SOAH DOCKET NO. 453-03-4463.M5
TWCC MR NO. M5-03-2041-01

SUHAIL AL-SAHLI, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ST. PAUL FIRE & MARINE	§	
INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Suhail Al-Sahli, D.C. (Provider) requested a hearing before the State Office of Administrative Hearings (SOAH) after the Texas Workers' Compensation Commission's Medical Review Division (MRD)[1] denied his request for reimbursement from St. Paul Fire & Marine Insurance Company (Carrier) in the amount of $2,370 for office visits and treatment provided to Claimant from May 1, 2002, through August 30, 2002. The issue in this dispute is whether the treatments and services were medically necessary to treat the compensable injury. The Administrative Law Judge (ALJ) finds that some of the disputed services were medically necessary and some were not. Therefore, Carrier is to reimburse Provider $1,495 for the medically necessary services.

II. PROCEDURAL HISTORY

ALJ Sharon Cloninger convened the hearing on December 16, 2003, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared by telephone and represented himself. Carrier was represented by Christine Karcher, attorney, who also appeared by telephone. The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law below. After evidence was presented, the hearing concluded and the record closed that same day.

III. DISCUSSION

A. Background

On ___, Claimant sustained a compensable injury when he slipped while standing in a muddy trench cutting a pipe. He twisted his right foot, right ankle, and low back. Claimant was diagnosed with ankle sprain, lumbar disc syndrome, lumbar sprain/strain, and radiculopathy.

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1 Pursuant to TEX. LAB. CODE ANN. § 413.031, the MRD assigned the appeal to an Independent Review Organization (IRO) to conduct a review of the disputed medical necessity issues between Provider and Carrier. The MRD issued its decision July 16, 2003, after reviewing the IRO decision issued July 14, 2003.

Provider began treating Claimant on April 2, 2001, using conservative treatment including therapeutic exercises, chiropractic adjustments, joint mobilizations, joint manipulations, and passive modalities.[2]

B. Applicable law

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

Provider, as the petitioner, has the burden of proof in this matter pursuant to 28 TEX. ADMIN. CODE (TAC) § 148.21(h).

C. Treatment and services at issue

The treatment and services in dispute are office visits, ultrasound, myofascial release, and therapeutic exercise provided to Claimant from May 1, 2002, through August 30, 2002. Carrier denied reimbursement on the basis that the treatment and services were not medically necessary. The disputed treatments and services are listed below by CPT code, in numerical order.

- **97035 (ultrasound therapy)** Provider billed $22 apiece for treatment provided on five dates of service and $25 for treatment provided on one date of service, for a total of $135.

- **97110 (therapeutic procedures one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)** Provider billed $35 per unit, for up to four units per day, for a total of 36 units and $1,260 on 12 dates of service.

- **97250 (myofascial release)** Provider billed $43 per treatment, for up to two treatments per day, on 10 dates of service for a total of $472 for 11 treatments.

- **99213 (office or outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. . . . Physicians typically spend 15 minutes face-to-face with patient.)** Provider billed Carrier $48 a piece for a total of $480 for 10 office visits.

D. Evidence and argument

Provider offered four exhibits, all of which were admitted, and testified on his own behalf. Carrier called one witness and offered two exhibits, one of which was admitted and the second of

2 Pet. Ex. 2-C, p. 2.

which was admitted in part. The ALJ took official notice of a rule of the Texas Workers' Compensation Commission (the Commission).

1. Documentary evidence

Carlton Smith, M.D., the Commission's designated doctor, evaluated Claimant on February 13, 2002, and concluded Claimant had not reached maximum medical improvement (MMI). Claimant told Dr. Smith that his pain level fluctuates between 5 and 10 (10 being extreme), and that sometimes exercise, physical therapy, hot packs, cold packs, ultrasound, and medication lessen his pain. Dr. Smith recommended that Claimant return to see him after having a root block and follow-up evaluations with Dr. Masroor Ahmed.[3]

Dr. Smith evaluated Claimant again on May 30, 2002, and found him to have reached MMI on that date. Claimant was assigned a whole person impairment rating of 15 percent, 10 percent for his lumbar spine and five percent for his ankle.[4]

On June 7, 2002, Claimant was seen by spine surgeon Mark F. McDonnell, M.D., for a consult regarding his low back pain. Dr. McDonnell said Claimant was a candidate for a lumbar arthrodesis, and needed at least a two-level lumbar fusion, L3 to S1. He recommended that Claimant have a discogram from L2 to S1, then return to discuss surgical options. He concluded Claimant's treatment was made necessary by his injury.[5]

Nassau Bay Rehab conducted a functional capacity evaluation (FCE) on Claimant on May 20, 2002. The resulting recommendation was that Claimant continue to remain off work because he did not demonstrate the necessary climbing, lifting, carrying, pushing, pulling, squatting and kneeling tolerances to return to his previous position as a pipe fitter's helper. Claimant demonstrated the physical abilities to perform within the medium level of physical strength requirements as defined by the U.S. Department of Labor. The primary barriers preventing Claimant from returning to his previous employment were pain, decreased range of motion, and poor endurance. The FCE evaluator recommended that Claimant participate in a work hardening program and vocational counseling to assist him in returning to his previous employment.[6] There is no follow-up FCE for comparison purposes.

At some point between January 28, 2002, and July 1, 2002, Claimant underwent individual therapy sessions which he found to be helpful.[7] Provider's notes dating from May 28, 2002, through August 30, 2002, document Claimant's subjective observation that his low back pain was sometimes better after "therapy", "therapy and manipulation", or "treatment."[8] His ankle injury is not mentioned.

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3 Pet. Ex. 4-F; Dr. Ahmed is not mentioned anywhere else in the evidence. There is no evidence as to whether the root block was performed, or whether Claimant was evaluated again by Dr. Smith.

4 Carrier's Ex. 1, 266-268.

5 Pet. Ex. 3-E. Dr. McDonnell did not elaborate as to what treatment was made necessary by Claimant's injury.

6 Pet. Ex. 2-C, pp. 1-2.

7 Carrier's Ex. 1, 286-289.

8 Carrier's Ex. 1, 24-36, notes from May 28, 31, June 4, 6, 11, 13, July 24, and August 30, 2002.

2. Testimony

a. Provider's testimony

Provider testified that overall, the treatment increased Claimant's range of motion, gave him his strength back, and caused him to gain 70-80 percent of the range of motion lost with his injury. He said that from May 1, 2002, through August 30, 2002, Claimant's range of motion increased periodically.

b. Testimony of Maury A. Guzick, D.C.

Maury A. Guzick, D.C., testified for Carrier that Claimant was extensively treated with passive modalities and exercise from April 2, 2001, through December 3, 2001, with no progress. He concluded that no care for Claimant's compensable injury was warranted after December 3, 2001. He said there is a reasonable medical probability that the treatments at issue were not medically necessary.

IV. ANALYSIS AND CONCLUSION

A. Analysis

To prove medical necessity, Provider needed to show that the services and treatments at issue cured or relieved the effects naturally resulting from the compensable injury; promoted Claimant's recovery; or enhanced the ability of Claimant to return to or retain employment, pursuant to TEX. LAB. CODE ANN. § 408.021(a). Between May 1, 2002, and August 30, 2002, Claimant was undergoing a variety of treatments in addition to the disputed ones. Provider relied on the fact that Claimant returned to the workforce as a security guard to indicate that the disputed treatment had been medically necessary. Provider failed to prove, however, the disputed treatments were reasonable and medically necessary to prepare Claimant to return to the workforce.

Provider supplied insufficient evidence to prove that the ultrasounds and myofascial releases met any of the requirements of TEX. LAB. CODE ANN. § 408.021(a). Although, according to Provider's notes, Claimant indicated that his pain was reduced by "therapy," "treatment and manipulation," and "treatment" Claimant did not specifically mention ultrasound or myofascial release. Because Claimant received multiple treatments and therapies during a single visit to Provider, it is not clear which therapies or treatments were beneficial. Because Claimant also received therapy from other treating professionals, it was not clear whether the pain reducing therapy was the individual therapy Claimant received from others or from Provider.

Provider testified that the disputed treatments resulted in improved range of motion, pain control, and daily living for Claimant, but gave no medical basis to support that conclusion. In short, Provider did not prove the ultrasound and myofascial release treatments were medically necessary.

However, Provider met his burden of proof as to the therapeutic exercise and office visits, showing they were necessary to promote Claimant's recovery.

1. Ultrasound

Provider failed to prove the ultrasound was medically necessary to relieve Claimant's pain or promote his recovery.

2. Therapeutic exercise

The therapeutic exercises were provided to increase Claimant's endurance and strength.[9] According to the FCE conducted May 20, 2002, poor endurance was identified as one of the primary barriers preventing Claimant from returning to work as a pipefitter. Therefore, the therapeutic exercises were medically necessary and reasonable to promote Claimant's recovery.

On nine of the disputed dates, documentation supports that the exercise was provided in a one-on-one setting, as required by this CPT code. Documentation for two dates failed to establish that the exercise was provided in a one-on-one setting. Therefore, reimbursement is warranted for all dates of service except May 17, 2002 (three units billed), and June 11, 2002 (four units billed), leaving 29 units at $35 each, for a total of $1,015.

3. Myofascial release

The evidence does not support reimbursement for myofascial release treatment billed under CPT code 97250 as Provider failed to establish they were medically necessary.

4. Office visits

Provider billed Carrier $48 for 10 office visits. An office visit can only be billed under this CPT code if two of the following three elements are satisfied: the visit includes an expanded problem focused history, an expanded problem focused examination, or medical decision making of low complexity.

Claimant was continuing to suffer low back pain related to his compensable injury on the dates in dispute. It was medically necessary for him to visit Provider, his treating doctor.

Provider's records for May 1, 3, 17, 28, June 4, 6, 11, 13, July 24, and August 30, 2002, indicate that the requirements of CPT code 99213 were met, in that there was an expanded problem focused examination and medical decision making of low complexity at each visit.

Provider sustained its burden of proof on this issue, and should be reimbursed $480 for the office visits.

B. Conclusion

Provider met its burden of proof in showing that reimbursement of $1,015 should be ordered for therapeutic exercises, and $480 should be ordered for office visits, for a total of $1,495. Provider did not meet its burden of proof as to ultrasound and myofascial release. Accordingly, the ALJ orders a total reimbursement of $1,495.

V. FINDINGS OF FACT

1. On ___, Claimant sustained a compensable injury when he slipped, twisting his right foot, ankle, and low back while standing in a muddy trench cutting a pipe. His employer's workers' compensation insurance carrier was St. Paul Fire & Marine Insurance Company (Carrier).

9 *See*, e.g., Carrier's Ex. 1, 226.

2. Suhail Al-Sahli, D.C., (Provider) began treating Claimant on April 2, 2001.

3. Claimant was diagnosed to have ankle sprain, lumbar disc syndrome, lumbar sprain/strain, and radiculopathy.

4. Provider's treatment of Claimant included therapeutic exercises, myofascial release, ultrasounds, chiropractic adjustments, joint mobilizations, joint manipulations, and passive modalities.

5. Poor endurance was one of the primary barriers preventing Claimant from returning to work as a pipefitter.

6. Therapeutic exercises were provided to increase Claimant's endurance and strength.

7. Claimant visited Provider on the disputed dates because he continued to have low back pain, stiffness, and limited range of motion.

8. During the disputed office visits, Provider examined Claimant and provided treatment based on the examination results.

9. Provider sought reimbursement of $2,370 from Carrier for services rendered to Claimant, and billed under the following CPT codes:

   - **97035 (ultrasound therapy)** Provider billed $22 apiece for treatment provided on five dates of service and $25 for treatment provided on one date of service for a total of $135.

   - **97110 (therapeutic procedures one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)** Provider billed $35 per unit, for up to four units per day, for a total of 36 units and $1,260 on 12 dates of service.
   - **97250 (myofascial release)** Provider billed $43 per treatment, for up to two treatments per day, on 10 dates of service for a total of 11 treatments and $473.

   - **99213 (office or outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. . . . Physicians typically spend 15 minutes face-to-face with patient.)** Provider billed Carrier $48 apiece for a total of $480 for 10 office visits.

10. Carrier refused to reimburse Provider for the above services on the basis that they were not medically necessary.

11. The ultrasounds did not lessen Claimant's pain, promote his recovery, or enhance his ability to return to work or retain employment.

12. The therapeutic exercises promoted Claimant's recovery.

13. The myofascial releases did not reduce Claimant's pain, promote his recovery, or enhance his ability to return to work or retain employment.

14. The office visits promoted Claimant's recovery.

15. Provider filed a request for medical dispute resolution with the Texas Workers' Compensation Commission's Medical Review Division (MRD), asking for reimbursement of $2,370 for the above-described services.

16. On July 16, 2003, the MRD denied Provider's request for reimbursement, after reviewing the Independent Review Organization decision dated July 14, 2003, finding that the disputed services were not medically necessary.

17. On July 22, 2003, Provider filed a request for hearing at the State Office of Administrative Hearings (SOAH), requesting relief from the MRD's decision.

18. On August 21, 2003, notice of the hearing was mailed to Provider and Carrier. The hearing notice informed the parties of the matter to be determined, the right to appear and be represented, the time and place of the hearing, and the statues and rules involved.

19. On December 16, 2003, SOAH Administrative Law Judge Sharon Cloninger convened the hearing in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Provider appeared via telephone, as did Christine Karcher, attorney for Carrier. The hearing concluded and the record closed that same day.

VI. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this case, 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. Provider timely filed notice of appeal of the decision of the Commission's Medical Review Division (MRD), as specified in 28 TEX. ADMIN. CODE (TAC) §148.3.

4. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TAC §148.4(b).

5. As the petitioner, Provider has the burden of proving the case by a preponderance of the evidence, pursuant to 28 TAC §148.21(h) and (i).

6. Based on the above Findings of Fact, Provider failed to prove the ultrasounds (CPT code 97035) and myofascial releases (CPT code 97250) were medically necessary pursuant to TEX. LAB. CODE ANN. § 408.021(a), and Provider should not be reimbursed for those treatments.

7. Based on the above Findings of Fact, Provider met its burden of proof regarding reimbursement of $1,015 for therapeutic exercise (CPT code 97110) and $480 for office visits (CPT code 99213) pursuant to TEX. LAB. CODE ANN. § 408.021(a), and Provider should be reimbursed for those treatments and services.

8. Based on the above Findings of Fact and Conclusions of Law, Provider's request for relief should be granted in part and denied in part, and Carrier should reimburse Provider $1,495.

ORDER

The relief sought by Suhail Al-Sahli, D.C., is granted in part and denied in part. IT IS ORDERED THAT St. Paul Fire and Marine Insurance Company reimburse Dr. Al-Sahli $1,495 for therapeutic exercises and office visits.

Signed February 17, 2004.

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS