SOAH DOCKET NO. 453-04-0014.M5

AMERICAN PROTECTION INSURANCE COMPANY, *Petitioner*	:	**BEFORE THE STATE OFFICE**
v.	:	**OF**
JACK BARNETT, D.C., *Respondent*	:	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

American Protection Insurance Company (Carrier) appealed the decision of Maximus, an independent review organization certified by the Texas Department of Insurance, approving reimbursement for physical therapy services by Dr. Jack Barnett (Provider) from April 24 through September 17, 2002. Carrier contends that the services were not medically necessary. For the reasons set forth below, the Administrative Law Judge (ALJ) finds that Carrier met its burden of proof that the provided services were not medically necessary.

I. PROCEDURAL HISTORY

The Administrative Law Judge convened a hearing May 24, 2004. Carrier appeared and was represented by Steven M. Tipton, attorney. Dr. Barnett was represented by William Maxwell, attorney. At the conclusion of the hearing, the record was closed.

II. EVIDENCE AND BASIS FOR DECISION

The documentary record in this case consisted of 104 pages of Claimant's therapy records from April to October 2002 submitted by Carrier (Ex. 1), and a packet of 33 pages of additional records (for therapy from January through April 22, 2002) submitted by Carrier (Ex. 2). In addition, Carrier presented the testimony of Dr. Casey Cochran.[1] Respondent presented the testimony of Dr. John Connell[2] and submitted 497 pages of records (Provider's Ex. 1).[3]

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[1] Dr. Cochran is Board-certified in family medicine and occupational medicine.

[2] Dr. Connell's qualifications do not appear in the record. The ALJ concludes from his testimony as a whole that Dr. Connell practices with Provider.

[3] Provider's Exhibit 1 consists of 2 volumes of documents. Volume I contains information related to billing; Volume II contains treatment records.

The issue presented is whether the services received by Respondent, *i.e.*, office visits , one-on-one therapy, myofascial release, aquatic therapy, hot and cold packs, and electrical stimulation from April 24 through September 17, 2002, were medically necessary.

A. Background

Claimant, a ___-year old female, suffered a compensable injury to her back on ___, while assisting a co-worker in moving a heavy cabinet. The next day, she sought treatment from Provider and was diagnosed with a lumbar and cervical sprain/strain. Claimant was referred for further diagnostic studies and consultations and, ultimately, had a 360-degree fusion between L3-4 and L4-5 in November 2001.[4] After the surgery, she received therapeutic rehabilitation from Dr. Jack Barnett.[5] Her rehabilitation was complicated by pain associated with her abdominal incision.[6] Carrier paid for therapeutic services until April 24, 2002, after which Carrier claimed that they were no longer medically necessary and refused to pay.[7]

B. Carrier's Position

Carrier argues that while it was medically necessary for Claimant to receive some physical therapy after her surgery, she received an excessive amount of therapy that was not medically necessary. Carrier acknowledges that Claimant's complaints of pain related to her abdominal incision delayed her post-surgical rehabilitative treatment. Carrier notes, however, that she had already received sufficient therapy in 32 sessions prior to the dates of service in dispute. Although Claimant's range of motion showed slight increases, Carrier claims that the increases were not significant and did not indicate a need for therapy. Further, Carrier notes that as of October 2002, Claimant's range of motion actually decreased.[8]

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[4] The surgery was performed by Howard B. Cotler, M.D.

[5] On January 8, February 25, May 17, June 21, 2002 and August 8, 2002, in a ASubsequent Medical Report,@ Dr. Barnett recommended that Claimant receive therapy under treatment codes 97110, 97113, and 97250 Aas dicated by progression by the patient and guidelines established for lumbar postsurgical 360 surgery.@ Carrier's Ex. 1, pp. 06, 9, 15, 17; Provider's Ex. 1, p. 245.

[6] In March 2002, Claimant underwent exploratory surgery of her abdominal incision to determine whether she had an incisional hernia; however, there was none.

[7] Claimant participated in a chronic pain management program in September 2002, and was discharged from the program in November 2002.

[8] Carrier does not agree that range of motion is an adequate measure of successful therapy in this case due to the 360-degree fusion, which necessarily results in a reduction in range of motion.

In support of its contention that the provided services were not medically necessary, Carrier presented the testimony of Dr. Casey Cochran who reviewed Claimant's treatment records as the basis for his medical opinion.[9] According to Dr. Cochran, after a 360-degree fusion, it is appropriate for a patient to receive two weeks of post-surgery therapy consisting of gentle stretching and perhaps some physical medicine as well, proceeding to eight additional weeks of therapeutic exercise. Dr. Cochran testified that twenty-four therapy visits were commonly required in a post-fusion program. He noted, however, that the Official Disability guidelines stated that a total of thirty-four visits may be required.[10] Claimant received twenty-seven sessions of treatment from January 7, 2002, through April 23, 2002. Dr. Cochran observed that due to concerns about a possible incisional hernia, the treatment may have been delayed, thus it was possible that Claimant needed more than twenty-four sessions. However, he said that a need for extended treatment was not adequately documented or supported by the medical records. In Dr. Cochran's twenty years of practice in the area of occupational medicine, he has never seen a patient who required more than 34 visits.

Dr. Cochran testified that formal therapy is not required after thirty-four visits because most of the exercises can be continued by the patient at home. Here, there was no indication in the medical records that Claimant could not perform home exercises. Dr. Cochran said that unnecessary extended physical therapy creates dependence in a patient and becomes an impediment to his recovery. Further, he observed that prolonged physical therapy does not relieve recurrent pain. Instead, it is important to identify the source of the pain and treat it.

In addressing the therapy given to Claimant, Dr. Cochran noted that the documentation did not contain a detailed description of the exercises Claimant performed. Dr. Cochran testified that exercises billed pursuant to CPT code 97110 consist of one-on-one exercises in which the therapist provides instruction throughout the exercise. He noted that the treatment records for April 24 through September 17 do not identify the need for one-on-one supervision during exercises such as using a treadmill, performing step-ups, riding a bicycle, performing total gym leg presses, or performing hamstring stretches. Further, he claimed that the need for such supervision was very unlikely as these were the types of exercises that a patient could perform on their own, once originally given instruction in how to do them.[11]

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[9] Dr. Cochran is board-certified in family medicine and occupational medicine.

[10] The disability guidelines referred to by Dr. Cochran are the Official Disability Guidelines from the Work Loss Data Institute.

[11] According to Dr. Cochran, spine stabilization exercises that a patient performed while on her stomach, doing extension-type exercises would have been beneficial for Claimant. The exercises she performed during therapy, such as the treadmill, upper extremity bicycle, hamstring stretches, leg presses, step-ups, and bicycling, are general exercises and are not considered extension-type exercises.

With regard to aquatic therapy, Dr. Cochran stated that this costly treatment can be useful for back injuries in the first week or two after surgery when a patient may need to be Aunweighted.@ Then, the use of gravity becomes necessary in further therapy. Dr. Cochran noted that no reason was identified for using aquatic therapy months after Claimant's surgery. He also testified that the medical literature did not support the use of aquatic treatment of post-op spine injuries.[12] In his opinion, aquatic therapy provided no benefit for Claimant's condition.

Regarding the use of myofascial release, Dr. Cochran said that this treatment is beneficial in acute stages as it may promote increasing range of motion and decreasing scar tissue. However, he observed that the medical literature did not support its use for a chronic, post-operative back injury and the Provider's treatment records did not indicate why it was prescribed.

Dr. Cochran disputed reliance upon Claimant's range of motion as a legitimate measure of her rehabilitation. He said that spinal motion is highly variable and can change throughout the day. He also noted that the range of motion in Claimant's spine would necessarily be restricted due to the fusion and there was no credible documentation that she received real benefit from the range of motion exercises. Additionally, when viewed from when Claimant began therapy to October 2, 2002, Claimant's range of motion actually worsened.

Lastly, Dr. Cochran testified that the treatment records did not document the necessity for the use of hot and cold packs or electrical stimulation. He said that these modalities did not provide real therapeutic value after the first couple of weeks.

C. Provider's Position.

Petitioner argues that Claimant received significant remedial benefit from the treatment, and while not cured, was helped with her pain levels. Further, Petitioner contends that the peer reviews relied upon by Carrier in denying reimbursement are unreliable because there was no showing that the doctors performing them were licensed to practice medicine in Texas. Lastly, Provider contends that Carrier relied upon a AC@ denial code in its EOBs for some services and Provider has not entered into a contract with Carrier which would support the use of the AC@ code.

Dr. Connell testified that Claimant had been prescribed a trunk orthotic to assist with post-surgical lumbar instability. Her movement was restricted due to discomfort caused by the orthotic during therapy, slowing her progress. Dr. Connell maintained that Claimant required one-on-one therapy because of her trunk instability. He offered no further support for this contention.

[12] The literature Dr. Cochran referred to was the Official Disability Guidelines; Philadelphia Physical Therapy study from the American Physical Therapy Association; Low Back Pain - Biophysical Model, OEM Press; and an Ivan Brox study published in *Spine,* September 2003.

Claimant also experienced radicular pain and increased lumbar pain that affected the length of time necessary to complete the therapy. With regard to the aquatic therapy, Dr. Connell noted that Claimant had increased pain with land-based activities and she obtained restoration of function as a result of the use of aquatics.[13] Dr. Connell testified that Claimant's overall pain level decreased as a result of the therapy, demonstrating that it was medically necessary.

D. Analysis.

The ALJ first considers the argument made by Petitioner's counsel that the peer reviews relied upon by Carrier should not be considered because they were not made by doctors who are licensed to practice in Texas. The peer reviewers were Drs. P. Alongi and Edwin Kletzel. Both are chiropractors licensed in the state of Florida. The Commission rules do not require that a peer reviewer be licensed to practice medicine in the state of Texas. 28 TEX. ADMIN. CODE ' 133.304(g). Petitioner has not claimed that the standards for practicing medicine in this area vary from state to state. The peer reviewers concluded that all treatment provided to Claimant was not medically necessary as it exceeded the reasonable and customary rehabilitation period for this type of injury.[14] Consequently, the ALJ does not find persuasive Petitioner's claim that the peer reviews are not a reliable basis upon which Carrier made its determination.

The ALJ agrees with Petitioner that Carrier's denial of claims based on the AC@ code, indicating a contract existed between the parties, was not valid because there was no evidence of a contract between the parties. However, for all dates except August 8 through September 17, 2002, Carrier had also denied reimbursement on the basis of peer review findings. Consequently, Provider knew that medical necessity was challenged on these claims because it appeared on the Carrier's EOBs. For the claims from August 8 through September 17, 2002, Provider was on actual notice that Carrier objected to treatment on the basis of medical necessity. The peer review letters clearly stated that the treatment was not medically necessary.[15] Consequently, the Carrier's failure to indicate peer review on its EOBs does not prevent Carrier from relying on this basis for denial because Provider was given notice as to Carrier's basis for denying reimbursement.[16].

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[13] Dr. Connell testified that he relied upon therapeutic guidelines provided by Dr. Cotler. These guidelines were not provided to Carrier during discovery despite a proper request. Therefore, they were not admitted into evidence.

[14] The peer reviewers also noted that the documentation was inadequate to support medical necessity and that there was a lack of quantifiable positive outcome measures in the treatment plan. The reviewers agreed that active and passive modalities were not medically necessary.

[15] Provider was notified by peer review letters dated October 8 and 23, 2002, and January 24, 2003, that the peer reviewer found no medical necessity for the treatment.

[16] *See., e.g.*, Twin City Fire Insurance Co. v. Main Rehab & Diagnostic, SOAH Docket No. 453-03-4035.M5; Oxymed v. United Pacific Insurance Co., SOAH Docket no. 453-02-3178.M5.

The treatment records in this case are not of much help in understanding the rationale for the treatment, its objectives, or its goals. The Atreatment plan@ merely consists of a check-off section indicating how frequently the treatment was to be given. It did not describe the purpose of the treatment or its desired results. There is no explanation as to why Claimant's treatment did not vary throughout this time period, taking into account her response, or lack of response, to treatment. Without more explanation in the records or through Dr. Connell's testimony, the ALJ is unable to conclude that Claimant needed such extensive treatment, including one-on-one therapy.[17]

The ALJ finds the testimony of Dr. Cochran to be persuasive. It appears that Claimant received treatment that became medically unnecessary to continue due to the length of treatment and to Claimant's substantially unchanging condition. Claimant received well in excess of 34 sessions, a number that Dr. Cochran testified was the most sessions supported by the medical literature for this condition. She continued to complain of pain and her condition remained virtually unchanged. The range of motion variations are not significant enough to support a conclusion that the treatment was medically necessary, particularly in light of Dr. Cochran's testimony that range of motion is variable. The records support Dr. Cochran's testimony that too much physical therapy can result in dependence by the patient upon the treatment, thus preventing a successfully recovery. In this case, Claimant ultimately did complete a chronic pain management program and, hopefully, will be better able to cope with the effects of her injury.

Based on the evidence, the ALJ concludes that Carrier's appeal should be granted because the physical therapy treatment records and other medical records support a finding that the services were medically unnecessary.

III. FINDINGS OF FACT

5. On ___, Claimant suffered a compensable injury to her back while assisting a co-worker in moving a heavy cabinet.

6. Claimant's injury is covered by worker's compensation insurance written for the Claimant's employer by the American Protection Insurance Company (Carrier).

7. After the injury, Claimant sought medical treatment from Dr. Jack Barnett. He diagnosed her with a lumbar and cervical sprain/strain, grade 2.

8. Claimant underwent several diagnostic procedures due to continued severe lower back pain.

9. On November 7, 2001, Claimant underwent a 360-degree fusion between L3-4 and L4-5.

10. Claimant was treated with therapeutic rehabilitation after the surgery.

[17] This is especially so when very expensive treatment modalities, such as aquatics therapy, is rendered.

11. Carrier paid for the treatment referred to in Finding of Fact No. 6 from January 7, 2002, through April 22, 2002.

12. From April 24, 2002 through September 17, 2002, Claimant received office visits, therapeutic procedure, myofascial release, aquatic therapy, application of a modality, electrical stimulation, and ultrasound therapy from Jack Barnett, D.C. (Provider).

13. The physical treatment referred to in Finding of Fact No. 8 is essentially the same as the type of treatment referred to in Finding of Fact No. 6.

14. Twenty-four sessions of therapeutic exercise are appropriate for a 360-degree fusion, although thirty-four sessions may be required by some patients.

15. Claimant received twenty-seven sessions of therapy prior to the disputed dates of service.

16. Claimant received more than thirty-four sessions of therapeutic services after her 360-degree fusion.

17. There was no explanation as to why Claimant required more than thirty-four sessions of treatment.

18. The treatment records did not contain a treatment plan which set forth goals and objectives for the program.

19. The treatment records did not describe a need for one-on-one supervision during exercises.

20. There was no explanation for the need of aquatic therapy so many months post-surgery.

21. There was no explanation for the need of myofascial release in a chronic post-operative back injury.

22. The treatment records did not contain explanation for the use of hot and cold packs or electrical stimulation.

23. Claimant's condition did not improve significantly as a result of the treatment.

24. Carrier refused to pay for the treatment described in Finding of Fact No. 8 on the basis that it was not medically necessary.

25. Claimant timely requested dispute resolution by the Medical Review Division of the Texas Workers' Compensation Commission (TWCC).

26. On July 16, 2003, the TWCC's Medical Review Division issued its order for Carrier to reimburse Provider for the disputed services, following review of the decision of the independent review organization.

27. The Commission sent notice of the hearing to the parties on September 18, 2003. The notice contained 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 section of the statutes and rules involved; and a short plain statement of the matters asserted.

28. The hearing was held on May 24, 2004, and all parties appeared and participated.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (TWCC) has jurisdiction to decide the issues presented pursuant to 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.' 413.031 and TEX. GOV'T CODE ANN. ch. 2003.

3. The Notice of Hearing complied with TEX. GOV'T CODE ANN. ''2001.051 and 2001.052.

4. Carrier has the burden of proving by a preponderance of the evidence that it should prevail in this matter. TEX. LAB. CODE ANN. ' 413.031.

5. Based on the above Findings of Fact and Conclusions of Law, the treatment rendered to Claimant from April 24 through September 27, 2002 was not medically necessary.

6. Based on Conclusion of Law No. 5, Carrier should not reimburse Provider for the treatment rendered to Claimant from April 24 through September 27, 2002.

ORDER

IT IS, THEREFORE, ORDERED that the American Protection Insurance Company is not required to reimburse Jack Barnett, D.C. for the amount claimed for services provided from April 24, 2002, through September 17, 2002.

SIGNED July 20, 2004.

SUZANNE FORMBY MARSHALL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS