SOAH DOCKET NO. 453-04-0365.M5[1]
TWCC MR NO. M5-03-2217-01

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
HUMPAL PHYSICAL THERAPY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

HUMPAL PHYSICAL THERAPY,	§	**BEFORE THE STATE OFFICE**
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TEXAS MUTUAL INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) disputes the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission, TWCC) in MR Case No. ___ ordering reimbursement of $4,658 to Humpal Physical Therapy & Sports Medicine Centers (Provider) for physical therapy provided to Claimant A from July 1, 2002, through August 23, 2002.

Provider disputes the decisions of the MRD declining to order reimbursement of $3,930 in MR Case No. ___ for physical therapy provided to Claimant B, and of an unstated amount[2] in MR Case No. ___ for physical therapy provided to Claimant C.

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[1] Per agreement of the parties, SOAH Docket Nos. 453-03-3624.M5, 453-03-3857.M5, and 453-04-0365.M5 were consolidated under lead docket number 453-04-0365.M5 for hearing purposes, pursuant to Order No. 3 in this matter, issued November 21, 2003.

[2] There is no evidence in the record as to what amount is in dispute for Claimant C's treatment.

The Administrative Law Judge (ALJ) finds the disputed treatments for Claimant A and Claimant C were not reasonable and medically necessary. Therefore, Carrier is not to reimburse Provider for the disputed treatments and services provided to Claimant A and Claimant C.

The ALJ finds that partial reimbursement of $964, as recommended by the independent review organization (IRO), is warranted for treatment rendered to Claimant B, because some of the disputed treatment was reasonable and medically necessary to relieve the effects naturally resulting from Claimant B's compensable injury to his lumbar spine.

I. PROCEDURAL HISTORY

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. Chapter 2003. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN., Chapter 2001 and SOAH's rules, 1 TEX. ADMIN. CODE (TAC) Chapter 155.

Notice and jurisdiction are not contested and are addressed in the Findings of Fact and Conclusions of Law set out below.

ALJ Sharon Cloninger convened the consolidated hearing on the merits on January 13, 2004, in the William P. Clements State Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Provider appeared via telephone through its president and CEO, Scott Humpal. Attorney Patricia Eads represented Carrier. The hearing concluded and the record closed that same day.

II. APPLICABLE LAW

The only issue in this case is whether, by a preponderance of the evidence, the requested treatment is medically necessary. Medical necessity is defined at TEX. LAB. CODE ANN. § 408.021(a), which states:

> (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.

Under 28 TAC § 148.21(h), the appealing party has the burden of proof in hearings, such as this one, conducted pursuant to TEX. LAB. CODE ANN. § 413.031. Thus, Claimant, as the petitioner, must prove the requested treatment is reasonably required within the meaning of TEX. LAB. CODE ANN. § 408.021(a).

III. BACKGROUND

1. Claimant A

Claimant A incurred a compensable injury on ___, when he twisted his left ankle while climbing off a truck at work. On March 11, 2002, he was diagnosed by Robert Q. Lewis, M.D., his treating physician, to have a lateral ligament injury which, a month after the incident, continued to be painful and swollen. Treatment for Claimant A's injury included immobilization of the ankle and pain medication.

After Claimant A failed to respond to conservative care, he was sent for an MRI which revealed two areas of cartilage abnormality in the ankle. On May 6, 2002, Claimant A underwent arthroscopic ankle surgery for removal of bone fragments and cartilage. Dr. Lewis referred Claimant A to Provider for post-operative physical therapy which began May 22, 2002. Claimant A finished his initial physical therapy on June 3, 2002, for which Carrier reimbursed Provider.

Dr. Lewis referred Claimant A to Provider for additional physical therapy from July 1, 2002, through August 23, 2002. In a July 3, 2002 letter, Dr. Lewis stated Claimant A was still recuperating from ankle surgery and trying to regain range of motion, and that he needed additional therapy. In a July 29, 2002 letter, Dr. Lewis stated Claimant A had been able to increase his range of motion due to physical therapy. In an August 26, 2002 letter, Dr. Lewis said he planned to stop the physical therapy because it seemed to be aggravating Claimant A's "problem".[3]

Carrier denied reimbursement for the July 1, 2002, through August 23, 2002 physical therapy on the basis that the treatment was not reasonable or medically necessary. Provider requested an appeal of Carrier's denial before the Commission's Medical Review Division (MRD), pursuant to 28 TAC § 134.600(g). The Commission referred the appeal request to an IRO, as permitted under 28 TAC § 133.308. The IRO recommended denial of treatment. On August 15, 2003, the MRD issued a decision denying reimbursement. On August 29 2003, Provider requested a hearing on the matter before SOAH.

[3] Dr. Lewis does not identify what Claimant A's problem is.

B. Claimant B

Claimant B incurred a compensable injury to his back on ___, when he slipped and fell at work, suffering a herniated disk at the L5-S1 level. He initially received conservative treatment, followed by a February 28, 2001 lumbar laminectomy for removal of the herniated disc. He reached maximum medical improvement (MMI) on May 28, 2001, and was assigned a 10 percent whole body impairment. Provider treated Claimant B from May 8, 2001, through August 16, 2001, and was reimbursed for that physical therapy. In dispute is Provider's subsequent treatment of Claimant B, from January 22, 2002, through June 6, 2002, during which time care included electric stimulation with moist heat pack, ultrasound, massage, aquatic therapy, and therapeutic exercise.

Provider requested an appeal of Carrier's denial before the MRD. The Commission referred the appeal request to an IRO. On April 24, 2003, the IRO recommended payment for treatment from January 22, 2002, through February 4, 2002, and denial of reimbursement for treatment rendered February 5, 2002, through June 6, 2002, because a two-week trial of physical therapy was appropriate for Claimant B's condition, but further treatment was not medically necessary. The MRD issued a decision on May 2, 2003, ordering Carrier to reimburse Provider for all treatment rendered from January 22, 2002, through February 4, 2002, but not for treatment rendered from February 5, 2002, through June 6, 2002, because it was not medically necessary. On May 28, 2003, Provider requested a hearing before SOAH.

C. Claimant C

Claimant C incurred a compensable injury to his left knee on ___, when he fell off a rack at work and fractured his tibia. He underwent open reduction internal fixation surgery on March 14, 2001. After the operation, he was in a wheelchair for about two months, after which he used crutches and a leg brace. He underwent a second surgery on February 12, 2002, to remove hardware mechanisms from his leg. He received post-operative physical therapy from February 19, 2002, through May 20, 2002, from Premier Physical Therapy & Sports Medicine. He received additional physical therapy from Provider from June 17, 2002, through July 30, 2002, during which time he became slightly stronger. Provider's disputed treatment of Claimant C included therapeutic procedures and therapeutic exercises, both requiring one-on-one supervision, and electric stimulation.

Provider requested reimbursement from Carrier, which was denied. Provider appealed Carrier's denial before the MRD. The Commission referred the appeal request to an IRO. On May 5, 2003, the IRO recommended denial on the basis that the disputed treatments were not adequately documented to establish medical necessity. The MRD issued a decision on May 9, 2003, denying reimbursement on the basis that the treatment and services were not reasonable or medically

necessary. On June 13, 2003, Provider requested a hearing before SOAH.

IV. DISCUSSION

A. Evidence regarding Claimant A

1. Provider's testimony

Scott Humpel, owner and CEO of Humpal Physical Therapy & Sports Medicine Centers, did not personally examine or treat Claimant A. He did not observe any of Claimant A's treatment. He was not present when Claimant A did his therapeutic exercises (CPT code 97110), for which one-on-one supervision is required.[4] He presumes one-on-one supervision was provided because the physical therapist billed under the 97110 CPT code. He said all the disputed treatments were reasonable and medically necessary to treat Claimant A's compensable injury.

2. Testimony of Nicolas Tsourmas, M.D.

Dr. Tsourmas, an orthopedic surgeon, testified on behalf of Carrier that in his review of the medical records, he did not see documentation demonstrating progress in Claimant A's strength, range of motion, or control of pain between July 1, 2002, and August 23, 2002. Dr. Tsourmas testified that Claimant A did not need physical therapy after July 1, 2002. He said the May and June 2002 formal in-house monitored physical therapy was sufficient. He agreed that Claimant A needed long-term rehabilitation, but said instead of the coaching and monitoring he received in July and August, Claimant A should have been doing daily exercises at home. He noted there was no evidence that Provider was trying to transition Claimant A to a home exercise program. He described Claimant A's ankle surgery as "simple," and said there was nothing in the medical records documenting the necessity for the intensity and duration of Claimant A's physical therapy that began July 1, 2002.

He pointed out that Claimant A had received 13 sessions of physical therapy in May and June 2002, so did not need one-on-one supervision for education and demonstration of the exercises. By July 1, 2002, Claimant A's strength was 4/5, and the modalities used by Provider would not improve a patient's strength. He said the iontephresis and joint mobilization, which are passive modalities, were not medically necessary, because those treatments are reserved for acute inflammation, which Claimant A did not have.

[4] One-on-one supervision is not documented in the evidentiary record.

He disagreed with the IRO conclusion that Claimant A suffered from neuropathic problems, because the conclusion is not substantiated by Claimant A's medical records. He also disagreed with the IRO conclusion that electric stimulation would get Claimant A's ankle moving passively.

3. Testimony of Scott Herbowy, physical therapist

Mr. Herbowy said the primary goal of physical therapy is to restore a patient's function by increasing range of motion, strength, and coordination, and by decreasing pain. He said Claimant A's condition improved after the May 6, 2002 surgery through July 1, 2002, but evaluations performed on July 23, 2002, and July 26, 2002, showed a decrease in Claimant A's range of motion; no increase in strength; and some improvement in weight bearing, although that could be due to the passage of time rather than physical therapy.

He said if there is no progress in a patient's condition after two weeks or so of physical therapy, as in Claimant A's case, a provider should change the program and discuss the appropriateness of continued treatment with the referring doctor. He said Provider did not do that, adding that a physical therapist should not see a patient for 23 visits with no improvement.

Mr. Herbowy said that to increase strength and range of motion, long-term active modalities should have dominated Claimant A's treatment. He said that as of July 1, 2002, instead of one-on-one active therapy, Claimant A needed a daily home exercise program, with review every two-to-three weeks by a physical therapist who would act as a guide and coach.

Mr. Herbowy said he found it odd that on July 1, 2002, Claimant A's active therapy was reduced, and his passive therapy was increased, because as care progresses, it is active therapy that should increase. He said a patient gains range of motion by changing soft tissue scarring (type 3 collagen) back to normal tissue (type 1 collagen) through exercise performed three or four times a day. He said passive modalities do not convert scar tissue to normal elasticity and flexibility. He explained that passive modalities such as myofascial release, joint mobilization, and soft tissue mobilization do not have a long-term effect on collagen, the building block of tissue. He said there is no scientific justification for ultrasound, which does not increase range of motion. He said heat does not change collagen structure. Instead, he said, exercise performed at an appropriate intensity and frequency will remodel collagen over a period of weeks or months.

4. Deposition of Claimant A

Claimant A states that his condition did not improve by August 23, 2002, with physical therapy, and that he later had a second surgery on his ankle. He said that while under Provider's care, he never had one-on-one supervision during which an employee stayed with him for the

duration of his exercises.

B. Evidence regarding Claimant B

1. Provider's testimony

Provider testified he treated Claimant B "sporadically". He said Claimant B was in a lot of pain, and no treatment seemed to improve his condition, although Claimant B was given every opportunity to get better. When asked how reasonable it is to continue physical therapy for a patient such as Claimant B, who refused to exercise beginning February 27, 2002, Provider responded that anything is reasonable as long as the physical therapist is trying to improve the patient's condition. He said that while Claimant B resisted exercise, he did agree to some treatment. Provider admitted on cross examination that the medical records fail to document the exercises Claimant B was assigned to do, and do not indicate if Claimant B met the goals of treatment. Provider testified that Claimant B did not, in fact, meet the goals of treatment.

2. Testimony of Dr. Tsourmas

Dr. Tsourmas agreed with the IRO recommendation that Provider should only be reimbursed for care provided January 22, 2002, through February 4, 2002. He testified that Provider's repetition of treatment, when it did not improve Claimant B's condition, was not medically necessary. He said passive therapy was not an effective way to alleviate Claimant B's chronic pain; instead, if Claimant B was to lessen his chronic back pain and remain active, he would have to consistently do back exercises, which should have been taught to him as part of a home exercise program.[5]

Dr. Tsourmas testified that using aquatic therapy with Claimant B after he had done land-based exercises was a step backward because aquatic therapy offers less cardiovascular training and less resistance. He said if Claimant B had pain, stiffness, or motion problems, aquatic therapy would have been appropriate, but there is no documentation to support the use of aquatic therapy.

In reference to Claimant B's eventual refusal to exercise as directed, Dr. Tsourmas said if a patient refuses to work at getting better, it is reasonable to discontinue a particular treatment and try something else.

The documentary evidence contains a June 5, 2003 review of Claimant B's medical records

[5] A July 25, 2001 progress note related to prior treatment of Claimant B by Provider indicates Claimant B was instructed in a home exercise program and discharged from Provider's care. The record does not indicate whether Claimant B followed the home exercise program prior to his re-evaluation by Provider on January 22, 2002.

by Dr. Tsourmas, in which Dr. Tsourmas states that passive modality therapies are not indicated unless an acute flare-up occurs. He said there is nothing in Claimant B's 2002 records to indicate an acute flare-up had occurred. Dr. Tsourmas nevertheless concludes some of the treatment for a possible acute flare-up would have been reasonable, but certainly not four-to-five months of physical therapy as indicated and prescribed by Claimant B's treating physicians. He suggested that the April 24, 2003 IRO decision to reimburse Provider for two weeks of care be followed.

3. Testimony of Mr. Herbowy

Mr. Herbowy testified that Claimant B's treatment goals as set out January 22, 2002, include four goals related to improving function and one goal related to decreasing pain.[6] He said that because four out of five goals were functional, Claimant B needed active therapy, and that passive modalities provided to Claimant B would not improve his function. Mr. Herbowy said that none of the passive modalities in dispute were reasonable or medically necessary.

Mr. Herbowy said he could not tell from the medical records what Claimant B's exercise program was. He said there is no documentation regarding what aquatic therapy was done, or if it was one-on-one, as required. He said Claimant B spent only six minutes on the treadmill on dates of service from February 11 through February 27, 2002, when at least eight minutes is required to bill for one unit of time, so Provider should not be reimbursed for therapeutic exercise provided to Claimant B on those dates.[7]

On cross, Mr. Herbowy said there is no indication Claimant B's physical therapy was revised to reflect his non-responsiveness to treatment. He elaborated that with no demonstrable change in a few visits, treatment should be stopped or modified.[8] He said there was no rationale for week after week of passive modalities, which should be used in an acute situation but not for chronic pain, such as Claimant B had. In Mr. Herbowy's opinion, once Claimant B refused to do the prescribed exercises, Provider's obligation to work with Claimant B ended, and Provider should have let Claimant B's treating doctor know the patient was not cooperating.

In addition, Mr. Herbowy noted that Claimant B's range of motion decreased between January 2002 and May 2002, when it should have increased had the treatment been effective. He did say, however, that a patient's failure to improve is not a reason to deny reimbursement.

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[6] Carrier Ex. 1-B, 43.

[7] Carrier Ex. 1-B, 47.

[8] Provider agreed with Mr. Herbowy's testimony at this point.

4. Documentary evidence

On January 22, 2002, Claimant B was seen by Provider for a physical therapy re-evaluation, at which time Claimant B complained of constant and intense low back pain. Provider's assessment was that Claimant B returned to physical therapy with decreased functional activity tolerance. Provider's goals for Claimant B were to decrease his complaints by 50 percent; to allow him to sit and stand for longer than 15 minutes without complaints of pain; to allow him to walk without complaints of pain; and to increase his right lower extremity strength to 5/5. Provider's treatment of Claimant B included ultrasound, electric stimulation with moist heat pack, massage, therapeutic exercise, and aquatic therapy.

A January 31, 2002 progress note states Claimant B noticed significant improvement for 30 minutes-to-an-hour after treatment sessions, but then his pain returned to its usual baseline. The February 8, 2002 progress note records that Claimant B again stated that he felt good for about 30 minutes after treatment, and also wanted to avoid surgery. A February 27, 2002 progress note documents Claimant B's unwillingness to participate in any exercise program except walking on the treadmill for six minutes, and his preference for passive modalities. The March 11, 2002 progress note documents that the treatment sessions continued to provide temporary relief for Claimant B, and that he was unwilling to participate in a lumbar stabilization program. Claimant B was discharged from Provider's care on March 11, 2002.

Claimant B returned to Provider on May 20, 2002, for a physical therapy re-evaluation, during which he complained of low back pain; his active trunk range of motion was limited to approximately 80 percent on all planes; and pain was produced with flexion, extension, and side bending. Provider's assessment was that Claimant B had continued complaints of low back pain and radicular symptoms into his right lower extremity, and decreased activity to his functional abilities.

The subsequent May 31, 2002 progress note states that Claimant B complained of an increase in pain after getting out of the swimming pool. Provider's assessment was that aquatic exercise had promoted unloading Claimant B's lumbar spine to decrease stresses while he exercised.[9]

The June 6, 2002 progress note says Claimant B might undergo spinal fusion surgery, that he had obtained relief from the treatment sessions, and that he had tolerated the aquatic exercise program.

[9] The record contains no information regarding which aquatic exercises were performed, how many repetitions of each exercise were done, or Claimant B's response to aquatic exercise.

C. Evidence regarding Claimant C

1. Provider's testimony

Dr. Humpal did not treat Claimant C, and was not present when Claimant C was treated. He said that he gives the physical therapists in his employ the definitions of various CPT codes, and expects them to bill correctly for their services. He said if a physical therapist used the CPT code 97110 for a treatment that requires one-on-one supervision, use of the CPT code is adequate documentation that the treatment was provided on a one-on-one basis.

2. Dr. Tsourmas' testimony

Dr. Tsourmas noted that Claimant C began treatment with Provider with a normal range of motion and 4/5 strength in his left leg, which is considered "good" strength. He agreed that there was a slight strength deficit, but said Claimant C did not need physical therapy. He said that by June 17, 2002, Claimant C had already had eight or nine months of physical therapy, so Provider's care of Claimant C was redundant. He said there is nothing in the medical records to suggest Claimant C could not have done strengthening exercises at home.

In a letter dated April 1, 2003, Dr. Tsourmas stated the disputed treatment was not medically necessary because by June 17, 2002, Claimant C had been adequately coached, trained, and educated to exercise at home; he no longer needed a monitored format. Dr. Tsourmas said the same end result set forth in Provider's October 7, 2002 letter of medical necessity could have been obtained with a health club membership, a home exercise program, or with a "tincture" of time.

3. Mr. Herbowy's testimony

Mr. Herbowy testified that Claimant C had normal range of motion and close to normal strength when Provider initially evaluated him on June 17, 2002, which is exactly what was recorded in Premier Physical Therapy's discharge note. He said Provider should have recommended "no treatment," other than initiation of a home treatment program, because Claimant C had no deficits. He said he does not understand how Provider's July 9, 2002 progress note can state there had been excellent improvement in Claimant C's range of motion, when the patient's range of motion was 100 percent at the initial evaluation. He said passive modalities were not indicated so long after Claimant C's surgery, especially because he had limited problems when Provider began seeing him. He said therapeutic exercise was not warranted. He said soreness in Claimant C's left knee did not warrant intense physical therapy.

4. Documentary evidence

Provider's June 17, 2002 initial evaluation of Claimant C indicated range of motion of the left knee to be within normal limits, with manual muscle testing of the left knee in extension to be 4/5 and into flexion to be 4+/5. Treatment included electric stimulation for pain control, and strengthening exercises.

By comparison, two months prior to Provider's initial evaluation, an April 15, 2002 letter from Premier Physical Therapy & Sports Medicine to Claimant C's treating physician reported Claimant C presented a full range of motion for his knee with no limitations noted, that his leg flexion was 4+/5 and his leg extension was 4+/5; that he had a normal gait pattern, with no limping noted at a regular pace. The assessment was that Claimant C was progressing well, that his muscle strength was good, and that he had good, pain-free range of motion. Premier Physical Therapy recommended that Claimant C continue his strengthening exercises to return to maximum activity level, and stated Claimant C had been advised to continue his home exercise program, to join a health club to continue with his strengthening exercise program with proper training, to walk prolonged distances, and to continue exercising on the stationary bicycle, if possible.

Provider's June 27, 2002 progress note states Claimant C was gradually tolerating increasing amounts, duration, and resistance in his exercise, although repetitive squatting aggravated the left knee. A physical therapy re-evaluation dated July 9, 2002, says that manual testing of the left knee into flexion and extension was 5/5 in both directions, that Claimant C was able to move into a full squat position with the left leg, was able to climb a normal 7-8" step with the left leg, and was able to walk with no gait deviations. Provider's July 26, 2002 progress note states Claimant C's range of motion and strength testing remained within normal limits, that he was able to step up and down on a 6" step 110 times at a normal stepping pace, and that his pain after the stepping activity was 2-3 on a 0-10 scale. The July 30, 2002 progress note states Claimant C had reached a plateau at his current level, his strength was good, his walking stability was good, that he was limited in stair climbing by pain, that he had improved since initiating therapy in his strength, control and stability of the left knee, but he had reached a plateau and was not making further progress toward functional tolerances.

In an October 7, 2002 letter of medical necessity, Brian Baker, a physical therapist who is employed by Provider, wrote that Claimant C began physical therapy with pain in his left knee, weakness in both flexion and extension of the knee, and a gait pattern that became effective with prolonged activity. Provider discontinued physical therapy when Claimant C regained normal strength, was able to climb stairs, and was able to walk with a normal gait pattern.

V. ANALYSIS

A. Claimant A

Carrier met its burden of proving the disputed treatment was not reasonable or medically necessary. Testimony by Dr. Tsourmas and Mr. Herbowy established the disputed treatments were inappropriate to improve Claimant A's function by increasing his strength, range of motion, and coordination, and decreasing his pain. Instead, a home exercise program from July 1, 2002, forward would have been sufficient to cure or relieve the effects naturally resulting from Claimant A's compensable injury; promote his recovery; or enhance his ability to return to or retain employment, pursuant to TEX. LAB. CODE ANN. § 408.021(a). Therefore, Carrier is not to reimburse Provider for treatment rendered to Claimant A.

B. Claimant B

All parties agree that treatment rendered by Provider to Claimant B from January 22, 2002, through February 4, 2002, should be reimbursed, and the ALJ concurs. It was reasonable and medically necessary to provide two weeks of physical therapy for Claimant B to ascertain if his chronic pain could be decreased, and if his strength, range of motion, and flexibility could be improved. However, because he had not suffered an acute flare-up, none of the passive modalities provided after February 4, 2002, were reasonable or medically necessary. If Claimant B had performed the active modalities as instructed, they would have been reasonable and medically necessary to treat his chronic pain. However, the active modalities should not be reimbursed because Claimant B did not spend enough time on the treadmill for the activity to be billed, and the record does not indicate what exercises, if any, Claimant B did in his aquatic therapy sessions, or how he responded to them.

Provider argues that "relief from pain" should be enough to find medical necessity for the passive modalities, but the record indicates Claimant B became dependent on temporary pain relief from the passive modalities rather than working toward long-term pain relief through exercise. Once Claimant B refused to exercise, and wanted only passive modalities, treatment should have been discontinued.

The ALJ agrees with Provider in general that even when a patient fails to meet his treatment goals, the care could have been reasonable and medically necessary. However, the treatment has to be reasonably calculated to improve a patient's condition. In Claimant B's case, it is clear there was no acute flare-up to warrant passive modalities, and Claimant B did not cooperate with Provider by exercising, so treatment should have been discontinued after two weeks.

Therefore, Carrier is to reimburse Provider $964 for treatment provided to Claimant B from January 22, 2002, through February 4, 2002, and nothing for treatment provided from February 5, 2002, through June 6, 2002.

C. Claimant C

Provider failed to meet his burden establishing that physical therapy rendered to Claimant C from June 17, 2002, through July 30, 2002, was reasonable and medically necessary. By the time Claimant C was initially evaluated by Provider, he already had 100 percent range of motion and only a slight deficit in strength, as well as eight or nine months of prior physical therapy. Claimant C could have increased his strength through a home exercise program, and did not need intense physical therapy to do so. There is no evidence that the disputed treatment was reasonable or medically necessary to cure or relieve the effects naturally resulting from Claimant C's compensable injury, to promote his recovery, or to allow him to retain employment. Thus, Provider is not entitled to reimbursement for treatment rendered to Claimant C.

VI. FINDINGS OF FACT

1. Notice of the hearing was sent to the parties on October 3, 2003, for Claimant A's case; on June 26, 2003, for Claimant B's case; and on July 23, 2003, for Claimant C's case.

2. The notices contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

3. The aforementioned dockets were consolidated, and a hearing on the merits was set for January 13, 2004, pursuant to Order No. 3 in this matter issued on November 21, 2003.

4. Administrative Law Judge Sharon Cloninger convened the hearing January 13, 2004, in the William P. Clements State Office Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Provider appeared via telephone. Carrier was represented by Patricia Eads, attorney. The hearing concluded and the record closed that same day.

Claimant A

1. Claimant A suffered a compensable work-related injury on ___, when he twisted his left ankle while climbing off a truck at work.

2. On that same date Texas Mutual Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant A's employer.

3. On March 11, 2002, Claimant A's treating physician Robert Q. Lewis, M.D., diagnosed him to have a lateral ligament injury.

4. Treatment for Claimant A's ankle injury included immobilization of the ankle, and pain medication.

5. After Claimant A failed to respond to conservative care, he was sent for an MRI which revealed two areas of cartilage abnormality in the ankle.

6. On May 6, 2002, Claimant A underwent arthroscopic ankle surgery for removal of bone fragments and cartilage.

7. Dr. Lewis referred Claimant A to Humpal Physical Therapy & Sports Medicine Centers (Provider) for physical therapy which was provided beginning May 22, 2002.

8. Carrier reimbursed Provider for post-operative physical therapy rendered to Claimant A from May 22, 2002, through June 30, 2002.

9. Based on a second prescription from Dr. Lewis, Provider continued treating Claimant A for his compensable injury from July 1, 2002, through August 23, 2002.

10. Provider's care of Claimant A from July 1, 2002, through August 23, 2002, included the following disputed treatments:

    a. Hot/cold pack treatments on July 1, 3, 29, and August 7, and 9 (2 x);
    b. Therapeutic exercises, with three units on July 1 and 12, and two units per day on July 2, 5, 8, 10,15,17,19,21,23,24,26,29,31 and August 2, 5, 12, 16,19, 22, and 23;
    c. Therapeutic procedures, functional activities at two units per day on July 5, 8, 10, 12, 15, 17, 23, 24, 26, 29, 31, and August 5, 7, 9, 12, 16, 19, 22, and 23;
    d. Myofascial release on July 10;
    e. An office visit on August 23;
    f. Joint mobilization on July 1, 5, 15, 17, 19, 23, 26, and August 5, 9, 12, 16, 19, and 22;
    g. Electric stimulation therapy on July 1, 3, 5, 8, 10, 12, 15, 17, and 24;
    h. Iontophoresis on July 8, 26, and 29, with two units per day on July 10, 12, 15, 17, 19, 21, 23, 24, and August 2, 5, 7, 9, 12, 19, 22, and 23;

i. Supplies and materials on July 5, 8, 10, 12 (2x),15,17,19,23,24,29, August 2 (2x), 5,7(2x),19
j. Group therapeutic procedures on July 3.

11. The purpose of physical therapy is to improve a patient's function by increasing strength and range of motion, and by decreasing pain.

12. From July 1, 2002, through August 23, 2002, Claimant A's function did not improve under Provider's care. He did not get stronger, increase his range of motion, or decrease his pain during that time, as indicated in evaluations conducted by Provider on July 1, July 26, July 29, and August 23, 2002, with results set out below:

a. From July 1, 2002, through August 23, 2002, Claimant A continued to use crutches. On July 1, he could bear weight on his entire left foot. By July 26, 2002, he was putting up to 40 percent of weight bearing on the left foot, but not consistently, and wore an air cast splint when walking. By July 31, he could walk short distances without his crutches, but typically used the crutches with 40 percent weight bearing on his left foot. By August 23, he was putting approximately 50-60 percent weight bearing on the left foot. He could walk for a few steps at a time without his crutches, but this caused his ankle to become painful fairly quickly.
b. Claimant A's range of motion decreased between July 1 and August 23, with inversion dropping from 47 degrees to 43 degrees; eversion from 20 degrees to 18 degrees, and plantar flexion from 45 degrees to 40 degrees. Dorsiflexion improved from 3+ degrees to 5 degrees.
c. Claimant A's strength on July 1, was basically normal at 4+/5 in all directions, and ranged from 4-/5 to 4/5 by August 23, depending on the direction the ankle moved.
d. Patient continues to have much pain on the anterior aspect of the ankle during stretching into dorsiflexion and he continues to have some heel pain when weight bearing onto the left foot.

13. Appropriate physical therapy for Claimant A's treatment from July 1, 2002, through August 23, 2002, would have been implementation of a home exercise program in which he exercised three or four times daily to regain range of motion and strength in his left ankle by converting scar tissue to normal tissue.

14. Passive modalities performed on Claimant A by Provider from July 1, 2002, through August 23, 2002, had no long-term medical benefit, and did not promote Claimant A's recovery from his compensable injury.

15. Provider's treatment of Claimant A was not reasonably required by the nature of his injury to relieve the effects naturally resulting from the compensable injury and to enhance Claimant A's ability to retain employment.

16. Provider sought reimbursement of $4,658 from Carrier for the treatment rendered to Claimant A.

17. Reasonable or medically necessary.

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

19. The MRD referred the appeal to an independent review organization (IRO). The IRO issued a decision on August 12, 2003, recommending that Provider be reimbursed, because the disputed treatments were medically necessary.

20. After reviewing the IRO decision, the MRD issued a decision on August 15, 2003, stating that Provider prevailed on the issue of medical necessity.

21. On August 29, 2003, Carrier requested a hearing before the State Office of Administrative Hearings (SOAH).

Claimant B

1. Claimant B suffered a compensable work-related injury to his lumbar spine on ___, when he slipped and fell at work.

2. On May 28, 2000, Carrier was the workers' compensation insurance carrier for Claimant B's employer.

3. Claimant B was diagnosed to have a herniated disc at the L5-S1 level.

4. Claimant B underwent surgery on February 28, 2001, for removal of the herniated disc.

5. From January 22, 2002, through June 6, 2002, Provider treated Claimant B on an irregular basis with physical therapy that included ultrasound, electrical stimulation with moist heat pack, massage, aquatic exercise, and general exercise.

6. Provider's treatment of Claimant B from January 22, 2002, through February 4, 2002, was reasonable and medically necessary to treat Claimant B's condition, because a two-week trial was appropriate to ascertain if physical therapy would improve Claimant B's strength and flexibility, and decrease his pain level.

7. Provider's care of Claimant B from January 22, 2002, through February 4, 2002, included the following treatments, listed with corresponding CPT codes and maximum allowable reimbursement (MAR) under the Commission's Medical Fee Guideline:

   a. ultrasound (CPT Code 97035; $22 per each 15 minutes) on January 22 (3x), 23 (3x), 24 (3x), 28 (3x), 29 (3x), and 31(2x) for a total of $374;
   b. electric stimulation (CPT Code 97014; $15) with moist heat pack (CPT Code 97010; $11) on January 22, 23, 28, 29, and 31 for a total of $130;
   c. therapeutic exercises (CPT Code 97110; $35 each 15 minutes) on January 24 (3x), 28 (3x), 29 (3x), and 31(2x) for a total of $385;
   d. office visit (99213; $48) on January 22 for a total of $48;
   e. and group therapeutic procedures (CPT Code 97150; $27) on January 24 for a total of $27.

8. Carrier should reimburse Provider $964 for treatment rendered from January 22, 2002, through February 4, 2002.

9. Provider's treatment rendered to Claimant B from February 5, 2002, through June 6, 2002, was not reasonable or medically necessary to treat Claimant B's condition because Claimant B had not suffered an acute flare-up that would warrant the use of passive modalities; the passive modalities decreased Claimant B's pain for up to an hour, without providing the long-term improvement that would have been afforded by active modalities; Claimant B did not spend enough time on the treadmill to have a training effect; and the aquatic exercises were not indicated, in that Claimant B did not suffer from pain, stiffness, or motion problems that would support the use of aquatic therapy.

10. Provider's treatment of Claimant B from February 5, 2002, through June 6, 2002, was not reasonably required by the nature of his injury to relieve the effects naturally resulting from the compensable injury, to promote his recovery, or to enhance his ability to retain employment.

11. Provider sought reimbursement of $3,930 from Carrier for the treatments rendered to Claimant B.

12. Carrier denied reimbursement for the above services on the basis that the treatments were not reasonable or medically necessary.

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

14. The MRD referred the appeal to an independent review organization (IRO). The IRO issued a decision on April 24, 2003, agreeing in part with Carrier's denial of reimbursement. The IRO decision stated that the office visits, physical therapy, and supplies provided from January 22, 2002, through February 4, 2002, were medically necessary, but those provided from February 5, 2002, through June 6, 2002, were not.

15. The MRD decision issued May 3, 2003, found Provider to have prevailed on the issue of medical necessity for the disputed dates of January 22, 2002, through February 4, 2002, but not for February 5, 2002, through June 6, 2002.

16. On May 28, 2003, Provider appealed the MRD decision to SOAH.

Claimant C

1. Claimant C suffered a compensable injury to his left knee on ___, when he fell off a pipe rack at work and suffered a fractured tibia.

2. Carrier was the insurance provider for Claimant C's employer at the time of his compensable injury.

4. Claimant underwent open reduction internal fixation surgery on March 14, 2001, to treat his compensable injury.

5. After the March 14, 2001 operation, Claimant C was in a wheelchair for about two months, after which he used crutches and a leg brace.

6. Claimant C underwent a second surgery on February 12, 2002, to remove hardware mechanisms from his leg.

7. Claimant C received post-operative physical therapy from February 19, 2002, through May 20, 2002, from Premier Physical Therapy & Sports Medicine.

8. When Claimant C was discharged from Premier Physical Therapy & Sports Medicine's care, he had normal range of motion, 4/5 strength, and a normal gait pattern.

9. When Claimant C was discharged from Premier Physical Therapy & Sports Medicine's care, and again when he was initially evaluated by Provider on June 17, 2002, he did not need further physical therapy. Instead, he needed to continue strengthening exercises at home or at a health club, take prolonged walks, and continue to workout on a stationary bicycle, if possible.

10. Claimant C received additional physical therapy from Provider from June 17, 2002, through July 30, 2002, during which time the strength in his left leg improved slightly from 4/5 to 5/5.

11. Provider's care of Claimant C from June 17, 2002, through July 30, 2002, included the following treatments, listed with the corresponding CPT code and MAR:

    a. electric stimulation (CPT code 97014; $15) on June 17, 19, 20, 24, 25, 27, and on July 1, 2, 3, 9, 12, 16, 17, 24, 26, 29 and 30 for a total of $255;
    b. therapeutic procedures (CPT code 97110; $35 per 15 minutes) consisting of two units each on June 17, 19, 20, 24, 25, 27, and July 1, 2, 3, 9, 12, 16, 17, 18, 23, 24, 26, 29, and 30 for a total of $1,330;
    c. and therapeutic activities (CPT code 97530; $35 per 15 minutes) consisting of two units each on June 17, 19, 20, 25, 27, and July 12, 16, 17,18, 23, 24, 26, 29, and 30 for a total of $980.

12. Provider's treatment of Claimant C from June 17, 2002, through July 30, 2002, was not reasonably required by the nature of his injury to relieve the effects naturally resulting from the compensable injury, to promote Claimant C's recovery, or to enhance Claimant's ability to retain employment.

13. Provider requested reimbursement from Carrier for the treatment rendered to Claimant C.

14. Carrier denied Provider's request for reimbursement on the basis that the treatments were not reasonable and medically necessary.

15. Following Carrier's denial, Provider filed a timely request with the Commission for medical dispute resolution.

16. The request was assigned to an IRO by the MRD. The IRO recommended denial of

reimbursement on May 5, 2003.

17. The MRD issued a decision May 9, 2003, denying reimbursement on the basis that the disputed treatment and services were not reasonable or medically necessary.

18. On June 13, 2003, Provider filed a timely request for a hearing before SOAH to contest the MRD decision.

VII. CONCLUSIONS OF LAW

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

2. State Office of Administrative Hearings 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. Chapter 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN., Chapter 2001 and SOAH's rules, 1 TEX. ADMIN. CODE (TAC) Chapter 155.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN.§ 2001.052.

5. Regarding Claimant A and MR Case No. M5-03-2217-01, and based on the above Findings of Fact and Conclusions of Law, Carrier met its burden of proving the requested treatment was not medically necessary and reasonably required within the meaning of TEX. LAB. CODE ANN. § 408.021(a).

6. Regarding Claimant B and MR Case No. M5-03-1223-01, and based on the above Findings of Fact and Conclusions of Law, Provider met its burden of establishing the requested treatment is medically necessary and reasonably required within the meaning of TEX. LAB. CODE ANN. § 408.021(a) for disputed dates of service January 22, 2002, through February 4, 2002, but not for disputed dates of service February 5, 2002, through June 6, 2002.

7. Regarding Claimant C and MR Case No. M5-03-1558-01, and based on the above Findings of Fact and Conclusions of Law, Provider failed to meet its burden of proving the requested treatment is medically necessary and reasonably required within the meaning of TEX. LAB. CODE ANN. § 408.021(a).

8. Based on the foregoing Findings of Fact and Conclusions of Law, partial reimbursement from Carrier to Provider in the amount of $964 is warranted.

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company shall reimburse Humpal Physical Therapy & Sports Medicine Centers nothing for treatment of Claimant A; $964 for treatment of Claimant B; and nothing for treatment of Claimant C.

SIGNED March 19, 2004.

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS