

**SOAH DOCKET NO. 453-05-3152.M5
TWCC MR NO. M5-04-3488-01**

**TEXAS MUTUAL INSURANCE
COMPANY,
Petitioner**

V.

**ALTA HEALTHCARE CLINIC,
Respondent**

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

DECISION AND ORDER

I. INTRODUCTION

Texas Mutual Insurance Company (Carrier) disputes the decision of an independent review organization (IRO) issued on behalf of the Texas Workers' Compensation Commission (TWCC or Commission)/Medical Review Division (MRD),¹ which directed Carrier to pay Alta HealthCare Clinic (Provider) for claims Carrier denied for lack of medical necessity (the disputed services).² The disputed services were provided to Claimant before he underwent shoulder surgery on October 30, 2003, (August 5, to October 29, 2003), and after the surgery (November 4, 2003, to January 28, 2004).

The disputed services included one-on-one therapeutic exercises (CPT 97110), one-on-one aquatic therapy (CPT 97113), manual therapy (CPT 97140), chiropractic manipulation (CPT 98940), massage therapy (CPT 97124), office visits (CPT 99213), limb muscle tests (CPT 95831), range of motion (ROM) measurements (CPT 95851), physical performance tests (CPT 97750), gait training therapy CPT (97116), mechanical traction therapy (CPT 97012), physician review of motion tests (CPT 96004), electrical stimulation other than wound (CPT G0283), body muscle testing, manual (CPT 95833), limb muscle testing, manual (CPT 95831), whirlpool therapy (CPT 97022) and special

¹ Effective September 1, 2005, the functions of the Commission have been transferred to the newly created Division of Worker's Compensation at the Texas Department of Insurance.

² Although, the MRD decision embraced several issues, Carrier is challenging those treatments the Carrier denied as not being medically necessary. Provider did not appeal any issue.

reports or forms (CPT 99080).³ The IRO found that these disputed services were medically necessary to treat Claimants compensable injury. MRD found that the medical report billed under CPT 99080-73, was a required report, not subject to an IRO review, and ordered Carrier to pay this amount. Carrier challenged this ruling as well.⁴

The ALJ finds that most of the disputed services were medical necessary and should be paid. However, the one-on-one therapy provided to Claimant eight weeks after his shoulder surgery, as well as office visits in excess of one per week were not medically necessary. Eight weeks after the shoulder surgery Claimant should have had sufficient one-on-one therapy to be able to progress to group therapy. As for the office visits, even Robert Todd Petersen, D.C., Provider's new owner, agreed that it was not medically necessary to conduct a level III office visit each time Claimant came to the clinic for physical therapy six weeks after Claimant's surgery. A level III office visit once a week should have been sufficient to address any complications Claimant might have experienced.

Therefore, Carrier is not liable to Provider for the one-on-one therapy provided to Claimant on and after December 29, 2003, and is not liable for any office visits billed in excess of one per week after December 16, 2003. Finally, the report Provider generated on December 19, 2003, was not issued because of a change in Claimant's medical condition, but solely because Provider customarily issued these reports every 30 days. Pursuant to 28 TEX. ADMIN. CODE (TAC) §129.5(d) Provider must file a work status report when the employee experiences a change in work status or has a substantial change in activity restrictions unless the carrier requests a different reporting schedule. None of these conditions occurred. Therefore, Carrier is not liable to Provider for this work status report.

³ The total in dispute is approximately \$9,771.12. The parties submitted a list of disputed services after the hearing, on September 28, 2005, which was marked and admitted as Joint Ex. A, at which time the record was closed.

⁴ Provider did not appeal any portion of the MRD decision. Carrier did not challenge any other portion of the MRD decision other than those issues identified above.

II. BACKGROUND

On____, Claimant sustained a compensable injury when he fell approximately 20 feet from a scaffold onto the concrete steps below. As a result of this fall, Claimant injured two separate areas of his body, his left shoulder and his lumbar spine. On June 6, 2003, Claimant went to Provider for chiropractic treatment of both his shoulder and his lower back. Claimant also went to specialized doctors for further treatment to his shoulder and his back. After examining Claimant and considering the other doctors' recommendations, Provider treated Claimant with one-on-one aquatic therapy, one-on-one physical therapy, and conservative chiropractic care. Carrier paid Provider for these medical services until August 5, 2003, when Carrier denied the claims as not being medically necessary.

On October 30, 2003, Claimant underwent surgery to repair his shoulder. Claimant returned to Provider for rehabilitative therapy. Carrier paid Provider for the rehabilitative services provided for a couple of days, through November 3, 2003, but denied services provided after this date as not being medically necessary.

Provider appealed the matter to MRD asking to be reimbursed for the medical services provided to Claimant from August 5, 2003, to October 29, 2003 (pre-surgery), and November 4, 2003, to January 28, 2004 (post-surgery). MRD referred the claims to IRO for a determination of the medical necessity. On September 1, 2004, IRO found that the disputed medical services were medically necessary.

III. DID CARRIER SHOW THAT THE DISPUTED MEDICAL SERVICES WERE NOT MEDICALLY NECESSARY?

A. IRO Opinion

The IRO found that the disputed services, provided both before and after the shoulder surgery, were medically necessary. In the Clinical History section of the IRO report, the IRO noted that the June 16, 2003 MRI of Claimant's left shoulder "indicated a Hill Sachs impaction fracture involving the lateral humeral head, a 4-5mm full thickness tear involving the lateral insertion supraspinatus tendon" in his shoulder.

The MRI of Claimant's lower back showed the following:

compression fracture of L3 with L2/3 right paracentral 3-4mm discal substance herniation contacting and minimally indenting the expected thecal sac contours, a 2-3 mm posterocentral discal substance herniation at L4/5, and a 2-3 mm posterocentral discal substance herniation at L5/S1.⁵

According to the IRO, Claimant sustained a "complex injury" that was initially treated with conservative care.⁶ When this treatment did not resolve Claimant's shoulder pain, Claimant underwent shoulder surgery on October 30, 2003, which included "a mini-arthrotomy and open repair of the full thickness tear of the rotator cuff."⁷ Following the shoulder surgery, the IRO opined that Claimant needed eight to ten weeks of postoperative therapy to control his pain and to restore his functional ability.

The IRO maintained that Provider had to address both areas of the compensable injury. Claimant's lower back had been braced for an extended period of time to treat the L3 compression fracture. Once the brace was removed in early October 2003, Claimant required strengthening therapy for his spine which had to be done in conjunction with the treatment for Claimant's shoulder injury. Because of the complexity caused by two separate injuries, the IRO concluded that the medical services provided by Provider to Claimant during the period in review were medically necessary.

B. Parties' Positions

1. Carrier

Carrier called David Alvarado, D.C., to testify as to the medical necessity of the disputed services. After reviewing the medical record, Dr. Alvarado agreed with the IRO that this was a complex injury. However, Dr. Alvarado concluded that while Claimant needed to engage in physical

⁵ TMIC Exhibit No. 1 at 7-8.

⁶ *Id.*

⁷ *Id.* at 8.

therapy, Claimant did not require the extended periods of one-on-one therapy provided either before or after his shoulder surgery. Dr. Alvarado opined that Claimant was physically and mentally capable of participating in group therapy or in a home exercise program, both of which are less expensive than one-on-one therapy.

Dr. Alvarado also questioned the appropriateness of treating Claimant's shoulder with aquatic therapy because aquatic therapy is used to remove pressure from the lower spine. Nothing in the record, Dr. Alvarado contends, shows that Claimant could not tolerate land-based therapy for his shoulder. In addition, after the first eight weeks of conservative care (August 5, 2003), Dr. Alvarado testified that it was clear Claimant's shoulder was not going to respond to conservative treatment and needed surgery, and that any additional physical therapy for his shoulder was medically unnecessary.

With respect to the lower back injury, Dr. Alvarado questioned the propriety of having Claimant participate in any active therapy, even aquatic therapy, because Claimant had a compression fracture of L2, a herniated disc. Dr. Alvarado referenced the July 8, 2003 report of John B. Payne, D.O., the neurosurgeon treating Claimant's lower back injury, in which Dr. Payne documented that Claimant was in a back brace and recommended that Claimant "not start any active therapy for the back until at least three months after his injury."⁸ Consequently, Dr. Alvarado maintains Provider should not have treated Claimant with active therapy until September 2003.

Dr. Alvarado also questioned the need for Provider to perform a level III office visit each time Claimant came to the clinic for therapy. A level III office visit requires two of the following three components: (1) an expanded problem-focused history; (2) a problem-focused examination; or (3) a medical decision of low complexity. Dr. Alvarado testified that it was excessive to do a level III examination each time Claimant came into the office.

⁸ TMIC Exhibit No. 1 at 33.

Under cross-examination, Dr. Alvarado agreed that an orthopedic surgeon, Joseph Daniels, D.O., was treating Claimant's left shoulder. On June 30, 2003, Dr. Daniels directed Claimant to receive conservative treatment with exercise, NSAIDS, and physical therapy.⁹ Dr. Alvarado agreed that given this report he would have performed four weeks of conservative care, but stated that if Claimant had not improved, he would not have continued with this type of treatment.

2. Provider

Dr. Petersen did not treat Claimant during the dates in dispute, but he did review Claimant's medical records. Dr. Petersen testified that because the fall injured Claimant's shoulder and his lower back this was a complex case to treat. The treatment for both areas of Claimant's body had to be coordinated to avoid injuring one area while providing therapy to the other.

Dr. Petersen explained that it takes at least six months to recover from the type of shoulder surgery performed on Claimant.¹⁰ In addition, Dr. Petersen explained, the medical records show that Claimant's range of motion in his shoulder and his back improved significantly with rehabilitative therapy.¹¹ The only time Claimant regressed was immediately following surgery, which was to be expected.

According to Dr. Petersen, Claimant's orthopedic surgeon, Dr. Daniel, asked Provider to begin therapy on Claimant's shoulder and Provider was obligated to do so. Dr. Daniels directed Claimant to "continue rehabilitative exercises for the left shoulder daily for four to six weeks."¹² On August 25, 2003, Robert M. Chouteau, D.O., another orthopedic surgeon, examined Claimant and recommended that Claimant continue therapy and treatment. On September 12, 2003, Claimant

⁹ Alta Exhibit No. 1 at 415.

¹⁰ Alta Exhibit No. 1 at 445.

¹¹ Alta Exhibit No. 1 at 203-219.

¹² TMIC Exhibit No. 1 at 39.

went to Mike Shah, M.D., a physiatrist, who also recommended that Claimant continue seeing Provider for therapy and treatment.¹³ Provider's goal was to follow the recommendations from the doctors treating Claimant's shoulder, and the doctor treating Claimant's lower back. Hence, the need for one-on-one therapy.

Following Claimant's shoulder surgery, Dr. Chouteau instructed Claimant to continue with "physical therapy for light range of motion and modalities."¹⁴ On December 22, 2003, Dr. Payne recommended that Claimant "complete back conditioning and work hardening."¹⁵ Provider was following the instructions of Claimant's various doctors in providing the disputed services. Dr. Petersen reaffirmed that it was medically necessary to use one-on-one therapy to prevent Claimant from hurting one injury while rehabilitation was being done to the other injury. Likewise, it was medically necessary to do level III office visit during these critical periods to ensure Claimant did not experience severe change in his condition.

Six weeks after the surgery, Dr. Petersen conceded it was medically necessary to conduct level III office visits once or twice a week. As for the work status report, Dr. Petersen clarified that it is customary to prepare a work status report every 30 days to avoid having carriers discontinue coverage despite what the Commission rule provides.

C. ALJ's Analysis

Carrier had the burden of proof in this matter. To meet this burden, Carrier relied heavily on Dr. Alvarado's assessment of Claimant's medical records. Dr. Alvarado concluded the disputed services were not medically necessary after conducting a review of Provider's medical records. The IRO and Dr. Petersen also reviewed all these records and reached a different conclusion, that the

¹³ TMIC Exhibit No. 1 at 55.

¹⁴ Alta Exhibit No. 1 at 431.

¹⁵ Alta Exhibit No. 1 at 433.

disputed services were medically necessary. While both Dr. Alvarado, as Carrier's expert, and Dr. Petersen have an interest in the outcome of this decision, the IRO physician opinion was unbiased.

No one disputes that therapy was medically necessary to treat Claimant's compensable injury. What is in dispute is the amount of services and the need for one-on-one therapy. Claimant suffered a complex injury when he fell almost 20 feet onto concrete stairs injuring his shoulder and his lower back. The shoulder injury ultimately required surgery. The lower back required an extended period of time in a brace. While one injury alone might call for a less intensive setting for the therapy, the combination of these two injuries called for a more intensive setting, one-on-one therapy, to prevent harming one injury at the expense of the other.

Carrier failed to prove by a preponderance of the evidence that the services provided by Providers before Claimant's shoulder surgery and for eight weeks after surgery were not medically necessary. Therefore, the ALJ finds that these disputed services provided by Provider to Claimant were medically necessary. However, Carrier did show that one-on-one therapy was not medically necessary eight weeks after the surgery. By that time, Claimant had sufficient time to recover from surgery, strengthened his back, and to have learned how to do the therapy in a less intensive setting. Carrier also showed that more than one level III office visit per week six weeks following the surgery was not medically necessary because Claimant's shoulder had healed enough not to require such an intensive office visit more than once a week. Even Dr. Petersen agreed that one office visit per week was sufficient. Therefore, Carrier is not required to pay for these services. Finally, the work status report generated by Provider was not required by either the Commission rules or requested by Carrier. Therefore, Carrier is not liable for this report.

IV. FINDINGS OF FACT

1. On____, Claimant sustained a work-related injury when he fell approximately 20 feet from a scaffold onto the concrete steps below while engaged in his work activities (compensable injury). Claimant injured both his left shoulder and his lower back
2. At the time of Claimant's compensable injury, Claimant's employer's workers' compensation insurance carrier was Texas Mutual Insurance Company (Carrier).
3. On June 6, 2003, Claimant went to Alta HealthCare Clinic (Provider) for chiropractic treatment of his compensable injury.
4. Claimant also went to Joseph Daniels, D.O., an orthopedic surgeon, for treatment of his left shoulder, and to John B. Payne, D.O., a neurosurgeon, for treatment of his lower back.
5. On June 16, 2003, Claimant had an MRI taken of his left shoulder and lower back.
6. The MRI of Claimant's left shoulder indicated a Hill Sachs impaction fracture involving the lateral humeral head and a 4-5mm full thickness tear of the supraspinatus tendon.
7. The MRI of Claimant's lower back revealed a compression fracture of L3 and herniations of L2/3, L4/5, and at L5/S1.
8. On June 30, 2003, Dr. Daniels directed Claimant to engage in physical therapy for his left shoulder.
9. On July 8, 2003, Dr. Payne recommended that Claimant not begin any active therapy for his lower back for a couple of months because Claimant was in a back brace to stabilize his lower back.
10. To accommodate the different instructions from Claimant's surgeons, it was medically necessary prior to Claimant's shoulder surgery for Provider to treat Claimant with one-on-one aquatic therapy, one-on-one physical therapy, and chiropractic care.
11. In late September 2003, Dr. Payne directed Claimant to begin active therapy to strengthen his lower back.
12. On October 30, 2003, Claimant underwent surgery to repair his left shoulder.
13. Subsequently, Claimant returned to Provider for postoperative rehabilitation.

14. Provider resumed treating Claimant with one-on-one aquatic therapy, one-on-one physical therapy, and conservative chiropractic care.
15. Due to the complexity of Claimant's compensable injuries it was medically necessary to perform one-on-one therapy to treat both his shoulder and his lower back for eight weeks following the surgery until December 29, 2003.
16. To ensure that Claimant did not reinjure either his shoulder or his lower back, it was medically necessary for six weeks following the surgery (through December 16, 2003) to perform level III office visits each time Claimant presented for therapy.
17. Carrier denied payment for the services provided by Provider to Claimant before surgery from August 5, to October 29, 2003, and after surgery from November 4, 2003, to January 28, 2004, as not being medically necessary (the disputed services).
18. The disputed services that were provided to Claimant included one-on-one therapeutic exercises (CPT 97110), one-on-one aquatic therapy (CPT 97113), manual therapy (CPT 97140), chiropractic manipulation (CPT 98940), massage therapy (CPT 97124), office visits (CPT 99213), limb muscle tests (CPT 95831), range of motion (ROM) measurements (CPT 95851), physical performance tests (CPT 97750), gait training therapy CPT (97116), mechanical traction therapy (CPT 97012), physician review of motion tests (CPT 96004), electrical stimulation other than wound (CPT G0283), body muscle testing, manual (CPT 95833), limb muscle testing, manual (CPT 95831), whirlpool therapy (CPT 97022) and special reports or forms (CPT 99080).
19. Provider filed a request for medical dispute resolution with the Texas Workers' Compensation Commission (TWCC) asking to be reimbursed for the claims Carrier denied.
20. TWCC's Medical Review Division (MRD) referred the claims to an independent review organization (IRO) to determine if the services were medically necessary.
21. Following the review of the appealed claims, the IRO found that the medical services provided from August 5, 2003, to January 28, 2004, were medically necessary.
22. Based on the IRO's findings, MRD ordered Carrier to reimburse Provider for the disputed services and found that Carrier owed Provider for the report billed under CPT 99080.
23. After the MRD order was issued, Carrier asked for a contested-case hearing by a State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ).

24. After December 29, 2003, Claimant no longer required one-on-one aquatic or physical therapy because he had undergone sufficient one-on-one therapy prior to that time to be able to do the exercises independently.
25. After December 16, 2003, it was not medically necessary to provide more than one level III office visit per week.
26. The December 19, 2003 work status report Provider generated was not prepared as a result of Claimant's change in work status or due to a substantial change in Claimant's activity restrictions.
27. Carrier did not ask Provider to prepare the December 19, 2003 work status report.
28. Required notice of a contested-case hearing concerning the dispute was mailed to the parties.
29. On September 13, 2005, SOAH ALJ Catherine C. Egan held a contested-case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Attorney Timothy Riley appeared for Carrier. Robert Todd Petersen, D.C. appeared telephonically for Provider.
30. The record remained open for the parties to file a list of the disputed services. On September 28, 2005, the parties filed a joint exhibit listing the services in dispute. The ALJ marked this exhibit as Joint Exhibit A, admitted it into evidence, and closed the record.

V. CONCLUSIONS OF LAW

1. 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 ANN. (Labor Code) §§402.073(b) and 413.031(k) and TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003.
2. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.
3. Carrier has the burden of proof in this case pursuant to 28 TEX. ADMIN.CODE (TAC) 148.14 and 1 TAC 155.41.
4. 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, promotes recovery, or enhances the ability of the employee to return to or retain employment. Labor Code § 408.021 (a).

5. Based on the above Findings of Fact and Conclusions of Law, the disputed services provided by Provider to Claimant from August 5, to October 29, 2003, and November 4,

2003, to January 28, 2004, were medically necessary to treat Claimant's compensable injury except the one-on-one aquatic therapy (CPT 97113), and the one-on-one physical therapy (CPT 97110), provided from December 29, 2003, to January 28, 2004, and each level III office visits (CPT 99213) billed in excess of one per week after December 16, 2003, which were not medically necessary.

6. The Commission rules require a treating doctor to file a work status report after the initial examination of the employee, regardless of the employee's work status; when the employee experiences a change in work status or a substantial change in activity restrictions; or on a scheduled by the insurance carrier. 28 TAC § 129.5(d).
7. Based on the above Findings of Fact and Conclusions of Law, the work status report issued by Provider on December 19, 2003, was not require by Commission rule or at the request of Carrier, therefore, Carrier is not liable for payment of this work status report.

ORDER

IT IS ORDERED THAT Texas Mutual Insurance Company is required to reimburse Alta HealthCare Clinic for the disputed services provided to Claimant from August 5, 2003, to January 28, 2004, except for the one-on-one aquatic therapy and one-on-one physical therapy provided on December 29, 2003, to January 28, 2004, any level III office visits billed in excess of one per week after December 16, 2003, and the work status report.

Signed November 28, 2005.

**CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS**