SOAH DOCKET NO. 453-04-1808.M5
TWCC MR NO. M5-03-1360-01

CENTRAL DALLAS REHAB	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TRANSCONTINENTAL INSURANCE	§	
COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

Petitioner, Central Dallas Rehab (Provider), appealed the Findings and Decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC) denying reimbursement from Transcontinental Insurance Company (Carrier) for medical services provided to _____, (Claimant). Provider disputes the IRO's conclusion that these services were not medically necessary. The Administrative Law Judge (ALJ) concludes that Provider has not met its burden of proof with respect to all services in dispute provided to Claimant between March 4, 2002, and July 23, 2002. Thus, Provider should not be reimbursed.

I. PROCEDURAL HISTORY

ALJ Penny Wilkov convened a hearing in this case on March 3, 2004, at the State Office of Administrative Hearings, Austin, Texas. Attorney Scott C. Hillard represented Provider. Attorney Erin Hacker Shanley represented Carrier. The hearing concluded on that date, but the record was held open until March 26, 2004, for the submission of written closing arguments and responses. The record closed on March 26, 2004.

The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

1. Background

Claimant, a forty-five-year old male, sustained a work-related back injury on _____, when he slipped and fell off his crane and landed on his left hip.[1] Claimant returned to work on August 12, 2002.

Claimant has been generally diagnosed with a subcapital fracture, left femoral neck, confirmed by CT scan performed on _____. Surgery was performed _____ to place a compression screw in his left hip and on March 21, 2002, to remove the left hip hardware due to pain. Claimant describes symptoms of pain in his left leg, from his knee to his low back area, particularly when he doesn't wear a shoe lift necessitated by the surgery, or when he overuses his leg.[2] He reports a subjective level of pain ranging from three to four on a scale of one to ten. The medical records indicate that he has been primarily under the care of Charles Hopkins, M.D., James E. Laughlin, D. O., Ted Krejcie, D. C., and Laurent Pelletier, D. C.

Carrier denied payment, using denial code V[3] for the following treatments administered between March 4, 2002, and July 23, 2002**:**

X office visits on fourteen occasions, eleven office visits with manipulation and three office visits with an expanded history and examination.[4]

---

[1] Respondent=s Exhibit 6, pages 6 and 12 (February 16, 2001, Denton Regional Medical Services and _____, CT Scan).

[2] Respondent's Exhibit 6, page 482 (June 21, 2002 examination, Matt Loewen, M.D.).

[3] Denial Code V is used when the insurance carrier is denying payment because the treatment or service is medically unreasonable and unnecessary based on a peer review.

[4] CPT Code 99213MP and 99213.

X therapeutic exercise (exercises with one-on-one supervision) performed on seven occasions.[5]

$ manual traction services performed on seven occasions.[6]

$ joint mobilization conducted on seven occasions.[7]

$ myofascial release services performed on seven occasions.[8]

2. Evidence and Argument

1. Provider

Ted Krejci, D.C., testified that he treated Claimant for multiple fractures during the dates of disputed service, March 4, 2002, to July 23, 2002, as Claimant chose physical therapy and rehabilitation (rehab) rather than medication. Dr. Krejci co-managed care with Dr. Laughlin, D.O., an orthopedic surgeon, in arriving at a plan for treatment.

Within hours of the injury, on _____, in an attempt to alleviate pain and promote recovery, Claimant underwent surgery on his hip to implant hardware which required surgical removal one year later, on _____. After the injury and surgery, Claimant's left leg was one-inch longer, necessitating an orthopedic shoe lift to align the spine. The recovery from the hardware removal surgery and the therapy for complications from the leg length discrepancy constitute the time frame for the disputed services.

Provider points to the various reports and recommendations of James E. Laughlin, D. O, as

[5] CPT Code 97110.

[6] CPT Code 97122.

[7] CPT Code 97265.

[8] CPT Code 97250.

the basis for medical treatment because Claimant was undergoing post-operative rehabilitation.[9] Although the therapy was completed on May 15, 2002, office visits continued through July to monitor the claimant's progress after his surgery.

Provider points to the independent medical evaluation in August 2001, and the initial impairment rating of sixteen-percent as an indicator of the success of the therapy.[10] Approximately one year later, a second independent medical evaluation placed impairment at a six-percent rating, a ten-percent reduction, arguably attributable to Provider's treatments.[11] Provider further gauged the success of the treatment by the Functional Abilities Evaluation performed on April 22, 2002, and again on May 6, 2002, to show the improvement level of Claimant's hip on range of motion.[12] As a further measure of the progress of the therapy, Claimant reached Maximum Medical Improvement (MMI) on June 21, 2002 and returned to full duty status at work on August 12, 2002.

2. Carrier

Carrier argues that it should not be required to reimburse Provider for all medical services provided between March 4, 2002 and July 23, 2002, since the treatments were unproductive and medically unnecessary.

In support of this argument, Carrier presented the testimony of William David Defoyd, D.C.,[13] who reviewed Carrier's compilation of medical evaluations, assessments, follow-ups, reviews, and test results, in formulating his testimony.

---

[9] Petitioner's Exhibit 1, page 102 (March 25, 2002).

[10] Petitioner's Exhibit 1, page 118 (August 8, 2001, Robert G. Winans, M.D.).

[11] Petitioner's Exhibit 1, page 54 (June 21, 2002, Matthew Loewen, D.O.).

[12] The flex of the hip and leg initial test after hardware was removed had improved from 44% of normal to 55% of normal and the extension of the hip test went from 47% of normal to 77% of normal, both being significant improvement.

[13] Dr. Defoyd is board certified in chiropractic orthopedics.

Dr. Defoyd testified that several things were problematic with the office visits and treatment provided in this case. First, the SOAP notes contained erroneous information (failure to recognize Claimant's surgery), vague references (describing tenderness and soreness on left leg), and scanty information (medical history and treatment plan). For instance, although hardware removal surgery had occurred weeks prior, the SOAP notes indicate that (Claimant) will need to have surgery to remove his hardware.[14] Second, the SOAP notes are generic and repetitive, reflecting a cursory history and no individualized treatment plan. The purpose of the therapy and accompanying notes, according to Dr. Defoyd, is to provide a method to monitor and evaluate the treatment. Here, there is no indication that any reevaluation occurred, no examination of sutures or incisions, no individualized treatment plan. Third, the office visit treatment regiment is very general. The SOAP notes do not indicate whether manipulation occurred on the office visits or if so, what was manipulated or when it occurred.

The types of therapy and treatment rendered in this case were also questionable, according to Dr. Defoyd. The therapeutic exercises are intended to be one-on-one, instructional, and geared to a specific problem. In this case, Claimant was given a packet of unidentified exercises and Provider failed to note specific information on the nature of the exercises, the number of repetitions, the amount of weight, or whether Claimant complied with the exercise. Moreover, since manual traction is a form of joint mobilization, without further information, these treatments should not have been billed for the same visit, in Dr. Defoyd's opinion, since it is duplicative.

Lastly, Dr. Defoyd does not agree that the ten-percent reduction in the impairment rating between August 2001 and June 2002 is attributable to the therapy; rather, he maintains, it was a change in the values between the *Guides to the Evaluation of Permanent Impairment,* Third Edition, Second Printing, American Medical Association and the *Guides to the Evaluation of Permanent Impairment,* Fourth Edition, American Medical Association. In other words, it was the evaluation techniques and criterion and not Claimant's condition that caused the ten-percent reduction in the impairment rating. Because of the lack specificity of treatment, it is difficult to determine if

[14] Respondent's Exhibit 1-6, page 433 (March 28, 2002).

Claimant's pain level or activity tolerance improved with treatment in any significant way.

3. Applicable Law

Under the workers' compensation system, an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment. TEX. LAB. CODE ANN. § 408.021. "Health care" includes "all reasonable and necessary medical . . . services." TEX. LAB. CODE ANN. § 401.011(19).

4. Analysis

Provider has not met the burden of proof to establish entitlement to reimbursement for any services administered between March 4, 2002, and July 23, 2002**.**

Concerning the disputed office visits on fourteen occasions, Provider testified that the office visits were necessary to monitor claimant after the surgery. Carrier, however, argues that the SOAP notes do not reflect that any significant services occurred, including manipulation, and there is no justifiable reason to bill for examination office visits for fourteen occasions. [15] The ALJ agrees that Provider failed to prove that the disputed office visits were shown to be medically necessary because the SOAP notes are generic and do not clearly indicate the nature of the treatment, the treatment plan, or the progress of the treatment. Accordingly, the Carrier is not required to reimburse for fourteen office visits and associated billings under CPT Codes 99213 and 99213MP.

As to therapeutic exercises, Provider testified that the exercise was necessary to assist with Claimant's surgical recovery and leg discrepancy issues. Carrier argued the services were neither required nor medically necessary because there was no treatment plan developed to determine the

[15] Office visits billed under 99213 requires two of these three key components: an expanded problem focused history; an expanded problem focused examination; or medical decision making of low complexity.

necessity and progress of the treatment. In light of the evidence that Provider did not make note of the particular therapeutic exercises used, the purpose of the exercise, the amount of repetitions, nor any other pertinent information, the ALJ finds Provider failed to demonstrate the medical necessity of the treatments. Accordingly, Carrier is not required to reimburse Provider for these services billed under CPT Code 97110.

In regard to the manual traction, mobilization, and myofascial release services, the ALJ finds there is an absence of specific treatment information concerning the purpose and amount of the treatment and measurable objective data to demonstrate the medical necessity of these services.

Thus, Carrier is not required to reimburse Provider for any of these services billed under CPT Codes 97122, 97012, and 97265.

5. Conclusion

Provider has not met the burden of proof to establish entitlement to reimbursement for any services administered between March 4, 2002, and July 23, 2002**.**

III. FINDINGS OF FACT

1. Claimant suffered a compensable injury to his back on _____.

2. At the time of the injury, Claimant's employer had its workers' compensation insurance through Transcontinental Insurance Company (Carrier).

3. Claimant has been generally diagnosed with a subcapital fracture, left femoral neck, confirmed by CT scan performed on _____.

4. Surgery was performed on _____ to place a compression screw in his left hip and on _____, to remove the left hip hardware due to pain.

5. Claimant describes symptoms of pain in his left leg, from his knee to his low back area, particularly when he does not wear a shoe lift necessitated by the surgery, or when he overuses his leg.

6. The recovery from the hardware removal surgery and the therapy for complications from the leg length discrepancy, constitute the time frame for the disputed services.

7. Provider submitted a claim to Carrier for treatment rendered to Claimant from March 4, 2002, until July 23, 2002, including procedures billed under CPT codes 99213 and 99213 MP (office visit and office visit with manipulation), 97110 (therapeutic exercises), 97122 (manual traction), 97265 (joint mobilization), and 97250 (myofascial release).

8. Carrier denied Provider's request for reimbursement.

9. On January 30, 2003, Petitioner requested medical dispute resolution with the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD).

10. An Independent Review Organization concluded that chiropractic treatments rendered from March 4, 2002, until July 23, 2002 were not medically necessary.

11. Provider filed a request for a hearing before the State Office of Administrative Hearings on November 26, 2003.

12. The Commission sent notice of the hearing to the parties on January 14, 2004. The hearing notice informed the parties of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the statutes and rules involved; and the matters asserted.

13. The hearing convened on March 3, 2004 and after the submission of written closing statements, the record closed on March 26, 2004. Provider appeared and was represented by Scott C. Hillard, attorney. Carrier appeared and was represented by Erin Hacker Shanley, attorney.

14. Despite the services rendered to Claimant between March 4, 2002, until July 23, 2002, by Provider, he reported no significant improvement in his pain which he continued to report as a level of pain ranging from three to four on a scale of one to ten.

15. Since the SOAP notes are generic and do not clearly indicate the nature of the treatment, the treatment plan, or the progress of the treatment, and do not show that manipulation occurred, the fourteen office visits, billed under CPT Code 99213, were not shown as medically necessary.

16. As Provider did not make note of the particular therapeutic exercises used, the purpose of the exercise, the amount of repetitions, nor any other pertinent information, the medical necessity of the treatments, billed under CPT Code 97110 rendered was not demonstrated.

17. In the absence of specific treatment information concerning the purpose and amount of manual traction, mobilization, and myofascial release services billed under CPT Codes 97122, 97012, and 97265, combined with the lack of objective data concerning progress of the treatment, Provider has not shown the medical necessity of these services.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings (SOAH) has jurisdiction over matters related to the hearing, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(K) and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely filed a request for hearing before SOAH, as specified in 28 TEX. ADMIN. CODE § 148.3.

3. The parties received proper and timely notice of the hearing pursuant to TEX. GOV'T CODE ANN. ch. 2001 and 1 TEX. ADMIN. CODE § 155.27.

4. Provider had the burden of proving the case by a preponderance of the evidence pursuant to 28 TEX. ADMIN. CODE § 148.21.

5. An employee who has sustained 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 cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

6. Health care includes all reasonable and necessary medical services. TEX. LAB. CODE ANN. § 401.011(19)(A).

7. Provider failed to establish that physical therapy modalities billed under CPT codes 99213 and 99213 MP (office visit and office visit with manipulation), 97110 (therapeutic exercises), 97122 (manual traction), 97265 (joint mobilization), and 97250 (myofascial release) are reimbursable under TEX. LAB. CODE ANN. §§ 401.011(19) and 408.021(a).

8. Providers claim should be denied.

ORDER

IT IS **ORDERED** that Central Dallas Rehab is not entitled to reimbursement by Transcontinental Insurance Company for the physical therapy modalities billed under CPT codes 99213 and 99213 MP (office visit and office visit with manipulation), 97110 (therapeutic exercises), 97122 (manual traction), 97265 (joint mobilization), and 97250 (myofascial release) provided to Claimant between March 4, 2002, and July 23, 2002.

SIGNED May 19, 2004.

PENNY WILKOV
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS