SOAH DOCKET NO. 453-03-4396.M5

JONATHAN D. SKERIES, D.C.,	**§**	**BEFORE THE STATE OFFICE**
Petitioner & Cross-respondent	**§**	
	§	
V.	**§**	**OF**
	§	
AMERICAN CASUALTY COMPANY	**§**	
OF READING, PA,	**§**	
Respondent & Cross-petitioner	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

American Casualty Company of Reading, PA. (Carrier) denied payment for services provided to a worker with cervical, thoracic, and lumbar injuries. Carrier asserted that many of the services provided were not reasonable or medically necessary. Jonathan D. Skeries., D.C., (Provider) requested medical dispute resolution. An independent review organization (IRO) concluded the services it reviewed for services between July 30, 2002, and September 6, 2002, were reasonable and medically necessary to treat this patient's condition.[1]

The Texas Workers' Compensation Commission's Medical Review Division (MRD) reviewed other dates of service and ordered reimbursement in the amount of $2,954 for office visits and physical therapy services rendered between July 29, 2002, and September 23, 2002.[2] Provider appealed, asserting that the MRD was wrong in finding that some of the services it reviewed were not adequately documented. Provider also asserted that the MRD order did not address approximately $2,368 in disputed services.[3]

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[1] The IRO reviewed services rendered in weeks 1, 5, and 6.

[2] Services denied based upon denial code "F" and those for which there was no explanation of benefits (EOB) form in the record.

[3] Most of these services were reviewed by the IRO and found to be medically necessary. The MRD did not

Carrier cross-appealed, challenging some of the IRO's and the MRD's conclusions that the office visits and services were medically necessary.

When the appeal in this case began, it appears the total amount in dispute was $5,322. During the pendency of the appeal, Carrier paid additional sums to Provider.

At the hearing, the Carrier announced that it no longer contested some services on several specific days. Provider also agreed to dismiss his claims to reimbursement on a few items. As a result of the unusual procedural history, and the large number of services in issue, this case is quite complex.

The Administrative Law Judge (ALJ) determines that Provider is entitled to reimbursement in the amount of $3,496.60.

I. PROCEDURAL HISTORY

On December 9, 2003, the hearing was convened at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared by telephone and represented himself. Carrier appeared through its attorney, David L. Swanson. Following the presentation of evidence, the record was left open for the submission of summary charts and closing arguments. On March 12, 2004, the record was reopened for additional briefing. The record finally closed on March 19, 2004.

II. DISCUSSION

1. General Facts

Claimant is a ____ male who was injured in an accident on _____, when the rear tire of the truck he was driving blew out. The truck rolled over onto its side, and Claimant's left head and shoulder hit the driver's side window and door. He was treated briefly by a doctor who prescribed

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quantify them in its order, but noted that Provider had prevailed on the issue of medical necessity for services rendered between July 30, 2002, and September 6, 2002.

muscle relaxants and released him to go back to work on July 22, 2002.

Claimant felt he was getting progressively worse and consulted Provider on July 29, 2002. He complained of bilateral neck pain with pronounced muscle spasm in the left side of his neck. Moving his neck and head caused the pain to intensify. He also complained of bilateral headaches with associated nausea, dizziness, and blurred vision. He had bilateral numbness and tingling in his upper extremities that intensified when he was writing or holding a steering wheel. Symptoms were more pronounced on his right side. He complained that his grip felt weaker since the accident. In addition to his neck pain, he complained of constant moderate mid low back pain, and intermittent moderate low back pain. Most movements caused his back pain to intensify. He was not sleeping well and woke tired in the mornings. On a pain scale of 1 to 10 with 10 being the most severe, Claimant rated his cervical pain at 7 and his back pain at 6.

Provider entered the following diagnoses after his initial examination of Claimant: cervicalintervertebral disc without myelopathy, acute traumatic thoracic sprain/strain, and acute traumatic lumbar sprain/strain. The initial treatment plan consisted of conservative chiropractic management, including specific chiropractic adjustments, joint mobilization, myofascial release, manual traction, and neuromuscular re-education to restore normal function to the cervical, upper thoracic and lumbar spine. Provider planned to add therapeutic active exercises when appropriate to increase muscle strength, improve function, and increase Claimant's range of motion (ROM). The estimated length of treatment was eight to twelve weeks. Provider planned to obtain an MRI and upper extremity EMG/NCV study if neurological signs persisted and to refer Claimant to a neurologist. Claimant began treatment the next day and was seen by Provider on a regular basis for approximately eight weeks.

2. Legal Standards

The Texas Labor Code (the Act) provides that 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 injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment.[4] "Health care" includes "all reasonable and necessary medical aid, medical examinations, medical treatment, medical diagnoses, medical evaluations, and medical services."[5]

Each party in this case bears the burden of proof to the extent it appealed the orders of the MRD or the IRO.[6]

3. The Decisions by the IRO and the MRD

An independent review organization (IRO) reviewed some of the services provided to Claimant by Provider between July 30, 2002, and September 6, 2002, including office visits and physical therapy, to determine if they were medically necessary.[7] These services had been denied by the Carrier with an explanation of benefits (EOB) code of "U."

The IRO found the services it reviewed were reasonable and medically necessary treatment, citing the *Mercy Guidelines* and Croft, *Cervical Acceleration/Deceleration Syndrome*.[8] The IRO did not quantify the significance of its ruling in terms of dollars owed to Provider by Carrier.

The MRD reviewed the IRO decision and determined it would review additional services denied by Carrier based upon EOB codes "F," and services for which "no EOB" was in the record. The dates of these services overlapped with those reviewed by the IRO, and extended to September 23, 2002. The MRD recommended Provider receive additional reimbursement of $2,954 based on its review of services. The MRD, like the IRO, did not quantify the financial consequences of the

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[4] TEX. LAB. CODE ANN. § 408.021.

[5] TEX. LAB. CODE ANN. § 401.011(19).

[6] 1 TEX. ADMIN. CODE § 155.41; 28 TEX. ADMIN. CODE §§ 133.308(p)(5), 148.21(h).

[7] The IRO apparently reviewed weeks of service 1, 5, and 6.

[8] IRO Notice of Independent Review Decision, dated April 25, 2003. Under the Commission's rules, an IRO decision is deemed a Commission decision and order. 28 TEX. ADMIN. CODE § 133.308(p)(5).

IRO's decision.

4. The Evidence

Provider testified and offered five exhibits comprised of approximately 345 pages of Claimant's medical and insurance records. Carrier submitted one exhibit of 106 pages and the testimony of Michael Bhatt, D.C.

5. The Disputed Services

The following services and procedures are at issue in this proceeding:

$ CPT Code 99213-MP, Manipulation, MAR $48, on August 5, 6, 7, 8, 12, 13, 15, 16, 19, 20, 22, September 16, and 18, 2002;

$ CPT Code 97012, mechanical traction, MAR $20 on July 31, August 5, 7, 12, and 13, 2002;

$ CPT Code 97250, myofascial release, MAR $43 on July 31, August 5, 6, 7, 8, 12, 15, 16, 19, 20, 22, September 5, 16, and 18, 2002;

$ CPT Code 97032, electric stimulation, MAR $22, on July 30, 31, August 1, 2, 5, 6, 7, 8, 12, and 13, 2002;

$ CPT Code 97265, joint mobilization, MAR $43, July 31, August 5, 6, 7, 8, 15, 16, 19, 20, 22, 27, September 16, and 18, 2002;

$ CPT Code 97110, therapeutic exercise, MAR $35 / unit, 2 units on August 8, 12, 13, 15, 16, 19, 20, and 22, 2002; 3 units on August 27, September 5, 16, 18, and 20, 2002;

$ CPT codes 95900-27, 95935-27, 95904-27, 95925-27, electrodiagnostic studies, nerve conduction velocity (NCV) studies on August 14, 2002;

$ CPT Code 99212, patient exam, MAR $32, on August 14, 2002;

$ CPT Code 99214, patient exams, MAR $71, on August 23, 99214-25 and September 20,

2002;

$ CPT Code 97750, physical performance test, computerized postural analysis, MAR $43, on August 23, 2002;

$ CPT Code 99455-RP, review of MMI report, MAR $50, on September 23, 2002;

$ CPT Code 97122, manual traction, MAR $35, on August 6, 16, 19, 27, September 3, 4, 5, 6, 16, and 18, 2002; and

$ CPT Code 97112, neuromuscular re-education, MAR $35 on August 13, 15, 20, 22, 26, 29, 30, and September 5, 2002.

1. The Lack of Explanation of Benefits (EOB) Forms

The lack of EOBs from the Carrier for many of the services and procedures in issue raised questions of jurisdiction. The ALJ requested briefing from the parties.

For the reasons given below, the ALJ concludes that the medical necessity of the services challenged by Carrier are appropriate issues in this case even though there were no EOBs for some of the dates of service being challenged.

Medical necessity is the fundamental basis for reimbursement under the Act. Where a carrier raises a credible question about it, it should be considered.[9] The Act provides that an injured employee is entitled to all *reasonable and necessary* medical treatment and services required by the nature of the injury.[10]

The MRD has a statutory obligation to ensure compliance with the rules and policies of the

[9] SOAH Docket No. 453-02-2320.M5 (ALJ Kilgore, October 2002), SOAH Docket No. 453-02-0996.M5, Order Denying Motion for Summary Disposition (ALJ Casarez, May 2002).

[10] TEX. LAB. CODE ANN. §§ 408.021; 401.011(19).

Commission, and to promote the stated purpose of the Act, *i.e.*, to ensure the efficient utilization of health care by injured workers.[11] The failure of a carrier to submit EOBs to a provider may result in a carrier being determined to be out of compliance with Commission rules, but it does not authorize payment for services that are not medically necessary. To allow such a result would be contrary to legislative intent.

It is apparent in this case that Provider knew Carrier was challenging the medical necessity of his services even though he did not receive an EOB for all dates of service. He received EOBs for the first week of treatment and, again, for the fifth and sixth weeks of treatment. In those EOBs, Carrier denied payment pursuant to denial code "V" - unnecessary based on peer review. Provider responded to those challenges and presented evidence and argument at the hearing about the medical necessity of his services, whether or not Carrier had provided an EOB.[12] Therefore, the ALJ will consider Carrier's medical necessity arguments for all dates of service it now appeals.

2. Frequency and Duration of Claimant's Treatments

Carrier challenged both the frequency and the duration of Claimant's treatment as not reasonable and medically necessary. Provider treated Claimant four times the first week, five times the second week, four times a week for weeks three through six, and three times a week during weeks seven and eight.

a. Carrier's Evidence and Argument

Carrier's witness, Dr. Bhatt, testified that, in his opinion, three treatments a week for a period of four weeks would be an appropriate trial of care for Claimant's diagnoses. This, he said, was consistent with the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* issued by Mercy Center Consensus Conference and other guidelines. He stated that the treatment paradigm

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[11] SOAH Docket No. 453-02-3878.M5 (ALJ Landeros, Nov. 27, 2002).

[12] See, e.g., SOAH Docket No. 453-02-1881.M4 (ALJ Newchurch, October 2002), SOAH Docket No. 453-01-2371.M5 (ALJ Card, November 2001).

recommended by Drs. Foreman and Croft in their textbook, *Whiplash Injuries: The Cervical Acceleration/Deceleration Syndrome, 2nd edition*, and cited by Provider in support of his treatment, was merely an untested theory. It was not based on any scientific study, nor has it been accepted as the standard of practice. In particular, he thought daily treatment for two weeks was not justified. Carrier also relied on the peer review doctor Mike O'Kelley, D.C., who stated that treatment three times a week was reasonable and that more than that was not.[13]

Carrier also asserted that the eight weeks' duration of Claimant's treatment was not medically necessary. Dr. Bhatt testified that after the first four weeks, he would have relied on utilization tests and subjective outcome measurement tools to help quantify patient's improvement and show that treatment was medically necessary. He named tools like neck disability questionnaires, pain questionnaires, and other tests completed by patients to help quantify their improvements. If a patient is not improving, he said, it is not appropriate to continue care, or the doctor should change his treatment approach. Carrier argued there was inadequate evidence of improvement in Provider's records to support continuing Claimant's care for eight weeks.

b. Provider's Argument

Provider argued that all patients and their injuries are unique. They have different degrees of physical fitness, diet, and unique skeletal biomechanics prior to an injury and these may increase or decrease the healing time. Some patients suffer a mild, moderate or severe sprain/strain; some may have neurological symptoms like headaches. That is why, he pointed out, guidelines are merely guidelines. He also pointed out that neither Carrier's peer reviewer or its witness at the hearing has actually examined the patient. As the treating doctor, Provider is "primarily responsible for the employee's health care for an injury" according to TWCC's Spine Treatment Guideline. Drawing on his own clinical experience, his knowledge of this patient, and advice offered in various reference books, he argued that the frequency and duration of treatment in this case was reasonable and medically necessary.

[13] Carrier Exhibit 1, pp. 27-28.

He testified that the texts he consulted agreed that treatment frequency of five times a week for the first two weeks was reasonable for a patient suffering from this type of injury. He cited Foreman and Croft in *Whiplash Injuries: The Cervical Acceleration/Deceleration Syndrome*, 2nd edition, as emphasizing that damaged tissues only have fifteen per cent of normal strength three weeks after injury, and that "excessive rough handling during this stage (from exercise, work, or therapy) will result in renewed inflammation."[14] The extent of damage to the tissues, Provider argued, justified the use of more passive modalities such as electrical stimulation, mechanical traction, myofascial release, joint mobilization, chiropractic manipulation, and traction modalities that help control pain and restore function to the spine.[15]

In response to Dr. Bhatt's testimony that he only continued treatment after four weeks if utilization tests and subjective outcomes quantify the patient's improvement, Provider cited the various self-reporting measures of pain and disability he used to measure the Claimant's perception of his pain and neck disability. Dr. Bhatt acknowledged during cross-examination that the tests mentioned by Provider were the same type of instruments he used.

On August 23, 2002, Provider recorded index scores for the Neck Disability Index , the Roland-Morris Low Back Pain, the Revised Oswestry Disability Index (for low back pain/dysfunction), and the Visual Pain Analogue Scale.[16] These were repeated during the re-examination of September 20, 2002.[17] They indicated Claimant was experiencing some improvement.

Provider also pointed out that, although Dr. O'Kelley, Carrier's peer review doctor, initially stated that care was reasonable up to six weeks, he later expanded his recommendation to add three

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[14] Provider Exhibit D, First Section, p. 24.

[15] *Id*.

[16] Provider Exhibit D, Other Documents, p. 10.

[17] Provider Exhibit D, Other Documents, p. 20.

more weeks of active care.[18] Dr. O'Kelley based his reconsideration on Claimant's "neck discomfort and the time frame." The additional three weeks, he said, would result in maximum therapeutic benefits for the present working diagnosis of a soft tissue injury.[19] An additional three weeks would have extended the treatment to October 6, 2002, approximately two weeks beyond the date it ended.

In addition, Provider cited the report of Dr. Scott Wallis, a chiropractor and Diplomate of the American Chiropractic Neurology Board, who performed physical, neurologic and electrodiagnostic examinations on Claimant at Provider's request on August 27, 2002. After reporting his EMG findings, Dr. Wallis recommended that Provider continue providing conservative care to Claimant and retest in four to six weeks if no improvement is seen.[20] Four weeks would have ended on or about September 24, 2002; six weeks on or about October 8, 2002.

Provider's treatment plan was influenced by the fact that Claimant had received no treatment for two weeks between the injury and beginning physical therapy. He stated that his experience and research have convinced him it takes frequency, repetition, and time to make any physical changes in the body. This case was complicated, he opined, by the great loss of the normal lordotic curve in the patient's cervical spine.

This symptom in particular, Provider said, made the continued use of passive modalities such as electrical stimulation, mechanical traction, myofascial release, joint mobilization medically necessary to help decrease pain, reduce muscle spasm, and restore function to the area.[21] Provider opined that Claimant would have been pain free if he had been able to continue treatment for another month.

c. ALJ's Analysis and Conclusion

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[18] Carrier Exhibit 1, pp. 28, 54.

[19] Carrier Exhibit 1, p. 54.

[20] Provider Exhibit D, beginning four pages from the end and continuing for three pages.

[21] Provider Exhibit D, First Section, p. 24.

The ALJ finds that Carrier has not proved that the frequency and duration of Claimant's treatments were not medically necessary. A doctor must exercise a great deal of judgment in deciding the appropriate frequency and duration of treatment for a particular patient. This record contains a variety of opinions. However, the doctors who offered opinions that the frequency and duration of the treatment was excessive have not examined Claimant.

Provider based his decisions about the frequency and duration of treatment in this case on his clinical experience, on various references in the field he consulted, and on his observations of his patient.[22] The references he consulted included a textbook that addressed Claimant's specific type of injury, i.e. a cervical acceleration/deceleration or "whiplash" injury, in contrast with the Mercy *Guidelines* that state "no attempt has been made to select individual conditions. . . . majority of quantitative information available addresses the management of low back and leg pain complaints."[23]

The *Mercy Guidelines* state they are not intended to be used as a cookbook to determine the absolute frequency and duration of treatment or care for any specific case. Their purpose is to "*assist* the clinician in decision-making based on the expectations of outcomes for the uncomplicated case."[24]

Further, the *Guidelines* note, "the ultimate judgment regarding the propriety of any specific procedures must be made by the practitioner in light of the individual circumstances presented by the patient."[25] This is what Provider did in this case.

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[22] Contrary to Carrier's assertions, the record does not establish that Provider was a new practitioner. Provider did testify that this location was a new *office* and that Claimant was his first patient in that office.

[23] Provider Exhibit D, First Section, p. 27.

[24] Emphasis added. Provider Exhibit D, pp. 27-28.

[25] *Id.*

The ALJ accords the Provider's opinion more weight because he has been treating Claimant and watched his progress on a daily basis, and because he was guided by reference books that addressed Claimant's specific type of injury.[26] Finally, although progress was slow, the ALJ finds adequate documentation of Claimant's improvement, including a decrease in pain level and an increase in range of motion, to justify the frequency and duration of Claimant's treatment.

3. CPT Code 99213-MP, Manipulation, MAR $48, on August 5, 6, 7, 8, 12, 13, 15, 16, 19, 20, 22, September 16, and 18, 2002[27]

All dates of service for this Code were found medically necessary by either the IRO or MRD. Carrier disputed some dates based on the frequency and duration of treatment. For the reasons stated in the above discussion, the ALJ agrees these services were medically necessary.

4. CPT Code 97012, Mechanical Traction, MAR $20, on July 31, August 5, 7, 12, and 13, 2002[28]

All dates of service were found medically necessary by either the IRO or the MRD. This code was challenged by Carrier based on the frequency of treatment. For the reasons stated in the discussion in paragraph 2 above, the ALJ agrees that these services were medically necessary.

5. CPT Code 97250, Myofascial Release, MAR $43 on July 31, August 5, 6, 7, 8, 12, 15, 16, 19, 20, 22, September 5, 16, and 18, 2002[29]

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[26] The IRO also cited *Croft, Cervical Acceleration/Deceleration Syndrome*, as well as the *Mercy Guidelines* in its one-paragraph rationale for finding medical necessity.

[27] At the hearing, Carrier indicated it no longer contested this treatment for the dates of August 5, 6, 8, 12, 15, 16, 19, and 20, 2002.

[28] At the hearing, the Carrier indicated it no longer contested this treatment for the dates of August 5, 12, and 13, 2002.

[29] At the hearing, Carrier indicated it no longer disputed dates of service of August 5, 6, 8, 12, 15, 16, 19, and 20, 2002.

Carrier challenged reimbursement for this service on these dates based on the frequency and duration of treatment. This procedure was found reasonable and medically necessary by the IRO or the MRD. As discussed above in paragraph 2, the ALJ agrees.

6. CPT Code 97032, Electric Stimulation, MAR $22, on July 30, 31, August 1, 2, 5, 6, 7, 8, 12, and 13, 2002[30]

Carrier challenged the medical necessity of this service because of the frequency of treatment. These services were found medically necessary by the IRO or the MRD. As discussed above in paragraph 2, the ALJ agrees.

7. CPT Code 97122, Manual Traction, MAR $35, on August 6, 16, 19, 27, September 3, 4, 5, 6, 16, and 18, 2002

The Carrier argued that manual traction was not medically necessary because it was always performed in conjunction with code 99213-MP, manipulation. According to Carrier, manual traction, manipulation, and joint mobilization all involve essentially the same action by Provider-passive movement of the cervical vertebrae, and all three are intended to accomplish the same result-greater movement of the cervical spine. Provider responded that when performing manual traction he did not turn Claimant's head at all. He had Claimant lie face up, cupped his head in his hands, and then pulled on his cervical spine by leaning directly back for ten minutes, using his (Provider's) body weight to stretch the spine. He also stated he sometimes performed different treatments on different joints.

The MRD denied reimbursement for this code with the notation that the documentation did not support one-to-one supervision. Because Provider appealed MRD's order for this code, he has the burden of proof on this issue. The ALJ finds that Provider did not prove that these services were reasonable and medically necessary and will not order reimbursement.

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[30] At the hearing, Carrier indicated it no longer disputed this service on August 1, 2, 5, 6, 8, and 12, 2002.

8. CPT Code 97265, Joint Mobilization, MAR $43, August 5, 6, 7, 8, 15, 16, 19, 20, 22, 27, September 16, and 18, 2002

Carrier argued that joint mobilization could not be billed on the same date that Provider billed for code 99213-MP (manipulation) because the two procedures were so similar. Both joint mobilization and manipulation involve Provider cupping Claimant's head and rotating his head from side to side-slowly when performing mobilization and quickly when performing manipulations. The purpose of both of these movements is to obtain greater movement of the cervical spine. Therefore, Carrier maintained, it is never medically necessary to perform them together.

Provider testified he used joint mobilization to soften the joint so it could be more effectively manipulated. Often, he said, a patient has ongoing muscle contractions or spasms. Putting some motion in the joint before adjusting it helps ensure a good cavitation or opening of the joint. He testified that first, he actively moves the joint, then he performs the manipulation-a high force, low velocity movement of the joint.

Provider also testified he sometimes used different modalities on different parts of Claimant's spine and back. For example, he pointed to his August 6, 2002, daily notes:

> Manual traction to cervical spine to restore joint motion. Myofascial release to relax tight muscles; remove toxins, waste in paraspinal muscles of mid-back. Electric stim. to trapezius and right thoracic musculature to decrease spasm. Joint mobilization to pelvis to help restore mobility. Specific chiropractic adjustments to indicated segmental dysfunctions.

This procedure was found medically necessary for these dates of service by the IRO or the MRD. The ALJ accepts Provider's rationale for using joint mobilization with manipulation. Therefore, the ALJ finds these services to be reasonable and medically necessary.

9. CPT Code 97110, Therapeutic Exercises, MAR $35 / unit, 2 units on August 8, 12, 13, 15, 16, 19, 20, and 22, 2002; 3 units on August 27, September 5, 16, 18,

and 20, 2002

The MRD denied reimbursement for this code because the documentation did not support one-on-one supervision. Provider's argument was that he did, in fact, provide one-on-one supervision while Claimant did these therapeutic exercises. Carrier argued that even if he did provide one-on-one supervision, he did not prove, and his records do not document, that such supervision was medically necessary. Provider, according to Carrier, should have billed these services as CPT code 97150, a code for which a provider is paid $27.00 regardless of the amount of time the patient spends exercising.

The ALJ finds that Provider did not prove that one-on-one supervision was medically necessary for these exercises. These services, however, would have been appropriately coded as 97150 and the ALJ will order reimbursement at the lower rate.

10. CPT Code 97112, Neuromuscular re-education, MAR $35 on August 13, 15, 20, 22, 26, 29, and 30, 2002

Provider billed code 97112 (neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception) for Claimant's use of a posture pump. The MRD found that the Provider's documentation did not support one-on-one supervision per the MFG and recommended no reimbursement. Provider appealed the MRD's denial of reimbursement for the dates it reviewed. The IRO found medical necessity for the dates of service August 26, 29, and 30, 2002, and the Carrier appealed that finding.

Carrier's peer reviewer, Dr. O'Kelley, and Dr. Bhatt, Carrier's witness at the hearing on the merits, opined that neuromuscular re-education is not appropriate for a soft-tissue injury like Claimant's. Neuromuscular re-education, according to Dr. Bhatt, is appropriate for persons who need re-training to improve the stimuli from the brain to the muscles. An example, he noted, was one-on-one gait training for a stroke victim who must re-learn how to eat and walk. He also testified this code was intended for active, not passive, therapy. On cross-examination, Dr. Bhatt acknowledged he was not familiar with the posture pump used by Provider. When it was described

to him, however, he still considered it passive therapy and inappropriate for reimbursement under this code.

Provider cited his narrative of medical necessity, in which he stated that the neuromuscular exercises with the posture pump are designed to

> Improve the inborn mechanisms by which the cervical spine maintains a stable, injury-free state. These exercises are designed to engage the cerebral cortex so that the contraction of the deep cervical flexors and the lower cervical / upper thoracic extensors can be driven into the subcortical aspect of the central nervous system.[31]

He argued that the posture pump makes the cervical spine contract and relax and that, in turn, engages the proprioceptive rich tissues of the cervical spine and helps restore balance and correct posture to that area of the spine.[32]

The ALJ concludes that the posture pump was not reasonable and medically necessary. Neuromuscular re-education involves retraining the stimuli from the brain to the muscles. The evidence did not prove that the posture pump provides such re-training. Further, there was no documentation that the use of the posture pump was provided with one-on-one supervision.

11. CPT Codes 95900-27, 95935-27, 95904-27, 95925-27, Nerve Conduction Velocity (NCV) Studies on August 14, 2002

Carrier challenged the medical necessity of nerve conduction velocity (NCV) tests performed by a technician, whose services were retained by Provider to perform these tests. The MRD reviewed these charges and found adequate documentation to support reimbursement for the tests, as follows:

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[31] Provider Exhibit D, First Section, p. 29.

[32] Provider attached some literature to his closing argument, purporting to show that the posture pump's use retrains balance and engages proprioceptors. Carrier objected, stating that it was too late for additional evidence to be introduced. The ALJ sustains Carrier's objection, and will not consider the additional documentation.

CPT Code 95900-27 B median, ulnar and radial nerves bilaterally, 6		200.00
CPT Code 95935-27 B F-wave testing of upper extremities, 2		74.10
CPT Code 95904-27 B antebrachial cutaneous, ulnar, median and radial nerves bilaterally, 8 358.40		
CPT Code 95925-27 B SSEP and DEP testing, 2		122.50
	Total	$755.00

a. Carrier's Evidence and Argument

Carrier argued that TWCC rule 28 TEX. ADMIN. CODE (TAC) § 134.801 requires the health provider that provided the treatment to submit its own bill, and therefore, Provider cannot bill for, and cannot be paid for, testing provided by a technician who was actually employed by Mobil Testing, Inc. Carrier also challenged code 95935-27 because it did not appear on the bill Provider submitted to Carrier and, therefore, Provider apparently never billed the Carrier for this service. Carrier also challenged code 95900-27 because the bill submitted by Provider charged for only two units and therefore limited any reimbursement to $44.80 for each of two units.[33] Carrier also challenged the medical necessity of these tests based upon the testimony of Dr. Bhatt, who opined that the only NCV tests necessary to evaluate cervical radiculopathy were two units of 95900 and two units of 95904.

b. Provider's Evidence and Argument

Provider testified the tests were performed in his office under his supervision. He leased the machine and the technician acted as his employee (*i.e.*, as an independent contractor) for that day. He argued he only billed for the technical component of the test and that it is standard practice for chiropractors in Texas to have this test performed by a technician and then have the findings interpreted by a neurologist. He also testified that Mobil Testing, Inc., did not submit a bill for the testing. He documented the medical necessity of these tests in his notes for August 14, 2002:

[33] Provider Exhibit F, p. 30.

> NCV study performed in clinic due to patient's cervical radiculopathy and to isolate the source of his neurological dysfunction. Patient complains of bilateral numbness and tingling in his upper extremities. Pre-dominantly on the right. He states moving his arms helps resolve the tingling but not the numbness. He has difficulty writing with his . . . *[illegible]* hand; driving. He states he found he had difficulty grasping a cardboard box yesterday. He has burning pain at the C9-T-1 area. He continues to have low back pain which is aggravated with movement.[34]

Provider also indicated the following findings on his order for the NCV diagnostic studies: left-right cervical compression, left-right cervical distraction, left-right shoulder depression, and decreased range of motion in cervical spine. He testified the test was done to confirm a diagnosis of radiculopathy based on the patient's subjective complaints and his neurological exam, and to provide the Carrier with an objective test.

c. ALJ's Analysis and Conclusion

The ALJ agrees with the MRD that these tests were medically necessary and concludes Provider should be reimbursed $644.60 for these charges.[35] The rule cited by Carrier, 28 TAC § 134.801, contains an exception for services provided by a nonlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill.[36] Provider was supervising the technician in this instance. There is nothing in the record in this case showing this exception does not apply. Since Carrier had the burden of proof on this issue, the ALJ concludes the MRD's order should be left undisturbed. Further, the test was medically necessary to attempt to identify the causes of Claimant's cervical radiculopathy, and to isolate the source of his neurological dysfunction.

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[34] Provider Exhibit F, p. 32.

[35] This is a reduced amount from that billed because Provider only billed Carrier for two units of 95900-27. It is not reduced for the alleged failure to submit 95935-27 in the August 14 bill sent to Carrier, because when it submitted that bill for reconsideration, it corrected the error. Provider Exhibit D, Second Section, p. 14.

[36] 28 TAC § 134.801(e)(4).

12. CPT Codes 99212, MAR $32; 99214, MAR $71; 99214-25, MAR $71, Office Visits and Patient Exams on August 14, 23, and September 20, 2002

The MRD found, and the ALJ agrees, that the patient exams were reasonable and medically necessary to evaluate and manage an established patient. The August 14, 2002, examination involved at least two of the three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. The August 23, 2002, and the September 20, 2002, examinations involved two of these following three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity.

13. CPT Code 97750, MAR $43, on August 23, 2002

CPT Code 97750 refers to a physical performance test or measurement (*e.g.*, musculoskeletal, functional capacity), with written report. A computerized postural analysis was performed, focused on Claimant's postural dysfunctional profile; in particular, it considered the loss of lordotic curve in his spine. The MRD found adequate documentation that this was medically necessary. The ALJ agrees. The test was reasonable and medically necessary to enable Provider to fashion an appropriate treatment plan and measure the progress of the patient.

14. CPT Code 99455-RP, Review of MMI Report, MAR $50, September 23, 2002

The MRD determined this report review to be properly documented and medically necessary. The ALJ agrees.

F. Conclusion

The ALJ concludes that the evidence supports reimbursement to Provider in the amount of $3,496.60.

III. FINDINGS OF FACT

1. On _____, Claimant sustained an on-the-job injury when the truck he was driving had a blow-out and rolled over onto its side, causing his left head and left shoulder to hit the driver's side window and door.

2. American Casualty Company of Reading, PA (Carrier), is the workers' compensation insurer for the claims at issue in this case.

3. Claimant consulted Jonathan D. Skeries, D.C. (Provider), a chiropractor, approximately two weeks after his injury, during which time his only medical treatment had been muscle relaxants. He complained of headaches, constant moderate neck pain with paresthesia and numbness in both upper extremities, and aching pain in his upper, mid, and lower back.

4. Provider diagnosed Claimant as having cervical intervertebral disc without myelopathy, acute traumatic thoracic sprain/strain, and acute traumatic lumbar sprain/strain.

5. Provider administered chiropractic therapy to Claimant from July 29, 2002, through September 23, 2002.

6. The Carrier declined to pay for a number of Provider's services to Claimant, primarily on the grounds they were not reasonable and medically necessary.

7. Provider requested medical dispute resolution. Some of his services were reviewed by an independent review organization (IRO); others were reviewed by the Medical Review Division (MRD) of the Workers' Compensation Commission.

8. On or about April 25, 2003, the IRO issued a decision finding that the services rendered during the first, fifth, and sixth week of treatment from July 30, 2002, to September 6, 2002, were reasonable and medically necessary to treat this patient's condition.

9. The MRD, after receiving the IRO's decision, concluded it would review additional services not reviewed by the IRO. It reviewed services denied by Carrier based upon EOB denial code "F" and services for which the record contained no explanation of benefits.

10. On July 2, 2003, the MRD issued an order finding that Provider should be reimbursed in the amount of $2,954 for the services it reviewed.

11. Carrier appealed the determinations of the IRO and the MRD that the following services were medically necessary and that reimbursement was appropriate:

1. Office visits with manipulation, CPT Code 99213-MP, MAR $48, on August 5, 6, 7, 8, 12, 13, 15, 16, 19, 20, 22, September 16, and 18, 2002. At the hearing, Carrier indicated it no longer contested this treatment for the dates of August 5, 6, 8, 12, 15, 16, 19, and 20, 2002.

2. Mechanical traction, CPT Code 97012, MAR $20, on July 31, August 5, 7, 12, and 13, 2002. At the hearing, the Carrier indicated it no longer contested this treatment for the dates of August 5, 12, and 13, 2002.

3. Myofascial release, CPT Code 97250, MAR $43, on July 31, August 5, 6, 7, 8, 12, 15, 16, 19, 20, 22, September 5, 16, and 18, 2002. At the hearing, Carrier indicated it no longer contested this treatment for the dates of August 5, 6, 8, 12, 15, 16, 19, and 20, 2002.

4. Electric stimulation, CPT Code 97032, MAR $22, on July 30, 31, August 1, 2, 5, 6, 7, 8, 12, and 13, 2002. At the hearing, Carrier indicated it no longer contested this treatment for the dates of August 1, 2, 5, 6, 8, and 12, 2002.

5. Joint mobilization, CPT Code 97265, MAR $43, on July 31, August 5, 6, 7, 8, 15, 16, 19, 20, 22, 27, September 16, and 18, 2002.

6. Therapeutic exercise, CPT Code 97110, one-on-one supervision, MAR $35 per unit, two units each on August 8, 12, 15, and 16, 2002. At hearing, Carrier indicated it no longer contested these.

7. Electrodiagnostic studies, CPT Codes 95900-27, 95935-27, 95904-27, and 95925-27 on August 14, 2002.

8. Patient examinations, CPT Code 99212, MAR $32, on August 14, 2002; CPT Code 99214-25, MAR $71, on August 23, and September 20, 2002.

9. Physical performance test, computerized postural analysis, CPT Code 97750, MAR $43 on September 20, 2002.

10. Review of MMI Report, CPT Code 99455-RP, MAR $50, on September 23, 2002.

12. Provider appealed MRD's determination that the following services were not medically necessary or properly documented and that no reimbursement was appropriate:

1. Manual traction, CPT Code 97122, MAR $35, on August 6, 16, 19, 27, September 3, 4, 5, 6, 16, and 18, 2002.
2. Therapeutic exercise, CPT Code 97110, one-on-one supervision, MAR $35, two units on August 13, 19, 20, 22, and three units on August 27, September 5, 16, 18, and 20, 2002.

3. Neuromuscular re-education, CPT Code 97112, MAR $35, on August 13, 15, 20, 22, 26, 27, 29, 30, and September 5, 2002.

12. Provider requested a hearing at the State Office of Administrative Hearings (SOAH) by letter dated July 14, 2003.

13. Carrier cross-appealed and requested a hearing at SOAH by letter dated July 18, 2003.

14. Notice of the hearing was issued August 20, 2003, 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.

15. The hearing was convened on December 9, 2003, by ALJ Nancy N. Lynch. Provider appeared by telephone and represented himself. Carrier appeared through its representative, David L. Swanson. The record was left open for the parties to submit a table of disputed services and written closing arguments. The record was reopened for additional briefing and was finally closed on March 19, 2004.

16. The frequency and duration of the following treatments received by Claimant was reasonable and medically necessary considering the nature and extent of Claimant's injuries:

1. office visits with manipulation, CPT Code 99213-MP,
2. mechanical traction, CPT Code 97012,
3. myofascial release, CPT Code 97250, and
4. electric stimulation, CPT Code 97032.

17. Office visits with manipulation on August 5, 6, 7, 8, 12, 13, 15,16, 19, 20, 22, September 16, and 18, 2002, billed to CPT Code 99213-MP, were reasonable and medically necessary.

18. Based on Findings of Fact Nos. 17 and 18, Provider is entitled to reimbursement for thirteen office visits with manipulation, at the MAR rate of $48, for a total of $624.

19. Mechanical traction treatments on July 31, August 5, 7, 12, and 13, 2002, billed to CPT Code 97012, were reasonable and medically necessary.

20. Based on Findings of Fact Nos. 17 and 20, Provider is entitled to reimbursement for five mechanical traction treatments at the MAR rate of $20 each, for a total of $100.

21. Myofascial release treatments on July 31, August 5, 6, 7, 8, 12, 15, 16, 19, 20, 22, September 5, 16, and 18, 2002, billed to CPT Code 97250, were reasonable and medically necessary.

22. Based on Findings of Fact Nos. 17 and 22, Provider is entitled to reimbursement for fourteen myofascial release treatments at the MAR rate of $43 each, for a total of $602.

23. Electric stimulation treatments on July 30, 31, August 1, 2, 5, 6, 7, 8, 12, and 13, 2002, billed to CPT Code 97032, were reasonable and medically necessary.

24. Based on Findings of Fact Nos. 17 and 24, Provider is entitled to reimbursement for ten electric stimulation treatments at the MAR rate of $22 each, for a total of $220.

25. Joint mobilization treatments relieve muscle contractions or spasms so a joint manipulation has a greater likelihood of achieving a good cavitation or opening of the joint.

26. Joint mobilization treatments on August 5, 6, 7, 8, 15, 16, 19, 20, 22, 27, September 16, and 18, 2002, billed to CPT Code 97265, were reasonable and medically necessary.

27. Based on Findings of Fact Nos. 26, and 27, Provider is entitled to reimbursement for twelve joint mobilization treatments at the MAR rate of $43 each, for a total of $516.

28. Provider supervised Claimant one-on-one as he performed therapeutic exercises as follows: two units per day on August 8, 12, 13, 15, 16, 19, 20, and 22, 2002; three units per day on August 27, September 5, 16, 18, and 20, 2002.

29. Therapeutic exercise for Claimant on the above dates was reasonable and medically necessary but one-on-one supervision for those dates was not documented and that level of service was not reasonable and medically necessary.

30. CPT Code 97150, for group exercise, is the appropriate billing code for the therapeutic exercises Claimant performed on August 13, 19, 20, 22, 27, September 5, 16, 18, and 20, 2002.

31. Based on Findings of Fact Nos. 29, 30, and 31, Provider is entitled to reimbursement for nine days of therapeutic exercises at the MAR rate of $27 per day for a total of $243.

32. Therapeutic exercises with one-on-one supervision are reasonable and medically necessary to ensure proper technique when a patient is learning new exercises.

33. Carrier withdrew its challenge to therapeutic exercises, CPT Code 97110, two units per day, on August 8, 12, 15, and 16, 2002.

34. Based on Findings of Fact Nos. 33 and 34, Provider is entitled to reimbursement for four days of therapeutic exercises, two units per day, at the MAR rate of $35 per unit for a total of $280.

35. Nerve conduction velocity (NCV) studies were performed by a technician in Provider's office, under his supervision.

36. The NCV studies were done and billed to Carrier as follows:

1. median, ulnar, and radial nerves bilaterally, CPT Code 95900-27 (billed for 2),
2. F-wave testing of upper extremities, CPT Code 95935-27 (2),
3. antebrachial cutaneous, ulnar, median and radial nerves bilaterally, CPT Code 95904-27 (8), and
4. SSEP and DEP testing, CPT Code 95925-27 (2).

37. The NCV tests were done to confirm a diagnosis of radiculopathy, and to isolate the source of claimant's neurological dysfunction, *i.e.*, the numbness and tingling in his upper extremities.

38. Based on Findings of Fact Nos. 36, 37, and 38, Provider is entitled to reimbursement in the amount of $644.60 for NCV studies as follows:

1.	CPT Code 95900-27 (2)	$ 89.60
2.	CPT Code 95935-27	$ 74.10
3.	CPT Code 95904-27	$358.40
4.	CPT Code 95925-27	$122.50

39. Patient examinations on August 14, 2002, CPT Code 99212, August 23, 2002, CPT Code 99214, and September 20, 2002, CPT Code 99214-25, were reasonable and medically necessary.

40. Based on Finding of Fact No. 40, Provider is entitled to reimbursement for one patient examination at the MAR rate of $32, and two patient examinations at the MAR rate of $71, for a total of $174.

41. The physical performance test, computerized postural analysis, performed on August 23, 2002, CPT Code 97750, was reasonable and medically necessary.

42. Based on Finding of Fact No. 42, Provider is entitled to reimbursement for the physical performance test at the MAR rate of $43.00.

43. Provider's review of Claimant's MMI report on September 23, 2002, CPT Code 99455-RP, was reasonable and medically necessary.

44. Based on Finding of Fact No. 44, Provider is entitled to reimbursement at the MAR rate of $50.00 for reviewing the MMI Report.

45. Provider did not prove that manual traction, CPT Code 97122, had been adequately documented and was reasonable and medically necessary on any of the dates it was billed.

46. Based on Finding of Fact No. 46, Provider is not entitled to any reimbursement for CPT Code 97122.

47. Provider did not prove that the posture pump provided neuromuscular re-education within the meaning of CPT Code 97112, nor that its use was reasonable and medically necessary on any of the dates it was billed.

48. Based on Finding No. 48, Provider is not entitled to any reimbursement for CPT Code 97112.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issue presented, pursuant to the Texas Workers' Compensation Act, TEX. LAB. 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 TEX. LAB. CODE ANN. §§ 402.073 and 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

3. Petitioner timely filed its request for hearing, as specified in 28 TEX. ADMIN. CODE § 148.3.

4. Carrier timely filed its request for hearing, as specified in 28 TEX. ADMIN. CODE § 148.3.

5. Adequate and timely notice of the hearing was effected upon the parties according to TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE § 148.4(b).

6. Each party seeking relief in this appeal has the burden to prove its entitlement to the requested relief by a preponderance of the evidence, pursuant to 28 TEX. ADMIN. CODE §148.21(h) and (i), and 1 TEX. ADMIN. CODE §§ 155.41.

7. An employee who has sustained 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 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. TEX. LAB. CODE ANN. §408.021(a).

8. Based on the above findings, Provider met its burden of proving that the following services were medically necessary, pursuant to TEX. LAB. CODE ANN. § 408.021(a):

> Office visits with manipulation, CPT Code 99213-MP, MAR $48, on August 5, 6, 7, 8, 12, 13, 15, 16, 19, 20, 22, September 16, and 18, 2002;
>
> Mechanical traction, CPT Code 97012, MAR $20, on July 31, August 5, 7, 12, and

13, 2002;
Myofascial release, CPT Code 97250, MAR $43, on July 31, August 5, 6, 7, 8, 12, 15, 16, 19, 20, 22, September 5, 16, and 18, 2002;

Electric stimulation treatments, CPT Code 97032, MAR $22, on July 30, 31, August 1, 2, 5, 6, 7, 8, 12, and 13, 2002;

Joint mobilization treatments, CPT Code 97265, MAR $43, on August 5, 6, 7, 8, 15, 16, 19, 20, 22, 27, September 16, and 18, 2002;

Group therapeutic exercises, CPT Code 97150, MAR $27 for therapeutic exercises on August 13, 19, 20, 22, 27, September 5, 16, 18, and 20, 2002;

Therapeutic exercises, one-on-one, CPT Code 97110, MAR $35 per unit, two units per day, on August 8, 12, 15, and 16, 2002;

NCV studies, CPT Code 95900-27, 95935-27, 95904-27, and 95925-27, on August 14, 2002, MAR $644.60;

Patient examinations, CPT Code 99212, MAR $32, on August 14, 2002; CPT Code 99214, MAR $71, on August 23, 2002; and CPT Code 99214-25 on September 20, 2002;

Physical performance test, CPT Code 97750, MAR $43, on August 23, 2002; and

Report review, CPT Code 99455-RP, MAR $50 on September 23, 2002.

9. Based on the above findings, Provider did not meet its burden of proving the following services were medically necessary, pursuant to TEX. LAB. CODE ANN. § 408.021(a):

Manual traction, CPT Code 97122, MAR $35, on August 6, 16, 19, 27, September 3, 4, 5, 6, 16, and 18, 2002;

Neuromuscular re-education, CPT Code 97112, MAR $35, on August 13, 15, 20, 22, 26, 27, 29, 30, and September 5, 2002; and

Therapeutic exercises, one-on-one, CPT 97110, MAR $35 per unit, two units per day on August 13, 19, 20, 22, and three units per day on August 27, September 5, 16, 18, and 20, 2002.

10. The Carrier is obligated to reimburse Provider for the services listed in Conclusion of Law No. 8, pursuant to TEX. LAB. CODE ANN. § 408.021(a).

11. Based on the foregoing findings and conclusions, Provider is entitled to additional reimbursement in the sum of $3,496.60.

ORDER

IT IS, THEREFORE, ORDERED that Carrier reimburse Provider the total of $3,496.60, plus interest as required by law.

SIGNED, April 29, 2004.

NANCY N. LYNCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS