DOCKET NO. 453-05-3038.M5
MDR NO. M5-04-2956-01

COTTON D. MERRITT, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	**OF**
	§	
	§	
CONTINENTAL INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Cotton D. Merritt, D.C., (Provider) challenges an independent review organization (IRO) decision denying reimbursement from Continental Insurance Company (Carrier) for therapeutic exercises, range-of-motion measurements, and office visits provided to an injured worker (Claimant). The Administrative Law Judge (ALJ) concludes the disputed services were not shown to be medically necessary for the treatment of Claimant's injury. Consequently, reimbursement for the disputed services should be denied.

I. PROCEDURAL HISTORY

Administrative Law Judge (ALJ) Bill Zukauckas convened the hearing on March 29, 2005. Attorney James M. Loughlin appeared on behalf of Carrier. Provider represented himself by telephone. The record closed on April 15, 2005, after receipt of closing arguments.

Notice and jurisdiction, which were not disputed, are addressed in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

A. Introduction

Provider seeks reimbursement for office visits and physical therapy modalities provided to the claimant from May 16, 2003, through August 8, 2003. The total original amount listed in dispute was $9,010, but Carrier has reimbursed Provider for the services provided from May 5, 2003 through May 15, 2003, consisting of the initial evaluation, functional capacity exam (FCE), and the first six physical therapy sessions and office visits billed by Provider. Therefore, these services are no longer in dispute. In addition, Provider has withdrawn CPT code 99213 for date of service October 8, 2003.This leaves $6,182.00 in dispute.

Carrier denied reimbursement for the treatments and services listed on Provider's Table of Disputed Services on the grounds that they were not reasonable and medically necessary to treat the claimant's compensable injury. The matter was appealed to Texas Workers' Compensation Commission (TWCC) and was assigned to an IRO. The reviewing healthcare provider agreed with Carrier and stated that the treatments and services in dispute were not medically necessary in this case. Based on the IRO decision, the MRD denied reimbursement. The Provider then appealed the decision to the State Office Of Administrative Hearings (SOAH).

The services remaining in dispute for this hearing consist of office visits and sixteen physical therapy sessions provided from May 16 to June 25, 2003. For each of these sixteen sessions Provider billed for an intermediate-level, established-patient office visit (99213). Each session he performed the same four modalities: 1) therapeutic procedures, one or more areas, each 15 minutes (97110); 2) therapeutic activities, direct (one-on-one) patient contact by the provider, each 15 minutes (97530); 3) myofascial release/soft tissue mobilization, one or more regions (97250); and 4) joint mobilization, one or more areas (peripheral or spinal) (97265). For each of the twenty-two physical therapy sessions billed by Provider, he billed four units, or one hour of therapeutic procedures (97110) and three units, or 45 minutes of therapeutic activities (97530). For each physical therapy session performed by Provider, the rate of reimbursement under the 1996 Medical Fee Guideline is $379.00 for the following combination of procedure codes:

99213	$48.00
97110	$140.00 ($35.00 x 4 units)
97530	$105.00 ($35.00 x 3 units)
97250	$43.00
97265	$43.00
	$379.00

Provider testified at the hearing that he did not actually provide the physical therapy modalities at each session. He stated that he employs an individual with a degree in exercise physiology and that he has trained that person to provide not only the therapeutic procedures and activities, but also to perform the myofascial release and joint mobilization.

B. Background

Claimant was injured on ___. Claimant worked at a retirement community as a ___ and injured herself when a television slid off its stand and she tried to catch it. She reported an injury to

her back and left wrist. Claimant went to the emergency room where she received x-rays that were negative and was released. Despite the negative x-ray, she experienced pain in her back and wrist. Claimant started treatment with W.S. Witkowski, M.D., on February 19, 2003. Dr. Witkowski prescribed physical therapy for Claimant that began on March 10, 2003. Claimant received five physical therapy sessions over a period of approximately two weeks. Each session consisted of two units, or thirty minutes, of therapeutic exercises (97110), along with electrical stimulation (97032) and hot packs (97010). Claimant had an MRI done on March 18, 2003, which showed age-related degenerative changes without acute injury.

Dr. Witkowski's notes for March 24, 2003, state that there was not much improvement subjectively and that the patient was referred to a pain clinic. Claimant was seen by Michel Oliva, M.D., at the Center for Pain Management on April 22, 2003 and Dr. Oliva noted, "She has had physical therapy in the past but that is ineffective in controlling her pain." Claimant was given a lumber epidural steroid injection by Dr. Oliva.

On May 5, 2003, approximately three months after the date of the injury, Claimant presented to Provider. Provider recommended additional physical therapy. Provider began treating Claimant with physical therapy at his clinic on May 8, 2003, and all of the physical therapy performed by Provider was for the lumbar region. No therapy was provided for the wrist or thoracic region. Provider continued to perform physical therapy for Claimant through June 25, 2003. On this date,

Provider discontinued therapy and referred her to Hemmo Bosscher, M.D., a pain management specialist, for a lumbar epidural steroid injection. Dr. Bosscher saw Claimant on July 9, 2003, and prescribed Hydrocodone/Acetaminophen and Zanaflex, a muscle relaxant.

C. Analysis and Conclusion

Provider's chiropractic treatments rendered to Claimant for dates of service between May 16 and June 25, 2003, were not shown by Provider to be medically necessary. Specifically, Steven

Minors, D.C., testified on behalf of Carrier that an appropriate chiropractic trial for Claimant would

have lasted about as long as the six sessions provided between May 5 and 16, 2003, which are not disputed. Dr. Minors provided persuasive testimony that an evaluation of the efficacy of treatment should had been made by Provider after this brief treatment trial. That was not done and a significant amount of additional treatment, including the dates of service in question, were rendered with some reduction in pain and some additional range of motion, but otherwise minimal improvement. Claimant ultimately required epidural steroid injections for relief of pain. The ALJ also agrees with the IRO that Provider should have given more deference to the failed active and passive care rendered in March of 2003 through Dr. Witkowski and made some evaluation of Dr. Witkowski's notations about "unusual [back] pain" and "amplification." The ALJ does not see documentation that Provider considered these things.

Even Provider agrees that by June 25, 2003, Claimant was not making gains, and for that reason stopped her treatments at that time. The ALJ believes this conclusion should have been reached prior to rendering the additional $6,515.00 of treatments in dispute, based on Claimant's history of failed physical therapy and a short trial period through Provider himself the six visits already reimbursed. Dr. Merritt's testimony that "significant" evidence of functional improvement was not observed was persuasive. The ALJ has looked also at the statements of Dr. Kelley and Dr. Osborne to which Provider refers and agrees with Carrier that these are very generic and not targeted at the cost effectiveness of Provider's services.

Finally, Carrier has raised some issues about whether Provider should have known, by doing a comprehensive medical history, that Claimant was taking the medications Xanax and Zoloft for anxiety and depression, respectively, and thus should have known that Claimant had psycho-social issues that might need to be addressed before physical therapy could be beneficial. The ALJ notes that both Carrier's witness and Provider testified that many patients receiving these medications. The ALJ agrees with Provider that, while it might have been useful to know this information, taking these

medications or experiencing conditions like anxiety or depression does not wholly negate the

benefits of physical therapy or chiropractic treatments. But, the ALJ again agrees with Carrier that Provider should have considered Dr. Witkowski's direct observations questioning the "unusual back pain" in determining with reasonable medical probability the efficacy of future physical therapy treatments. The ALJ believes the evidence indicates this was inexplicably discounted or overlooked by Provider.

The ALJ finds the services were not medically necessary and finds that no additional reimbursement is due Provider.

III. FINDINGS OF FACT

1. An injured worker (Claimant) suffered a compensable injury on ___.

2. At the time of Claimant's injury, her employer held workers' compensation insurance coverage with Continental Insurance Company (Carrier).

3. Claimant's treating doctor was Cotton D. Merritt, D.C. (Provider), and from May 5 to June 25, 2003, and on August 8, 2003, Claimant received chiropractic services from Provider.

4. Provider has been reimbursed for six dates of service between May 5 and May 15, 2003, and those dates are not at issue. Dates of service from between May 16 and June 25, 2003, are at issue.

5. On multiple dates between May 16 and June 25, 2003, Provider provided services to Claimant and billed $379.00 each day for the following combination of procedure codes:

99213	$48.00
97110	$140.00 ($35.00 x 4 units)
97530	$105.00 ($35.00 x 3 units)
97250	$43.00
97265	$43.00
	$379.00

6. An independent review organization (IRO) assigned to review Provider's claim concluded

the services provided for dates of service in question were not medically necessary. The Medical Review Division (MRD) ordered that no reimbursement was due to Respondent for the services reviewed by the IRO.

7. Provider appealed the MRD decision to SOAH.

8. None of the services in consideration were medically necessary because Provider continued to provide these treatments beyond the date of a reasonable six-visit trial period, when Claimant had not shown significant signs of improvement.

9. Provider failed to persuasively articulate why the failed physical therapy provided to Claimant by W.S. Witkowski, M.D., in March 2003, should not have negatively impacted his decision to provide 22 more physical therapy sessions for Claimant.

10. Notice of the hearing was sent to the parties on December 28, 2004. The notice informed the parties of the date, time, and location of the hearing; a statement of the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

11. The hearing convened and closed on March 29, 2005, and the record closed upon the submission of post-hearing filings on April 15, 2005.

IV. CONCLUSIONS OF LAW

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

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) § 133.305(g) and §§ 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. As Petitioner, Provider bears the burden of proof in this proceeding. 28 TAC §148.21(h).

6. Provider failed to show the disputed services were medically necessary as ongoing treatment for Claimant's compensable injury.

ORDER

IT IS ORDERED that Continental Insurance Company has no additional reimbursement liability to Cotton D. Merritt, D.C., for chiropractic services provided to Claimant between May 16, and June 25, 2003.

SIGNED June 3, 2005.

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS