SOAH DOCKET NO. 453-04-3601.M5
TWCC NO. M5-03-1804-01

CENTRAL DALLAS REHAB, **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
LIBERTY INSURANCE CORPORATION, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

After an Independent Review Organization (IRO) determined that its treatment of Claimant after July 25, 2002, was not medically necessary and denied reimbursement, Cental Dallas Rehab (Provider) requested a hearing. Provider seeks reimbursement of approximately $9,000 for services rendered. This decision finds that Provider proved that services for which it charged $554 were medically necessary, but that it did not prove the remaining disputed services were medically necessary healthcare for Claimant.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice, or venue. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.[1]

The hearing in this matter convened June 7, 2004, at the State Office of Administrative Hearings (SOAH), 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Charles Homer III presiding. Provider was represented by its attorney Scott C. Hilliard and Liberty Insurance Corporation was represented by counsel, Kevin Franta. The record was closed the same day, but was reopened on June 28, 2004, until August 12 to allow the parties to respond to prior briefing of a procedural issue that Provider raised in closing argument[2] and to supplement or respond to an exhibit admitted into evidence on June 28. The record closed on August 12, 2004.

[1] The parties agree that Provider has the burden of proof in this proceeding. 1 TEX. ADMIN. CODE (TAC) ' 155.41.

[2] Provider argued that Carrier's entire case was outside the MRD record because it denied payment for medical necessity - peer review and its witness at the hearing testified that he had not considered peer reviews. The argument is addressed in Part III below.

II. DISCUSSION

1. Claimant's Treatment History

On ___, Claimant sustained a compensable injury to his lower back when the wind caught a ladder he was moving in the course of his duties applying caulking or sealing compounds. Claimant apparently injured himself attempting to hold the ladder steady. He began treatment with a medical doctor the next day. On June 11, 2002, Claimant saw Provider, and soon thereafter Provider began daily conservative treatment with chiropractic manipulations, manual traction, joint mobilization, and therapeutic exercise.[3] A lumbar spine MRI in June 2002 showed a central disc herniation at the L4-L5 level with annular tear.[4]

At Dr. Krejci's referral, on August 20, 2002, Charles Tuen, M.D. performed motor nerve conduction velocity (NCV) studies and other electrodiagnostics on Claimant. He found normal NCVs in both legs, and everything else also within normal limits except for a Very mild prolonged dermatosensory latency of bilateral L5 and S1 . . . Suggestive of nerve root or sensory pathway dysfunction at bilateral L5 and S1 level.[5] Claimant continued therapy and exercise sessions with Provider for the remainder of 2002.

2. Applicable Law

All services in dispute were rendered before August 1, 2003. Therefore, the 1996 Medical Fee Guidelines provide a basis for analysis of the medical necessity of the disputed services.[6] Whether benefits are available is also determined by the Texas Workers' Compensation Act.[7]

3. Provider's Evidence

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[3] Pet. Exh. 1, p. 53.

[4] Pet. Exh. 1, p. 28. There is a bright signal seen . . . Which will correlate with annular tear. There is also a 2-mm posterior herniation at this level. The report also describes a herniation at L5-S1 that is not impinging any neural structures.

[5] Res. Exh. 1, at A 0073.

[6] *Texas Medical Association v. Texas Workers Compensation Commission*, 137 S.W. 3d 342 (Tex. App. -- Austin, 2004, no. pet.)

[7] Tex. Labor Code ' 408.021 provides: **(**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.

Ted Krejci, D.C., testified that the disputed therapy and office visit services were medically necessary because of Claimant's herniated disc. He stated that Claimant's range of motion and strength improved during treatment and his pain decreased during some range of motion exercises, and that both of these improvements show that the treatments were effective. Dr. Krejci testified that orthopedic surgeon James Laughlin, M.D., saw Claimant on July 8, 2002, and recommended conservative care, for a period of time whose duration is not shown.[8] Dr. Krejci cited the October 18, 2002, evaluation of Claimant by Aya Dayian, M.D., in which Dr. Dayian stated that Claimant had not reached maximum medical improvement. Dr. Dayian believed that Claimant should have a surgical consult to discuss possible options.[9] Dr. Krejci also relies on Francisco Batlle, M.D., who evaluated Claimant on January 6, 2003,[10] and wrote that Claimant may benefit from continued physical therapy for symptomatic relief and that he could also consider lumbar epidural steroid injections.

Dr. Krejci agreed with Carrier that Claimant consistently rated his pain level at 4" throughout his care, but stated that Claimant's ultimate return to work demonstrates that Provider's therapy and work hardening benefitted him. He also testified that Dr. Batlle's evaluation confirms that Claimant did not become a surgical candidate despite his herniated disc, and credits his treatment for that outcome. Dr. Krejci stated that Provider's work hardening facility is CARF-certified. He testified that progression to work hardening did not mean that the prior treatment was not effective; rather, he stated, Provider gave Claimant work hardening because Claimant did not meet Department of Labor medium level requirements, which meant that after therapy Claimant still had deficits that required work hardening. Dr. Krejci pointed out documented improvements in Claimant's performance on various activities during his work hardening.[11]

Provider also presented documentary evidence, including daily reports of treatment, billing and other correspondence, in two exhibits, both of which were admitted.

4. Carrier's Evidence

Casey Cochran, D.O., testified that Claimant's injuries are musculo-skeletal and not disc-related. He testified that passive modalities are appropriate in the acute post-injury phase, but have little value five months after an injury. He disagreed with Provider that there was any indication after the twelfth visit for continued manipulative therapy, traction, or joint mobilization. He stated that Claimant had no objective findings to support continuing therapy beyond that time, and that

[8] See Pet. Exh. 1, at p. 20. Neither party cited the ALJ to Dr. Laughlin's report, which is apparently not in evidence.

[9] Res. Exh. 1, A 0101.

[10] *Id.* at pp. 30-33.

[11] *Id.*, pp. 134-201.

continuing beyond four weeks[12] could be counter-productive by increasing Claimant's reliance on the physician and inducing chronic pain syndrome. Dr. Cochran believed that all necessary exercises could have been done at home after four weeks. He evaluated the MRI report as demonstrating only multi-level degenerative back disease, and said that annular tears are common among such patients. Dr. Cochran described each of the treatments and therapies given Claimant by CPT code and stated that none were medically necessary.

Carrier offered documentary evidence in one exhibit comprising 206 pages, which was admitted.

III. PROVIDER'S MOTION TO STRIKE TESTIMONY OF DR. COCHRAN

Carrier's expert witness, Dr. Cochran, testified extensively about the reasons he believed that the disputed services were not medically necessary. He also stated, in response to Provider's question, that he had not reviewed any peer review of the treatment to prepare for his appearance in this proceeding. Carrier did not offer the peer reviews into evidence. At the close of the hearing, Provider argued that the Carrier had attempted to raise issues in the hearing that it did not present to the MRD, by basing its case at the hearing on the testimony of Dr. Cochran. In closing argument, Provider requested the ALJ to, in essence, ignore Dr. Cochran's testimony and accept that of its witness, and cited the ALJ to a SOAH decision[13] and two Commission rules.[14]

The ALJ has reviewed both parties' briefs and the SOAH decisions cited therein. In the cases Provider cites, Carrier asserted a reason for denial that was different from the one it had put before the Provider and the MRD. But in this case, Carrier is not presenting a different reason. Carrier's defense was and is lack of medical necessity. No case presented to the ALJ holds that reliance on a peer review before the MRD prevents the Carrier from offering evidence of lack of medical necessity from new sources, who either have or have not relied on the peer review.

Another consideration weighs in favor of the conclusion reached here. Implementing the rule Petitioner requests would create a procedural trap: only after Carrier has rested may Provider assert that Carrier's evidence may not be considered because no evidence of a peer review was submitted in a V denial case. If Provider is correct, the entire hearing becomes sound and fury signifying nothing except that Carrier loses after Provider allows it to try all its issues by consent. The rationale of the SOAH decisions cited is to implement the statutory goal of review of medical services by paper trail, and to prevent carriers from expanding the case at SOAH beyond issues that were before the MRD.[15] No such purpose is served by the radical expansion of the no new issues

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[12] The ALJ understands the four weeks to refer to the period beginning on Claimant's first treatment by Provider, a time span that would terminate in mid-July.

[13] SOAH Docket No. 453-03-2355.M5.

[14] 28 TAC ' 133.304(c) and 28 TAC ' 133.307(j)(2). Both Commission rules are procedural and pertain to requirements that the Carrier state the reasons for its denial when it denies payments and that the carrier not raise new reasons for denial in a review of its determination.

[15] SOAH Docket No. 453-01-3909.M5, at p. 6 (February, 2001). In the case cited orally by Provider at the hearing, Carrier had denied payment under Code V, but the evidence affirmatively showed that it never had conducted a peer review. SOAH Docket No. 453-03-2355.M5, at p. 1 (July 31, 2003) Therefore, the ALJ held that Carrier had no

doctrine that Provider urges. Provider does not seek here to limit issues; it seeks to limit evidence. The motion is denied, and the ALJ will consider both parties' evidence in a *de novo* review of the MRD/IRO decision.

IV. ANALYSIS

1. Physical Medicine and Office Visits

The ALJ concludes that certain services Provider rendered between July 25 and August 16, 2002, were medically necessary, but that Provider failed to prove that the services it rendered after August 16 were medically necessary. This conclusion agrees with Provider's initial assessment of Claimant and with Dr. Tuen's negative findings on August 20, 2002. The ALJ concludes that there is insufficient evidence that the work hardening program was medically necessary.

To show the medical necessity of the relatively long duration of active and passive therapies and exercises, Provider relies heavily on the positive MRI findings and on Dr. Batlle's report. The ALJ agrees in part: the MRI and Claimant's relative youth (he was 26 when the MRI was done) advocate against Dr. Cochran's testimony that Claimant had merely multi-level degenerative disc findings. Furthermore, Claimant remained off narcotic pain medications and ultimately returned to work. Therefore, the ALJ is persuaded that chiropractic care for more than the minimal duration espoused by Dr. Cochran was medically necessary.

In the absence of Dr. Laughlin's report[16], the ALJ relies on Dr. Krejci's initial assessment that he anticipated releasing Claimant on August 16, 2002.[17] Dr. Krejci maintained this estimate through every SOAP note in evidence through July 26. On July 29, however, he revised that estimate to August 30. A thorough comparison of the SOAP notes for July 26 and July 29 reveals that the two are identical except for the omission on July 29 of some elements that appeared under management on July 26.[18] Subjective and objective findings are identical across the two dates, as are the exercises and therapies. Thus, there is no reason in the record for extending Claimant's care beyond the initially determined period ending on August 16, and the ALJ finds that services performed after August 16, 2002, were not medically necessary.

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basis for denial and ordered reimbursement. Such is not the case in this proceeding.

[16] Dr. Laughlin's report from his July 2002 assessment of Claimant would show whether, as Dr. Krejci recalls, he recommended continuation of therapy, and, if so, for how long.

[17] Pet. Exh. 1, p. 53.

[18] Res. Exh. 1, pp. A 0056-A 0059. The words that appear on the July 26 entry but not on July 29 are: The patient's response to conservative care: Patient is doing better and moves better as indicated by increased ROM however his pain still persists.

Dr. Batlle's comments in January 2003 do not establish medical necessity for continuing therapeutic exercises/activities beyond August 16, 2002. Dr. Batlle indicated that Claimant may benefit from continued physical therapy.[19] But Dr. Batlle also offered to Claimant with apparently equal weight the alternatives of Adoing nothing and possible epidural steroid block.

In Provider's billing from July 25 through August 16, 2002, charges for office visits with manipulation (99213-MP) are duplicative of 97250 and/or 97265 (myofascial release and joint mobilization)[20], and indicate that office visits were billed much more frequently than medically necessary according to Medical Fee Guidelines, the IRO reviewer, and Dr. Cochran. The one-on-one supervised therapeutic exercises (97110) may well have been helpful to Claimant, but Dr. Krejci testified to only one reason for conducting them in a one-on-one setting: his belief that patients tend to slack off in their exercises if not supervised. Preventing an able patient without behavioral problems from non-compliance with an exercise regimen is not medically necessary. For these reasons, the 99213MP and 97110 charges from July 26 through August 16 were not medically necessary. Reimbursement for $554 of physical medicine services will be ordered in the amount shown below.

Disputed Services 7/26 - 8/16, 2002

July 26	99213MP				
July 31		97110			
August 1	99213MP	97110	97265 - $43	97250 - $43	97122 - $35
August 2	99213MP	97110	97265	97250	97122
August 9	99213MP	97110	97265	97250	97122
August 12	99213MP	97110	97265	97250	97122
Reimburse-ment Totals			**$172**	**$172**	**$210**

[19] Pet. Exh. 1, p. 32.

[20] Although not shown in the chart below because charges for them are not disputed, treatment records show that services coded as 97265, 97250, and 97122 were provided on July 26.

2. Work Hardening

Work hardening programs are interdisciplinary, with capabilities to provide behavioral and vocational treatment as well as physical and functional treatment.[21] No testimony and no documents suggest that Claimant needed behavioral or occupational therapy. Dr. Dayian did not, as Dr. Krejci suggests, recommend any treatment (including work hardening); rather, he wrote that further therapy after work hardening would not be of any benefit.[22] Nor is there evidence that Provider designed its work hardening program for Claimant's specific needs and focused it on returning him to work. The evaluation performed on October 3 contains many details, but none about Claimant's actual or intended job and the specific job-related deficits he might have had.[23] On December 20, 2002, at the end of his program, Claimant reported to Provider that he does not feel able to return to work.[24] Some evidence that Claimant might have benefitted in a general way from work hardening[25] does not suffice to prove its medical necessity. Therefore, the ALJ will not disturb the IRO finding that there was no medical necessity for work hardening.

IV. FINDINGS OF FACT

1. On ___, Claimant sustained a lower back injury compensable under the Texas Workers' Compensation Act.

2. Liberty Insurance Corporation provides workers' compensation insurance covering Claimant's compensable injuries.

3. The Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD) issued a decision dated January 26, 2004, which found that no services that Central Dallas Rehab (Provider) rendered to Claimant from July 26, 2002, through January 21, 2003, were medically necessary.

4. On February 3, 2004, Provider requested a hearing in response to the MRD decision and the case was referred to the State Office of Administrative Hearings (SOAH).

5. The Commission sent notice of hearing to all parties on March 2, 2004.

6. Claimant began a course of treatment and evaluation with Provider on June 12, 2002, and Provider continued to perform services for him beyond December 19, 2002.

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[21] MFG 1996, Medicine Ground Rules II.E.

[22] Res. Exh. 1, A 0101.

[23] Pet. Exh. 1, pp. 45-47.

[24] Pet. Exh. 1, p. 197.

[25] Id., pp. 41-44 (FCE October 3, 2002); Pet. Exh. (A peer review supporting four weeks of work hardening).

7. The disputed services are office visits, one-on-one supervised activities, therapeutic procedures, and physical medicine treatments provided from July 25 through December 19, 2002.

8. Claimant's compensable injuries involve a herniated disc at L4-L5.

9. In June, 2002, Provider evaluated the necessary duration of his treatment as ending August 16, 2002.

10. On July 26, 2002, Provider extended Claimant's treatment to August 30, 2002.

11. No documented reason existed on July 26, 2002, for Provider's extension of Claimant's treatment.

12. At various times after July 26, Provider extended Claimant's treatment, and the disputed treatments ended on December 19, 2002.

13. Provider began what it designated as a work hardening program for Claimant on October 17, 2002.

14. From June 11 through October 17, 2002, Claimant did not exhibit a need for behavioral or vocational therapy.

15. Work hardening programs are interdisciplinary programs with capabilities to provide behavioral and vocational treatment as well as physical and functional treatment.

16. Provider did not design its work hardening program for Claimant's specific needs, if any, and focus the program on returning him to work.

17. The program given Claimant from October 17, 2002, through December 20, 2002, did not meet the work hardening requirements set out in the *Guideline*, Medicine Ground Rule II.E., adopted at 28 TEX. ADMIN. CODE § 134.201, because:

    a. It was not a highly structured, goal-oriented, individualized treatment program designed to maximize Claimant's ability to return to work.
    2. It did not consist of real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks.
    3. There was no indication that an individualized plan of treatment was created for Claimant.
    4. The program provided to Claimant was a generalized conditioning program.

18. Claimant was not an appropriate candidate for a work hardening program because he did not have behavioral or vocational issues that needed to be addressed in a multi-disciplinary program.

19. Carrier denied Provider's claim for reimbursement for the work hardening program because it was not medically necessary.

20. The following services rendered on the dates shown either benefitted Claimant or were in reasonable medical probability likely to do so at the time they were rendered:

August 1	97265 - $43	97250 - $43	97122 - $35
August 2	97265	97250	97122
August 9	97265	97250	97122
August 12	97265	97250	97122

21. Provider claims $554 in reimbursement for the services described in Finding of Fact No. 20.

22. Except for the services described in Finding of Fact No. 20, Provider failed to show that the office visits, treatments, and therapies provided from July 26 through December 19, 2002, were medically necessary for Claimant.

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 ' 413.031(k) of the Texas Worker's Compensation Act and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely appealed the IRO decision.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. '' 2001.051 and 2001.052.

4. Provider Central Dallas Rehab had the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) '' 148.21(h) and 133.308(w); 1 TAC ' 155.41.

5. The disputed services described in Finding of Fact No. 20 were medically necessary for Claimant.

6. Provider did not show that any of the remaining disputed services were medically necessary for Claimant.

7. Based on the foregoing Findings of Fact and Conclusions of Law, except for services described in Finding of Fact No. 20, Provider is not entitled to reimbursement for services rendered to Claimant from June 12 through December 19, 2002.

ORDER

It is ORDERED Carrier reimburse Central Dallas Rehab $554 for services rendered to Claimant from July 26 through August 12, 2002. It is further **ORDERED** that Provider's remaining claims for reimbursement are denied.

SIGNED October 11, 2004.

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CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS