SOAH DOCKET NO. 453-04-8210.M5

PAIN & RECOVERY CLINIC, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
ZNAT INSURANCE COMPANY **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is an appeal by Pain & Recovery Clinic (Petitioner or Provider) from a decision of an independent review organization (IRO) on behalf of the Texas Workers' Compensation Commission (Commission) in a dispute regarding medical necessity for chiropractic treatment. The IRO found that the insurer, ZNAT Insurance Company (Respondent or Carrier), properly denied reimbursement for 59 physical therapy sessions that Petitioner provided from April 2 to October 17, 2003, to Claimant suffering from a right wrist injury. Petitioner challenged the decision on the basis that the treatment at issue was, in fact, medically necessary, within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision agrees with that of the IRO, finding that reimbursement of Petitioner for the disputed services should be denied.

I. STATEMENT OF THE CASE

The State Office of Administrative Hearings (SOAH) 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 Act and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction or venue. Administrative Law Judge (ALJ) Lilo D. Pomerleau convened the hearing in this docket on February 16, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th Street, Austin, Texas. Petitioner was represented by William Maxwell. Respondent was represented by James M. Loughlin. The record closed on March 14, 2005.

On ___, Claimant was moving a chair and felt a pop in her right wrist. Dr. Nicholo Chamma at Concentra Medical Center (Concentra) diagnosed the injury as a wrist sprain. Claimant was returned to work on January 30, 2003, with restrictions (no repetitive lifting over five pounds, no pushing/pulling over five pounds, and limited use of right hand/wrist) and received four physical therapy sessions at Concentra. Claimant changed doctors and, on February 6, 2003, met with Warren B. Dailey, M.D. She complained of ongoing wrist pain, increased pain with movement, weakness of the right hand, and swelling of the right wrist and hand. Dr. Bailey took Claimant off work and referred her to Petitioner. That same day, Claimant had an MRI, which showed preexisting degenerative changes in Claimant's wrist and no acute injury.[1] A nerve conduction velocities test conducted on March 27, 2003, was normal.[2]

On February 7, 2003, Petitioner began physical therapy at Petitioner's clinic five days a week.[3] In addition to the four therapy sessions at Concentra, she received 30 sessions at Petitioner's clinic before the dates of service in dispute, which began on April 2, 2003. Petitioner provided 59 physical therapy sessions from April 2 to October 17, 2003. The medical necessity of these sessions are at issue in this case. Claimant underwent wrist surgery on August 25, 2003. The IRO approved post-surgical rehabilitation consisting of three units of therapy. These sessions are not at issue in this case.

III. THE EVIDENCE AND ARGUMENTS

A. PETITIONER

Petitioner submitted into evidence medical records and argument previously submitted to the IRO but no witness testimony.[4] Petitioner did not file closing argument. In the record, Petitioner's

[1] *See* Carrier's Ex. 1 at 198.

[2] Carrier's Ex. 1 at 92; testimony of Dr. DeFoyd.

[3] Carrier's Ex. 1 at 51.

[4] In response to Respondent's discovery requests, Petitioner designated his expert witness as a fact witness only. Thus, when Petitioner attempted to put its witness on the stand to testify, the ALJ sustained Respondent's objection to the calling of the witness as an expert and not a fact witness.

position is stated in a request for reconsideration, which disputes an April 7, 2003 peer review and notes that Claimant had not reached maximum medical improvement (MMI) on April 23, 2003. Petitioner contended that because the designated doctor, Dr. Moosa, acknowledged the fact that [Claimant] was still in physical therapy and stated that he would be glad to see her after two more months of care that the service performed on the dates during this time period were necessary to get patient to MMI.[5] Petitioner further argued that Claimant had a treatment plan as of March 12, 2003.

B. RESPONDENT

Respondent presented the testimony of William DeFoyd, D.C., and timely submitted closing argument. Dr. DeFoyd testified that Claimant had an adequate trial of physical therapy (29 visits) before the disputed dates of service. He noted that Claimant did not have a neurologic deficit she had not lost function in her wrist and should have been able to transition to a home therapy program before the disputed dates of service. Dr. DeFoyd also took issue with the services provided and the billing codes used by Provider, as detailed below:

- Code 97110 (one-on-one therapy) is not often used for an extended period of time, only for certain conditions, such as therapy requiring continuous and exclusive contact with the provider for a stroke or amputation patient. Yet this code was billed at 45 minutes for each session with no notes to explain frequency, intensity, or duration of the exercises provided.

- Code 97112 (neuromuscular re-education) is used to restore a neuromuscular defect, which Claimant did not have. No description of the activities performed under this code were provided.

- Code 97250 (myofascial release) is a passive modality used early in treatment. Services were billed under this code months after the date of injury with no documentation stating which muscles received treatment.

- Code 97265 (joint mobilization) also is passive care applied early in treatment and a provider usually notes the treatment with specificity so that a therapist can vary treatment if a patient is not responding. There were no specific notes.

[5] Provider's Ex. 1 at 26.

- Codes 99212 and 99213 (office visits) require evaluations such as patient history and expanded problem history, but the daily progress notes do not state why these codes were used for an established patient.

Dr. DeFoyd stated that generally, therapy sessions last 30 to 45 minutes whereas the disputed sessions lasted 45 minutes plus other services 10-15 minutes each. For a wrist injury, in his opinion, therapy would initially last 45 minutes, at most, but progress to 30-minute sessions and then to home exercises. He also stated that the practice guidelines generally allow for 12 weeks of therapy. Dr. DeFoyd concluded that a longer treatment period had to be justified but, in this instance, Claimant had no meaningful improvement over the entire course of treatment, and thus, the disputed sessions were not medically necessary.

III. ANALYSIS

Petitioner bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. Petitioner failed to meet that burden. The treatment notes fail to support the need for the disputed services in light of the fact that the injury was a simple sprain with no indication of a nerve conduction block. Dr. Dailey's notes did not state why the patient was removed from work, and his treatment plan gave no indication of the amount of therapy necessary to treat Claimant. Upon Dr. Dailey's referral, Provider had no treatment plan or significant chiropractic evaluation.[6] Based on the daily progress notes, Claimant began and ended the disputed sessions with the same subjective difficulties listed. Moreover, the notes (pre-surgery) have identical objective findings that, the patient still have (*sic*) signs of weakness in the right hand and wrist. There is severe range of motions deficits in the right hand and wrist.[7] Also, for each session, the notes indicate Claimant participated in treadmill and stationary bike exercises for 15 minutes each, but

[6] In a request for reconsideration sent to Carrier, Provider referred to a March 12, 2003 treatment plan. However, no such plan is in the record. The letter referenced a plan that is identical to the plan of care found in a July 23, 2003 physical therapy progress note (except for the addition of ultrasound, hot packs, interferential current, and myofascial release) but contained no defined time period for providing therapy. Six months after the date of injury, there is no indication of progress or an end date of providing extensive therapy. *See* Provider's Ex. 1 at 25 and 380-381.

[7] Carrier's Ex. 1 at 51 compared to Provider's Ex. 1 at 403. Post surgery, the objective findings change, while the treatment billed and the plan of treatment do not.

there is no stated reason why such exercises were medically necessary for a wrist sprain injury. The medical bills submitted to Carrier are incomplete,[8] and Dr. DeFoyd's testimony that Provider failed to substantiate either the services provided (codes 97110, 97112, 99212, and 99213) or the need for passive care (codes 97250 and 97265) was not refuted.

A number of reviewing doctors opined that the treatment provided was unnecessary. Dr. DeFoyd so testified at the hearing. On April 7, 2003, Timothy Fahey, D.C., performed a peer review on Claimant and stated that four weeks of daily treatment with six procedures per visit (not including three units of exercises per visit) was not medically necessary.[9] On June 30, 2003, Philip C. Lening, D.C., reviewed Claimant's records and found that the further the case progressed from the date of injury, Claimant's complaints became more diffuse and expansive. Dr. Lening indicated he was at a loss to explain Claimant's ongoing complaints and disability after extensive therapeutic efforts. He stated that current treatment/testing are no longer reasonable and medically necessary for what has been described as a simple wrist sprain.[10] According to Dr. Lening, six to eight weeks of care should have been sufficient to treat the injury. On June 27, 2003, Gregory Goldsmith, M.D., also reviewed Claimant's records and concluded much the same. He found Claimant should have had a temporary wrist sprint, two weeks of physical therapy (three modalities, three times a week), anti-inflammatory medications, and some activity modifications. As Claimant had some mild to moderate degenerative changes in her wrist according to the initial MRI, he found her condition questionable as to whether the incident at work could be classified as a work injury.[11]

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[8] A complete medical bill includes supporting documentation for the three highest level office visits . . . and physical medicine treatment(s) and/or services(s): a copy of progress notes and/or SOAP . . . notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates . . . . 28 TEX. ADMIN. CODE ' 133.1(3)(E)(i).

[9] Carrier's Ex. 1 at 110-112.

[10] Provider's Ex. 1 at 239.

[11] Provider's Ex. 1 at 245.

Under § 408.021 of the Act, an injured worker is entitled to health care reasonably required to relieve the effects of the injury or to enhance the ability to continue working. However, care that provides only superficial improvement or relief at inordinate cost is not reasonably required. In the ALJ's view, the record in this case fails to demonstrate that Petitioner's treatment was necessary after more than thirty sessions with no discernible progress. Further, there is no showing that Petitioner was guided by any specific protocol or pattern of practice in administering particular modalities and treatment. According to Provider's own records, Claimant made no improvement after receiving the care in dispute. Petitioner has not demonstrated by a preponderance of the evidence, as legally required, that it should be reimbursed for the disputed services.

IV. FINDINGS OF FACT

1. On ___, Claimant was moving a chair and felt a pop in her right wrist. The injury was a compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. Claimant's injury produced wrist pain and joint tenderness. She was diagnosed with a wrist sprain.

3. Claimant received treatment from Concentra Medical Center beginning the day after the injury occurred. She received hot and cold packs, therapeutic exercises, and iontophoresis and was returned to work on January 30, 2003, with restrictions (no repetitive lifting over five pounds, no pushing/pulling over five pounds, and limited use of right hand/wrist).

4. Claimant changed doctors and met with Warren B. Dailey, M.D. on February 6, 2003. She complained of ongoing wrist pain, increased pain with movement, weakness of the right hand, and swelling of the right wrist and hand. Dr. Bailey referred Claimant to Petitioner.

5. Petitioner provided 59 physical therapy sessions, from April 2 to October 17, 2003, to Claimant for the injury noted in Finding of Fact No. 1.

6. Petitioner sought reimbursement for therapy sessions from ZNAT Insurance Company (Respondent), the insurer for claimant's employer.

7. Respondent denied the requested reimbursement.

8. Petitioner made a timely request to the Texas Workers' Compensation Commission (Commission) for medical dispute resolution with respect to the requested reimbursement.

9. The independent review organization (IRO) to which the Commission referred the dispute

issued a decision on June 17, 2004, and concluded the services provided by Petitioner (except for three post-surgical sessions that are not in dispute) had not been medically necessary.

10. The Commission's Medical Review Division reviewed and concurred with the IRO's decision in a decision dated July 13, 2004, in dispute resolution Docket No. M5-04-2348-01.

11. Petitioner requested in a timely manner a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.

12. The Commission mailed notice of the hearing's setting to the parties at their addresses on August 5, 2004.

13. On February 16, 2005, Lilo D. Pomerleau, an Administrative Law Judge with SOAH, convened a hearing in this matter at the William P. Clements Building, 300 W. 15th Street, Austin, Texas. Petitioner was represented by William Maxwell, and Respondent was represented by James M. Loughlin. The record closed March 14, 2005.

14. From April 2 through October 17, 2003, Petitioner treated Claimant with office visits, one-on-one therapy, neuromuscular re-education, myofascial release, joint mobilization, therapeutic activities, and manual therapeutic techniques.

15. Claimant made no improvement after receiving the disputed services.

16. Provider did not have a detailed treatment plan for the care and services Claimant received on the disputed dates of service.

17. The daily progress notes for all the pre-surgery disputed services listed the same subjective difficulties and identical objective findings; no changes were listed from April 2 through August 22, 2003.

18. Provider failed to substantiate the services provided under codes 97110, 97112, 99212, and 99213.

19. Provider failed to substantiate the need for passive care provided under codes 97250 and 97265 after more than thirty previous treatments sessions.

20. The duration of treatment was not reasonable and necessary.

21.

VII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (the Act), TEX. LABOR 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 § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE (TAC) §§ 148.001-148.028.

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

5. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

6. Based upon the foregoing Findings of Fact, the treatments for the claimant on April 2 through October 17, 2003, do not represent elements of health care medically necessary under § 408.021of the Act.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions of the IRO and of the MRD were correct.

ORDER

IT IS THEREFORE, ORDERED that the appeal of Pain & Recovery Clinic, seeking reimbursement for chiropractic services performed from April 2 through October 17, 2003, be denied.

SIGNED May 10, 2005.

LILO D. POMERLEAU
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS