**SOAH DOCKET NO. 453-05-7332.M5**
**MDR NO. M5-05-1835-01**

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| **CORNERSTONE MUTUAL INSURANCE COMPANY, c/o COVENANT GROUP, Petitioner** | § | **BEFORE THE STATE OFFICE** |
| **VS.** | § | **OF** |
| **SUMMIT REHABILITATION CENTERS, Respondent** | § | **ADMINISTRATIVE HEARINGS** |

## DECISION AND ORDER

An Independent Review Organization (IRO) determined that various chiropractic services rendered by Summit Rehabilitation Centers (Provider) to an injured worker (Claimant) for his compensable injury were medically necessary. The Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission)[1] ordered Cornerstone Mutual Insurance Company (Carrier) to reimburse Provider $1,509.34 for all disputed services, after deleting from the total medically necessary charges billed some services billed under code 97110 that the MRD determined were inadequately documented. Carrier requested a hearing.

This decision finds that some disputed office visits for which Provider seeks reimbursement were not medically necessary and orders Carrier to reimburse Provider, but not for the entire amount ordered by the MRD.

## I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

Administrative Law Judge (ALJ) Charles Homer III convened the hearing in this case on April 20, 2006, at the Austin hearing facility of the State Office of Administrative Hearings (SOAH). Attorney H. Douglas Pruett appeared on behalf of Carrier, and Todd Peterson, D.C., appeared for Provider. Notice and jurisdiction were not disputed and are addressed in the Findings of Fact and Conclusions of Law. The hearing record closed on April 20.

## II. DISCUSSION

### A. Medical History and Background.

Claimant, a 52-year-old man who worked for a restaurant chain, suffered a compensable injury to his right shoulder___, when the company car he was driving turned over twice on an icy street in Colorado after a tire blew out. He had immediate and severe pain in his right shoulder, but

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the Division of Workers' Compensation at the Texas Department of Insurance.

drove the car back to the company's Dallas office. He received X-rays to the shoulder and cervical spine areas, as well as a prescription for pain medication, and was discharged with an arm sling. His pain continued, and on February 9, 2004, he was instructed not to work. On March 18, 2004, he visited Marivel Subia, D.C., of Provider's office, where he began a course of treatment that is not disputed in this appeal.

Claimant continued to have trouble with his right shoulder, and revisited Provider on August 5, 2004, where he continued therapy until, on August 23, John C. McConnell, M.D., performed arthroscopic surgery to repair the rotator cuff tendon in the affected shoulder.[2] Claimant returned to Provider on September 7 and was prescribed a course of electrical stimulation, manual therapy, and one-on-one supervised therapeutic activities and exercises, which Claimant continued until the last date of disputed services, October 27, 2004.

Provider billed Carrier for services provided from August 5 to October 27, 2004. Carrier denied reimbursement for most charges based upon lack of medical necessity and, as to services coded 97110, insufficient documentation.[3] Provider requested medical dispute resolution. The reviewing IRO concluded that Provider's services for Claimant from August 5 to September 6, 2004, were not were medically necessary, but that services rendered from September 7 to October 27, 2004, were medically necessary. In response, Carrier requested this proceeding before SOAH. Provider did not appeal the MRD's decision that most of the services coded 97110 were insufficiently documented. The following table identifies the disputed services by date and billing code.

| | | | | | | |
|---|---|---|---|---|---|---|
| 9/22/04 10/25, 26, and 27/04 | 10/25/04 | 10/25/04 | 10/25/04 | all dates of service after first two weeks of therapy | all dates of service from 9/07/04 to 10/27/04 | all dates of service after first two weeks of therapy |
| 97110 therapeutic procedures | 95831 manual muscle testing, with report | 95833 total evaluation of body (except hands) | 96004 physician review, interme-diate analysis | 97140 manual therapy | 99213 office visit | G0283 unattended electrical stimulation[4] |

**B. Summary of Evidence and Argument**

[2] Provider Ex. 1, pp. 31-32.

[3] Carrier Ex. 1, Table of Disputed Services (two unnumbered pages).

[4] 97032, manual electrical simulation was billed one day, September 24, 2004.

**1. Carrier**

In general, Carrier argues that standard protocol endorses the first two weeks of Provider's post-surgical treatment of Claimant, but that no more is medically necessary without some documented reason. Neither party was able to cite Medicare guidelines specific to post-surgical rehabilitation; rather, each based its case on its testimony and other guidelines, such as the Official Disability Guidelines (ODG), guidelines published by the American College of Occupational and Environmental Medicine (ACOEM) and cited by the IRO, and those of the Medical Disability Advisor (MDA), also cited by the IRO.[5]

For Carrier, Cynthia L. Tays, D.C., testified that some chiropractic care was medically necessary for Claimant after his surgery, because of the effects of cutting the muscle and inactivity of the related joint. She observed that Dr. McConnell did not prescribe any post-surgery chiropractic care and that some of Provider's care was focused on the cervical spine, where there had been no surgery. Dr. Tays also stated her opinion that more than two weeks of passive therapies (other than ice and heat) is not indicated unless there is a documented exacerbation of the patient's injury (such as re-injury or inflammation of the affected area) and that there was no such indication in Dr. Subia's notes. Thus, in her opinion, unattended electrical stimulation (G0283) and myofascial release (97140) should have been terminated at two weeks.

Dr. Tays stated that the services coded 99213 were not necessary (except for a visit two weeks after the first day of therapy and monthly thereafter), because that code applies to a problem-focused exam, an expanded medical history, or medical decision-making of low complexity - entailing 15 minutes of provider's time spent face-to-face time with the patient -none of which is documented in Provider's records according to her. She explained that when there is no change in the therapy regimen, as was usually the case with Claimant, there is nothing to support a 99213 or 96004 charge. Dr. Tays stated that she found no expansion of Claimant's medical history after his September 7 surgery, nor even any mention of the surgery in Provider's records, and noted that treatment after surgery was little changed from before; in fact, Claimant had been on essentially the same regimen with Provider for months beforethe surgery

**2. Provider**

[5] Provider Ex. 1, p. 7.

Provider argues that the IRO distinguished post-surgical rehabilitation from prior treatment, and specifically found that the latter was medically necessary. Testifying for Provider, Dr. Peterson pointed out that Claimant only reached maximum medical improvement on November 1, 2004, and questioned whether any specific guidelines supported Carrier's two-week limitation on passive modalities. Dr. Peterson invoked peer reviewers who stated that more post-surgical therapy was appropriate[6] and *Clinical Orthopaedic Rehabilitation* (2nd Ed. 1996, at pp. 176-179) (COR), which opines that twelve weeks of exercise and passive modalities would be medically necessary.[7]

Dr. Peterson asserted that the IRO's reliance on ACOEM guidelines was appropriate and emphasized that frequent range of motion measurements are required in rehabilitation after rotator cuff surgery and that such measurements are separate services from office visit evaluations and should be billed separately. Dr. Peterson stated his belief that myofascial release was appropriate for Claimant during the entire treatment period because it improves range of motion, which is determinative of how quickly a post-surgical shoulder can recover.

## III. ANALYSIS AND CONCLUSION

Carrier has the burden of proof and did not meet that burden with respect to the duration of treatment. The record in this case contains equally compelling authority for both Carrier's and Claimant's positions. For one example, a peer reviewer writing before Claimant's surgery stated that four to six weeks would be adequate post-surgical rehabilitation.[8]

Another example, cited by Provider as noted above, is the COR guidance specific to rotator cuff surgery, which supports months of therapy after surgery.[9] Treatment of such intensity and duration appears to be designed for professional athletes and those with "major" rotator cuff tears, rather than sedentary workers with lesser injuries such as Claimant. For example, the COR authorizes joint immobilization for up to eight weeks after surgery, when the record here shows that Claimant was moved into active and passive therapies three weeks after his surgery.

Nevertheless, the ALJ finds corroboration in the COR guidelines for Provider's testimony that continued passive modalities promote recovery for more than two weeks and adopts Provider's

[6] *Id.*, pp. 47-48.

[7] Provider Ex. 1, pp. 14-15.

[8] Carrier Ex. 1. pp. 47-48.

[9] Provider Ex. 1, 14-17.

position regarding passive modalities. COR approves maintaining patients on electrical stimulation, a passive modality, for the first 12 weeks of post-surgical rehabilitation, and the Texas Workers' Compensation Act (Act) does not distinguish between Claimant and a baseball pitcher insofar as the kind of modalities that a Claimant is entitled to (as opposed to the amount of treatment, which the Act subjects to cost controls).[10] Considering all the credible evidence, the ALJ finds that six weeks of treatment was reasonably necessary for Claimant after his August 23 surgery, a period that runs from September 7 to October 27, 2004, allowing two additional calendar days.

On the other hand, Carrier's witness provided persuasive testimony that there is no medical necessity for office visit evaluation when there is little or no change in the patient's therapy and treatment. This finding affects the 99213 services billed on September 22, October 25, and October 26. Concerning the office visit on October 27, the date the disputed services ended, without relying on SOAH decisions cited by Provider (because those cases involve different facts), the ALJ finds that an office visit after six weeks of therapy is reasonable and medically necessary. Regarding the contested muscle testing studies, the ALJ concludes that Carrier has not shown that one unit of each, the amount billed in the time this decision addresses, is excessive.

Summarizing, except for those services coded 99213, 96004, and 97110, reimbursement should be ordered for all services rendered between September 7 and October 27, 2004. In addition, the one-to-one therapeutic exercises billed under 97110 on September 22, October 25, 26, and 27 should be reimbursed, because Carrier produced no evidence specifically concerning those services, and the MRD decision did not disallow those particular dates of one-on-one supervised exercises, although it disallowed many other dates for insufficient documentation. The office visit coded 99213 on October 27 should also be reimbursed.

## IV. FINDINGS OF FACT

1. On_____ (Claimant), an employee of ___, suffered a compensable injury to his right shoulder when a company vehicle he was driving had a blowout of a front tire and rolled over twice on an icy street.

2. At the time of Claimant's injury, his employer held workers' compensation insurance coverage that covered Claimant with Cornerstone Mutual Insurance Company (Carrier).

3. On and after August 5, 2004, Claimant was a patient of Summit Rehabilitation Centers (Provider).

[10] Act § 408.021. ENTITLEMENT TO MEDICAL BENEFITS. (a) 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. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

4. Provider treated Claimant from September 7 through October 27, 2004, and billed Carrier for the following: one-on-one supervised therapeutic activities and exercises (coded 97110), electrical stimulation (G0283), and manual therapy (97140). Provider also charged for muscle testing (95831), muscle testing (total body) (95833), a physician review (96004), office visits (99213), and one unit of manually administered electrical stimulation (97032).

5. On August 23, 2004, John C. McConnell, M.D., performed arthroscopic surgery on Claimant's right shoulder to repair a torn rotator cuff tendon.

6. Dr. McConnell neither recommended that Claimant resume therapy with provider, nor advised against doing so.

7. Provider billed Carrier for services provided from August 5 through October 27, 2004.

8. Carrier denied reimbursement for the disputed services as not medically necessary.

9. Provider requested medical dispute resolution before the Texas Workers' Compensation Commission (Commission) based on Carrier denial of reimbursement for services provided from August 5 through October 27, 2004.

10. The reviewing Independent Review Organization concluded that all services rendered on September 7 and afterward were medically necessary, while those rendered before September 7 were not.

11. The Commission's Medical Review Division (MRD) ordered reimbursement for all disputed services rendered after September 7, 2004, except for most dates of services coded 97110.

12. On June 2, 2005, Carrier requested a hearing before the State Office of Administrative Hearings (SOAH).

13. This case was referred by the Commission and accepted by SOAH for hearing before September 1, 2005.

14. Notice of the hearing was sent to the parties on July 11, 2005. The notice contained the date, time, and location of the hearing; a statement of the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

15. Carrier did not prove that the one-to-one-supervised therapeutic exercises billed under 97110 on September 22, October 25, 26, and 27 were not medically necessary, nor did the MRD decision disallow those particular dates of 97110 billing.

16. Carrier did not prove that one unit each of 95831 and 95833 were not medically necessary.

17. Because there was little or no change in the patient's therapy and treatment, the office visits billed on September 22, October 25, and October 26, 2004, under code 99213 provided insufficient benefit for Claimant to justify their being billed to Carrier.

18. Because there was little or no change in the patient's therapy and treatment, the office visit/physician evaluation billed on September 16, 2004, under code 96004 provided insufficient benefit to Claimant to justify its being billed to Carrier.

## V. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (or its successor agency, the Texas Department of Insurance) has jurisdiction over this matter pursuant to TEX. LABOR CODE ANN. (Labor Code) § 413.031.

2. 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 Labor Code §§ 402.073(b) and 413.031(k) (West 2005), TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003 (West 2005), and Acts 2005, 79th Leg., ch. 265, § 8.013, eff. Sept. 1, 2005.

3. The hearing was conducted pursuant to Gov't Code ch. 2001.

4. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

5. Cornerstone Mutual Insurance Company timely filed its request for a hearing with the Texas Workers' Compensation Commission.

6. Cornerstone Mutual Insurance Company, the party seeking relief, had the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

7. The following disputed services provided from September 7 to October 27, 2004 were reasonably required by the nature of Claimant's injury, and were, therefore, medically necessary. Labor Code §408.021.

| Sept. 22, Oct. 25, 26, & 27, 2004 | all dates | all dates | none | all dates | only October 27, 2004 | all dates |
|---|---|---|---|---|---|---|
| 97110 therapeutic procedures | 95831 manual muscle testing, with report | 95833 total evaluation of body (except hands) | 96004 physician review, interme-diate analysis | 97140 manual therapy | 99213 office visit | G0283 electrical stimulation (and 97032, manual electrical stimulation, Sept. 24, 2004.) |

8. Provider is entitled to reimbursement for each of the service units shown in Conclusion of Law No. 7.

9. Provider is not entitled to reimbursement for any disputed service not described as medically necessary in Conclusion of Law No. 7.

## ORDER

**IT IS ORDERED** that Cornerstone Mutual Insurance Company reimburse Summit Rehabilitation Centers for the services it provided to Claimant ___from September 7 to October 27, 2004, as detailed in Conclusion of Law No. 7.

**SIGNED June 19, 2006.**

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**CHARLES HOMER III**
**ADMINISTRATIVE LAW JUDGE**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**