SOAH DOCKET NO. 453-04-6068.M5
TWCC CASE NO. 04-1583

TEXAS MUTUAL INSURANCE CO., **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
ELISA MIRANDA, P.T., **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Co. ("Carrier") challenged the decision of an independent review organization ("IRO") on behalf of the Texas Workers' Compensation Commission ("Commission") in a dispute regarding the medical necessity of physical therapy services. The IRO found that Carrier improperly denied reimbursement for physical therapy that Elisa Miranda, P.T., ("Provider") administered between February 11 and 21, 2003, to a claimant suffering from a foot injury.

Carrier challenged the decision on the basis that the treatment at issue was not, in fact, medically necessary, within the meaning of '' 408.021 and 401.011(19) of the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision disagrees with that of the IRO, finding that reimbursement of the disputed services should be denied.

JURISDICTION, NOTICE, AND VENUE

The Commission has jurisdiction over this matter pursuant to ' 413.031 of the Act. The State Office of Administrative Hearings ("SOAH") has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to ' 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction, notice, or venue.

STATEMENT OF THE CASE

The hearing in this docket was convened on November 17, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge ("ALJ") Mike Rogan presided. Carrier was represented by Katie Kidd, Attorney. Provider appeared by telephone, representing herself. Both parties presented evidence and argument. The hearing then adjourned and the record closed on the same date.[1]

The record revealed that on ___, the claimant suffered a compensable injury to his left foot B *i.e.*, a fracture that eventually produced an area of damaged soft tissue on the medial aspect of the ankle. Treatment required splinting and a skin graft. Provider supervised subsequent rehabilitation through physical therapy, in an effort to increase the patient's strength and range of motion.

Carrier (the insurer for the claimant's employer) reimbursed Provider for much of the physical therapy provided to the claimant. However, Petitioner denied reimbursement for services (including office outpatient visits, therapeutic exercises, whirlpool, ultrasound therapy, and message therapy) that were provided from February 11 through 21, 2003, on grounds that these services were not medically necessary.

Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on April 13, 2004, concluding that Carrier should have reimbursed Provider for the disputed services. The IRO noted:

> [T]he patient made steady progress in his left ankle range of motion, strength and with his activity level between 2/11/03 and 2/20/03. . . .[T]he patient's left ankle active range of motion had improved to within normal limits (as compared to the 1/16/03 exam), his pain level was zero, motor strength improved to within normal limits in his left lower extremity, and the patient was able to toe walk/heel walk, and get up. . . .[T]he patient's only limitation was the inability to fully squat. . . .[T]he patient achieved good results with continued physical therapy, and . . .the skilled physical therapy was medically necessary to achieve near normal range of motion, strength, and function in the left ankle.

[1] The staff of the Commission formally elected not to participate in this proceeding, although it filed a general "Statement of Matters Asserted" with the notice of the hearing.

The Commission's Medical Review Division ("MRD") reviewed the IRO's decision and, on April 19, 2004, issued its own decision confirming that the disputed services were medically necessary and should be reimbursed. Carrier then made a timely request for review of the IRO and MRD decisions before SOAH.

THE PARTIES' EVIDENCE AND ARGUMENTS

A. Carrier

Carrier presented the deposition testimony of Mark Miller, a physical therapist who regularly treats patients and frequently lectures on treating spinal and musculo-skeletal conditions. Based upon a review of medical records, Mr. Miller stated that at the outset of the course of care administered by Provider, the claimant already met the "medium" physical demand level prescribed for his specific employment as a foreman or supervisor of construction work B as shown by a functional capacity examination ("FCE") on December 12, 2002. Although the claimant at that time still exhibited some lost range of motion ("ROM") in the foot and ankle and still had an open wound that physical therapy might help resolve, he did not need the type of closely supervised therapy that was administered by Provider.

At the time of the disputed services, Mr. Miller contended, the claimant's case presented none of the valid justifications for one-on-one supervision of therapeutic exercise. The claimant was not being initially introduced to the exercise program, the program was not being adjusted or modified in response to constant monitoring of the patient's performance, and the patient's condition did not raise questions as to the safety of his performing the exercises unsupervised. According to Mr. Miller, a home exercise program for the claimant could have supplanted the disputed therapy. Home exercise is particularly appropriate for improving range of motion, he added, since performing exercises on a regular basis throughout each day promotes such improvement much more effectively than just one hour of formally supervised exercise three times a week. He also described home exercise as more effective for a patient's "remodeling process" B *i.e.*, learning to make the injured body part move and function in various directions in the aftermath of the injury.

Mr. Miller specifically questioned why the claimant would have needed supervision while exercising on a treadmill during the disputed dates of service. He stated that a patient with more than 10 degrees of dorsiflexion can clear the toe during walking and therefore does not need supervision on a treadmill. The claimant had 15 degrees of dorsiflexion even before his program with Provider began.

Mr. Miller also addressed the passive modalities provided to the claimant on the disputed dates of service. He stated that massage therapy, if useful for promoting circulation and scar reduction in the claimant's foot and ankle, could have readily been taught to the patient, who could have then performed it effectively at home. As to ultrasound therapy provided the claimant, Mr. Miller said that it may not have effectively augmented other treatments for promoting circulation, and in any event the rationale for its use in this case was not explained in the medical records. He added that whirlpool treatment would not have been useful after the closure of the claimant's open wound, which records indicate had occurred by February 4, 2003.

Mr. Miller cited a medical evaluation dated February 27, 2003, by Dr. Brooke Roberts (one of the claimant's treating physicians), reporting that the claimant had been back at work, performing full duties for eight hours a day, since December 27, 2002. In Mr. Miller's view, this normal work activity would have been sufficient to stimulate needed circulation in the claimant's injured foot, obviating the need for any of the passive modalities administered by Provider during the same period. Indeed, concluded Mr. Miller, the best rehabilitation for enabling a patient to return to normal activity is precisely the performance of such normal activity, if the patient can do it safely.

Finally, Mr. Miller questioned the logical consistency between Provider's assessment of the claimant's status during office visits and the therapy subsequently administered to the patient. Provider's report for an office visit on January 15, 2003, recommends that the claimant receive two or three more weeks of physical therapy. Mr. Miller observed that three more weeks would have extended the therapy to February 5, 2003, but in the actual event, Provider ended up ignoring her own recommendation and continued to provide treatment until February 21, 2003. Provider's notes for an office visit on February 20, 2003, state, "From a manual muscle perspective, this patient is within normal limits. However, they are still having some very minor difficulty to get into a full squat." In Mr. Miller's interpretation, the Provider's essential conclusion on this date was that further therapeutic intervention in the case was unnecessary. (Indeed, in a report to Dr. Roberts on

the same date, Provider summed up the patient's status with "Assessment: Goals met.") And yet, anomalously, Provider then proceeded to put the claimant through the whole range of passive and active modalities that had become routine over the previous weeks, not only on February 20 but on the next day, as well. According to Mr. Miller, Provider's failure to follow her own plans or recommendations calls into question the validity of either her assessment process, the therapy intended to implement such assessments, or both.

In conclusion, Carrier characterized the disputed services as lacking in cost-effectiveness, even if they might have made the patient feel somewhat better. Carrier concluded that the claimant's ultimate recovery was about what would have been expected, with or without the Provider's disputed therapy.

B. Provider

Provider did not submit any documents into evidence in this case. She testified, though, that when she began her treatment of the claimant with the FCE on December 12, 2002, the patient's physicians were anticipating that he would need a work hardening program for satisfactory rehabilitation. However, Provider determined that a less intensive program of physical therapy would suffice. This program, which Provider personally supervised, ultimately allowed the claimant to return to work with a zero impairment rating, near-normal ROM, and no pain. According to Provider, the last two weeks of the program (*i.e.*, the disputed dates of service) clearly contributed to the overall success, since at the start of that period, the claimant was still exhibiting antalgic gait (limping) and was working only three days a week. Also, in a letter to Carrier dated June 24, 2003 (and placed in evidence by Carrier), Provider's office manager noted that the claimant's doctor issued a prescription on January 21, 2003, for four more weeks of physical therapy, which would have encompassed the disputed dates of service.[2]

Provider disputed Mr. Miller's contention that the passive modalities used in this case were only efficacious for treating the claimant's open wound and scar. She stated that whirlpool, ultrasound, and massage treatments also helped improve the claimant's ROM, in part through the reduction of swelling. Further, massage eased pain in the injured area, allowing the claimant to

[2] The prescription, for active and passive physical rehabilitation modalities, includes the instruction "Evaluate and Treat," indicating that the therapist should apply the prescribed treatment to the extent needed.

perform therapeutic exercises more effectively.

Provider also testified that the claimant, during his supervised therapy, received instruction in performing a home exercise program and that he was directed to continue such exercising on his own when discharged from the supervised program.

ANALYSIS

Carrier bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. In the ALJ's view, Carrier has discharged that burden.

Mr. Miller's analysis of the case was considerably more methodical and persuasive than either Provider's or the IRO's. As he suggested, an extensive program of physical therapy for a patient who already met the physical demand level for his non-sedentary occupation was somewhat questionable from the outset. However, the last ten days of the program appeared to be particularly inconsistent with the doctors' evaluations of the patient's progressing condition. Moreover, as Provider herself noted in testimony, a calcaneal injury, such as that suffered by the claimant, typically takes a significant time to heal fully, which casts doubt on the usefulness of extending a course of therapy to address slight but lingering symptoms in such a case.

Provider's somewhat generalized explanation of the need for the disputed services seemed notably inconsistent with documentary evidence in several instances. While Provider suggested that the passive modalities in question were justifiable, in part, as treatment for the claimant's open wound and scar tissue, the patient's plastic surgeon (Todd Adam, M.D.) reported in his "Patient Notes" that the wound was "near completely healed" by October 29, 2002, and was reduced to "a slight area of callous on the back of the posterior heel" by February 4, 2003 (a week before the first of the disputed dates of service). Provider stated that the claimant continued to exhibit a limp at the beginning of the disputed period of service, but clinical notes from the claimant's treating physician (Brooke Roberts M.D.) on December 19, 2002, and January 21, 2003, state that the patient is already able to walk without antalgic gait and has progressed to wearing regular shoes.

While Provider reported that the claimant was only working three days a week at the outset of the disputed dates of service, Dr. Roberts' notes from February 25, 2003, state that the patient has

been "performing regular duties for the last two months without limitations." And, as noted by Mr. Miller, Provider's decisions to administer treatment on the disputed dates of service (and particularly on the last two such dates) seem to conflict with her prospective written recommendation on January 15, 2003, and her written assessment that the therapy had reached its goal on February 20, 2003. Perhaps other documentation, not placed in evidence, would have supported Provider's position in this case more effectively, but since she did not submit any documentation, she has foregone the opportunity to create a documentary record that weighs less heavily against her.

The IRO's decision cites the claimant's "steady progress" in ROM, strength, and activity between February 11 and 20, 2003 (seemingly overlooking February 21, when Provider administered therapy after reporting "Goals met" the previous day). Although this conclusion may be correct, the ALJ cannot perceive how the IRO would have reached it, based upon the record presented in this docket. That record provides no clear comparison of the claimant's condition on February 11 versus February 20 and no coherent description of how the claimant was progressing from one day of therapy to the next during this short period. The only definite evidence of such progress that was presented to the ALJ consisted of general assertions in Provider's testimony B which was not well-corroborated by the documentary record.

CONCLUSION

The ALJ finds that, under the record provided in this case, the disputed medical services have not been shown to be medically necessary. Reimbursement for these services should be denied, counter to the previous determination by the IRO.

FINDINGS OF FACT

1. On July 22, 2002, claimant suffered an injury to his left foot that was a compensable injury under the Texas Worker's Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. Treatment of claimant's injury required splinting and a skin graft. Subsequently, Elisa Miranda, P.T., ("Provider") supervised rehabilitation through physical therapy, in an effort to increase strength and range of motion in the affected parts of the body.

3. The therapy program supervised by Provider included office outpatient visits (CPT Code 99213), therapeutic exercises with one-on-one supervision (CPT Code 97110), whirlpool (CPT Code 97022), ultrasound therapy (CPT Code 97035), and massage therapy (CPT Code

97124).

4. Provider sought reimbursement for services noted in Finding of Fact No. 3 B including care provided on dates of service from February 11 through 21, 2003 B from Texas Mutual Insurance Co. ("Carrier"), the insurer for claimant's employer.

5. Carrier denied the requested reimbursement for those services provided from February 11 through 21, 2003.

6. Provider made a timely request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

7. The independent review organization ("IRO") to which the Commission referred the dispute issued a decision on April 13, 2004, and concluded that the services in dispute had been medically necessary to improve claimant's range of motion, strength, and activity level.

8. The Commission's Medical Review Division ("MRD") reviewed and concurred with the IRO's determination in a decision dated April 19, 2004, in dispute resolution docket No. M5-04-1583-01.

9. Carrier requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the MRD decision regarding reimbursement.

10. The Commission mailed notice of the hearing's setting to the parties at their addresses on June 16, 2004.

11. A hearing in this matter was convened before SOAH on November 17, 2004. Carrier and Provider were represented. The record in the proceeding closed on the same date.

12. At the time of the disputed services, the claimant's case presented none of the valid justifications for one-on-one supervision of therapeutic exercise, as the claimant was not being initially introduced to the exercise program, the program was not being adjusted or modified in response to constant monitoring of the patient's performance, and the patient's condition did not raise questions as to the safety of his performing the exercises unsupervised.

13. At the outset of the course of care administered by Provider, the claimant already met the "medium" physical demand level prescribed for his specific employment as a foreman or supervisor of construction work B as shown by a functional capacity examination on December 12, 2002.

14. While Provider justified the disputed period of service in part on the basis that the claimant continued to exhibit a antalgic gait at the beginning of that period, clinical notes from the claimant's treating physician (Brooke Roberts M.D.) on December 19, 2002, and January 21, 2003, state that the patient is already able to walk without antalgic gait.

15. While Provider justified the disputed period of service in part on the basis that the claimant was only working three days a week at the outset of that period, Dr. Roberts' notes from February 25, 2003, state that the patient has been "performing regular duties for the last two

months without limitations."

16. Provider did not demonstrate that the documentary record provides any clear comparison of the claimant's condition on February 11, 2002, versus February 21, 2002, or any coherent description of how the claimant was progressing from one day of therapy to the next during this disputed period of service.

CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ' 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 § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE ("TAC") § 133.305(g) and §§ 148.001-148.028.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Carrier, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

6. Based upon the foregoing Findings of Fact, those disputed services for the claimant noted in Findings of Fact Nos. 3 through 5 do not represent elements of health care medically necessary under § 408.021of the Act.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions in this matter of the IRO, issued on April 14, 2004, and of the MRD, issued on April 19, 2004, were incorrect. Contrary to those decisions, Reimbursement of Provider for the disputed services noted in Findings of Fact Nos. 3 through 5 should be denied.

ORDER

IT IS THEREFORE, ORDERED that Texas Mutual Insurance Co. shall not be required to reimburse Elisa Miranda, P.T., for those disputed therapy services provided from February 11 through 21, 2002, as addressed in dispute resolution docket No. M5-04-1583-01 of the Texas Workers' Compensation Commission's Medical Review Division.

SIGNED December 1, 2004.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS