DOCKET NO. 453-04-4178.M5
TWCC MRD NO. M5-03-2737-01

ERIC A. VANDERWERFF, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner,	§	
	§	
VS.	§	**OF**
	§	
MID-CENTURY INSURANCE	§	
COMPANY	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Eric Vanderwerff, D.C. (Petitioner) seeks reimbursement for 42 physical medicine sessions he provided to the Claimant from July 2, 2002, through February 19, 2003. Mid-Century Insurance Company (Carrier or Respondent) opposes reimbursement on the grounds that the sessions were not properly documented or reasonable and medically necessary to treat the Claimant's February 2, 2001 compensable injury. The Administrative Law Judge (ALJ) finds abundant evidence in the record that the disputed physical medicine sessions were not adequately documented and were not reasonable or medically necessary. She, therefore, denies Petitioner's appeal for reimbursement.

II. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were not disputed and are established in the findings of fact and conclusions of law. On October 20, 2003, an Independent Review Organization (IRO) reviewed this matter at the request of the Texas Workers' Compensation Commission (Commission), and agreed with Carrier that the disputed services were not medically necessary.[1] Based on the IRO determination, the Commission's Medical Review Division (MRD) denied Petitioner reimbursement for all physical medicine sessions, except those provided on July 8 and 10, 2002, and October 9, 23, and 30, 2002, that were not billed under CPT Code 97110. Petitioner appealed the MRD decision to State Office of Administrative Hearings (SOAH), where a contested hearing was converned on August 25, 2004.[2] Attorney Gilbert Maxwell represented Petitioner and Attorney James Laughlin represented Carrier. The record closed September 29, 2004.

III. BACKGROUND AND CONTESTED ISSUES

The Claimant was employed by___. as a seamstress. She injured her left leg, left hip, back, and waist on___, when she tripped over a pallet and fell while carrying a box at work. The Claimant was off work for a week, then

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[1] Resp. Ex. 1 at pp. 433-434.

[2] With the parties' consent, ALJ Charles Homer presided over the hearing for ALJ Deborah L. Ingraham; ALJ Ingraham prepared this decision based on the evidentiary record made at the hearing.

Returned to work for approximately a month when she was laid off. She then sought treatment from Petitioner's clinic, the Millennium Chiropractic and Scoliosis Center, on March 15, 2001.[3]

Petitioner diagnosed the Claimant with a lumbar disc herniation with myelopathy, lumbar subluxations, paravertebral muscle spasms, and paresthesia, and removed her from all work duties. From March 15, 2001, to February 19, 2003, he provided 190 physical medicine sessions during which he treated the Claimant with the same set of six modalities: 1) CPT Code 99213-MP: office visit with a chiropractic manipulation; 2) CPT Code 97261: an additional manipulation; 3) CPT Code 97250: myofascial release/soft tissue mobilization, one or more regions; 4) CPT Code 97014: electrical stimulation (unattended); 5) CPT Code 97110: therapeutic procedures, one or more areas, 15 minutes each; and 6) CPT Code 97265: joint mobilization, one or more areas (peripheral or spinal). On February 19, 2003, Petitioner released the Claimant from regular care.[4]

Of the 190 physical medicine sessions, only sessions 148 through 149, 152 through 180, 182, and 185 through 190, performed from July 2, 2002, through February 19, 2004, are in dispute.[5] Petitioner has the burden of proving by a preponderance of evidence that the disputed physical medicine sessions were reasonable and medically necessary to treat the Claimant's February 2, 2001 injury.[6]

IV. REASON FOR DECISION

A. Parties' Positions

Petitioner asserts that several published studies support a prolonged treatment plan of at least one year to properly heal certain tissue, and in his view, the Claimant's treatment should be assessed under this school of thought. He contends that his goal in providing the Claimant with prolonged treatment was to avoid surgery for her herniated disc. Petitioner insists that throughout the physical medicine sessions, the Claimant showed steady, objectively measured improvement, which he recorded in his daily notes. He also relies on the Claimant's Qwestry results, arguing that they show she consistently improved throughout his treatments. Petitioner claims that he is, therefore, entitled to full payment for all sessions the MRD denied.[7]

In Carrier's view, the evidence overwhelmingly establishes that the disputed sessions were not documented, not reasonable and not necessary. Carrier complains that Petitioner removed the Claimant from work status beginning March 15, 2001, until

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[3] Resp. Ex. 1 at pp. 3, 98, 230.

[4] Resp. Ex. 1 at p. 404.

[5] *See* Appendix A for list of treatments by date.

[6] 28 TEX. ADMIN. CODE '148.21(h)-(i).

[7] Pet. Ex. 1at pp. 001-021; Testimony of VanderWerff.

December 20, 2002, one year and nine months after her injury.[8] Carrier also asserts that Petitioner's daily notes inadequately document the Claimant's progress with the passive and active modalities, and that the reports of Gary Martin, D.C., Paul LaMay, D.C., Maury Guzick, D.C., Michael Precure, D.C., and the IRO reviewer, as well as the testimony of William Defoyd, D.C., all support a finding that this care was not properly documented and medically unnecessary. Carrier also considers the treatment record in this case an example of the overbilling abuses plaguing the workers' compensation system in Texas.[9]

Carrier further asserts that, from a broader perspective, providing the same physical medicine sessions over and over while keeping the Claimant off even light or modified duty for nearly two years is unconscionable and did the Claimant a disservice. As the Commission has recognized, necessary treatment may place the injured worker at medical risk, cause loss of income, and may lead to a disability mindset. Unnecessary or inappropriate treatment can cause an acute or chronic condition to develop."[10]

B. ALJ's Analysis

The ALJ finds that Petitioner failed to carry his burden of proof, and is not entitled to reimbursement for physical medicine sessions 148 through 149, 152 through 180, 182, and 185 through 190, performed from July 2, 2002, through February 19, 2004, or for services billed under CPT Code 97110 even though no Explanation of Benefits (EOB) was issued. There is abundant evidence in the record to support a finding that the disputed sessions were not medically necessary.

Insufficient Documentation. In general, the evidence contains no treatment plan documenting the type of physical medicine Petitioner prescribed to address the Claimant's injury, a prognosis, or a time frame for her re-evaluation. Petitioner provided five passive modalities and one active modality at each physical medicine session.[11] Petitioner's form for daily notes contains boxes to check the modalities perfored; however, the notes do not indicate the part of the body treated with the modalities, the level of the spine treated with passive modalities, the specific passive technique used or the Claimant's response to the treatments during each visit. Likewise, the notes do not indicate the active modalities provided, such as the specific therapeutic procedure or exercise, the number of repetitions, the amount of weight, or the Claimant's response. Only a box for CPT Code 97110 is checked on most of the forms. For later dates of service, the evidence contains a different form with no boxes for the different modalities,

[8] Resp. Ex. 1at p. 394.

[9] *See* Resp. Closing Brief.

[10] 26 Tex. Reg. 9874, 9875 (2001).

[11] The Glossary to the former *Spine Treatment Guideline*, effective February 1, 2000, defines active care as modes of treatment or care requiring that the injured employee participate in and be responsible for the phase of care received. Passive care is defined as modes of treatment or care which do not require the injured employee to participate in his/her care, for example, the care is >done to' or >applied to' the injured employee (e.g., hot packs or cold packs)

but no information about which modalities were performed.[12]

MRD's Review of Billing for Therapeutic Exercises. In the fee dispute portion of this case, the MRD reviewed and denied payment for all treatments billed under CPT Code 97110, even where Carrier issued no EOB, due to the inadequacies and confusion that has surfaced concerning one-on-one treatment (i.e. dates of service 07/08/02, 07/10/02, 10/09/02, 10/23/02, and 10/30/02) because:

> Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed.[13]

At the hearing, Petitioner argued that the MRD improperly reviewed this code and denied payment because Carrier did not provide an EOB for the dates of service at issue. Because Carrier did not raise any defenses to payment, Petitioner argues that the MRD was required to order payment for CPT Code 97110 on those dates of service. Carrier disagrees, asserting that the MRD has a statutory duty to deny payment whenever it finds inadequate documentation regardless of a Carrier's actions.

The MRD has the obligation to ensure compliance with the requirements of CPT Code 97110 whether the issue was raised by Carrier or not. When it is apparent from the record that an order to pay or refund a sum would produce a resulting payment in excess of, or in violation of, the amount permitted by the ground rules, medical standards, or fee guideline limits, that issue is always within the scope of a medical dispute.

CPT Code 97110 has been defined by the American Medical Association (AMA) and interpreted and applied by the Commission, to require one-on-one continuous contact and supervision. Prior SOAH decisions have recognized that one therapist moving from patient to patient after a few minutes does not constitute one-on-one therapy under CPT Code 97110. It is the one-on-one continuous contact and supervision that justifies the high cost of $35 per 15 minute unit.

In this case, the ALJ concludes the MRD properly declined to order payment for CPT Code 97110 for dates of service July 8, 2002, July 10, 2002, October 9, 2002, October 23. 2002, and October 30, 2002. The MRD was responding to a widespread lack of proper documentation and comprehension of one-on-one therapy and gave Petitioner an opportunity to submit additional records to establish his entitlement to payment.

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[12] Resp. Ex. 1 at pp. 398- 399, 402-406.

[13] Resp. Ex. 1 at MRD Decision. In the past several years, the Commission, perhaps because of the current state of medical costs in the Texas Workers' Compensation system, has begun cracking down on the over-utilization of 97110. The high rate of reimbursement per 15 minute unit has provided an incentive to some to misinterpret, apply, and improperly bill for this code. The maximum allowable reimbursement ("MAR") for CPT code 97110 is $35 per 15 minute unit. CPT Code 97110 is for one-on-one continuous contact and supervision by a health care provider, as opposed to therapeutic procedures performed in a group setting, which are billed under CPT code 97150 at a MAR of $27 regardless of the amount of time. *See* Resp. Closing Brief.

However, his records did not demonstrate that exclusive one-on-one therapy was reasonable, necessary, and properly provided because they lacked information about: 1) the specific activities the Claimant was performing; 2) the Claimant's progress in each activity; and 3) the manner in which these services were provided. Moreover, they failed to document the person actually performing the services.

Even with an opportunity on appeal to prove he should be paid for the active modalities provided, Petitioner cannot meet his burden. Petitioner's daily notes do not document that one-on-one therapeutic exercises were actually provided. Petitioner testified that the Claimant exercised with bands and a wobble board, but his notes do not document the reason the Claimant needed one-on-one supervision to perform those exercises. In addition, his daily notes do not indicate who was supervising the Claimant with the therapeutic exercises each visit. Although Petitioner testified on cross-examination that the Claimant received continuous and exclusive one-on-one contact from his employee, David Rodriguez, he also stated that Mr. Rodriguez is not a licensed health care provider, which calls into question the usefulness and quality of the one-on-one exercises.

The ALJ is persuaded that one-on-one therapy was not reasonable and necessary. Carrier's expert, Willam Defoyd, D.C., explained that therapeutic exercises are considered active modalities. Dr. Defoyd testified that to bill under CPT Code 97110, continuous and exclusive contact for the period of time billed is required. The code is typically used, he explained, to bill for instructing patients how to perform the exercise program during the first few sessions until they can perform it on their own and for additional instruction when the program is modified. Dr. Defoyd testified that situations where one-on-one therapy might be provided for extended periods of time might include stroke victims or other individuals with cognitive and physical disabilities. In Dr. Defoyd's expert opinion, the exercises Petitioner described in his testimony did not require continuous and exclusive one-on-one supervision and they were not provided in the least intensive setting. After 147 prior sessions, the Claimant should have been able to perform these exercises on her own by session 148. Continuing one-on-one therapy was not reasonable and necessary medical treatment.

The MRI. Petitioner argued that the physical medicine sessions were a means of avoiding surgical intervention for a herniated disc; however, evidence that the Claimant was a surgical candidate is lacking. On the contrary, MRI results indicate that the Claimant had degenerative disc disease resulting in mild concentric bulges without neural compromise, not a herniated disc. Every medical expert in this case referenced those results and none questioned their accuracy, except Petitioner.[14]

[14] Dr. Martin stated, "The lumbar spine MRI shows only lumbar disc degeneration." Dr. Precure stated, "An MRI was completed on 7/10/2001 which revealed a degenerative condition of the L4/5 and L5/S1 segmental levels. Mild disc bulging at both levels was also identified with no significant canal or foraminal narrowing or neural compromise." He gave a primary diagnosis of a lumbar sprain/strain. In the report from his examination of January 16, 2003, Dr. Martin stated, "The primary diagnosis is lumbar sprain/strain (847.24) resolved." The IRO decision stated only that, "MRI indicates degenerative disc disease at both the L4/L5 and L5/S1 disc levels." Furthermore, Dr. Defoyd testified that the evidence did not show that the claimant had a herniated disc but showed only degenerative changes consistent with the claimant's age. *See* Resp. Ex. 1 at pp. 119, 155, 159, 401, 432; Testimony of Defoyd.

Petitioner's Work Status Report indicates that expected follow-up services included, "Physical medicine 3 x per week for 12 weeks starting on 03/15/01."[15] The lumbar MRI was conducted on July 10, 2001, three months after Petitioner made his diagnosis and, nine weeks into his treatments. The MRI results should have prompted Petitioner to reevaluate the physical medicine treatments as well as the Claimant's medical needs after that initial 12 week period. The ALJ further rejects Petitoner's explanation of why the later MRI did not show the disc herniation he diagnosed on March 29, 2001.[16]

Peer Reviews. The ALJ also rejects Petitioner's argument that a different school of thought should be applied to evaluate the medical necessity of the Claimant's care. First, Petitioner offered no legal support for his argument. Second, the five doctors of chiropracty who reviewed the Claimant's treatment in this case all questioned the necessity and usefulness of Petitoner's repeated passive modalities, and none of them endorsed the alternate school of thought espoused by Petitioner. The ALJ finds their medical opinions about the Claimant's care highly persuasive, not only for their relative consistency, but for their candor in questioning Petitioner's choice and course of treatment for this Claimant.

After 54 physical medicine sessions, Gary Martin, D.C. saw the Claimant on August 31, 2001, for an independent medical examination. Dr. Martin found positive Waddell's tests, with three or more significant for possible symptom magnification. He described in his report that:

> Superficial skin is tender to gentle touch, non-anatomical deep tenderness is felt over a wide area and is not localized to one structure, axial loading causes low back pain while exerting pressure over the examinee's skull, rotation of the pelvis and lumbar spine causes pain when rotated in the same plane, straight leg raising is significant for 30 degrees difference between sitting and supine straight leg raise, and subjective complaints are out of proportion to objective findings.[17]

He evaluated the Claimant at maximum medical improvement (MMI) with a zero percent impairment rating, stating:

> [The Claimant] is currently at MMI. There is no need for ongoing treatment as it has not proved effective in relieving pain or restoring function. There is also sparse documentation to support any ongoing treatment. The lumbar spine MRI shows only lumbar disc degeneration. The knee shows normal range of motion. There is no evidence of ongoing instability.
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> It is difficult to determine her ability to return to work due to the symptom magnification; however, she should attempt light duty for 3 weeks that

[15] Resp. Ex. 1 at p. 20

[16] Resp. Ex. 1 at pp. 20, 83.

[17] Resp. Ex. 1 at pp. 112, 116.

> Would include no lifting over 25 lbs. This is mainly due to the possibility of deconditioning with being off work for so long. A typical disability for this injury would be 3 to 4 weeks. The treatment should not have been longer than 12 weeks at the most.[18]

After 73 physical medicine sessions, a TWCC designated doctor, Michael Precure, D.C., examined the Claimant on October 19, 2001, and noted that she ". . . gave a questionable effort in performing the [range of motion] testing. She was very unwilling to complete the tasks and had to be reminded that she must give her best effort." Dr. Precure stated in conclusion that:

> I do not believe certain aspects of active care were necessary to achieve complete healing. Therefore, I must caution Dr. Vanderwerff to be expedient and without excess . . . to remind him that all eyes are watching our profession for cases of excessive care and system abuse. Dr. Vanderwerff stated in a letter dated October 4, 2001 that ____'s would require at least 4 more months to heal. Therefore, I believe that MMI should be reached no later than January 4, 2002.[19]

Dr. Precure evaluated the Claimant after 119 physical medicine sessions, and on March 22, 2002, he again determined her to be at MMI, stating in his report:

> I understand that Dr. Vanderwerff will be seeking pre-authorization to place (Claimant) in a work conditioning program. I believe that this would be beneficial in improving the patient's ability to regain her ability to have an active lifestyle and to gain future employment. However, I must raise the question as to why this not been addressed sooner than now. After reading Dr. Vanderwerff's SOAP notes and observing the patient's progress therein, it appears that [the (Claimant]) could have started the program 3 or 4 months ago. Also, his SOAH notes tellingly show around 114 days of treatment. This could be seen as excessive in the absence of concrete signs of steady improvement. My intention in bringing this up is not to be critical of Dr. Vanderwerff (Indeed, I am not.) But only to be objective on behalf of the patient concerning the data I have. With this in mind, I am quite sure that (Claimant) has improved as much as she is going to with this type of therapy.
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> *** * ***
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> I would think that 4-6 weeks of continued therapy in the form of work hardening would be fine with the understanding that other treatment (continued electrical, manipulative, or other therapies) is not warranted.[20]

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[18] Resp. Ex. 1 at pp. 119-20.

[19] Resp. Ex. 1 at pp. 153, 157, 160.

[20] Resp. Ex. 1 at p. 239.

Although it was Dr. Precure's medical opinion that the Claimant was MMI, Petitioner continued to treat the Claimant with physical medicine sessions that extended into 2003.

Petitioner contends that it would have been premature to place the Claimant into the work hardening program at his clinic any earlier because she was deconditioned and he was still concerned about pain and spasms in her muscles and wanted ensure those were treated before he started her in his work hardening program. However, neither Drs. Martin, LaMay, Guzick, Precure, Defoyd, or the IRO reviewing health care professional thought the Claimant was not ready for a work hardening program. In fact, Dr. Precure specifically rejected this argument stating:

> I initially felt that she could have begun the program in the fall of 2001. I admit that this could possibly have been a few months early (for her to begin), however, I noted in the second report that work hardening could certainly begin shortly after 3/22/02. Yet [the Claimant] did not begin the program until October 2002 and there is no clear indication as to why this is so. This, plus the fact that treatment in the form of continued therapy was performed into the summer months of 2002 causes me to question either the patient's desire to get back to work or the handling of this case by the treating physician, or both . . . .[21]

Paul LaMay, D.C. also conducted a peer review of the Claimant's case on April 19, 2002. In his report, Dr. LaMay states:

> The documentation supplied for review reveals inconsistent treatment patterns with out explanation. There is no objective evidence of improvement supplied by the treating provider's records that suggest that the patient has improved following a therapeutic trial of care. The treating provider's records reveal that the patient remained totally disabled from 3/15/01 - 6/30/01. The inability to return to work in any capacity indicates a lack of objective improvement in the patient's clinical condition, therefore, continued care beyond a therapeutic trial is not supported as necessary.[22]

Another peer review was conducted on December 26, 2002, by Maury Guzick, D.C. Dr. Guzick states in his report that:

> The Claimant, a 41 year old, slightly obese female, alleges injury to the low back and left side of her hip and leg in a slip and fall. She indicates she was taken off work for a week by the company doctor then returned to work for a month before seeking chiropractic evaluation and treatment. She was taken off work by her chiropractor who treated her with an intensive yet occasionally sporadic treatment plan of manipulation, passive modalities and therapeutic exercise. There are no periodic re-evaluations to assess the outcome of care. The daily treatment notes provide no objective evaluation of the Claimant's progress and are generally repetitive of the same findings without objective comparison.

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[21] Resp. Ex. 1 at p. 416.

[22] Resp. Ex. 1 at p. 257.

* * *

> Based on the available clinical information, the necessity for continued chiropractic care and physical medicine beyond 8/23/01 is not supported.
>
> There are multiple inconsistent findings noted. There is documented lack of Claimant effort during testing to indicate Pathomimesis. There was no trial of returning the Claimant to work as she was claimed to have progressed. She was previously able to work a month before seeking care. She has been placed at MMI as of this date. As it appears her condition was limited to the low back, the necessity for an additional area of manipulation (97261) is not supported. Since the Claimant was undergoing manipulation to the spine, additional joint mobilization (97265) of the same area would be duplicative.[23]

On January 16, 2003, Dr. Martin again examined the Claimant for an Independent Medical Examination and stated:

> The diagnosis is a lumbar sprain/strain with mild radiculopathy that is functionally resolved. The Claimant continues to have pain, but there is no objective findings to substantiate the ongoing pain . . . The symptoms would not be related to the original work injury . . . The Claimant should be able to return to work without lifting over 25 lbs.
>
> The treatment has been well beyond the normal amount as set forth by TWCC guidelines. Treatment should have been done by 8/23/01. The Claimant has not shown any functional improvement since that time. I see no need for future care.[24]

On April 12, 2003, the Claimant was examined for a third time by Dr. Precure. He wrote in his report that:

> In my last report I stated in my closing comments, "I would think that 4-6 weeks of continued therapy in the form of work hardening would be fine with the understanding that other further treatment (continued electrical, manipulative, or other therapies) is not warranted." I stand by that statement in regard to physical therapy that was performed after March 22, 2004.However, I believe that work hardening and any therapies performed to accentuate the effectiveness of the program should be considered necessary in getting [the Claimant back to work. I also must raise the question as to why it has taken so long to get [the Claimant] in a work hardening program.[25]

The medical opinions of Drs. Martin, LaMay, and Guzick are consistent in concluding that no medical necessity existed for physical medicine sessions after March 22, 2002.

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[23] Resp. Ex. 1 at pp. 395-96.

[24] Resp. Ex. 1 at p. 401.

[25] Resp. Ex. 1 at p. 416.

When evaluating questions of medical necessity, an IRO must provided "the specific reasons, including the clinical basis for the decision" and "a description and the source of the screening criteria that were utilized" pursuant to Commission Rule 133.308(p). Like Drs. Martin, LaMay, Guzick, and Precure, the reviewing IRO health care professional also concludes in the decision issued October 3, 2003, that the disputed services were not medically necessary:

> The objective findings in this case do not indicate a severity of injury sufficient to warrant this length of acute recovery time. The records submitted by the provider (for the dates in question) do not support the medical necessity for the extensive modalities that were used on this patient.
>
> Virtually all of the researched articles that I have reviewed conclude with less than glowing recommendations of almost all therapeutic interventions for acute and chronic back pain, either conservative or invasive. The overreaching conclusion reached in my Ameta analysis of these research papers, in summation, is this: Exercise is the most effective therapy for back pain. Passive therapeutic modalities are very limited in their effectiveness as compared to sham treatment or placebo. Manipulation is no better or no worse than many invasive procedures (as far as long term outcomes) patient selection not withstanding.[26]

Testimony of Dr. Defoyd. William Defoyd, D.C. testified as Respondent's medical expert. Dr. Defoyd practices in Austin at the Spine and Rehab Center, a multi-disciplinary spine group of doctors of medicine, chiropractors, and physical therapists. Noting that the Claimant's MRI revealed degenerative changes consistent with her age, Dr. Defoyd concluded from his review that the Claimant sustained a sprain/strain type injury. In his opinion, the disputed physical medicine sessions provided July 2, 2002 through February 19, 2003, were not reasonable and medically necessary to treat the Claimant's February 2, 2001 injury.

The ALJ finds Dr. Defoyd testimony persuasive. He is the Chiropractic Representative for the Workers' Compensation Commission's Medical Advisory Committee and also serves on the Executive Committee of the Commission's Medical Quality Review Panel, which was established pursuant to Section 413.0512 of the Texas Labor Code (Act) to perform the duties set forth in Section 413.0512, including reviewing actions by doctors, insurance carriers, and utilization review agents. His testimony deserves additional weight given his role in these workers' compensation matters.

Dr. Defoyd found from his review of Petitoner's records that:

1. No initial exam, no history, and no treatment plan were documented by Petitioner;

2. The Claimant only sought treatment with Provider after she was laid off;

[26] Resp. Ex. 1 at p. 433.

3. Multiple positive Waddell signs were observed by Dr. Martin, and the Claimant would not cooperate with Dr. Precure, D.C. during her examination, indicating possible secondary gain motives and symptom magnification;

4. No objective evidence of substantive and continued improvement over time appeared in the notes;

5. Petitioner's office notes did not contain any objective measures of the Claimant's progress, such as range of motion, strength, decreased medication usage, increased functionality, or return to work, and recorded only her subjective, self-reported pain levels; and

6. No re-evaluation of the treatment plan based on the Claimant's lack of response to treatment appeared in the records.

Dr. Defoyd testified that there was no medical necessity for myofascial release, joint mobilization, electrical stimulation, manipulation, or one-on-one therapy, over a year and a half after the date of injury, which is when the disputed dates of service begin in this case, on July 2, 2002. According to Dr. Defoyd, the passive modalities chiropractic manipulation, myofascial release, joint mobilization, and electrical stimulation Bare used primarily during the acute phase of an injury, about four to six weeks. The Claimant could have received the same benefits of those treatments after the acute phase with a home exercise program. The ALJ finds persuasive Dr. Defoyd conclusion that prolonged care seemed to be contra-indicated.

In Petitioner's position statement to the IRO, he argued that the patient's reported pain levels decreased during the course of treatment and, therefore, he is entitled to reimbursement pursuant to Section 408.021of the Act. But the ALJ is persuaded by Dr. Defoyd testimony that Petitioner's records do not demonstrate any improvement in the Claimant's reported pain levels over the nearly two year treatment period, and nothing indicates that the treatments finally resolved her pain rather than the simple passage of time. Dr. Defoyd testified that if this course of treatment were effective, results would be seen in weeks - not months or years.

V. CONCLUSION

The ALJ finds based on the evidence that Petitioner is not entitled to the reimbursement he seeks. The care he provided to the Claimant was poorly documented, unreasonable, and medically unnecessary. The ALJ quoted liberally from the peer review excerpts Carrier cited in its brief because she has never seen a case in which the medical reviewers questioned so directly the medical necessity and potential excessiveness of the care provided by one of their peers.[27]

[27] Carrier pointed out that the combination of modalities Petitioner billed for each physical medicine session have a combined Maximum Allowable Reimbursement ("MAR") of $192 per session. Petitioner billed the MAR for each session resulting in total reimbursement for 190 sessions of $36,480.00.

VI. FINDINGS OF FACT

1. Eric Vanderwerff, D.C. (Petitioner) seeks reimbursement for 42 physical medicine sessions he provided to the Claimant from July 2, 2002, through February 19, 2003.

2. Mid-Century Insurance Company (Carrier or Respondent) denied reimbursement on the grounds that the sessions were not properly documented or reasonable and medically necessary to treat the Claimant's February 2, 2001 compensable injury.

3. On October 20, 2003, an Independent Review Organization (IRO) reviewed this matter at the request of the Texas Workers' Compensation Commission (Commission), and agreed with Carrier that the disputed services were not medically necessary.

4. Based on the IRO determination, the Commission's Medical Review Division (MRD) denied Petitioner reimbursement for all physical medicine sessions, except those provided on July 8 and 10, 2002, and October 9, 23, and 30, 2002, that were not billed under CPT Code 97110.

5. Petitioner appealed the MRD decision to the State Office of Administrative Hearings (SOAH), where a contested hearing was convened on August 25, 2004, after notice of the hearing was mailed to the parties containing 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.

6. The Claimant sustained a compensable injury on___, when she tripped over a pallet and fell while carrying a box at work.

7. The Claimant was off work for a week, then returned to work for approximately a month when she was laid off.

8. The Claimant first sought treatment from Petitioner at his clinic, the Millennium Chiropractic and Scoliosis Center, on March 15, 2001.

9. Petitioner diagnosed the Claimant with a lumbar disc herniation with myelopathy, lumbar subluxations, paravertebral muscle spasms, and paresthesia, and removed her from all work duties.

10. From March 15, 2001, to February 19, 2003, he provided 190 physical medicine sessions during which he treated the Claimant with the same set of six modalities: 1) CPT Code 99213-MP: office visit and a chiropractic manipulation; 2) CPT Code 97261: an additional manipulation; 3) CPT Code 97250: myofascial release/soft tissue mobilization, one or more regions; 4) CPT Code 97014: electrical stimulation (unattended); 5) CPT Code 97110: therapeutic procedures, one or more areas, 15 minutes each; and 6) CPT Code 97265: joint mobilization, one or more areas (peripheral or spinal).

11. Of the 190 physical medicine sessions, sessions 148 through 149, 152 through 180, 182, and 185 through 190, performed from July 2, 2002, through February 19, 2004, were properly documented, reasonable or medically necessary treatment for the Claimant's injury because:

    a. Petitioner failed to adequately document the treatments in his daily notes, which in some cases were wholly inadequate;

    b. The Claimant's July 10, 2001 MRI showed degenerative disc disease resulting in mild concentric bulges without neural compromise, not a herniated disc.

    c. The Claimant was at maximum medical improvement on August 31, 2001.

    d. The Claimant had positive Waddell's tests, with three or more significant for possible symptom magnification;

    e. The Claimant was very uncooperative during independent examinations;

    f. The Claimant sustained a sprain/strain type injury;

    g. There was no objective evidence of substantive and continued improvement over time in this case.

    h. Petitioner's office notes did not contain any objective measures of the Claimant's progress, such as range of motion, strength, decreased medication usage, increased functionality, or return to work, and recorded only her subjective, self-reported pain levels;

    i. There was no re-evaluation of the treatment plan based on the Claimant's lack of response to treatment.

12. Petitioner's records did not demonstrate that exclusive one-on-one therapy was reasonable, necessary, and properly provided because they lacked information about: 1) the specific activities the Claimant was performing; 2) the Claimant's progress in each activity; and 3) the manner in which these services were provided.

VII. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to TEX. LAB. CODE § 413.031.

2. 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. ch. 2003.

3. Petitioner timely filed a notice of appeal as specified in 28 TEX. ADMIN. CODE § 148.3.

4. Proper and timely notice of the hearing was effected in accordance with TEX. GOV'T CODE § 2001.052 and 28 TEX. ADMIN. CODE § 148.4.

5. Under TEX. LABOR CODE § 408.021(a)(1), 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 that cures or relieves the effects naturally resulting from the compensable injury.

6. Petitioner failed to carry his burden of proof to show that the services provided were properly documented, and reasonable and necessary medical treatment for Claimant's injury. 28 TEX. ADMIN. CODE § 148.21 (h) and (i).

7. The MRD properly declined to order payment for CPT Code 97110 for dates of service July 8 and 10, 2002, and October 9, 23, 30, 2002.

8. Based on the above Findings of Facts and Conclusions of Law, Petitoner's request for reimbursement is denied.

ORDER

IT IS HEREBY ORDERED that Petitioner's request for reimbursement for physical medicine sessions performed from July 2, 2002, through and including February 19, 2003, is denied.

SIGNED December 31, 2004.

DEBORAH L. INGRAHAM
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX A
Physical Medicine Sessions 1 - 147

001) 03/19/01[28]- p. 002, 002) 03/21/01 - p. 004, 003) 03/22/01 - p. 006, 004) 03/28/01 - p. 018, 005) 03/29/01 - p. 019, 006) 04/02/01 - p. 043, 007) 04/04/01 - p. 044, 008) 04/09/01 - p. 045, 009) 04/11/01 - p. 046, 010) 04/12/01 - p. 047, 011) 04/23/01 - p. 049, 012) 04/25/01 - p. 050, 013) 04/26/01 - p. 051, 014) 04/30/01 - p. 053, 015) 05/02/01 - p.

[28] The 15 underlined dates of service represent the dates on which the Provider's daily note form does not indicate that any modalities were performed. For example, Provider is seeking reimbursement for dates of service 07/02/02 and 07/03/02 for the same set of modalities provided on all the other dates of service. *See* Provider's Exhibit Packet at p. 26 (Table of Disputed Services). However, the boxes on the daily note form indicating the different modalities are not checked. Carrier's Exhibit Packet at pp. 295-96. When asked on cross-examination if this meant that the services were not actually provided on these dates, Provider said that was not the case. Provider further testified that we could assume that the same set of modalities were provided on each of these dates of service as was provided on the dates where the boxes are checked.

054, 016) 05/03/01 - p. 055, 017) 05/07/01 - p. 056, 018) 05/10/01 - p. 057, 019) 05/16/01 - p. 059, 020) 05/21/01 - p. 060, 021) 05/23/01 - p. 061, 022) 05/24/01 - p. 062, 023) 05/31/01 - p. 063, 024) 06/04/01 - p. 065, 025) 06/06/01 - p. 066, 026) 06/11/01 - p. 068, 027) 06/13/01 - p. 069, 028) 06/20/01 - p. 071, 029) 06/21/01 - p. 072, 030) 06/25/01 - p. 073, 031) 06/27/01 - p. 074, 032) 07/02/01 - p. 075, 033) 07/04/01 - p. 076, 034) 07/07/01 - p. 082, 035) 07/11/01 - p. 084, 036) 07/12/01 - p. 085, 037) 07/16/01 - p. 086, 038) 07/19/01 - p. 087, 039) 07/21/01 - p. 088, 040) 07/25/01 - p. 089, 041) 07/26/01 - p. 090, 042) 07/30/01 - p. 091, 043) 08/01/01 - p. 092, 044) 08/02/01 - p. 093, 045) 08/08/01 - p. 094, 046) 08/09/01 - p. 095, 047) 08/13/01 - p. 096, 048) 08/15/01 - p. 108, 049) 08/16/01 - p. 109, 050) 08/20/01 - p. 110, 051) 08/23/01 - p. 128, 052) 08/27/01 - p. 129, 053) 08/29/01 - p. 130, 054) 08/30/01 - p. 131, 055) 09/05/01 - p. 132, 056) 09/06/01 - p. 134, 057) 09/09/01 - p. 135, 058) 09/12/01 - p. 136, 059) 09/13/01 - p. 137, 060) 09/17/01 - p. 138, 061) 09/19/01 - p. 139, 062) 09/20/01 - p. 140, 063) 09/24/01 - p. 141, 064) 09/26/01 - p. 142, 065) 09/27/01 - p. 143, 066) 10/01/01 - p. 144, 067) 10/03/01 - p. 145, 068) 10/04/01 - p. 146, 069) 10/08/01 - p. 147, 070) 10/10/01 - p. 148, 071) 10/11/01 - p. 149, 072) 10/17/01 - p. 150, 073) 10/18/01 - p. 151, 074) 10/22/01 - p. 152, 075) 10/24/01 - p. 164, 076) 10/25/01 - p. 165, 077) 10/29/01 - p. 166, 078) 10/31/01 - p. 167, 079) 11/01/01 - p. 169, 080) 11/08/01 - p. 168, 081) 11/12/01 - p. 170, 082) 11/14/01 - p. 171, 083) 11/15/01 - p. 172, 084) 11/20/01 - p. 173, 085) 11/26/01 - p. 174, 086) 11/28/01 - p. 175, 087) 11/29/01 - p. 176, 088) 12/03/01 - p. 177, 089) 12/05/01 - p. 178, 090) 12/10/01 - p. 179, 091) 12/12/01 - p. 180, 092) 12/13/01 - p. 181, 093) 12/17/01 - p. 182, 094) 12/19/01 - p. 183, 095) 12/20/01 - p. 184, 096) 12/27/01 - p. 185, 097) 01/02/02 - p. 186, 098) 01/03/02 - p. 187, 099) 01/07/02 - p. 188, 100) 01/09/02 - p. 189, 101) 01/10/02 - p. 190, 102) 01/14/02 - p. 191, 103) 01/15/02 - p. 192, 104) 01/16/02 - p. 193, 105) 01/21/02 - p. 194, 106) 02/04/02 - p. 195, 107) 02/06/02 - p. 197, 108) 02/07/02 - p. 196, 109) 02/11/02 - p. 198, 110) 02/18/02 - p. 199, 111) 02/21/02 - p. 200, 112) 02/25/02 - p. 201, 113) 02/27/02 - p. 202, 114) 03/04/02 - p. 203, 115) 03/06/02 - p. 204, 116) 03/13/02 - p. 206, 117) 03/18/02 - p. 223, 118) 03/20/02 - p. 224, 119) 03/21/02 - p. 225, 120) 03/23/02 - p. 226, 121) 03/28/02 - p. 227, 122) 04/01/02 - p. 250, 123) 04/03/02 - p. 251, 124) 04/08/02 - p. 252, 125) 04/10/02 - p. 254, 126) 04/15/02 - p. 255, 127) 04/18/02 - p. 253, 128) 04/22/02 - p. 258, 129) 04/24/02 - p. 259, 130) 04/25/02 - p. 260, 131) 05/01/02 - p. 261, 132) 05/02/02 - p. 262, 133) 05/06/02 - p. 263, 134) 05/08/02 - p. 264, 135) 05/09/02 - p. 265, 136) 05/13/02 - p. 266, 137) 05/16/02 - p. 267, 138) 05/20/02 - p. 268, 139) 05/22/02 - p. 269, 140) 05/28/02 - p. 270, 141) 05/29/02 - p. 271, 142) 05/30/02 - p. 272, 143) 06/03/02 - p. 273, 144) 06/05/02 - p. 274, 145) 06/06/02 - p. 275, 146) 06/26/02 - p. 276, 147) 06/27/02 - p. 277.

Disputed Sessions 148-190

148) 07/02/02, 149) 07/03/02, 150) 07/08/02, 151) 07/10/02, 152) 07/11/02, 153) 07/16/02, 154) 07/17/02, 155) 07/18/02,156) 07/22/02, 157) 07/24/02, 158) 07/25/02, 159) 07/31/02, 160) 08/01/02, 161) 08/05/02, 162) 08/07/02, 163) 08/08/02, 164) 08/12/02, 165) 08/14/02, 166) 08/15/02, 167) 08/19/02, 168) 08/22/02, 169) 08/26/02, 170) 08/28/02, 171) 09/05/02, 172) 09/09/02, 173) 09/11/02, 174) 09/16/02, 175) 09/19/02, 176) 09/23/02, 177) 09/25/02, 178) 09/26/02, 179) 10/02/02, 180) 10/03/02, 181) 10/09/02, 182) 10/16/02, 183) 10/23/02, 184) 10/30/02, [29]185) 12/18/02, 186) 12/30/02, 187) 01/08/03, 188) 01/22/03, 189) 02/05/03, 190) 02/19/03[30]

[29] Pet Ex. 1at p. 34

[30] Resp. Ex. 1 at pp. 295-404.