SOAH DOCKET NO. 453-04-3686.M5
TWCC MDR NO. [M5-03-1681-01]

GALAXY HEALTH CARE CENTERS, **Petitioner**	:	**BEFORE THE STATE OFFICE**
v.	:	**OF**
AMERICAN HOME ASSURANCE COMPANY, **Respondent**	:	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

Galaxy Health Care Centers (Provider) appealed the decision of Envoy Medical Systems, LLC, an independent review organization (IRO) certified by the Texas Department of Insurance, in Texas Workers' Compensation Commission (TWCC) Medical Review Division (MRD) tracking number M5-03-1681-01, denying reimbursement for medical services provided to the Claimant. Additionally, the Provider appealed the MRD's decision denying reimbursement for services not considered by the IRO. This decision orders that American Home Assurance Company (Carrier) is not required to reimburse the Provider for the services in dispute.

The Administrative Law Judge (ALJ) convened a hearing on August 19, 2004. The hearing was concluded and the record closed that date. The Provider appeared through its representative Kenneth Gilley, attorney. The Carrier appeared through M. Steven M. Tipton, attorney.

II. EVIDENCE AND BASIS FOR DECISION

The issue presented in this proceeding is whether the Carrier should reimburse the Provider $11,497 plus interest for medical services provided between August 21, 2002, and November 15, 2002, and billed under CPT Codes 99213 (office visit), 97110 (therapeutic exercises), and 97112 (neuromuscular reeducation). The Carrier argued that none of the medical services provided to the Claimant were medically necessary or reasonably required to treat the compensable injury. Further,

reimbursement for the office visits was denied on the basis that the charges exceeded the fee schedule.[1]

The documentary record in this case consisted of seven exhibits (Pet. Exh. 1 - 4 pages, Pet. Exh. 2 - 11 pages, Pet. Exh. 3 - 193 pages, Pet. Exh. 4 - 37 pages, Pet. Exh. 5 - 37 pages, Pet. Exh. 6 - 37 pages, and Pet. Exh. 7 - 10 pages). Additionally, the Provider submitted an excerpt from the video deposition of Philip Lening, D.C., who also testified on behalf of the Carrier.

The Claimant, a 46-year-old man, suffered an injury to his lower back on____.[2] The Claimant was diagnosed with herniated nucleus pulposus at the L5-S1 level and lumbar disc disruption with discogenic pain at the L5-S1 level. Apparently, the Claimant received extensive treatment following his injury.[3] Due to continued pain, the Claimant underwent an IDET procedure on July 16, 2002.[4] The Claimant was prescribed active therapy three times per week following the IDET procedure, which was delivered by the Provider. The services delivered by the Provider were one-on-one therapeutic exercises and neuromuscular reeducation. Also, the Provider billed for an office visit each time the Claimant received physical therapy.[5]

Dr. Lening is licensed in Texas and his career has included an active chiropractic practice, consulting, and 13 years of teaching at Texas Chiropractic College. He reviewed the Claimant's medical records, which revealed that prior to the IDET procedure, the Claimant received considerable physical medicine modalities from the Provider consisting of rehabilitation, manipulation, and a work hardening program. Dr. Lening testified that the Claimant received much

[1] In summary, this case had both a fee dispute and a medical necessity dispute. The Carrier agreed at the hearing that it would be unnecessary to consider its fee dispute if its medical necessity denial was sustained.

[2] The record did not reveal the cause of the injury.

[3] Medical records dated prior to July 16, 2002, were not included in the documents submitted by the Provider.

[4] IDET is the acronym for intradiscal electrothermal therapy

[5] CPT Code 99213 is an office visit for the evaluation and management of an established patient, and requires two of three key components: an expanded problem focused history; an expanded problem focused examination; or medical decision making of low complexity.

of the same treatment from the Provider following the IDET procedure. In his opinion, the Claimant did not require one-on-one treatment because he was familiar with the exercises from having performed them prior to the IDET procedure. He stated that it might be reasonable to provide one-on-one treatment during the first week of the program following an IDET procedure, but that the Claimant had already done most, if not all, of the exercises many times. Dr. Lening believed the Claimant could have done his exercises in either a group or home-based setting.

As mentioned above, the Provider billed for an office visit each time the Claimant went in for physical therapy. Dr. Lening pointed out that there was no evidence in the record that the Claimant needed direct physician contact on each day of therapy and that the prescription for physical therapy did not require an examination. Additionally, he testified that the medical ground rules require SOAP notes to be attached to the billings but there were no SOAP notes in the record.

In conclusion, the provider failed to prove that the medical services delivered from August 21, 2002, to November 15, 2002, were medically necessary and reasonably required to treat the Claimant's compensable injury. As testified to by Dr. Lening, the Claimant was very familiar with the exercise program and he could have participated in it through either group therapy sessions or performed the exercises at home. One-on-one direct supervision was not medically necessary. Additionally, the record did not support the necessity for an office visit each time the Claimant went for physical therapy.[6] Therefore, the Provider should not be reimbursed for the services delivered to the Claimant.

[6] A Provider could be entitled to reimbursement for some office visits in this type of situation, however, the Provider in this case failed to submit evidence to support any reimbursement.

III. FINDINGS OF FACT

1. On ____, the Claimant suffered a compensable injury to his lower back.

2. The Claimant's injury is covered by workers' compensation insurance written for the Claimant's employer by American Home Assurance Company (Carrier).

3. The Claimant received extensive treatment following his injury consisting of rehabilitation, manipulation, and a work hardening program from Galaxy Health Care Centers (Provider) following a diagnosis of herniated nucleus pulposus at the L5-S1 level and lumbar disc disruption with discogenic pain at the L5-S1 level.

4. The Claimant continued to suffer from pain and underwent an IDET procedure on July 16, 2002.

5. Following the IDET procedure, the Claimant was prescribed active therapy three times per week for four weeks. The therapy was continued for a total of 12 weeks.

6. The Provider's treatment of the Claimant's injury was billed under CPT Codes 99213 (office visit), 97110 (therapeutic exercise), and 97112 (neuromuscular reeducation).

    1. An office visit was billed for each session of physical therapy.

    2. The therapeutic exercises and neuromuscular reeducation was provided by one-on-one contact with the therapist.

7. The medical services in dispute were provided from August 21, 2002, to November 15, 2002.

8. Direct one-on-one contact with the treating physician at each session of therapy was neither prescribed nor necessary to treat the Claimant's injury.

9. The exercises performed by the Claimant both before and after the IDET procedure were mostly the same.

10. The Claimant could have done his exercises in either a group or home-based setting instead of a one-on-one setting.

11. There was insufficient documentation in the record to confirm delivery of neuromuscular reeducation services.

12. The Provider timely requested dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC).

13. On January 23, 2004, the MRD issued its decision concluding that the disputed expenses should not be paid, and the Provider timely appealed this decision.

14. TWCC sent notice of the hearing to the parties on March 15, 2004. The hearing notice informed the parties of the matter to be determined, the right to appear and be represented by counsel, the time and place of the hearing, and the statutes and rules involved.

15. The hearing on the merits convened August 19, 2004, before Michael J. Borkland, Administrative Law Judge. The Provider through Kenneth Gilley, attorney. The Carrier appeared through Steven M. Tipton, attorney.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (TWCC) has jurisdiction to decide the issues presented pursuant to TEX. LABOR CODE '413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a Decision and Order, pursuant to TEX. LABOR CODE '413.031 and TEX. GOV'T CODE ch. 2003.

3. Based on Finding of Fact No. 13, the Notice of Hearing issued by TWCC conformed to the requirements of TEX. GOV'T CODE '2001.052.

4. The Provider has the burden of proving by a preponderance of the evidence that he should prevail in this matter. TEX. LABOR CODE '413.031.

5. Based on Findings of Fact Nos. 8 - 10, the Provider failed to prove that reimbursement for treatment provided from August 21, 2002, to November 15, 2002, should be ordered.

ORDER

IT IS, THEREFORE, ORDERED that American Home Assurance Company shall not be required to reimburse Galaxy Health Care Centers for the disputed services provided in treating the Claimant.

SIGNED September 7, 2004.

MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS