SOAH DOCKET NO. 453-03-4250.M5
MDR TRACKING NO. M5-03-1608-01

MAIN REHAB AND DIAGNOSTIC, Petitioner,	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
AMERICAN CASUALTY COMPANY OF READING, PA., Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Main Rehab and Diagnostic (Petitioner) sought reimbursement from American Casualty Company of Reading, Pa. (Carrier) for physical therapy and office visits from July 1, 2002, through October 7, 2002, provided to ___ (Claimant). Carrier contended that the services were not medically reasonable or necessary. An Independent Review Organization (IRO) agreed with Carrier and issued a decision denying the requested reimbursement. The amount in dispute is $8,726.00. The ALJ denies Petitioner's appeal because it failed to prove that the disputed physical therapy and office visits were medically reasonable and necessary.

I. JURISDICTION, NOTICE, AND VENUE

There were no contested issues of jurisdiction, notice, or venue. Therefore, those issues are addressed in the Findings of Fact and Conclusions of Law without further discussion here.

II. STATEMENT OF THE CASE

Administrative Law Judge (ALJ) Suzanne Formby Marshall convened a hearing in this case on November 24, 2003, at the State Office of Administrative Hearings, William P. Clements State Office Building, Austin, Texas. Petitioner and its attorney, Mr. Scott Hilliard appeared by telephone, and Carrier appeared in person through its attorney, David Swanson. The hearing concluded on that date, but the record was held open until December 10, 2003, in order to allow Carrier to submit a medical article discussed during the hearing and for Petitioner to respond to the article.

The documentary record in this case consisted Petitioner's Exhibit 1 (104 pages of records submitted to the IRO), Petitioner's Exhibit 2 (additional documentation in support of unpaid bills), Petitioner's Exhibit 3 (response to medical article), Carrier's Exhibit 1 (decision and order of the IRO), Carrier's Exhibit 2 (294 pages of records submitted to the IRO), and Carrier's Exhibit 3, (medical article).[1] Testimony was presented by Dr. Osler Kamath, D.C. and Dr. William Defoyd, D.O.

[1] Petitioner's response to the medical article submitted by Carrier is admitted as Petitioner's Exhibit 3.

III. DISCUSSION

A. Background

Claimant, ___, is a ___ who suffered a compensable injury to his left wrist, neck and back on ___, when he tripped and fell backwards while working at a construction site.[2] He sought treatment from K-Clinic the next day, and was diagnosed with cervical, lumbar and left wrist strains. Carrier's Ex. 2., p. 13. K-Clinic prescribed anti-inflammatory medications, ordered x-rays, and referred Claimant for physical therapy.[3] Claimant received a physical therapy evaluation on February 12, 2001, that recommended Claimant continue physical therapy. Carrier's Ex. 2, pp. 14-17.[4] Claimant did not comply with the recommended physical therapy sessions or follow-up treatment, and he was discharged from care on April 26, 2001. Carrier's Ex. 2, p. 23. The record reflects that Claimant was incarcerated sometime after his last visit to K-Clinic in February 2001 until November of 2001.

On July 1, 2002, he was examined by Dr. Osler Kamath of Main Rehab and Diagnostic Center and complained of back, neck, and wrist pain. X-rays were taken of Claimant which showed no fracture and Claimant was referred for physical therapy. Dr. Kamath diagnosed Claimant with: (1) median nerve neuritis; (2) lumbar disc disorder; (3) cervical segmental dysfunction; and (4) lumbosacral radiculitis. Dr. Kamath prescribed physical therapy four times a week for five weeks to increase his range of motion and muscle strength, alleviate pain, enhance functionality and expedite achievement of maximum medical improvement. Carrier's Ex. 2, p. 32. Claimant continued to be treated by Petitioner from July through October of 2002.[5]

Carrier denied payment for the physical therapy services and office visits based on a peer review for lack of medical reasonableness or necessity. Petitioner appealed Carrier's denial of payment. On June 20, 2003, Medical Review of Texas, an Independent Review Organization (IRO), upheld Carrier's position, finding that the services and visits were not medically necessary.

B. Petitioner's Evidence and Arguments

In addition to offering Claimant's medical records into evidence, Petitioner called Dr. Osler Kamath (D.C.) as a witness. Dr. Kamath has practiced chiropractic for over three years. He testified

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[2] Claimant's employer was ___.

[3] The x-rays were normal for the lumbar spine and left wrist. They showed a straightening of the cervical spine, which was thought by the K-Clinic doctor to be related to muscle spasms. Carrier's Ex. 2, p. 23.

[4] The evaluation and SOAP notes indicate that pre-authorization would be sought for physical therapy four times a week for five weeks, and three times a week for four to six weeks. Petitioner did not argue that Carrier pre-authorized the services in dispute and the record does not reflect pre-authorization of services.

[5] The disputed dates of service are: July 1, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31; August 5, 7, 9, 14, 27; September 3, 10; and October 7, 2002.

that he examined Claimant on July 1, 2002, and was told that Claimant had received little care, if any, after the injury and continuing to that date.

Dr. Kamath said that he attempted to obtain medical records from K-Clinic, but did not receive them prior to or during his treatment of Claimant. The first time he saw the K-Clinic records was during the peer review process. Based upon his examination of Claimant, Dr. Kamath recommended physical therapy four times a week for five weeks. Claimant received passive treatment modalities of joint mobilization, myofasical release and manual traction. Dr. Kamath testified that emphasis was placed on active strengthening. According to Dr. Kamath, Claimant improved his range of motion and flexion and his level of pain decreased.

Dr. Kamath contends that the K-Clinic's diagnosis of cervical strain, lumbar strain, and wrist strain was incorrect and that Claimant's injuries were actually more serious. In support of his contention that Claimant was originally mis-diagnosed, he relies on Claimant's MRI results on July 29, 2002, showing a disk bulge at L3-L4, disc dessication at multiple levels, and injury in the trapezoid joint on the left wrist. A CT scan showed that Claimant had a chip fracture in the back of his wrist that had not united.

Dr. Kamath testified that Claimant benefitted from the physical therapy, demonstrating that the services were medically necessary. He also said that, even if Claimant's injuries were considered a soft tissue injury, the medical literature indicates that physical therapy services, such as those provided to Claimant, are appropriate, even if they are provided at a time that is not close to the date of the injury.

C. Carrier's Evidence and Arguments

Carrier relied on the Claimant's medical records and the testimony of Dr. William Defoyd, D.C. Dr. Defoyd is a board certified Chiropractic Orthopedist who practices with the Spine and Rehab Center in Austin, Texas. He reviewed Claimant's medical records, but did not examine Claimant.

Dr. Defoyd was critical of Petitioner's failure to obtain more information about Claimant's medical care during the sixteen months between the date of injury and the July examination by Dr. Kamath. Dr. Defoyd testified that too much information was unknown when Petitioner began treating Claimant. Dr. Defoyd said that it was very important to know what happened during the time between the K-Clinic visits and July of 2002, *i.e.*, why Claimant had not sought care, what other treatments or tests may have been given to Claimant, because this information is necessary when determining the appropriate treatment for Claimant. Further, Dr. Defoyd said that Dr. Kamath's findings at Claimant's initial examination were extremely generic and included no functional status documentation or documentation of range of motion or strength, which are basic requirements for intake on office visits billed under CPT code 99205.

Dr. Defoyd also noted that the medical records contained no description of meaningful, objective findings, *i.e.*, the exercise program was not described at all, either in terms of frequency or intensity, and contained no information about Claimant's response to it. Dr. Defoyd said this lack of documentation is significant when determining medical necessity because the notes should reflect Claimant's progress and changing condition. Dr. Defoyd testified that if improvement was not

occurring, there should be a focused assessment and perhaps a change in the treatment plan.

Likewise, if improvement did occur, it should be reflected in the notes and the treatment plan should be adjusted accordingly. Dr. Defoyd said that the records do not reflect a cognitive, ongoing re-evaluation process.

With regard to the SOAP notes, Dr. Defoyd observed that there was no quantification of Claimant's subjective complaints of pain, such as through the use of a numeric scale, questionnaire, or visual analog scale. There were also no notes describing how Claimant's pain symptoms were affecting his life, such as the impact on his activities of sitting, standing, or walking. Dr. Defoyd was also critical of the objective findings in the medical notes because they failed to state specifically what exercises were being done with regard to the wrist. Dr. Defoyd observed that the notes are virtually identical for every visit. He testified that if Claimant's response remained the same, the treatment should change.

Dr. Defoyd disputed Dr. Kamath's testimony regarding Claimant's improvements. Dr. Defoyd said that the improvements were not substantive and it is not possible to know from the documentation whether any improvements are the result of treatment, or whether Claimant has simply learned how to do the activity better, i.e., through stretching and home exercises.

With regard to the management section of the SOAP notes, Dr. Defoyd said that the manual procedures are described in generic terms so that a reviewer cannot really tell what was done. According to Dr. Defoyd, the use of traction and joint mobilization appear to be repetititive. The therapeutic exercises are not described and Dr. Defoyd commented that it is unusual for these exercises to consistently be billed at one hour of one-on-one time without any documentation of what is being done and why one-on-one assistance is required. As to Dr. Kamath's note on July 19, 2002, that projects the need for four months of treatment, Dr. Defoyd testified that this was unusual after having only seen Claimant on one occasion and that it becomes a self-fulfilling prophecy.

Dr. Defoyd testified that there were no indications for ordering the MRI and CT scans of the cervical or lumbar spine or the wrist. There was no demonstrated need for information from the tests to assist clinical decision-making. He was also critical of the need for these scans because there was no evidence that the results of these tests impacted the clinical decision-making at all, because Claimant's treatment did not change.

In August of 2002, Dr. Mike O'Kelley (D.C.) performed a chiropractic peer review for Carrier. Dr. O'Kelley's written review opined that Claimant's diagnosis was more appropriately that of a strain or sprain to the left wrist, cervical spine and lumbar spine. He observed that a soft tisuee injury has a natural history that is self-limiting to eight to twelve weeks. According to Dr. O'Kelley, the treatment regimen of Petitioner did not make sense because it was designed for a soft tissue injury which should have already healed. Rather than receiving physical therapy, Dr. O'Kelley felt that diagnostic and orthopedic tests would have been more appropriate in order to ascertain the nature of Claimant's condition. Dr. O'Kelley was also greatly concerned about the fourteen-month gap in care between Claimant's visits to K-Clinic and the Petitioner. He did not believe treatment by

Petitioner was appropriate due to this gap in care, without diagnostic testing or a referral to an

orthopedic surgeon or board certified neurologist. Carrier's Ex. 2, pp. 1-3.

D. ALJ's Analysis and Decision

The issue in this case is whether the services and treatment provided to Claimant on the disputed dates of service were medically necessary.

After considering the evidence in this case, the ALJ agrees that the physical therapy services and office visits are not medically warranted in this case. Petitioner failed to provide a persuasive rationale for the necessity of the treatment. In particular, the ALJ finds that Petitioner's failure to obtain Claimant's medical records from K-Clinic and the lack of a referral for further diagnostic evaluation is significant. Petitioner appears to have been eager to begin treating Claimant's injuries, without a sound medical basis for doing so. Petitioner did not appear to be concerned about the lengthy gap in care, almost sixteen months from the time of the K-Clinic visit to the initial visit with Petitioner. If Claimant had been non-compliant with care, Petitioner should have wanted to find out what caused the non-compliance, especially before relying on Claimant to be compliant with any treatment program to be developed by Petitioner.

Further, Petitioner should have questioned why Claimant was continuing to experience pain, given that his injuries should have healed by the time of his visit. Petitioner claims that Claimant was mis-diagnosed with soft tissue injuries. The ALJ finds that the medical evidence is to the contrary. In addition to the evidence from Drs. Defoyd and O'Kelley, Claimant was examined by at least three other doctors who concurred that Claimant suffered soft tissue injuries: (1) the K-Clinic; (2) Dr. Crawford Sloan, M.D.; and (3) Dr. Karim Meghani, M.D. On July 11, 2002, Dr. Sloan evaluated Claimant as part of a medical consultation. He diagnosed Claimant with a cervical and lumbar strain/sprain and a left wrist strain. Carrier's Ex. 2, p. 65. On September 16, 2002, Dr. Meghani performed an examination to determine whether Claimant had reached maximum medical improvement. Dr. Meghani's assessment stated that Claimant had a left wrist strain and cervical and lumbar strain, as well as degenerative joint disease of the cervical and lumbar spine. He certified maximum medical improvement as of that date and noted a 10% whole person impairment (5% for the cervical spine, 5% for the lumbar spine, and no impairment for the left wrist, "as it is a soft tissue injury"). Carrier's Ex. 2, pp. 292-294. The medical evidence and testimony supports the conclusion that Claimant's injuries were soft tissue injuries.

Further, the ALJ is concerned that the medical notes for Claimant, over the three-month period of treatment, remain virtually identical for each visit. This indicates to the ALJ that Petitioner may be merely duplicating the notes from one visit to another, without making any real evaluation as to whether the treatment plan continues to be appropriate for Claimant or whether Claimant is making satisfactory progress. The medical notes do not provide adequate documentation of the need for treatment, the actual treatment that was given, or the response by Claimant to the treatment. As such, they do not establish medical necessity in this case.

After reviewing all the evidence in this case, the ALJ finds that the services and office visits

provided to Claimant from July 1, 2002, through October 7, 2002, were not medically reasonable or necessary.

IV. FINDINGS OF FACT

1. ___ (Claimant) worked for ___ and sustained an injury to his left wrist, neck and back on ___, when he tripped and fell while working at a construction site.

2. ___ maintains worker's compensation insurance through American Casualty Company of Reading, Pennsylvania (Carrier).

3. Claimant sought treatment for the injury on ___, at K-Clinic. He was examined, x-rays were taken, and he was diagnosed with a lumbar strain, neck strain, and wrist strain. He was prescribed anti-inflammatory medications and physical therapy services, and was given a wrist brace.

4. Claimant attended some physical therapy sessions, but discontinued treatment from K Clinic.

5. Sometime after ___, Claimant became incarcerated. He was released in November of 2001. There is no evidence regarding the medical treatment, if any, he received until July of 2002.

6. On July 1, 2002, approximately fourteen months after the injury, Claimant sought treatment from Main Rehab and Diagnostic (Petitioner). He was examined and evaluated by Dr. Osler Kamath. Dr. Kamath recommended physical therapy four times a week for five weeks.

7. The physical therapy treatment consisted of joint mobilization, myofascial release and therapeutic exercises.

8. Dr. Kamath did not obtain medical records about Claimant's condition from K-Clinic prior to treating Claimant.

9. Claimant's injuries were soft tissue injuries which normally heal within twelve weeks of injury.

10. Claimant began treatment with Petitioner approximately sixteen months after the date of injury.

11. Petitioner did not refer Claimant for diagnostic evaluation prior to treating him.

12. The medical notes do not provide specific information about the treatment provided to Claimant or his response to the treatment.

13. The medical notes do not indicate that an ongoing medical evaluation was made by Petitioner as to the effectiveness of the treatment plan.

14. The evidence did not establish that the physical therapy services and office visits were medically reasonable and necessary for Claimant at the time they were provided.

15. A hearing was conducted in this case on November 24, 2003; the record remained open until December 10, 2003, in order for the parties to offer additional evidence.

16. Petitioner and Carrier attended the hearing referred to in Finding of Fact No. 15.

17. 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.

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

V. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issuespresented pursuant to the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN. §413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to §§ 407.073(b) and 413.031(d) of the Act and TEX. GOV'T CODE ch. 2003.

3. Petitioner timely requested a hearing pursuant to 28 TEX. ADMIN. CODE §§ 102.3, 102.5(h), 102.7, and 148.3.

4. The parties received adequate and timely notice of the hearing pursuant to TEX. GOV'T CODE § 2001.051.

5. Venue was established pursuant to 28 TEX. ADMIN. CODE § 148.6.

6. An employee who sustains a compensable injury is entitled to health care that relieves the effects naturally resulting from the injury, promotes recovery, and enhances the ability to return to or retain employment. § 408.021 of the Act.

7. Petitioner had the burden of proof in this matter to establish its claim by a preponderance of the evidence. 28 TEX. ADMIN. CODE § 148.21(h) and (i).

8. Based on the above Findings of Fact and Conclusions of Law, Petitioner failed to prove that the physical therapy services and office visits from July 1, 2002, through October 7, 2002, were medically necessary to treat Claimant's compensable injury.

9. Based on Conclusion of Law No. 8, Petitioner's claims are denied.

ORDER

THEREFORE, IT IS ORDERED that the relief sought by Petitioner Main Rehab and Diagnostic is denied and that Petitioner shall have and recover nothing in this case from Respondent American Casualty Company of Reading, Pa., for the claims made the subject of this proceeding.

SIGNED February 9, 2004.

SUZANNE FORMBY MARSHALL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING