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TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
TARRANT COUNTY CHIROPRACTIC & REHABILITATION, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

Texas Mutual Insurance Company (Carrier) sought review of a decision issued on June 17, 2003, by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission). In that decision, the MRD ordered reimbursement to Tarrant County Chiropractic & Rehabilitation (Provider) for sessions of physical medicine performed on behalf of ____ (Claimant) between February 14, 2002, and May 1, 2002, as well as for supplies and related office visits. Carrier had denied reimbursement on the ground the treatments were not medically necessary.

The hearing was held on October 2, 2003. The record closed on October 10, 2003, to permit parties to file additional information.[1] Monica Sharp, collections and billing manager, appeared on behalf of Provider. Katie Kidd, attorney, appeared on behalf of Carrier. The Texas Workers' Compensation Commission did not participate in the hearing. Based on the evidence, the Administrative Law Judge (ALJ) concluded that Carrier met its burden of proof to show that the treatments, and also equipment and supplies used to administer them, were not medically necessary. Further, the office visits billed for this service period arose from the treatment sessions, so are likewise not medically necessary. Carrier is not required to make any further reimbursement to Provider.

II. DISCUSSION

The dispute in this case is for therapy administered after Claimant had undergone a two-week course of physical medicine shortly after his slip and fall injury on ____. To meet its burden of proof to show the treatments in issue were not necessary, Carrier relied on two sources, the history of Provider's treatment, and the testimony of David Alvarado, D.C. Provider relied on those records and the testimony of Ms. Sharp who, in addition to managing Provider's billing, is also a registered massage therapist (RMT) who may be called on to treat patients. She did not treat Claimant, although she did participate in the staff conference on Claimant's care conducted on April 13, 2002. The records of physical medicine treatments by the Provider and the other medical evidence in this case proved to be at such variance that Carrier was able to sustain its burden of proof that the treatments were not necessary. Since the need for all the office visits, a staff conference, and

[1] After discussions between the parties after the hearing on the merits, Carrier agreed to pay for office visits (CPT Code 99211) on March 8 and 20, 2003. (Report to Administrative Law Judge, October 13, 2003). These items will not be further addressed in this Decision.

supplies were related to and arose out of the primary treatments, the ALJ also determined these were not medically necessary.

Although the early diagnosis was back strain, in February 2002, an MRI showed Claimant had a disc protrusion at the L4-L5 level which might be causing nerve compression.[2] On February 15, 2002, an EMG (nerve conduction) examination was performed which showed Claimant had no radiculopathy (radiating nerve pain). However, Claimant continued to complain of leg and back pain throughout the Spring of 2002. Claimant apparently took pain medication for some period, but eventually discontinued it. He was prescribed a TENS unit which he used successfully to reduce his pain. Anthony Esquivel, D.C., was the doctor overseeing Provider's treatments; it is not clear whether Dr. Esquivel was Claimant's treating physician at any time during the service period.

In mid-March, Claimant was examined by F. Chalifoux, Jr., D.O., a neurosurgeon, who recommended a course of epidural injections for the disc problem, with surgery to follow if the injections failed to reduce Claimant's pain.[3] At that time he recommended some physical medicineBMackenzie protocol exercises and tractionBalthough it is not clear that Dr. Chalifoux referred Claimant to Provider for administration of those treatments.[4] There is no indication in Provider's records that its staff administered the specific types of treatment that Dr. Chalifoux recommended. Ms. Sharp appeared unfamiliar with the Mackenzie protocols, casting further doubt on the idea that Provider administered the therapy which Dr. Chalifoux recommended.

Provider's notes from April 2002 list Phillip M. Cantu, M.D., as the referring physician. However, there is no evidence that Dr. Cantu prescribed those treatments which Provider administered before May 1, 2002. In the record of this case, the first reference by Dr. Cantu to physical medicine occurred on May 5, 2002, four days after the end of contested service period. At that time, after he had administered a spinal injection, Dr. Cantu recommended Claimant undergo four weeks of aquatherapy. Provider Exh. 1, pp. 657-658. Dr. Cantu had first seen Claimant on April 25, 2002, at which time he recommended epidural steroid injections. Provider Exh. 1, p. 654. He did not prescribe additional physical therapy, passive modalities, or neuromuscular reeducation in April.

Even assuming all factors in Provider's favor, i.e., that the slip and fall incident caused the disc protrusion, and that Claimant continued to experience pain and limited functioning due to that condition, there is still nothing in the record that demonstrates exactly what component of Claimant's condition Provider was treating after the end of February 2002. That is, it is unknown whether it was offering pain relief, or attempting to further increase Claimaint's range of motion or lifting capacity. The activities listed in Provider's notes pertained primarily to cardiovascular fitness and strengthening, i.e., bicycles, treadmill, and weight equipment. Provider Exh. 1, pp. 747B808. Specific exercises which are listed appear also for the most part to be strengthening exercises or activities to promote general flexibility. Provider Exh. 1, Tab L.

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[2] All medical care providers and parties in this case apparently agreed that the disc injury was caused or at least worsened by the fall in early January 2002, and proceeded on that basis.

[3] Claimant did not consent to surgery, at least during the disputed service period.

[4] All that is known is that Dr. Chailfoux sent a copy of his report to Dr. Esquivel. Provider Exh. 1, p. 651. Dr. Chalifoux also stated that Claimant should have "back school," a term that is never explained elsewhere in the evidence, nor referenced in Provider's records in any way that the ALJ could discern.

For the service period that spans a 27-week period, Provider's records are devoid of any specific treatment goals and objectives, and fail to clearly indicate what aspect of Claimant's injury it was treating. There is no physician referral in the record for treatment for the entire range of treatments provided during the service period at issue. From day to day, the treatment notes are all but indistinguishable from one another.

Dr. Alvarado stated that a four-to-six week trial of physical therapy that fails to show measurable effects is a message that further diagnostic work is needed to search further for the true cause of patient's condition. He stated he could find no medical reason for a prolonged course of physical therapy that appeared to be having no result. He further stated that the records give little or no indication that Provider was administering therapeutic exercises targeted to increase Claimant's flexibility, balance, body awareness (proprioception), or range of motion, all of which would be indicated to treat a slip and fall type injury to the back and hip.

In essence, Dr. Alvardo broke the injury down into two components, the mechanical injury which he concluded was well on the way to healing by mid-February, and the neurological component, which required treatment other than what Provider was offering. Dr. Alvarado also noted that Claimant had made substantial progress between his date of injury and the end of February in range of motion and muscle strength, and that mechanical back problems will often continue to improve on their own if this rate of improvement is shown. Carrier's position in this regard is strengthened by the fact there is no prescription or referral which calls for physical medicine, either active or passive modalities, at the frequency and for the duration that Provider administered them.[5] Further there appears to have been no objective testing conducted after February 27, 2002, to ascertain whether Claimant was experiencing any measurable effects from the treatments. In regard to the neurological component, Dr. Alvarado also questioned whether additional manipulations should have been performed after the possibility of a neurological deficit, i.e., possible disc injury, was detected on February 11, 2002, as some manipulations can further irritate inflamed spinal tissue. Provider administered one supplemental manipulation on March 11, 2002, and spinal manipulation continued to be a part of Claimant's regular treatments. Provider Exh. 1, pp. 767B808.

There was no medical evidence to support the need for a team conference (CPT Code 99361) conducted on April 13, 2002. First, all participants comprised Provider's staff. Provider Exh. 1, p. 794, 799. Second, Claimant was not involved in a multi-disciplinary or multi-agency program in April 2002. In the Commission's rules, 28 TEX. ADMIN. CODE §134.201 (*Medical Fee Guideline* [MFG]), a team conference (CPT Code 99361) is defined as follows:

[5] Carrier also raised issues concerning the apparent mismatch between the services for which the Provider billed and what was actually provided. These issues are not *per se* medical necessity issues, so will not be treated separately. The discrepancy issues are as follows. Provider billed for 19 hour-long sessions of one-on-one physical therapy. However, Ms. Sharp's description of Provider's usual practices in administering therapy supported the conclusion that therapy was offered in a group setting. Nothing in the Provider's treatment notes stated that one therapist worked with Claimant for an entire hour (four units), or described any aspect of Claimant's condition which would have necessitated one-on-one therapy. Dr. Alvarado also stated that neuromuscular reeducation (CPT Code 97112) is a term of art which describes active work to improve a patient's movement, for example, gait retraining. Thus, he said it was inaccurate for Provider to label a session of trigger point releases, as described in the treatment notes, as neuromuscular reeducation. This form of therapy is defined in the MFG as "neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception."

Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes.

In sum, Carrier demonstrated that after mid-February 2002, there were no clear medical indications for extensive physical therapy, including myofascial releases, trigger point releases, cardiovascular conditioning, or joint mobilization to treat or relieve the effects of Claimant's slip and fall injury. Carrier further demonstrated that there were no medical instructions to Provider from doctors who were treating Claimant's disc injury to administer the types of treatments at the frequency provided during the disputed service period.

Based on the evidence in this case, the ALJ concludes that no sessions of physical medicine administered to Claimant between February 14, 2002, and May 1, 2002, should be reimbursed as they were not medically necessary to treat the compensable injury. In addition, Carrier met its burden of proof in regard to related charges for office visits, a team conference, and any supplies or equipment used to administer or support those the sessions of physical medicine, as these services all arose out of the therapy sessions and did not have an independent reason to have been provided.

III. FINDINGS OF FACT

1. On ___, ___ (Claimant) injured his back when he slipped on an icy slope while at work, rolling into a concrete pole. Claimant was employed as a laborer with a contracting firm.

2. Texas Mutual Insurance Company (TMIC) was the responsible insurer on Claimant on the date of injury.

3. On his date of injury, Claimant's initial diagnosis was lumbar strain and hip contusions (bruises).

4. On January 10, 2002, Claimant's treating doctor authorized Claimant to return to work on January 24, 2002, with limitations on stooping, pushing or pulling, lifting, and climbing stairs or ladders.

5. On January 10, 2002, Claimant's treating doctor referred Claimant for two weeks of physical medicine treatments, three sessions per week.

6. Claimant continued off work for an unknown length of time after January 24, 2002.

7. By mid-February 2002, Claimant showed substantial improvement in his back mechanics, including a 25 degree increase in his back flexion, a 10 degree increase in his back extension, a five degree increase in his left lateral flexion, and a five degree increase in his right lateral flexion. He showed an increase in his back muscle strength, from 2 to 3 on a five-point scale.

8. By mid-February 2002, Claimant showed a substantial increase in the flexibility in his left hip flexion and extension, and increase in hip strength from 2 to a 3 on a five-point scale.

9. On February 15, 2002, a nerve conduction study of Claimant's legs showed no evidence of radiating pain to the leg (lumbosacral radiculopathy), although it suggested a right peroneal motor neuropathy at the head of the fibula.

10. Claimant continued to report varying levels of moderate pain throughout the Spring of 2002, as well as some muscle spasms in his lower back. He also complained of continuing pain in his left leg.

11. Claimant was prescribed a TENS unit for use at home, and discontinued pain medications at some unknown time during the Spring of 2002. Claimant's pain was relieved by application of the TENS unit.

12. A functional capacity evaluation (FCE) was administered to Claimant on January 18, 2002. That test showed that Claimant was rated as capable of performing only sendentary work due to restrictions on his lifting capacity, his pain, and the lack of range of motion in his back and left hip.

13. It is unknown when or if limitations on Claimant's work were changed or lifted, or when he was released to work.

14. An MRI taken on February 11, 2002, showed Claimant's hips and pelvis to be normal but his lumbar spine displayed a diffuse disc protrusion at the L4-L5 level extending into the foramen (internal aperture) of the spine, with possible compression of the L4 nerve root.

15. An X-ray of Claimant's spine taken on March 19, 2002, showed the spinal bones to be normal.

16. On March 19, 2002, Roland F. Chalifoux, Jr., D.O., recommended a course of spine traction for one hour, three times a week, and a course of therapeutic exercise using the Mackenzie protocols, to be followed by a course of epidural steroid injections. Dr. Chalifoux did not recommend continued, regular administration of joint mobilization, myofascial release, or other passive modalities. It is not clear whether Dr. Chalifoux referred Claimant to Provider for administration of the Mackenzie exercise program and traction.

17. Provider's treatment notes after March 19, 2002, do not reflect administration of exercises under the Mackenzie protocols or the administration of traction.

18. On April 25, 2002, Phillip Cantu, M.D., prescribed a course of epidural spinal injections to treat Claimant's back pain. Dr. Cantu did not prescribe additional joint mobilization, physical therapy, or trigger-point releases or massage.

19. Dr. Cantu administered an epidural spinal injection to Claimant on May 13, 2002.

20. During the disputed service period, from February 14, 2002 to May 1, 2002, Provider's treatments consisted primarily of overseeing Claimant's performance of cardiovascular and general strength and flexibility exercises, administering passive manipulations of Claimant's left hip joint and back, and performing trigger- point releases or massage.

21. Provider's treatment notes fail to list specific treatment goals or plans for Claimant's condition or to state whether he met his activity goals at any given session. The treatment notes do not specify whether the treatments were provided to alleviate Claimant's pain, increase his range of motion, his lifting capacity, or to address any specific symptoms arising from the compensable injury.

22. Provider's treatment notes do not show any substantial progression or change in Claimant's condition.

23. Provider did not administer physical therapy to Claimant on a one-to-one basis on any date of service at issue. Provider billed Claimant for 19 sessions of one-on-one therapy.

24. Provider billed for neuromuscular reeducation (CPT Code 97112) on most dates of treatment, but provided trigger-point releases or massage.

25. Provider billed for treatment sessions between February 14 and May 20, 2002, with a follow-up office visit in conjunction with each session. Provider also billed for several additional office visits during the service period.

26. Provider billed for a physician-team conference on April 13, 2002. Claimant was not involved in a multi-disciplinary program on April 13, 2002.

27. Carrier denied reimbursement to Provider on the grounds that none of the treatments during the service period were medically necessary to treat the compensable injury, so declined to reimburse Claimant for any treatments, and any supplies used to administer the treatments, or for any office visits during the disputed period of service.

28. Provider appealed Carrier's denial of benefits to the Medical Review Division (MRD) of the Texas Workers Compensation Commission (TWCC), which referred the dispute to an Independent Review Organization (IRO).

29. On June 17, 2003, the MRD, based on the analysis of the IRO, ___, concluded that the services were medically necessary, so ordered the Carrier to reimburse Provider.

30. On July 7, 2003, Carrier filed a timely request for a hearing at the State Office of Administrative Hearings (SOAH) on the MRD decision.

31. On July 29, 2003, the Commission issued a notice of hearing which included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement on the nature of the matters asserted.

32. SOAH Administrative Law Judge (ALJ) Cassandra Church convened a hearing on these

issues on October 2, 2003, and the record closed on October 10, 2003, to allow the parties to submit additional information.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a Decision and Order, pursuant to TEX. LABOR CODE ANN. § 413.031 and TEX. GOV'T CODE ANN. ch. 2003.

2. The notice of hearing issued by the Commission was sufficient under the terms of TEX. GOV'T CODE ANN§§2001.051 and 2001.052.

3. As the petitioning party, Carrier has the burden of proving by a preponderance of the evidence that it should prevail in this matter, pursuant to TEX. LABOR CODE ANN§413.031 and 28 TEX. ADMIN. CODE §148.21 (h).

4. Carrier proved by a preponderance of the evidence that the physical medical sessions, supplies, related office visits, and team conference for which Provider billed for between February 14, 2002, and May 1, 2002, were not reasonable and medically necessary to treat Claimant's work-related injury, within the meaning of TEX. LABOR CODE ANN. §§ 408.021 and 401.011(19).

ORDER

IT IS ORDERED that Texas Mutual Insurance Company is not required to reimburse Tarrant County Chiropractic & Rehabilitation for any sessions of physical medicine and supplies provided on behalf of Claimant ___ between February 14, 2002, and May 1, 2002, or for any office visits and team conferences held on or between those dates of service.

SIGNED December 9, 2003.

_____

CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS