DOCKET NO. 453-05-2036.M5
MR NO. M5B04-3925-01

SOUTHEAST HEALTH SERVICES, INC., **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
ALBERTSON'S INCORPORATED, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This is a dispute over reimbursement for services performed to treat an injury suffered by Claimant while in the course and scope of her employment. The Administrative Law Judge (ALJ) concludes that the disputed services should not be reimbursed because Southeast Health Services (Provider) failed to meet its burden to prove medical necessity for the disputed services.

I. FACTUAL AND PROCEDURAL HISTORY

Claimant suffered a work-related injury to her lower back on _____. Thereafter, Provider treated Claimant through January 2004. On September 22, 2003, the Claimant received a two-level "IDET" procedure. Thereafter, on October 20, 2003, Provider started Claimant on post-IDET treatment. According to the post-IDET protocols suggested by Claimant's surgeon, Claimant should have received an initial four weeks of flexibility and range of motion exercises (three to four days a week) followed by a second four weeks of core stabilization and lumbar strengthening (three days a week). Claimant received 90 minutes to two hours of combined aquatic and land therapy three to four days a week prior to December 8, 2003. The ultimate goal of the protocol was to prepare the Claimant for work-hardening. During the second four-week period of post-IDET treatment, the Provider transitioned Claimant to core stabilization and lumbar strengthening.

Albertson's Incorporated (Carrier), the Claimant's provider of workers' compensation insurance, disputed the medical necessity of the post-IDET services rendered from December 8,

2003, through January 8, 2004. The disputed services in that date range were billed under CPT

Codes 98940, 97110, 97140-59, 99212 and 99213 (disputed services). Although the parties were ordered at the hearing to provide an agreed consolidated table of disputed services, only the Carrier submitted a table. The ALJ relies on the Carrier's table of disputed services in rendering this decision. The amount in dispute is $1,195.17.

The Provider filed this dispute with the Texas Workers' Compensation Commission (Commission), and on October 8, 2004, the Commission's Medical Review Division (MRD) denied certain of Provider's requested reimbursements and attached the decision of an Independent Review Organization (IRO). The IRO denied the Provider's request stating:

> . . . The therapy in question is over one year post injury . . . after the claimant was released to therapy, a short term of therapy lasting approximately 4 weeks is seen as reasonable and necessary. Since this claimant had had an extensive amount of therapy, ongoing and redundant care is not seen as necessary. With over one year of therapy with the treating doctor, the claimant would be well versed in active therapies that would continue to improve her symptoms. Continued one on one therapy protocols is not considered appropriate to treat the compensable injuries and would more likely induce potential doctor dependence. . .

The Provider filed timely requests for hearing before the State Office of Administrative Hearings (SOAH) on October 28, 2004. The Commission issued a notice of hearing in this matter on November 29, 2004. A hearing was held on July 14, 2005, before ALJ Travis Vickery. Provider and Carrier participated in the hearing, which was adjourned the same day. The record closed on August 9, 2005, after each party filed post-hearing briefing.

II. ANALYSIS

The Provider bears the burden of proof in this proceeding. At the hearing, Brian Weddle, D.C., the treating chiropractor, testified on behalf of Provider. The Provider also offered Provider's Exhibit 1, which is 44 pages consisting of: treatment-related notes; observations; a largely

incomplete treatment plan; follow-up reports; Commission forms; a functional capacity evaluation that reflected inconsistent and submaximal efforts; voluntary and pyschophysical terminations of

tests; procedure outlines; disability questionnaires; performance charts and exercise illustrations.

The point of this proceeding is to determine *why* the treatment was medically necessary for this Claimant. Dr. Weddle's testimony and Provider's Ex. 1 establish observations about the Claimant and the fact that she performed tests and exercises. Yet, there is very little evidence that actually explains *why* treatment was medically necessary, much less why such treatment was necessary for the length of time conducted. Dr. Weddle's testimony focused primarily on a treatment protocol developed by the doctor who performed the IDET procedure. But the protocol was never offered as an exhibit, so there is no record of the protocol other than Dr. Weddle's testimony. Furthermore, Dr. Weddle offered a *description* of the services the alleged protocol called for, but there is still no evidence as to why those services were necessary for the Claimant's injury. It is not enough to simply say the protocol called for a set of services, without an articulation of the Claimant's need and how these services satisfied that need.

According to Dr. Weddle, the protocol suggested six-to-eight weeks of post-IDET therapy, including four weeks of flexibility and range of motion exercises followed by four weeks of core stabilization and lumbar strengthening. Treatments began on October 20, 2003. The first stage, consisting of aquatic and land therapy, should have been completed by Friday, November 21, 2003. There are a few documents regarding the exercises performed at Provider's Ex.1 at 39 B 44, but they do not shed light on when the second four week treatment session began.

Regardless, while Provider's Ex.1 at 39-44 is evidence of the exercises performed, there is no necessary nexus between those exercises and the Claimant's condition. There is a distinct lack of evidence proving that the Claimant needed the disputed services. With regard to treatments billed under CPT Code 97110, the record suggests that the Claimant was very familiar with the exercises and that they could easily have been duplicated either at home or in a group setting. Nothing in the record explains why one-on-one guidance was necessary for the duration of each session. The Provider is not entitled to reimbursement for one-on-one therapeutic exercises.

The Provider seeks to recover for a number of office visits (CPT Codes 99212 and 99213). The IRO determined that monthly office visits may have been necessary to monitor progress. The Carrier points out that it has already reimbursed the Provider for office visits from October 20, 2003 through December 8, 2003. Carrier also reimbursed the Provider for a 99213 level office visit on December 23, 2003, and asserts that an office visit was reimbursed for December 15, 2003, although a 99212 visit is still listed on the table of disputed services. Regardless, numerous office visits have been reimbursed. Yet, there has been no justification offered for the office visits by the Provider. The Provider failed to meet its burden of proving that the disputed office visits were medically necessary.

The Provider seeks to recover for four units of spinal manipulation (CPT Code 98940). As pointed out by the Carrier, there is no evidence that spinal manipulation was part of the post-IDET protocol. The Provider could have offered an independent explanation of why these services were medically necessary, but did not. While the ALJ understands that the Claimant suffered an injury to her lower back, there is no evidence of a rationale for the rendering of these services to this Claimant. The Provider is not entitled to reimbursement for spinal manipulation.

Finally, there is no evidence that myofacial release (CPT Code 97140) administered on December 15, and December 22, 2003, was medically necessary. Like other services discussed herein, there are documents that reflect that the service was rendered, but there are no documents explaining why it was necessary. Regarding the December 15, 2003, treatment the Carrier also points out that it was not coupled with required "other therapeutic procedures such as codes 97110." The Provider is not entitled to reimbursement for myofacial release.

In conclusion, the Carrier need not reimburse the Provider for disputed services rendered under CPT Codes 98940, 97110, 97140-59, 99212 and 99213 from December 8, 2003, through January 8, 2004, in the amount of $1,195.17. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant suffered compensable, work-related injuries to her lower back on _____.

2. Albertson's Incorporated (Carrier) is the self-insured provider of workers' compensation insurance covering Claimant for her compensable injury.

3. Southeast Health Services, Inc. (Provider) treated Claimant from December 8, 2003, through January 8, 2004 (the disputed services).

4. Carrier declined to reimburse Provider's treatments (disputed services), contending that the Provider's services were not medically necessary.

5. Based on the Carrier's Table of Disputed Services, the total amount in dispute is $1,195.17. The disputed services involve CPT Codes 98940, 97110, 97140-59, 99212 and 99213.

6. Provider sought medical dispute resolution through the Commission.

7. On October 8, 2004, the Commission's Medical Review Division (MRD) denied Provider's requested reimbursements attaching the decision of an Independent Review Organization (IRO) stating that the disputed services were not medically necessary.

8. On October 28, 2004, the Provider requested a hearing before the State Office of Administrative Hearings (SOAH).

9. The Commission issued a notice of hearing in this matter on November 29, 2004.

10. The hearing convened on July 14, 2005, with ALJ Travis Vickery presiding. Provider appeared telephonically through its representative, Brian Weddle, D.C. Carrier appeared through its attorney, Steven M. Tipton. The hearing concluded and the record closed on August 9, 2005.

11. No party objected to notice or jurisdiction.

12. Provider failed to show that the disputed services were medically necessary to treat Claimant's compensable injury. The disputed services were rendered from December 8, 2003, through January 8, 2004, under CPT Codes 98940, 97110, 97140-59, 99212 and 99213.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedures Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE (TAC) ch. 148.

3. The request for a hearing was timely made pursuant to 28 TAC § 148.3.

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

5. Provider had the burden of proof in this matter under a preponderance of the evidence standard. 28 TAC §§ 148.21(h), (i) and 1 TAC § 155.41(b).

6. Claimant sustained a compensable injury on _____.

7. Provider failed to meet its burden to prove that the disputed services were medically necessary.

8. Provider is denied reimbursement for the disputed services rendered from December 8, 2003, through January 8, 2004, under CPT Codes 98940, 97110, 97140-59, 99212 and 99213.

ORDER

Albertson's, Inc. need not reimburse Southeast Health Services for the services in dispute in this proceeding.

SIGNED September 13, 2005

TRAVIS VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS