spine and Rehabilitation Center in Austin, Texas. He serves on the Texas Worker's Compensation Commission's Medical Quality Review Panel which performs an oversight function to the

[3] It was brought to the ALJ's attention that Carrier has paid 50% of the amounts Provider billed for the office visits under CPT Code 97110 and for the physical therapy services billed under CPT Code 97110. Carrier's counsel said that Carrier would not seek reimbursement from Provider in the event that Carrier prevailed in this matter. The issue of partial payment and how it applies in this case is discussed later in this decision.

Commission. He is also a chiropractor representative to the Commission's medical advisory committee which provides advice to the Commission's Medical Review division.

Dr. Defoyd reviewed the medical records contained within Provider's Exhibit 1 and Carrier's Exhibit 1 as a basis for his expert opinion in this case. Dr. Defoyd testified that the medical records showed that Claimant's wrist had a healing fracture at the time she sought treatment from Provider. He discussed the differences between a healing fracture and a healed fracture. Dr. Defoyd disputed the need for active physical therapy for a healing fracture because he said it was more important to immobolize the fracture, so that it can continue to heal. Further, because Claimant was diabetic, Dr. Defoyd noted that she was likely to have a longer than normal healing time. Dr. Defoyd said that performing active physical therapy on a healing fracture could result in a mal-union as the fractured segment healed, with resulting bad alignment. Dr. Defoyd testified that the medical records reflect a mal-union occurred in Claimant's wrist, which was documented in the record approximately two months later. Carrier's Exhibit 2, p. 96.

Dr. Defoyd said that the medical records did not describe the specific exercises prescribed for Claimant. He also noted that Provider billed for one-on-one instruction during the physical therapy exercises, which was unnecessary once Claimant had been instructed on how to perform the exercises and shown that she could do them. Further, the frequency and intensity of the therapeutic exercises was not noted in the records and cannot be determined.

With regard to the disputed office visits, Dr. Defoyd said that the visits, billed at CPT Code 99213, were not necessary for an established patient. Dr. Defoyd testified that this type of extended office visit is necessary in order to re-examine or re-assess a patient in order to change their treatment plans; however, there was no evidence of a re-evaluation or re-assessment during the visits. Instead, it appeared that the visits were repetitively billed, although no cognitive services were rendered by the Provider.

2. Provider's Evidence

Provider's Exhibits Nos. 1 and 2 were admitted into evidence, consisting of the documents that were sent to the IRO and additional medical records related to the claim. Provider did not call any witnesses to testify.

Provider questioned Dr. Defoyd about the two peer reviews[2] that were performed in this case. The first was performed by Dr. David Niekamp (D.C.) on September 27, 2003. Carrier's Exhibit 2, pp. 140-143. Dr. Niekamp was critical about the management of Claimant's fracture by Dr. Kamath of Main Rehab, stating that treating fractures was not within the scope of the chiropractic practice. Dr. Niekamp reported that active and passive modalities of treatment from May 28 through August 20, 2003, and office visits from May 28 through July 4, 2003, were controversial without the involvement of an orthopedic physician in the case.

The second peer review was performed by Dr. Phillip Rohner (D.C.) on March 18, 2003. Carrier's Exhibit 2, pp. 174-180. Dr. Rohner's review was obtained for the purpose of determining whether a work hardening program was medically necessary. In his review, Dr. Rohner says that an aggressive rehabilitation program was reasonable on May 24, 2002, due to Claimant's cast being removed on May 17TH with no indication of rehabilitation afterward. Dr. Rohner also noted that

[2] Both peer reviewers were chiropractors, as is Dr. Kamath from Main Rehab.

the
rehabilitation was extensive and excessive.

Dr. Kamath prepared a response to Dr. Niekamp's peer review in which he disputed the contention of Dr. Niekamp that the chiropractic care given to Claimant was inappropriate. Dr. Kamath's letter stated that Claimant was also under the care of Dr. James Laughlin (M.D.), an orthopedic specialist, and Dr. Crawford Sloan, (M.D.), during this time. The ALJ could find no records indicating treatment by Dr. Sloan, although he was mentioned during the peer review of Dr. Rohner. It appears from the record that Claimant was first seen by Dr. Laughlin on July 24, 2002. Carrier's Exhibit 2, p. 96.

Provider also claims that Carrier is prevented from disputing medical necessity in this case because the partial payments indicate that Carrier did believe the services were medically necessary. Provider asserts that because there is no mechanism for a partial payment in order to buy additional time in which to obtain a peer review, Carrier has waived the ability to challenge medical necessity.

V. DISCUSSION

In reviewing the evidence in this case, the ALJ believes that Carrier met its burden of proof that the disputed physical therapy services and office visits were not medically necessary. The ALJ is particularly persuaded by the testimony of Dr. William Defoyd relating to the inappropriateness of active physical therapy on an unhealed fracture and the danger of a mal-union when the fracture healed. Unfortunately, in this case, this is exactly what occurred. It appears that not only were the services in this case medically unnecessary, they were actually harmful to Claimant. The extent of the harm is unknown. We do not know whether Claimant would still have suffered the carpal tunnel problems that she later suffered if she had not received the physical therapy until after her fracture had clearly healed.

Further, the extended weekly office visits were also unnecessary for an established patient such as Claimant. There did not appear to be any reason for the visits, such as a re-evaluation or modification of Claimant's treatment plan in light of some change in her condition. The ALJ believes that the codes for billing the physical therapy and office visits were used in order to receive maximum reimbursement when Claimant could have received the same services in a less costly manner, such as group therapy and only an occasional extended office visit. This presumes, of course, that the therapy and visits were medically necessary at all and the ALJ has found that they were not.

With regard to the issue of Carrier's partial payment in this case and the argument that Carrier consequently waived any challenge to medical necessity, the ALJ is unpersuaded by Provider's arguments. Provider was on notice that Carrier challenged medical necessity of the therapy and office visits. For example, Carrier's Explanation of Benefits (EOBs) dated July 24, 2002, use the denial code "H - Reimbursement is based upon half of the fee amount pending decision of audit or review." Provider's Exhibit 1, pp. 10-20. In January 2003, Provider was notified by Carrier that it had received the invoices submitted by Provider for reconsideration and the Carrier requested additional documentation and medical information. Carrier's Exhibit 2, p. 86. Carrier's Explanation of Reimbursement "Resubmission" indicated that the services were finally denied with the code "V," based on a peer review indicating the treatment was not medically reasonable or necessary. *Id.* at pp. 78-85

While it is true that the Commission's statute and rules do not provide for a Carrier to make a

partial payment while seeking a peer review (thereby extending the time beyond the 45 day requirement for a carrier to make a final decision about the bill while the peer review is being sought and received), the ALJ notes that Provider was on actual notice that Carrier challenged medical necessity throughout this dispute and Carrier is not arguing a new basis for denial of reimbursement at this hearing. On February 27, 2003, Provider requested Medical Dispute Resolution after Carrier's refusal to pay any additional monies on the basis that "these medical rehab services have been denied for necessity." Provider's Exhibit 1, p. 7. The ALJ finds that, under these facts, Provider received notice as to the grounds for Carrier's denial.

Carrier has established that the physical therapy and office visits from May 28 through June 19, 2002, were not medically necessary. Based upon the evidence in this case, the ALJ concludes that no reimbursement is owed to the Provider by Carrier.

VI. FINDINGS OF FACT

1. Claimant is a fifty-four-year-old woman who suffered a compensable worker's compensation injury on ___, when she fainted, fell, and broke her left wrist while working as a housekeeper for a federal employer.

2. Claimant's injury is covered by worker's compensation insurance provided by her employer, and carried through Twin City Fire Insurance Company.

3. Claimant was evaluated by Dr. Osler Kamath of Main Rehab & Diagnostic Center on May 24, 2002, approximately seven weeks post-injury.

4. X-rays taken of Claimant's wrist on May 24, 2002, at Main Rehab & Diagnostic Center revealed that Claimant had an unhealed fracture on the distal radius of the left wrist.

5. Dr. Kamath prescribed a combination of passive and active physical therapy five times a week for two weeks and four times a week thereafter.

6. There is no documentation of the specific exercises, including their frequency and intensity, that were part of the physical therapy.

7. Active, daily physical therapy on a patient with an unhealed fracture could lead to further injury.

8. In July of 2002, X-rays taken of Claimant's wrist revealed a mal-united wrist.

9. Extended weekly office visits are not necessary for a Claimant when there is no evidence of a re-evaluation or re-assessment of Claimant's condition or treatment plan during the visits.

10. In its Explanation of Benefits, Carrier paid half the requested amounts for some of the requested services and visits, and noted that payment was made pending an audit or review.

11. Carrier obtained two peer reviews in this case.

12. Carrier denied payment of the charges for the physical therapy and office visits from May 28, 2003 through June 19, 2002, on the grounds that the services were not medically

necessary.

13. Provider requested reconsideration of Carrier's decision; Carrier again denied the request to reimburse the therapy and office visits.

14. Provider had actual notice that Carrier disputed the reimbursement claims on the basis of medical necessity.

15. Provider requested dispute resolution by the Texas Worker's Compensation Commission Medical Review Division (MRD) on seeking reimbursement for the medication. The matter was referred to an IRO for review.

16. On June 10, 2003, the MRD issued a decision granting reimbursement for the physical therapy and office visits from May 28 through June 19, 2002.

17. On July 1, 2003, Carrier appealed the MRD's decision.

18. On July 29, 2003, the Commission sent a notice of hearing to the parties. The notice contained a statement of the time and place of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular section of the statutes and rules involved; and a short plain statement of the matters asserted.

19. On November 10, 2003, a hearing was held at the State Office of Administrative Hearings. The parties appeared and were represented by counsel. The record closed the same day.

20. All parties received not less than 10 days notice of the time, place, and nature of the hearing; the legal authority and justification 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.

21. All parties were allowed to respond and present evidence and argument on each issue involved in the case.

VI. CONCLUSIONS OF LAW

1. The Texas Worker's Compensation Commission (Commission) has jurisdiction to decide the issues presented pursuant the Texas Worker's Compensation Act (Act), TEX. LABOR CODE ANN. § 413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(d) of the Act and TEX. GOVT. 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. As the party appealing the MRD decision, the Petitioner has the burden of proof in this matter, pursuant to 28 TEX. ADMIN. CODE § 148.21(h).

5. Based on the above Findings of Fact and Conclusions of Law, the office visits and physical therapy provided from May 28 through June 19, 2002, were not medically necessary.

6. Based on the above Findings of Fact and Conclusions of Law, Petitioner is not entitled to reimbursement under TEX. LABOR CODE §§ 413.015 and 408.021(a).

ORDER

IT IS ORDERED that Carrier's appeal is granted and the Carrier should not reimburse Main Rehab & Diagnostic for the office visits and physical therapy services provided to Claimant from May 28 through June 19, 2002, that were disputed in this case.

SIGNED January 9, 2004.

SUZANNE FORMBY MARSHALL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS