SOAH DOCKET NO. 453-05-1132.M5
TWCC MR NO. M5-03-2648-01

CARL M. NAEHRITZ III, D.C.,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	**OF**
V.	**§**	
	§	
FIDELITY & GUARANTY INSURANCE,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Carl M. Naehritz III, D.C. (Provider) appealed the Texas Workers' Compensation Commission's Medical Review Division's (MRD's) decision issued on August 19, 2004. MRD generally accepted the Independent Review Organization's recommendation but calculated the amount to be reimbursed as $384 for eight office visits. MRD denied reimbursement for other disputed services rendered from July 29, 2002, through April 2, 2003, finding they were not medically necessary.

Notice and jurisdiction were not contested and are discussed only in the Findings of Fact and Conclusions of Law. The hearing for this case convened on May 17, 2005, at the State Office of Administrative Hearings, 300 W. 15th St., 4th Floor, Austin, Texas. The Provider represented himself, and attorney John Fundis represented Fidelity & Guaranty Insurance (Carrier).

The Provider asserted that the physical medicine care he provided alleviated the claimant's pain and increased her strength. The Carrier argued that the care was not needed to treat the claimant's compensable shoulder injury. As reflected in the Findings of Fact and Conclusions of Law, this decision finds that some, but not all, of the Provider's care was medically necessary.

II. FINDINGS OF FACT

Procedural History and Notice

1. On August 19, 2004, the Texas Workers' Compensation Commission's Medical Review Division (MRD) determined the reimbursement request of Carl M. Naehritz III, D.C. (Provider), for treatment of a workers' compensation claimant whose employer had workers' compensation insurance with Fidelity & Guaranty Insurance (Carrier) on the date the claimant was injured.

2. MRD determined monthly office visits were medically necessary on July 29, September 6, October 1, November 7, and December 3, 2002, and January 6, March 14, and April 2, 2003, and awarded the Provider $384 for them; however, MRD declined to order reimbursement for other disputed services.

3. The Provider timely requested a contested case hearing.

4. Notice of the hearing was sent to the parties on November 9, 2004.

5. 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.

6. The hearing convened on May 17, 2005, and both parties were represented.

Background

7. The claimant suffered a compensable injury to her right shoulder on ___.

8. The Provider first treated the claimant on the date she sustained the injury and was her treating doctor.

9. The amount in dispute is $5,956, and the services in question included: physician phone consultation, other office visits with manipulation, joint mobilization, therapeutic activities, myofascial release, brace support, muscle testing, range-of-motion (ROM) measurements, neuromuscular re-education, reports, physician home consultation, ultrasound regional manipulation, differential WBC count, and arthritis panel, office visits, chiropractic manipulations, and other physical medicine treatments.

10. June 19, 2002, through April 21, 2003, are the service dates in dispute.

Diagnosis and Early Treatment

11. The claimant's May 2002 MRI revealed impingement of the rotator cuff and fluid around the bicipital tendon.

12. As revealed in computer muscle testing, the claimant had significant, right-shoulder deficits.

13. The claimant was diagnosed as having shoulder derangement, bicipital-tendinitis impingement, rotator cuff syndrome, and tenosynovitis syndrome.

14. Six-to-eight weeks of chiropractic care is a typical treatment period for an injury like the claimant's; however, in order for the claimant to maintain ongoing mobility, it was necessary for her to have once-a-week treatment with active and passive modalities until her surgery date, October 10, 2002.

15. The Carrier reimbursed the Provider for muscle tests performed on June 27, 2002, at the maximum allowable reimbursement (MAR) but did not reimburse the Provider for ROM testing that day.

16. The ROM testing was necessary to determine whether the claimant had responded to treatment.

17. As of July 18, 2002, the claimant's right shoulder flexion was 115 , and the shoulder abduction was 52 ; these were the claimant's best objective ROM results.

18. The Provider treated and billed for CPT codes 99213-MP (office visit), 97265 (joint mobilization), 97530 (active exercises), and at times, 97250 (myofascial release), on July 26, 29, 31; August 5, 7, 12, 19, 26; and September 6, 11, 18, 2002.

19. Prior to the claimant's surgery, these types of treatments were medically necessary once a week.

20. The Carrier reimbursed the Provider at the MAR rate for physical medicine treatments provided on July 26 and 31 and reimbursed the Provider at one-half the MAR rate for treatments provided on August 7, 12, 19, and 26.

21. Because once-a-week treatment was necessary, it is appropriate for the Carrier to reimburse the Provider at the MAR rate for August 12, 19, 26, 2002, and at the MAR rate for treatment provided on September 6, 11, and 18 for CPT codes 99213-MP, 97265, 97530, and if it was provided on one of those dates, 97250.

22. The claimant needed a brace and medical supplies to treat pain related to her compensable injury.

23. These supplies provided on August 12 and 26, 2002, and billed under CPT code 99070, were medically necessary.

24. As of September 23, 2002, conservative medical management had failed to assist the claimant:

- her bilateral upper extremity exams were essentially unchanged;
- she clearly needed surgery; and
- she should have discontinued therapy until after her surgery.

Surgery

25. On October 10, 2002, the claimant underwent surgery on her right shoulder.

26. The surgery included:

- manipulation of the right shoulder under anesthesia;
- right shoulder joint arthroscopy with synovectomy and extensive debridement;
- right shoulder subacromial decompression with bursectomy, coracoacromial ligament release, and acromioplasty; and
- placement of a Stryker pain buster pain pump catheter.

Post-Surgical Care

27. After surgery, the claimant participated in twelve sessions of physical therapy provided over six weeks through her surgeon's office. The treatment dates were October 11, 22, 25, 29; and November 5, 7, 11, 13, 18, 20, 25, 26, 2002.

28. Eight weeks of post-operative therapy was reasonable since the claimant had extensive surgical intervention.

29. Even when she received physical therapy through her surgeon's office, the claimant also needed some care from the Providers to alleviate her pain, and after she completed physical therapy at her surgeon's office, to continue her rehabilitation.

30. Once the claimant completed physical therapy through her surgeon's office, she had 115 flexion and 95 abduction ROM in her right shoulder, and these were the claimant's highest ROM measurements after surgery.

31. On November 5, 2002, the Provider performed a comprehensive evaluation on the claimant and billed CPT code 99215-MP.

32. The comprehensive evaluation included observations regarding ROM, posture, and sensitivity , "ortho/neuro" tests, palpatory and trigger-point evaluations, a brief record of findings, and a treatment recommendation.

33. Documentation was sufficient to demonstrate the medical necessity of the comprehensive evaluation on November 5, 2002.

34. The claimant performed active exercises at both her surgeon's and the Provider's offices on November 5, 7, 13, and 25, 2002.

35. There was insufficient evidence to demonstrate the need for the claimant to perform active exercises at both her surgeon's office and the Provider's office on the same days.

36. Although the Provider completed forms for the Texas Workers' Compensation Commission on November 7 and December 3, 2002, there was insufficient evidence to show the MAR or reasonable reimbursement rate for completing these forms.

37. The Carrier reimbursed the Provider at one-half the MAR rate for an office visit billed on November 25, 2002, under CPT code 99213-MP.

38. Because the office visit was within the eight-week period following surgery, it was medically necessary.

39. As evidenced by the documentation for December 3, 2002, the claimant received physical medicine services billed under CPT code 97530, 97265, 97250, and 97112 from the Provider.

40. These services provided on December 3, 2002, were within the eight weeks needed for post-surgical rehabilitation.

41. The Provider should be reimbursed at the MAR rate for these services.

42. After December 3, 2002, the therapeutic exercises that the claimant needed could have been done at home with monthly office visits to monitor her progress.

43. From December 3, 2002, until the claimant's disability examination on April 14, 2003, once-a-month case management was the appropriate care for the claimant

Specific CPT Codes and Testing

44. If the Medical Fee Guideline physical medicine code states Aone or more areas@ but has no time limit, then only one unit can be charged regardless of the number of body areas treated.

45. CPT code 97265 is for joint mobilization in one or more areas.

46. The Provider should be reimbursed for only one charge of 97265 on any treatment date for which reimbursement is ordered.

47. CPT code 97530 is for 15 minutes of therapeutic activities in which the patient and provider have direct, one-on-one contact, and dynamic activities are used to improve functional performance.

48. Because CPT 97530 code specifies a time limit, additional units of this code can be charged once the amount of time contained in the description has been exceeded.

49. ROM tests are to be reimbursed per body area.

50. The Provider performed muscle tests (CPT code 97750-MT) and ROM tests (CPT code 95851) on September 18, 2002.

51. There was insufficient evidence to establish the medical necessity of the tests performed on September 18, 2002.

52. The Provider performed manual muscle tests (CPT code 95831-MT) and ROM tests (CPT code 95851) on November 7, 2002.

53. The Provider failed to demonstrate the medical necessity of performing these tests so soon after the claimant's surgery.

54. Nerve and muscle tests performed on November 25, 2002 (CPT codes 95900, 95904, 95935, 95861) were necessary to determine the claimant's progress after surgery.

Final Disability Review

55. On April 14, 2003, the claimant was at maximum medical improvement with 14% impairment and was released to return to work.

56. On April 14, 2003, the Provider used CPT code 99455 to bill for the claimant's disability examination review.

57. When the treating doctor performs a disability impairment rating examination for one area, the MAR rate is $300. Evaluation/Management Ground Rule XXII.

58. The $300 MAR includes all testing for that day, including any ROM or muscle testing.

Other Services

59. There was insufficient evidence to support reimbursement for other services billed by the Provider in regard to the claimant.

III. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction over this matter pursuant to TEX. LAB. CODE ANN. § 413.031.

2. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. ' 413.031 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§2001.052.

4. The Provider had the burden of proof in this matter, pursuant to 28 TEX. ADMIN. CODE § 148.21(h).

5. Pursuant to TEX. LAB. CODE ANN**.** §408.021, the Carrier should reimburse the Provider at the MAR rate for:

   - ROM testing (CPT code 95851) billed on June 27, 2002;
   - medical supplies (CPT code 99070) provided on August 12 and 26, 2002;
   - the difference between the amount paid and the MAR rate for treatment provided on August 12, 19, 26, 2002, and at the MAR rate for treatment provided on September 6, 11, and 18, 2002, for CPT codes 99213-MP, 97265, 97530, and if it was provided on one of those dates, 97250;
   - a comprehensive office visit (CPT code 99215-MP) performed on November 5, 2002;
   - the difference between the amount paid and the full MAR rate for CPT code 99213-MP billed on November 25, 2002;

- B nerve and muscle tests (CPT codes 95900, 95904, 95935, 95861) performed on November 25, 2002;
- B physical medicine treatment (CPT codes 97530, 97265, 97250 and 97112) provided on December 3, 2002; and
- B $300, the MAR for the claimant's final disability testing on April 14, 2003.

6. On any treatment date for which reimbursement is ordered in the preceding Conclusions of Law, the Carrier is required to reimburse the Provider for only one charge of CPT code 97265.

7. The Provider's other requests for reimbursement should be denied.

ORDER

IT IS, THEREFORE, ORDERED that Fidelity and Guaranty Insurance shall reimburse Carl M. Naehritz III, D.C., for the services listed in Conclusion of Law No. 5.

SIGNED July 13, 2005.

SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS