DOCKET NO. 453-04-4756.M5

ZURICH AMERICAN INS. CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner,	§	
	§	
VS.	§	**OF**
	§	
SOUTHEAST HEALTH SERVICES,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Claimant ___ injured her back on ___, when she was involved in an automobile accident. She began receiving passive chiropractic care about a week following the accident. At issue in this case are office visits, hot/cold packs, electrical stimulation, joint mobilization, and traction administered by Southeast Health Services (SHS) from January 15, 2003, through February 12, 2003. Asserting a lack of medical necessity, Zurich American Insurance Company (ZAIC) denied reimbursement. An Independent Review Organization (IRO) concluded that the treatments were medically necessary. ZAIC requested a hearing.

The Administrative Law Judge (ALJ) concludes that the hot/cold packs and five of the office visits were not reasonable or necessary, but the remaining services were necessary and should be reimbursed.

I. DISCUSSION

A. Procedural History

The IRO decision is dated March 12, 2004. The Texas Workers' Compensation Commission's Medical Review Division (MRD) issued the decision as an order on March 16, 2004. ZAIC made a timely request for hearing. The Commission issued notice of the hearing on April 29, 2004. The hearing was convened on August 2, 2004, before State Office of Administrative Hearings (SOAH) Judge Shannon Kilgore. Steven Tipton, attorney, represented ZAIC. Bryan Weddle, D.C., appeared by telephone for SHS. The hearing concluded that same day. The ALJ held the record open following the hearing for submission of additional evidence. The record closed August 27,

2004, with the submission by ZAIC of a response to additional medical records filed by SHS.

B. The Disputed Services

On ___, the van ___ was driving at about 30 miles per hour hydroplaned on a wet roadway and hit a cement barrier or guard rail. Following the accident, ___ was transported by ambulance to an emergency room at the Medical Center of Mesquite. An x-ray of her lumbar spine showed no obvious acute bony injury.[1] ___ was in her early twenties at the time of the accident.

___ began seeing Jerald Kelly, D.C., at a clinic associated with SHS on December 9, 2002. Dr. Kelly began treating ___ with passive chiropractic treatments. ___ also saw Steven Bander, D.O., on December 11, 2002, and his impression was cervical, dorsal and lumbar sprain post concussion syndrome secondary to MVA while on the job.@[2] Dr. Kelly's use of passive treatment continued throughout January and into early February. ___ reported moderate to severe back pain throughout the period of time in question. A peer review by George Medley, M.D., based on his examination of ___ on January 9, 2003, determined that she did not need further treatment.[3] Dr. Bander's impression following an exam on February 5, 2003, included radiculitis.[4]

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[1] Carrier Ex. 3 at 116.

[2] Carrier Ex. 3 at 142. Counsel for ZAIC stated that ___ probably made up the contention that she suffered a head injury in the accident. The ALJ finds insufficient evidence to come to a conclusion concerning whether ___ lost consciousness or received a head injury in the accident. In any event, this question is not directly at issue in this case.

[3] Carrier Ex. 1.

[4] Carrier Ex. 3 at 120.

At issue in this case are the following treatments, provided six to ten weeks post-injury:[5]

Date of Service	CPT Code	Treatment
1-15-03	99215 97265 97032 97012 97010	office visit joint mobilization electrical stimulation traction, mechanical hot or cold packs
1-16-03	99213 97265 97032 97012 97010	office visit joint mobilization electrical stimulation traction, mechanical hot or cold packs
1-20-03	99213 97265 97032 97012 97010	office visit joint mobilization electrical stimulation traction, mechanical hot or cold packs
2-3-03	99213 97265	office visit joint mobilization
2-5-03	99213 97265 97032 97012 97010	office visit joint mobilization electrical stimulation traction, mechanical hot or cold packs
2-12-03	99211	office visit

The total amount in dispute is $732.00.

[5] It appears from the record that there were at least two other sessions during the same period that are not at issue. Provider Ex. 1 at 19-20.

C. Applicable Law

The Texas Labor Code contains the Texas Workers' Compensation Act (Act) and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims.[6] In particular, the Act provides in pertinent part that:

> (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.
>
> * * *

Health care includes all reasonable and necessary medical aid, medical examinations, medical treatment, medical diagnoses, medical evaluations, and medical services.[7]

The 1996 Medical Fee Guideline (MFG), which is applicable to services provided prior to August 1, 2003**,** establishes some billing parameters for services provided to workers' compensation claimants.[8] Further, the Commission's rules require documentation for the higher-level office visits that substantiates the care given and the need for further treatment, and indicates progress,

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[6] TEX. LAB. CODE ' 408.021.

[7] TEX. LAB. CODE ' 401.011(19).

[8] Medical Fee Guideline (1996). *See* 30 TEX. ADMIN. CODE ' 134.201(Commission's rule adopting the Medical Fee Guideline by reference). For services rendered after August 1, 2003, the 2002 Medical Fee Guideline is applicable. 28 TEX. ADMIN. CODE ' 134.202; *Texas AFL-CIO v. Texas Workers Compensation Commission*, 137 S.W.3d 342 (Tex. App Austin 2004, no pet. hist.).

improvement, the date of the next treatment, complications, and expected release dates.[9]

The burden of proof in this case is on ZAIC to show by a preponderance of the evidence that the disputed services were not reasonable and necessary medical treatments.[10]

D. IRO Decision

The IRO decision[11] noted that the patient had a nonsurgical strain/sprain injury. The IRO reviewer cited to the North American Spine Society's guidelines for lower back pain for the principle that the initial phase of treatment for such an injury can last six to twelve weeks. The IRO reviewer also noted that ___ had pain, muscle spasms, and decreased range of motion in the lumbar and cervical spine during the course of treatment. For these reasons, the IRO reviewer concluded that the treatments were medically necessary.

E. General Description of the Evidence

The evidence in this case consists of: (1) medical and billing records;[12] (2) the testimony of the peer reviewer, Dr. Medley; and (3) the testimony of Dr. Weddle.

Dr. Medley's testimony. Dr. Medley, an orthopedic surgeon trained at the University of

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[9] 28 TEX. ADMIN. CODE ' 133.1(a)(3)(E)(i).

[10] 28 TEX. ADMIN. CODE '' 133.308(p)(5), 148.21(h)-(i). *See also* TEX. LAB. CODE ' 413.031. The IRO decision is entitled to presumptive weight. 28 TEX. ADMIN. CODE ' 133.308(w).

[11] Provider 2 at 6-7.

[12] Carrier Ex. 1-4; Provider Ex. 1-2. The parties submitted some materials following the hearing. With respect to the materials submitted by SHS, the ALJ has marked as Provider Ex. 1 and now admits the 42-page exhibit beginning with a letter by Dr. Weddle and ending with Dr. Medley's report. The ALJ treats the first two pages of this exhibit, which comprise Dr. Weddle's letter about medical necessity, as argument. The ALJ has marked as Provider Ex. 2 and now admits the 7-page exhibit beginning with Advisory 98-06 and ending with the IRO report. Further, the ALJ has marked as Carrier Ex. 4 and now admits the materials submitted by ZAIC following the hearing. The ALJ treats the 4-page Carrier's Response to Order No. 1" as argument, but regards the attachments to that response as evidence.

Texas Medical Branch at Galveston and Parkland Hospital in Dallas, examined ___ on January 9, 2003, as part of a peer review. Dr. Medley testified that ___ reported pain in her neck and back but had normal posture and only slight limitations in the range of motion in her cervical and lumbar spine. According to Dr. Medley, the claimant had no radiculopathy. He stated that prior to the disputed dates of service ___ had already undergone considerable passive therapy, consisting of about 15 office visits with some passive modalities at every (or almost every) visit. Dr. Medley's peer review report of January 9, 2003, concluded that ___ had recovered from her injuries and needed no further treatment other than instruction in home exercises.

Dr. Weddle's testimony. Dr. Weddle, a practicing chiropractor at SHS, was not ___'s treating doctor, although he did examine her once. He stated that ___'s injury was severe, and the treatment provided was within Anational guidelines,@ which he twice identified as the Mercy guidelines.[13] He also mentioned the Official Disability Guidelines.[14] He stated that 18 to 24 visits is reasonable for this kind of injury in the absence of complicating factors such as obesity, smoking, or diabetes.[15]

F. **Analysis and Decision**

Office visits. There are six disputed office visits, one of which was billed under CPT Code 99215, one of which was billed under 99211, and the rest of which were billed under 99213. The ALJ sees no justification for the billing for five of the six office visits.

The visit on January 15, 2003, was billed under 99215. This code is the highest code that can be used for an office visit. Under the MFG, use of this code requires two of the following: a comprehensive history, a comprehensive examination, and medical decision making of high

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[13] These guidelines are not in evidence.

[14] *See* Carrier Ex. 4. These guidelines provide that for cases of low back pain not involving radiculopathy, therapy should cease at four weeks. The guidelines also say that in severe cases with evidence of functional improvement, therapeutic chiropractic care can be extended to a total of 8 visits over 6-8 weeks. Carrier Ex. 4.

[15] The record suggests that ___ was obese (or nearly so); she was reported to be 5'7" tall and to weigh 215 pounds. Carrier Ex. 1 at 2.

complexity.[16] The MFG further says that the presenting problems are usually of moderate to high severity, and require a visit typically lasting about 40 minutes. While the documentation for the January 15 office visit includes evidence of a more detailed exam than was usually performed, there is no evidence that a comprehensive history or medical decision making of high complexity was warranted or performed.[17]

Code 99213 requires two of the following: an expanded problem focused history, an expanded problem focused examination, or medical decision making of low complexity.[18] The records of the office visits on January 16 and 20 and February 3 and 5, 2003, show that the patient was asked about her pain and given an exam as usual, but there is no evidence that an expanded problem focused history or medical decision making of low complexity was needed or done.[19] Further, it certainly makes no sense that there should be a need for an expanded history, exam, or complex decision making on January 16, the day following an office visit billed under 99215.

SHS billed under 99211 for the visit on February 12, 2003. This code is used for brief, straightforward visits. The documentation shows that ___ saw Dr. Kelly that day and they talked about her care.[20] This office visit alone, of the six office visits at issue, should be reimbursed.

Hot/cold packs. The record shows that on her first visit, ___ was instructed in using ice and heat at home. There is nothing in the record to indicate why, weeks later, she needed to have hot/cold packs applied in the office. The ALJ concludes that these charges were not reasonable and necessary.

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[16] MFG at 20.

[17] Carrier Ex. 3 at 126.

[18] MFG at 19.

[19] *See* Carrier Ex. 3 at 128, 125, 121, and 119.

[20] Carrier Ex. 3 at 122.

Joint mobilization, electrical stimulation, mechanical traction. Dr. Medley testified that joint mobilization, manipulation, and manual traction[21] are all essentially the same treatment and should not be separately billed. He also testified that the medical literature does not show the efficacy of electrical stimulation in patients like ___ However, Dr. Medley's overall credibility is diminished by the fact that his peer review report did not in any way attempt to address the patient's reports of severe back pain. Dr. Medley's report noted that ___ rated her pain as eight on a scale of ten. He went on to say that ___ had recovered from her injury, required no further treatment, and could return to work with no restrictions. This report was made five weeks after ___'s injury and four weeks after the commencement of her chiropractic care (with an addendum written a few weeks later but apparently based on information obtained in the course of making the initial report). Perhaps Dr. Medley believed that ___ had psychological issues affecting her perception of pain, although he did not say so nor did he recommend a psychological evaluation. Perhaps he believed that ___ was a malingerer; however, he did not say so. He simply ignored her reported pain and pronounced her fit to be released from treatment and returned to full work status. Severe pain was ___'s chief complaint. The ALJ declines to rely on the opinions of a reviewer who utterly failed to address the patient's primary health concern in reaching his conclusions.

In the absence of credible expert testimony on behalf of the carrier's position, the ALJ finds insufficient reason to overturn the IRO's decision. While the ALJ agrees with ZAIC that the course of treatment at issue here seems to have exceeded that laid out in the Official Disability Guidelines, the ALJ does not have the benefit of the Mercy guidelines, on which Dr. Weddle testified he also relied. Further, the Official Disability Guidelines appear to recommend as much as six to eight weeks of care under some circumstances.[22] According to the IRO reviewer, the North American Spine Society's guidelines provide that the initial phase of treatment for such an injury can last six to twelve weeks. At issue here are five sessions of treatment that occurred from January 15 to February 5, 2003 B in the fifth to eighth weeks of care. Given ___ unresolved symptoms, ZAIC has failed to

[21] The ALJ notes that ___ underwent mechanical, as opposed to manual, traction. Dr. Medley testified about manual traction. The ALJ is unsure whether the distinction is material.

[22] The care that preceded the disputed dates of service appears to have been more intensive than recommended by the Official Disability Guidelines. Those prior dates of service are not at issue here.

show that these treatments were not reasonable and necessary.

Summary. The office visits billed under 99213 and 99215 and the hot/cold packs were unnecessary. However, the carrier has failed to meet its burden to show that the office visit billed under 99211, as well as the joint mobilization, traction, and electrical stimulation, were not reasonable and necessary medical care.

II. FINDINGS OF FACT

1. Claimant ___ suffered a severe back sprain on ___, when she was involved in an automobile accident while on the job.

2. Zurich American Insurance Company (ZAIC) is the workers' compensation insurer with respect to the claims at issue in this case.

3. ___ began seeing Jerald Kelly, D.C., at a clinic associated with Southeast Health Services (SHS) on December 9, 2002. Dr. Kelly began treating ___ with passive chiropractic treatments.

4. Prior to January 15, 2003, ___ received treatment at SHS on about 15 occasions.

5. SHS billed for office visits, hot/cold packs, electrical stimulation, joint mobilization, and traction administered on six dates from January 15, 2003, through February 12, 2003.

6. ZAIC declined to pay for the services described in Finding of Fact No. 5, asserting that they were not medically necessary.

7. SHS requested medical dispute resolution.

8. In a decision dated March 12, 2004, an Independent Review Organization (IRO) determined that the services were medically necessary.

9. ZAIC made a timely request for hearing.

10. The Commission issued notice of the hearing on April 29, 2004.

11. 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 sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

12. The hearing was convened on August 2, 2004, before State Office of Administrative Hearings (SOAH) Judge Shannon Kilgore. Steven Tipton, attorney, represented ZAIC. Bryan Weddle, D.C., appeared by telephone for SHS. The hearing concluded that same day.

13. The ALJ held the record open following the hearing for submission of additional evidence. The record closed August 27, 2004, with the submission by ZAIC of a response to additional medical records filed by SHS.

14. ___ suffered from moderate to severe back pain associated with her injury.

15. There was no need for Dr. Kelly to perform a comprehensive history or medical decision making of high complexity during ___'s office visit on January 15, 2003.

16. The office visit on January 15, 2003, billed under CPT Code 99215, was not medically necessary.

17. There was no need for Dr. Kelly to perform an expanded problem focused history or medical decision making of low complexity during the office visits on January 16 and 20 and February 3 and 5, 2003.

18. The office visits on January 16 and 20 and February 3 and 5, 2003, billed under CPT Code 99213, were not medically necessary.

19. The brief, straightforward office visit on February 12, 2003, billed under CPT Code 99211, was medically necessary.

20. On her first visit at Dr. Kelly's clinic, ___ was instructed in the home application of heat and ice.

21. The application of hot/cold packs during office visits on January 15, 16, and 20, and February 5, 2003, was unnecessary.

22. The use of joint mobilization, electrical stimulation, and mechanical traction on January 15, 16, and 20, and February 5, 2003, as well as the additional use of joint mobilization on February 3, 2003, were reasonable and necessary.

III. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter. pursuant to ' 413.031 of the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ch. 401 *et seq*.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE ' 413.031; TEX. GOV'T CODE ch. 2003.

3. TMIC timely filed a request for hearing as specified in 28 Texas Administrative Code §148.3.

4. Adequate and timely notice of the hearing was provided in accordance with the Administrative Procedure Act. TEX. GOV'T CODE ' 2001.052.

5. ZAIC has the burden of proof in this matter. 28 TEX. ADMIN. CODE '' 133.308(p)(5) and (w), 148.21(h)-(i).

6. 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. TEX. LAB. CODE ' 408.021.

7. Office visits billed under CPT Code 97215 must involve two of the following: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Medical Fee Guideline (MFG) at 20 (1996). *See also* 30 TEX. ADMIN. CODE § 134.201 (Commission's rule adopting the Medical Fee Guideline by reference).

8. Office visits billed under CPT Code 97213 must involve two of the following: an expanded problem focused history, an expanded problem focused examination, or medical decision making of low complexity. MFG at 19.

9. Based on the above Findings of Fact and Conclusions of Law, the Act requires ZAIC to reimburse SHS for the office visit on February 12, 2003, and the use of joint mobilization, electrical stimulation, and mechanical traction on January 15, 16, and 20, and February 5, 2003, as well as the additional use of joint mobilization on February 3, 2003.

10. Based on the above Findings of Fact and Conclusions of Law, the Act does not require ZAIC to reimburse SHS for the office visits on January 15, 16, and 20, and February 3 and 5, 2003.

11. Based on the above Findings of Fact and Conclusions of Law, the Act does not require ZAIC to reimburse SHS for the application of hot/cold packs during office visits on January 15, 16, and 20, and February 5, 2003.

ORDER

IT IS THEREFORE ORDERED that, in connection with claimant ___, Zurich American Insurance Company pay for the office visit on February 12, 2003, and the use of joint mobilization, electrical stimulation, and mechanical traction on January 15, 16, and 20, and February 5, 2003, as well as the additional use of joint mobilization on February 3, 2003. Zurich American Insurance Company need not pay for the office visits on January 15, 16, and 20, and February 3 and 5, 2003, or the application of hot/cold packs during office visits on January 15, 16, and 20, and February 5, 2003.

ISSUED September 29, 2004.

_____

SHANNON KILGORE
STATE OFFICE OF ADMINISTRATIVE HEARINGS
ADMINISTRATIVE LAW JUDGE