SOAH DOCKET NO. 453-04-0042.M5
MDR NO. M5-02-3249-01

TEXAS MUTUAL INSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
	§	**OF**
	§	
SCD BACK & JOINT CLINIC,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (TMIC) and SCD Back & Joint Clinic (Clinic) seek review of a decision by the Texas Workers' Compensation Commission (Commission), acting through an independent review organization (IRO), in a dispute regarding the medical necessity of physical medicine treatments provided to Claimant ___, who suffered from a lower back injury. TMIC and the Clinic both challenged the decision. This decision finds that the Clinic should be reimbursed $378.00.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The hearing convened on August 24, 2004, at the facilities of the State Office of Administrative Hearings (SOAH) in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Katherine L. Smith presided. TMIC was represented by Patricia Eads, an attorney. The Clinic was represented by William Maxwell, an attorney. The hearing adjourned the same day. The record closed on September 7, 2004, after the filing of additional information. Neither party challenged the adequacy of notice or jurisdiction.

II. BACKGROUND

Claimant suffered a compensable injury to his lower back on ___, while he was driving a front end loader. Sam Liscum, D.C. began treating Claimant at the Clinic on September 10, 2001. Dr. Liscum diagnosed a lumbar sprain/strain, thoracic sprain/strain, right lateral epicondylitis, and muscle spasm.

Dr. Liscum ordered Claimant taken off work because his pain level and joint dysfunction made him susceptible to exacerbation and/or reinjury. On September 25, 2001, Dr. Liscum re-evaluated Claimant. Dr. Liscum noted that the claimant has Aconstant low back pain that increases with bending over, and he reports a periodic dull pain in his right elbow that increases with extension of his elbow.@[1] A new treatment plan was formulated for an additional six weeks, incorporating much of the earlier plan and declaring, A[t]he patient will work out in the clinic a maximum time of three hours in therapeutic exercises, with the goal of returning to full normal activities of daily living and return to work@ after completion of the plan.[2] The evaluation concluded by projecting the claimant's date of maximum medical improvement (MMI) and return to work as November 25, 2001. In addition, Claimant underwent an MRI on October 4, 2001, that revealed a herniated disc at the L5-S1 level. There was a break in Claimant's treatment for injections and because Claimant took at two week trip to Mexico.

Similar re-evaluations occurred on November 15, 2001, January 8, 2002, and February 26, 2002. After each, Dr. Liscum re-instituted, in effect, the previous treatment plan, while pushing back further the patient's projected date of MMIBfrom January 15, 2002, to March 8, 2002, to April 26,

[1] Ex. 1 at 108.

[2] *Id.* at 113.

2002. Claimant continued to receive treatment through the Clinic until February 26, 2002. Claimant was released to part-time restricted work on January 23, 2002. On February 26, 2002, Dr. Liscum released him for full-time work with restrictions.

At issue are physical medicine treatments and diagnostic studies provided from October 1, 2001, to February 26, 2002, that TMIC denied as being either unnecessary medical treatment or insufficiently documented in support of treatment outside the Commission's guidelines.[3] The IRO found that the treatment up to January 8, 2002, was medically necessary, but that after then, further treatment was not because Claimant had not made enough progress to warrant continued physical therapy and had actually experienced decreasing range of motion in the lumbar region

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and made further findings. MRD found that joint mobilization (CPT code 97265), one-on-one therapeutic exercises (CPT code 97110), group therapeutic exercises (CPT code 97150), myofascial release (CPT code 97250), and electrical stimulation (CPT code 97014) provided on November 7 and 9, 2001, were not reimbursable because they had not been preauthorized.[4] MRD also found that reports of Claimant's work status dated November 15, 2001, and January 9, 2002, (CPT code 99080-73) were not necessary. MRD approved, however, reimbursement for testing done on January 8, 11, and 28, and February 13, 2002, (CPT code 99750-MT), but found that the testing performed on February 25, 2002, exceeded the number of functional capacity evaluations provided by the Medical Fee Guideline.[5] MRD also approved reimbursement of TENS supplies (CPT code E1399) on

[3] At the hearing TMIC agreed to compensate the Clinic for disputed treatments provided on September 25 and 27, October 26, and November 15, 2001, and billed as current procedural codes (CPT) 95851 and 97750-MT.

[4] Preauthorization was required for physical therapy beyond eight weeks in 2001, but not in 2002. 28 TEX. ADMIN. CODE (TAC) ' 134.600(h)(10).

[5] Medical Fee Guideline 1996, adopted by reference in 28 TAC ' 134.201.

January 23, 2002, but did not address those billed on January 18, 2002. The attached appendix outlines the services provided and the underlying determinations provided by the IRO and MRD.

On July 21, 2003, MRD issued its decision ordering TMIC to pay $5,791.00, plus accrued interest, to the Clinic.

III. PARTIES' EVIDENCE AND ARGUMENTS

A. Clinic

David Bailey, D.C., the principal owner of the Clinic, testified at the hearing. He contended that intensive and aggressive one-on-one treatments provide optimum rehabilitation in returning injured workers to work. He pointed specifically to the 150% increase in Claimant's lumbar strength that occurred between September and November 2001. Dr. Bailey contended that it was inappropriate for the IRO to consider retrospectively the medical necessity of the treatment provided after January 8, 2002.

B. TMIC

At the hearing, TMIC presented David Alvarado, D.C., as its expert witness, who testified that the Clinic's treatment of Claimant demonstrated insufficient efficacy to justify continuing it into the disputed period. He noted more specifically that Claimant was capable of performing the physical requirements of his job as early as September 25, 2001, although his pain level remained the same. Although the additional treatment increased Claimant's strength, it did nothing to decrease the pain, which was why Claimant was not returned to work. Furthermore, the record indicates that the pain became worse from September 25, 2001, to November 15, 2001. Whereas on September 25,

2001, Dr. Liscum reported that Claimant's pain was a constant, dull, low back pain that increased with bending over, on November 15, 2001, he wrote that Claimant "complains of constant deep aching pain in the upper and lower back. He states that his pain increases to a sharp throbbing pain with bending, twisting, sitting, and standing."[6] Dr. Alvarado also noted that the program was not significantly modified in reaction to Claimant's lack of progress. Dr. Alvarado also criticized the failure to change the treatment in October, when the MRI revealed that Claimant had a disc lesion, particularly when Claimant was still being instructed to perform squats and lumbar flexions.

IV. ANALYSIS

1. November 7 and 9, 2001

Addressing first the physical medicine treatments provided on November 7 and 9, 2001: joint mobilization (CPT code 97265), one-on-one therapeutic exercises (CPT code 97110),[7] group therapeutic exercises (CPT code 97150), myofascial release (CPT code 97250), and electric stimulation (CPT code 97014), the ALJ agrees with MRD that preauthorization was required for those services. In 2001, 28 TAC ' 134.600(h)(10) required preauthorization of physical therapy beyond eight weeks of treatment. Medicine Ground Rule I.A.10.a. defined a physical medicine session Aas any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541).[8] Claimant began receiving physical therapy at the Clinic on September 11, 2003, which was a Tuesday. On that date, the services provided were

[6] Ex. 1 at 108, 120.

[7] At the hearing the Clinic withdrew its request for reimbursement for the one-on-one therapeutic exercises provided on November 7 and 9, 2001.

[8] Medical Fee Guideline.

joint mobilization, myofascial release, electric stimulation, and diathermy (CPT code 97024).[9]

Claimant received physical medicine care or therapy consistently thereafter.[10] November 7 and 9, 2001, fell on Wednesday and Friday of the ninth week of treatment, thus requiring preauthorization.

2. October 1 through November 5, 2001

Next at issue are joint mobilizations and one-on-one therapeutic exercises provided between October 1 and November 5, 2001. Although Dr. Bailey testified that joint mobilizations are a hands-on treatment meant to improve joint function, Dr. Alvarado testified that it is a passive form of care not generally needed beyond the first four to eight weeks of acute care, and that when it is provided, documentation must show that the patient is responding positively to the care. As Dr. Alvarado noted, the record does not justify the need for this form of passive care at this time in Claimant's treatment.

With regard to the one-on-one therapeutic exercises, Dr. Alvarado questioned the need for seven to eight 15-minute units of one-on-one therapy per session after October 1, 2001. Therapeutic exercises were introduced in September 18, 2001. According to Dr. Alvarado, one-on-one treatment is needed only when first introducing an injured worker to an exercise, if patient safety is a concern, or if there is a change in the routine. Dr. Alvarado recognized, for example, that the introduction of weight training on October 1, 2004, justified the need for some one-on-one instruction. According to Dr. Alvarado, at this point in the dispute, there was no need for more than one single unit of one-on-one instruction because there was no indication in the record that Claimant was having difficulty

[9] Ex. 2 at 170.

[10] *Id.* at 170-79.

performing the therapeutic exercises, except for the canned statementBAdifficulties monitored and adjustments made.@[11] Although Dr. Bailey testified that much more was done and that it is impossible for the care giver to write everything down, the ALJ is not persuaded. Wanting payment of $280 for two hours of one-on-one treatment behooves the care giver to make the effort. Furthermore, Dr. Bailey provided little or no evidence supporting the Clinic's position that one-on-one therapy was provided for two hours, and Dr. Bailey admitted that much of the therapy was provided in a group setting.

Dr. Alvarado also noted that the point of therapeutic exercises is to promote functionally independent persons, and that the eventual goal is a patient who can perform the exercises in either a group setting or at home. Dr. Alvarado pointed out that even though a home exercise program was documented initially, the record does not identify what the program consisted of beyond hot and cold palliatives, and the record does not indicate how Claimant was progressing in the program.

The Clinic has already been reimbursed $35.00 for each treatment day in question. The ALJ finds, nevertheless, that the Clinic is entitled to reimbursement of an additional $27.00 pursuant to CPT code 97150 (group therapeutic exercises) for each session between October 1 and November 15, for a total of $378.00.[12]

3. January 8 to February 26, 2002

As did the IRO, the ALJ concludes that none of the services provided after January 8, 2002, including those authorized by MRD, should be reimbursed. Although Dr. Bailey argues that it was

[11] Ex. 1 at 169-182.

[12] *See* Docket No. 453-99-1216.M5 at 4-6, in which the ALJ interpreted the Commission=s comment published in 21 *TexReg* 2380 (March 22, 1996) to mean that CPT code 97150 would be billed only once per session.

not appropriate for the IRO to second guess the treating doctor and to deny medical necessity of the treatment after the fact, Dr. Liscum should have questioned providing more of the same treatment in 2002, when it had not worked in 2001. That Claimant returned from a two-week trip to Mexico in a deconditioned state shows the inefficacy of the Clinic's treatment and is evidence that the Clinic's so-called aggressive treatment was ineffective. When left to his own devices, Claimant deteriorated, which suggests either malingering or that Claimant had become overly dependent on his treating doctor.[13]

Accordingly, TMIC is required to reimburse the Clinic $378.00.

VI. **FINDINGS OF FACT**

1. Claimant ___ suffered a compensable injury on ___, resulting in pain at his lower back.

2. At the time of the injury, Claimant's employer had workers' compensation insurance coverage with Texas Mutual Insurance Co. (TMIC).

3. Sam Liscum, D.C., who practiced through SCD Back & Joint Clinic (Clinic), began treating Claimant on September 10, 2001, and diagnosed him as suffering from "lumbar sprain/strain, thoracic sprain/strain, right lateral epicondylitis, and muscle spasm."

4. The Clinic sought reimbursement for services provided to Claimant from September 10, 2001, through February 26, 2002, from TMIC.

5. TMIC denied reimbursement of services from September 25, 2001, through February 26, 2002, on the grounds that the disputed treatments were either medically unnecessary or were inadequately documented to show need for treatment outside of the treatment guidelines.

[13] Ex. 1 at 138.

6. The Clinic made a timely request to the Texas Workers' Compensation Commission (Commission) for medical dispute resolution.

7. The independent review organization (IRO) to which the Commission referred the dispute concluded that the disputed treatment was medically necessary up to January 8, 2002.

8. The Commission's Medical Review Division reviewed the IRO decision as well as other services not addressed by the IRO and issued its own decision on July 21, 2003, ordering TMIC to pay $5,791.00, plus all accrued interest, to the Clinic.

9. The Clinic and TMIC requested a hearing in a timely manner with the State Office of Administrative Hearings (SOAH), seeking review of the MRD decision.

10. On September 10, 2003, the Commission issued the notice of the hearing, which stated the date, time, and location of the hearing and cited to the statutes and rules involved, along with a short, plain statement of the factual matters involved.

11. The hearing convened on August 24, 2004, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Katherine L. Smith, an Administrative Law Judge with SOAH. The Clinic and TMIC appeared through counsel.

12. At the hearing, TMIC agreed to compensate the Clinic for range of motion and testing provided on September 25 and 27, October 26, and November 15, 2001, and billed using current procedural codes (CPT) 95851 and 97750-MT.

13. Claimant began receiving physical therapy at the Clinic on September 11, 2001. On that date, the services provided were joint mobilization (CPT code 97265), myofascial release (CPT code 97250), electric stimulation (CPT code 97014), and diathermy (CPT code 97024). Claimant received similar physical medicine care or therapy thereafter.

14. Physical medicine treatments consisting of joint mobilization (CPT code 97265), one-on-one therapeutic exercises (CPT code 97110), group therapeutic exercises (CPT code 97150), myofascial release (CPT code 97250), and electric stimulation (CPT code 97014), were provided on November 7 and 9, 2001, during the ninth week of treatment.

15. At the hearing the Clinic agreed to withdraw its request for reimbursement for one-on-one physical therapeutic exercises (CPT code 97110) provided on November 7 and 9, 2001, and for reports of Claimant's work status (CPT code 99080-73) dated November 15, 2001, and January 9, 2002.

16. Dr. Liscum did not adequately document Claimant's need for joint mobilizations, a form of passive physical medical care, provided between October 1 and November 5, 2001, beyond the acute phase of care.

17. One-on-one therapeutic exercises were introduced to Claimant on September 18, 2001.

18. One-on-one supervision is needed only when first introducing an injured worker to an exercise, if patient safety is a concern, or if there is a change in the routine.

19. Dr. Liscum did not adequately document Claimant's need for more than one unit of one-on-one therapeutic exercises during the treatment sessions provided between October 1 and November 5, 2001.

20. Dr. Liscum did not document that up to two hours of one-on-one therapeutic exercises were provided to Claimant during the treatment sessions provided between October 1 and November 5, 2001.

21. The Clinic was reimbursed $35.00 for providing one unit of one-on-one therapeutic exercises during treatment sessions provided to Claimant between October 1 and November 15, 2001.

22. Although Claimant's strength increased from September 25 to November 15, 2001, his complaints of pain also increased.

23. Although Claimant was introduced to a home exercise program, the program and Claimant's progress with the program was not documented.

24. Claimant returned from a two-week trip to Mexico in a deconditioned state. The Clinic's treatment prior to Claimant's trip to Mexico was ineffective in addressing Claimant's complaints of pain.

25. The treatments provided to Claimant from January 8, 2001, to February 26, 2002, were no more effective in reducing Claimant's complaints of pain than those provided in 2001.

VII. CONCLUSIONS OF LAW

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

2. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to §413.031(k) of the Act and TEX. GOVT. CODE ANN. ch. 2003.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOVT. CODE ANN. §§2001.051 and 2001.052.

4. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOVT. CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. GOVT. CODE (TAC) § 133.305(g) and §§ 148.001-148.028.

5. In 2001, 28 TAC ' 134.600(h)(10) required preauthorization of physical therapy beyond eight weeks of treatment.

6. Medicine Ground Rule I.A.10.a. of the Medical Fee Guideline, 28 TAC ' 134.201 defined a physical medicine session as any combination of four modalities (CPT codes 97010-97039), procedures (CPT codes 97110-97150) and/or physical medicine activities and training (CPT codes 97220-97541).

7. The physical medicine treatments provided on November 7 and 9, 2001, set out in Finding of Fact No. 14 required preauthorization.

8. The joint mobilization treatments provided to Claimant between October 1 through November 5, 2001, were not medically necessary health care under § 408.021of the Act.

9. One-on-one therapeutic exercises provided to Claimant beyond one 15-minute session between October 1 through November 5, 2001, were not medically necessary health care

under §408.021of the Act.

10. Treatments that the Clinic provided to Claimant from January 8 through February 26, 2002, were not medically necessary health care under §408.021 of the Act.

11. Based upon the foregoing Findings of Fact and Conclusions of Law, the Clinic's request for reimbursement is denied except for group therapeutic exercises provided in treatment sessions from October 1 through November 5, 2001.

ORDER

IT IS THEREFORE, ORDERED that TMIC shall reimburse the Clinic $378.00. As to all other disputed claims at issue in this case, TMIC owes nothing.

SIGNED December 3, 2004.

KATHERINE L. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS