SOAH DOCKET NO. 453-04-6406.M5
TWCC MR NO. M5-03-0061-01

NEUROMUSCULAR TESTING AND REHAB CENTER,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
V.	**§**	**OF**
	§	
LIBERTY MUTUAL FIRE INSURANCE COMPANY,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Neuromuscular Testing and Rehab Center (Provider) requested a hearing on the findings and decision of the Texas Workers' Compensation Commission's Medical Review Division in MDR Docket No. M5-03-0061-01 that denied certain reimbursements to Provider for physical therapy services provided to workers' compensation claimant, ___ (Claimant). Liberty Mutual Fire Insurance Company (Carrier) denied certain reimbursements primarily on the ground that not all of the services billed were reasonable and medically necessary healthcare and that documentation was inadequate. This decision and order finds that all of the disputed services were reasonable and medically necessary for Claimant and that the services were adequately documented.

I. FACTUAL AND PROCEDURAL HISTORY

An evidentiary hearing was held on November 30, 2004 at 1:30 p.m. Although Provider appeared telephonically, Carrier did not appear at all. ALJ Travis Vickery presided over the hearing and took judicial notice of the Texas Worker's Compensation Commission's notice of hearing sent to both parties on June 23, 2004. In addition, Provider testified that using prior valid addresses, several unsuccessful attempts were made by phone and in writing to contact the Carrier after the notice of hearing was issued. Based on what appeared to be a valid notice of hearing, the ALJ proceeded with the hearing and heard and admitted evidence regarding the disputed issues. The hearing concluded that day and the record closed on December 7, 2004.

Claimant reported a compensable, work-related injury when she fell forward and struck her face and arms on ___. Claimant was treated by a chiropractor and an orthopedic surgeon. Dissatisfied with her recovery after surgery, Claimant changed her treating physician to orthopedic

surgeon Dr. Daniel Valdez, M. D. Dr. Valdez evaluated her on August 20, 2001 and advised that she undergo a surgical procedure to repair her rotator cuff and initiate a distal clavicle resection and decompression of an osteophyte. Surgery was performed on October 9, 2001 and she began post-surgical therapy on October 15, 2001.

On November 28, 2001, Dr. Valdez released Claimant to return to work with limitations. Due to pain and a restricted range of motion, Claimant was unable to return to work and on December 7, 2001, Dr. Valdez recommended work hardening to start as soon as possible to capitalize on gains in her treatment.

Claimant then requested a change in her treating physician to Dr. Donald Phillips, D. C. Dr. Phillips, who is affiliated with the Provider, referred Claimant for an evaluation to determine the propriety of a work hardening program for her. A functional capacity evaluation was conducted on Claimant and showed that she was an appropriate candidate for work hardening. The evaluation also established a baseline for her treatment and progress.

The work hardening program began on December 27, 2001. Three weeks later, on January 13, 2001, Claimant performed an interim functional capacity evaluation. In that evaluation, Claimant demonstrated reduced pain, progress in walking and sitting tolerance, and an increased tolerance for job-specific tasks of typing and the use of a computer mouse.

On February 7, 2002, six weeks after the program began, the Provider requested a two-week extension of Claimant's work hardening program. In spite of Claimant's demonstrated progress, Carrier denied the request and Provider discharged Claimant. On March 4, 2002, exit testing revealed that Claimant experienced improved walking and sitting tolerance and an increased function in other tasks.

Carrier, as the workers' compensation insurance carrier for Claimant's employer, declined to reimburse Provider's work hardening treatments, contending principally that they were not medically necessary and inadequately documented. According to Provider and the Table of Disputed Services, the total amount in dispute is $7,432.

In response to Carrier's denial of reimbursement, Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission). The MRD determined that

the Provider was not entitled to reimbursement because the Provider failed to provide documentation adequate to support the services rendered (M5-03-0061-01). Provider then requested a hearing before the State Office of Administrative Hearings (SOAH).

The hearing convened on November 30, 2004, with ALJ Travis Vickery presiding. Provider appeared telephonically. Carrier failed to appear telephonically or in person. The hearing concluded that day and the record closed on December 7, 2004. There were no objections to notice or jurisdiction. Under 28 TEX. ADMIN. CODE (TAC) §148.21(h), the Petitioner (Provider) has the burden of proof in hearings, such as this one, conducted pursuant to TEX. LAB. CODE ANN. §413.031. The ALJ determined that, as the Petitioner, the Provider met its burden in this proceeding.

II. DISCUSSION AND ANALYSIS

This case involves a dispute over whether the work hardening program was medically necessary and adequately documented. The services in issue were rendered from December 27, 2001 through February 7, 2002 and involved work hardening (CPT Codes 97545 and 97546) and a functional capacity evaluation (CPT Code 97750) (the disputed services).

1. Inadequate Documentation

Both the Carrier and the MRD denied Provider reimbursement for the disputed services on the grounds that Provider submitted inadequate documentation. In reaching its decision, the MRD stated that the Provider submitted only three notes dated January 10, 2002, January 29, 2002 and February 5, 2002. It is plain to the ALJ that Provider's documentation submitted at the SOAH Hearing on November 30, 2004, far exceeds that which the MRD received. Provider's Exhibit 1 was 125 pages long and contained notes before, during and after treatment from various doctors, functional capacity evaluations, physical performance evaluations, daily notes created during the work hardening program, weekly activity and progress sheets, bills, psychological reports and interdisciplinary team reviews. The ALJ finds that the documentation Provider submitted in Exhibit 1 adequately supports the disputed services and shows that they were properly provided and documented.

2. Medical Necessity

The Provider has established that the disputed services were reasonable and medically necessary. As set forth above, the Claimant reported a compensable, work-related injury on ___. During February -- December, 2001, Claimant was treated by a chiropractor and two orthopedic surgeons, and received two surgical procedures. Dr. Valdez, her second surgeon, performed surgery on Claimant on October 9, 2001 and she began post surgical therapy on October 15, 2001.

Although Claimant was released to return to work on November 28, 2001, she was unable to work due to pain. On December 7, 2001, Dr. Valdez recommended work hardening to start as soon as possible and referred her to Provider. Prior to rendering any services to Claimant, Provider performed a functional capacity evaluation and determined that she was an appropriate candidate for such treatment. Multi-disciplinary treatment began in late December 2001, and was monitored against the baseline of the initial functional capacity evaluation. The exercises and Claimant's performance and progress were recorded, in writing, on a daily and weekly basis and through further functional capacity evaluations and team reviews. Services ended on February 7, 2002, after the Carrier denied a continuation of the work hardening program. Although a March 4, 2002, physical performance evaluation determined that Claimant was still unable to return to work full time, Dr. Phillips testified that the evaluation also revealed progress.

The ALJ finds that the Provider met its burden of demonstrating the medical necessity of the disputed services and that the services were adequately documented. The ALJ concludes that Provider is entitled to recover for all of the disputed services (billed under CPT Codes 97545, 97546 and 97750) for a total reimbursement of $7,432. Carrier is ordered to reimburse Provider for this amount. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant ___ suffered compensable, work-related injuries when she fell forward and struck her face and arms on ___.

2. Liberty Mutual Fire Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for her compensable injury.

3. Provider treated Claimant for work hardening between December 27, 2001 and February 7, 2002.

4. Carrier declined to reimburse Provider's work hardening treatments, contending that they were not medically necessary and lacked adequate documentation.

5. The total amount in dispute is $7,432. The disputed services involve work hardening (CPT Codes 97545 and 97546) and a functional capacity evaluation (CPT Code 97750).

6. Provider sought medical dispute resolution through the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

7. The MRD determined that the Provider was not entitled to reimbursement because the Provider failed to provide documentation adequate to support the services rendered.

8. Provider then requested a hearing before the State Office of Administrative Hearings (SOAH).

9. On June 23, 2004, notice of the hearing in SOAH Docket No. 453-04-6406 was sent to all parties by the Commission.

10. Notice to the Carrier was provided by the Commission placing the notice of hearing in the Carrier's box identified in the Commission records as: Hammerman & Gainer, Box 28, Liberty Mutual Fire Insurance Company.

11. The hearing convened on November 30, 2004, at 1:30 p.m. Provider appeared telephonically. Carrier did not appear at all. ALJ Travis Vickery presided over the hearing and took judicial notice of the Texas Workers' Compensation Commission's notice of hearing sent to both parties on June 23, 2004. The ALJ proceeded with the hearing and heard and admitted evidence regarding the disputed issues. The hearing concluded that day and the record closed on December 7, 2004.

12. No party objected to notice or jurisdiction at the November 30, 2004 hearing.

13. All of the work hardening billed under CPT Codes 97545 and 97546 and listed on the Table of Disputed Services was reasonable and medically necessary for treatment of Claimant's compensable injury and adequately documented. The Provider should be reimbursed $7,232 for those services.

14. The functional capacity evaluation billed under CPT Code 97750 and listed on the Table of Disputed Services was reasonable and medically necessary for treatment of Claimant's compensable injury and adequately documented. The Provider should be reimbursed $200 for that service.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Provider has the burden of proof. 28 TEX. ADMIN. CODE §§ 148.21(h) and 133.308(w).

6. Provider has shown, by a preponderance of the evidence, that all units of treatment provided to Claimant, billed under CPT Code 97545 and listed in the Table of Disputed Services were reasonable and medically necessary for treatment of Claimant's compensable injury and were adequately documented under the applicable statutes and rules.

7. Provider has shown, by a preponderance of the evidence, that all units of treatment provided to Claimant, billed under CPT Code 97546 and listed in the Table of Disputed Services were reasonable and medically necessary for treatment of Claimant's compensable injury and were adequately documented under the applicable statutes and rules.

8. Provider has shown, by a preponderance of the evidence, that the unit of treatment provided to Claimant, billed under CPT Code 97750 and listed in the Table of Disputed Services was reasonable and medically necessary for treatment of Claimant's compensable injury and was adequately documented under the applicable statutes and rules.

9. Carrier is liable to reimburse Provider a total of $7,432.

ORDER

Liberty Mutual Fire Insurance Company shall reimburse Neuro Muscular Testing and Rehab Center a total of $7,432.00 for the services in dispute in this proceeding.

SIGNED December 10, 2004.

TRAVIS E. VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS