SOAH DOCKET NO. 453-04-4599.M5
TWCC NO. M5-04-422-01

ALAMO HEALTH CARE **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
TEXAS MUTUAL INSURANCE COMPANY, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

After an Independent Review Organization (IRO) determined that its treatment of Claimant from January 27 through June 9, 2003, was not medically necessary, Alamo Health Care (Provider) requested a hearing. This decision finds that the first 24 therapy sessions were medically necessary, except that therapeutic exercises billed under 97110 should be billed at the rate for code 97150, and orders appropriate reimbursement for those services. It also finds that the remaining disputed services were not medically necessary healthcare for Claimant, and orders no reimbursement for them.[1]

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.[2]

[1] On November 10, 2004, Carrier submitted an amended table of disputed services that reduced the scope of this appeal; notice of that submission is hereby taken. Accordingly, this decision and order addresses no formerly disputed service rendered from January 23 through February 23, 2003, nor one unit each of Codes 97110 and 97010 on February 26 and 28, 2003, and March 3, 2003. The new beginning date of disputed services is February 24, 2003, but calculations concerning the first 24 therapy sessions and references to the start of therapy, as opposed to disputed services, are based on a beginning date of January 23, 2003.

[2] The parties agree that Provider has the burden of proof in this proceeding, and the ALJ assigned that burden accordingly. 1 TEX. ADMIN. CODE (TAC) ' 155.41; 28 TAC '' 133.308(w) and 148.21(h).

The hearing in this matter convened September 8, 2004, at the State Office of Administrative Hearings (SOAH), 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Charles Homer III presiding. The record was held open for the sole purpose of receiving a stipulated notice of withdrawal of appeal as to a part of the service dates at issue, and was closed on September 17, 2004. Provider was represented by attorney Allen Tysinger, and Texas Mutual Insurance Company (Carrier) was represented by counsel R. Scott Placek.

II. DISCUSSION

A. Claimant's Treatment History

On ___, Claimant, a marketing representative at a call center, sustained an injury compensable under the Texas Workers' Compensation Act when she dropped papers onto the floor and bent down to pick them up.[3] After a course of conservative therapies with Provider[4], she was diagnosed with degenerative disc disease at L5-S1 and underwent lumbar fusion (L5-S1) on November 22, 2002.[5] On December 5, 2002, she was seen by surgeon James W. Simmons, D.O., and reported that the leg pain she had suffered before surgery was Acompletely resolved.@ She reported continuing to have back discomfort and treating the discomfort with a cold therapy machine. She was taking one Darvocet per day, and sometimes ibuprofen in the evening. Dr. Simmons rated her legs as Aneurologically intact@ and observed that her strength was intact in all motor groups of her legs. He instructed Claimant to avoid bending, lifting, or twisting, to continue cold therapy and wearing an abdominal brace. She was to Awean herself from the walker as tolerated@ and return in four weeks.[6]

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

[4] Res. Exh. 4, p. 164.

[5] *Id.*, pp. 40, 144-146.

[6] *Id.*

In January 2, 2003, Claimant returned to Dr. Simmons; she did not complain of leg pain, but did say that she had some back discomfort that, according to Dr. Simmons's notes Ais improving.@[7] After examining her and evaluating the surgical results (the placement of hardware, and progress of bone graft), Dr. Simmons recommended to Claimant that she:

(1) continue to avoid bending, twisting, or lifting;
(2) could begin to drive, and walk for exercise;
(3) wear her corset for comfort;
(4) return to Dr. Roberts in six weeks for re-evaluation and continued treatment.[8]

On January 23, 2003, Claimant visited Provider, and contradicted what she had told Dr. Simmons by complaining of constant pain at an intensity of 7 on a scale of 0-10. She began three sessions per week of rehabilitation including chiropractic manipulations, ultrasound, electrical stimulation, massage and ice packs.[9] In late February, she began increasing active exercises. At the end of the disputed course of therapy in late May and early June, Claimant did not report significant improvement in her pain. Over time, Provider was unable to measure any significant extension of her range of motion, except a small increase in lumbar lateral range of motion.[10]

2. Provider's Evidence

Spiro Ioannidis, D.C., testified that Claimant was at high risk after her November 2002 lumbar spinal fusion because Claimant's surgery was delayed until fifteen months after her injury and because of her obesity. (Claimant, a 5 foot, 1 inch female, weighed 253 pounds two weeks before her lumbar surgery). He admitted that Claimant's four-month duration of therapy was not typical, and attributed the additional time to those two factors. He testified that Claimant was begun on passive therapy but introduced to more active therapy beginning February 21, 2003, and discussed

[7] *Id.*, 153.

[8] *Id.* Dr. Roberts is a colleague of Dr. Simmons.

[9] *Id.*, p. 41.

[10] Res. Exh. 4, at pp. 268, 321, 322, and 331.

how the services Provider gave Claimant were therapeutic for inflammation of tissues around the surgical incision. On cross-examination, Dr. Ioannidis acknowledged that Provider's records did not document any inflammation, and that therapeutic exercises for which Provider billed under code 97110 were not one-on-one in the sense that no one on the Provider's staff attended and supervised the Claimant's exercises to the exclusion of other duties.[11]

Robert John Lowry, M.D., who is board-certified in pain management, testified that the services Provider rendered were reasonable for this Claimant, based upon the delay in her spinal fusion and the fact that, at her weight, just standing up puts more stress on her spine than he would recommend for a recent surgical patient. He observed that Claimant reported to Provider in January 2003 that she was not performing a full range of daily life activities, and stated his belief that, without Provider's services in pushing Claimant to exercise, Claimant's hips and spine would have deteriorated and she might have remained on a walker for life. Dr. Lowry responded to the absence of specific documentation of inflammation by stating that in spinal surgery, inflammation would be implied. Dr. Lowry also addressed the issue about billing therapeutic exercises with 97110 and 97150, and stated that in all fields of treatment except workers' compensation, it is standard to bill 97110 for exercises where one therapist supervises a small group of patients. In his view, conflict among medical authorities has deprived the profession of a definition of true one-on-one therapy.

Provider presented hundreds of pages of documentary evidence, including its evaluations of Claimant, daily reports of treatment, billing and other correspondence.[12]

3. Carrier's Evidence

William D. DeFoyd, M.D., testified by deposition that a rehabilitative program for lumbar fusion patients is beneficial, but found three faults with the program at issue. First, Dr. DeFoyd did not find in Provider's records any focused, detailed description of Claimant's status when she

[11] Res. Exh. 3, pp. 64-66.

[12] See also Pet. Exh. 1, 2, and 3.

presented to Provider on January 23, 2003.[13] Secondly, Dr. DeFoyd stated that any passive modalities are secondary to active modalities when the patient is two months post-surgery, as here, and finally, Dr. DeFoyd said that he observed no progress during therapy, and no change in the therapy provided as a result of Claimant's progress, or lack of it.[14] Dr. DeFoyd also observed that Provider's records do not mention any special treatment or care because of Claimant's weight.

John C. Pearce, M.D., testified by deposition for Carrier. He supported the delay of two months after surgery in beginning Claimant's rehab program and the medical necessity of such a program for Claimant,[15] but limited the duration from 12 to 24 weeks. Dr. Pearce stated that although Provider's records did not sufficiently document the therapy and patient's response to it, he believed that the treatment Provider rendered was medically necessary for up to 24 visits, including passive modalities.[16]

Carrier offered several hundred pages of documentary evidence, including reports by various reviewers.

III. ANALYSIS

The ALJ concludes that the services Provider rendered Claimant from February 24 through April 2, 2003, were medically necessary except for therapeutic exercises coded 97110, which are allowed but ordered to be reimbursed at the rate for code 97150. Services rendered after April 2 were not medically necessary because they exceeded a reasonable duration for post-operative rehabilitation, were not focused on specific, treatable deficits of Claimant, and produced no significant, documented response in Claimant.

[13] Res. Exh. 3, p. 76.

[14] *Id*, at pp. 76-78, 80-81.

[15] Res. Exh. 2, p. 10.

[16] *Id.*, at pp. 11, 14 and 37.

Claimant's reports of her symptoms and pain to Provider are wildly inconsistent from those recorded by Dr. Simmons. She reported no aggravating event nor any other reason why between January 2 and 27, 2003, she declined from being free of serious pain and permitted by Dr. Simmons to drive and walk on January 2 to reporting to Provider a pain level 7 of 10 and that her pain was continuous. Dr. Iannodis reviewed his notes of January 23, and testified that Claimant's only pain complaint to him on that date was of back pain at her surgical incision. She presented with a walker and wearing a corset, but without other history than the November spinal surgery. Claimant's statement to Dr. Bishop that she was confined to bed for a month is contrary to Dr. Simmons's records.

In short, even allowing for a surgeon's optimism about his own work, nothing in the record from before January 27 offers any reason for her to report to Provider high pain levels on January 27 and only 25% of normal ability to perform straight leg raising. The only available inference from a comparison of Provider's records with those of Dr. Simmons is a gross understatement to Dr. Simmons or a similar exaggeration to Provider. Based on the entire record, the latter inference is compelling.

The record supports the assessment by Leslie M. Bishop, M.D., that Claimant wanted to receive continued medical attention and reported her subjective signs and symptoms accordingly.[17] As Dr. Pearce stated, A[T]here really wasn't a whole lot of objective data in this case, I thought, to even proceed to surgery in the first place. But I don't think that's a question in this case at all.@[18] The ALJ will not substitute his judgment for that of Carrier's witness Dr. Pearce, supported by Drs. Ioannidis and Lowry, and finds that all services rendered by Provider from February 24th through the 24th therapy session on April 2, 2003, were medically necessary, except those billed under code 97110, which are reasonable and medically necessary only if charged under code 97150.

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[17] Pet. Exh. 1, pp. 138-140. AOn the designated doctor examination of 10/29/02 there were no objective medical findings, objective medical data, or neurological deficits, corresponding to the claimant's subjective complaints, or that could be attributed to the compensable injury of___, when the claimant >bent over to >pick up several sheets of paper that had fallen on the floor. The physical examination was riddled with functional overlay, symptom magnification, [and] clinical inconsistencies, but there were no dermatomal patterns of altered sensation or myotonal weakness to identify any radicular process.@ Dr. Bishop reiterated this opinion on January 3, 2003, after reviewing a responsive letter from Dr. Ioannidis. Res. Exh. 1, pp. 140-142.

[18] Res. Exh. 2, p. 39.

Provider's assertions concerning the indications for Claimant's extensive course of therapy, even if true, do not overcome the contrary evidence because those assertions are not evidence that that Provider addressed any specific condition that was caused by the delay in her surgery or her weight or post-surgical inflammation, the three indications Provider cited. Further, nothing in Claimant's treatment records with Provider addresses her overweight condition, and Dr. Zavala, her treating medical doctor, did not prescribe anything for inflammation.[19] Dr. DeFoyd addressed the timing between injury and spinal fusion in general, and stated that fusion is a last resort that is not taken promptly after an injury,[20] suggesting that the delay of which Provider complains was not unusual.

For services rendered after April 2, 2003, the ALJ finds that none were reasonably likely to accomplish any of the mandated treatment goals because there is no evidence of continued progress or a focused attempt aimed at specific, treatable deficits in order to stimulate progress beyond April 2.[21] Dr. Lowry emphasized that Claimant needed to be pushed into active exercise. But this record does not indicate that Provider Apushed.@ Neither the voluminous documentation nor the testimony of either of Provider's witnesses indicates such an effort. Therefore, Provider failed to meet its burden of proof regarding services rendered after April 2, 2003, and its appeal concerning those services should be denied. To repeat, no finding in this decision is intended to alter the agreement between the parties as reflected in Respondent's Amended Table of Disputed Services submitted herein on November 10, 2004.

IV. FINDINGS OF FACT

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

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[19] *E.g.*, Pet. Exh. 1, p. 171, 172.

[20] Res. Exh. 3, at p. 74.

[21] Medically necessary health care is treatment that A(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.@ TEX. LABOR CODE ANN. ' ' 408.021

2. Texas Mutual Insurance Company (Carrier) provides workers' compensation insurance covering Claimant's compensable injuries.

3. After Carrier denied as medically unnecessary the claims of Alamo Health Care, Provider, for certain services rendered to Claimant, Provider requested medical dispute resolution through the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD).

4. The MRD issued a decision dated March 9, 2004, which found that none of the disputed services Provider rendered to Claimant from January 27 through June 9, 2003, were medically necessary.

5. On March 17, 2004, Provider requested a hearing in response to the MRD decision and the case was referred to the State Office of Administrative Hearings (SOAH).

6. The Commission sent notice of hearing to all parties on April 15, 2004.

7. Claimant received a lumbar spinal fusion (L5-S1) on November 22, 2002, for relief of effects of her compensable injury.

8. Claimant's surgeon examined her December 5, 2002, and January 2, 2003, and on the second visit released her to drive and begin walking for exercise.

9. Claimant began a course of therapy sessions three times per week with Provider on January 27, 2003.

10. An acceptable range of duration of such therapy is four to eight weeks, three sessions per week, or up to 24 sessions.

11. Goals for therapy were to increase Claimant's range of motion and decrease her pain.

12. Claimant continued her therapy with Provider from January 27 through June 9, 2003.

13. On June 9, 2003, Claimant's pain was 6 of 10 compared to 7 of 10 on January 27, 2003.

14. On May 19, 2003, two of three measures of Claimant's range of motion had declined from March 12, 2002, and one had increased.

15. The disputed services are office visits, kinetic activities, therapeutic procedures, therapeutic exercises and activities, and physical medicine treatments provided from February 24 through June 9, 2003, excluding one unit each of Codes 97110 and 97010 on February 26 and 28, 2003, and March 3, 2003.

16. On January 27, 2003, Claimant reported her pain to Provider as much more intense than she reported to her surgeon Dr. Simmons on January 2, 2003; she continued to report similar high levels of pain throughout her course of therapy.

17. No objective findings and no reported history explain the difference in Claimants reports of pain on January 2, 2003, and January 27, 2003.

18. Claimant's straight leg raising test on January 27 is inconsistent with the result Dr. Simmons obtained on January 2, 2003.

19. Provider's SOAP notes concerning Claimant's treatment between January 23 and June 9, 2003, do not show any inflammation.

20. Provider did not supervise one-on-one the therapeutic exercises it billed under code 97110.

21. Services billed under codes 97110 and code 97150 have similar therapeutic outcomes.

22. Code 97150 is the correct billing code in a workers' compensation case when provider does not attend one-on-one to a patient for the entire exercise session.

23. Provider failed to show that Claimant benefitted from the office visits, treatments, and therapies provided from April 4 through June 9, 2003, or that she was in reasonable probability more likely than not to benefit from them.

V. CONCLUSIONS OF LAW

1. Provider timely appealed the IRO decision.

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

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 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. Provider's disputed services rendered to Claimant from January 27 through April 2, 2003, were medically necessary.

6. Provider's disputed services for Claimant after April 2, 2003, were not medically necessary.

7. Based on the foregoing Findings of Fact and Conclusions of Law, Provider is entitled to reimbursement for services it rendered to Claimant from January 27 through April 2, 2003, but is not entitled to reimbursement for services it rendered to Claimant from April 4 through June 9, 2003.

ORDER

It is **ORDERED** that Texas Mutual Insurance Company reimburse Alamo Health Care for all disputed services except those coded 97110 rendered to Claimant from February 24 through April 2, 2003. It is further **ORDERED** that Texas Mutual Insurance Company reimburse Alamo Health Care at the 97150 rate for all disputed services coded 97110 rendered from February 24 through April 2, 2003. This order does not address one unit each of services coded 97110 or 97010 on February 26 and 28, 2003, and March 3, 2003. It is further **ORDERED** that the request of Alamo Health Care for reimbursement for all other disputed services rendered to Claimant be, and the same is hereby, denied.

SIGNED November 15, 2004.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS