SOAH DOCKET NO. 453-05-3159.M5
MDR Tracking No. M5-04-3519-01

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
WACO ORTHO REHAB ASSOCIATES, LLC	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

This case is an appeal by both Texas Mutual Insurance Company (Carrier) and Waco Ortho Rehab Associates, LLC, (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 Carrier improperly denied reimbursement for certain office visits, supplies, therapeutic exercises, and group therapy. Carrier appealed on the basis that these services were medically unnecessary, 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*. The IRO further found that Carrier properly denied reimbursement for massage therapy, and Provider challenged that decision on the basis that the services were medically necessary according to the Act. Both appeals are addressed in this decision.

The Administrative Law Judge (ALJ) finds that reimbursement to Provider for the disputed services should be denied in all instances.

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. 2005. No party challenged jurisdiction or venue. ALJ Lilo D. Pomerleau convened the hearing in this docket on May 23, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th Street, Austin, Texas. Carrier was represented by Patricia Eads; Provider was represented by William Maxwell. The record closed that same day.

On ___, Claimant was collecting tools next to a forklift when the forklift operator raised the bucket, which caught and injured Claimant's right knee, striking with enough force to lift him off the ground. Claimant finished work that day and continued working for approximately two weeks, despite knee pain and swelling. On November 30, 2003, Claimant sought treatment from William E. Blair, Jr., M.D., who evaluated Claimant, recommended an MRI, and restricted Claimant to clerical work. On October 13, 2003, Claimant underwent an MRI, which indicated a bone marrow contusion, posterior horn medial meniscal tear, and small joint effusion.[1] Dr. Blair re-evaluated Claimant on October 20, 2003, and, based on the MRI results, indicated that surgery (arthroscopic evaluation and resection) was warranted.[2]

Subsequently, Claimant switched treating doctors and began seeing Provider on November 6, 2003.[3] On December 12, 2003, Claimant had surgery to repair his knee. Six days later, on December 18, 2003, Claimant was examined by Provider.[4] Provider again re-evaluated him on December 22, 2003, with Dynatron knee muscle testing and other diagnostic testing. Claimant subsequently received additional chiropractic treatments from Provider, beginning December 23, 2003.[5]

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[1] Provider's Ex. A at 9; *see also* Carrier's Ex. C (Deposition) at 10-11.

[2] Provider's Ex. A at 1.

[3] Provider's Ex. A at 44-45.

[4] Provider's Ex. B at 210. This office visit is not in dispute.

[5] Carrier's Ex. C at 199-200.

At issue are chiropractic services provided from November 6 through December 31, 2003. At the hearing, Carrier stipulated its agreement to pay for the following services and supplies: the December 18, 2003 office visit, CPT Code 99212; group therapy provided on December 23, 24, and 31, 2003, under Code 97150; and the Biofreeze provided on November 6, 2004.

III. THE EVIDENCE AND ARGUMENTS

A. Carrier

Carrier submitted into evidence medical records and argument previously submitted to the IRO, the deposition testimony of John Pearce, M.D.,[6] and the testimony of David Alvarado, D.C.[7] In general, Carrier argued that Provider over-treated Claimant, both too long and too intensely, with no benefit from the more intensive one-on-one therapy. According to Carrier, this intensely supervised "platinum treatment" fails to fall within the ambit of reasonable care.

Dr. Pearce explained that a meniscus tear, for most people, will result in swelling and pain with activity, possibly a mechanical locking of the joint if it is a tear that blocks the range of motion between the femur and the tibia.[8] With respect to Claimant, Dr. Pearce did not see any indication that Claimant had mechanical locking. Thus, Dr. Pearce concluded that conservative care–ice and some electrical stimulation in the quadriceps muscle–would have been appropriate. Dr. Pearce further took issue with Provider's chiropractic manipulations before surgery because the notes did not indicate where the manipulations took place (back or knee) and that manipulation of the knee applied to a patient with an inflamed knee may make the injury worse.[9] Dr. Pearce also suggested massage for a knee injury (unlike a soft-tissue type of injury) would not likely be beneficial. Concerning myofacial release, Dr. Pearce indicated that such treatment would only be beneficial if

there were scarring, and there was no documentation of such for Claimant. Concerning therapeutic

[6] Dr. Pearce is a orthopaedic surgeon.

[7] Dr. Alvarado is a Doctor of Chiropractic medicine.

[8] Carrier's Ex. C (Deposition) at 9.

[9] *Id.* at 13-14.

exercise, Dr. Pearce noted that Claimant had the same pain levels before he came in and after the exercises. He also stated that one-on-one therapy (supervision) for stationary bike and treadmill are unnecessary after one or two visits. Finally, Dr. Pearce reported that the overall therapy sessions, which lasted from one and one-half hours to two hours, were:

> . . . probably a little bit excessive. [Claimant] always seemed to have a continuation of his pain. And prior to surgery you're trying to reduce inflammation, get the range of motion up, trying to calm the knee down before you're having surgery because you're going to excite the knee again with surgery. So if you go into surgery with a knee that's inflamed, your results are probably not going to be as good at the end of the surgical procedure because the knee being more inflamed, there's a higher chance of it being still sore, loss of range of motion."[10]

Dr. Alvarado generally agreed with Dr. Pearce that the treatment in question was intense and excessive. Additionally, Dr. Alvarado testified that a provider's treatment plan should set goals; however, if those goals are not met, the plan should be altered. In this instance, he stated that Claimant did not improve after weeks of treatment, yet Provider never altered the treatment plan. For a similar injury (torn meniscus), Dr. Alvarado would have used ice and ultrasound–essentially passive modalities for one to three weeks. If no response, he would stop or modify treatment. Dr. Alvarado stated that the use of approximately 17 hours of one-on-one therapy (after Carrier has already paid for 39 units, with each unit comprising 15 minutes of therapy) was not cost-effective, plus Claimant failed to progress from this intensive therapy.

Dr. Alvarado also took issue with Provider's daily progress notes for a number of reasons:

1. Notes did not state why electric stimulation was provided–was it to relieve pain or to strengthen muscles and to reduce muscle spasms? If for a reduction in pain, that was not in Claimant's records.

2. Notes did not document what muscles had massage and further failed to document whether the massage was effective.

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[10] *Id.* at 20.

3. No mention in notes as to the progress of the home exercise program–no specifics in the plan to address if home program not working. Moreover, on the initial November 6, 2003 visit, Provider only waited four days before beginning in-house therapy rather than waiting two weeks to see if home exercise worked.

4. Office visits, Code 99213, require evaluations such as patient history and reevaluation, but the daily progress notes do not state why these codes were used for Claimant, an established patient.

5. On November 11, November 12, November 18, November 21, December 1, December 5, December 10, December 18, and December 31, 2003, Provider's notes indicate that Dr. Linderman discussed administrative issues related to the workers' compensation law. Dr. Alvarado stated it is not appropriate to charge for non-medical advice.[11]

6. Provider performed a chiropractic manipulation on Claimant under Code 98943, yet charged for office visits (Codes 99212 and 99213). Generally, office visits should not be charged when a manipulation is also performed that same day.[12]

Concerning treatment provided after the surgery, Dr. Alvarado opined that Provider's use of massage therapy and chiropractic treatment six days post-surgery was too early. Similarly, muscle testing on December 22, 2003, ten days post-surgery, was also too early to provide baseline data.

B. Provider

Provider submitted into evidence medical records and argument previously submitted to the IRO and the testimony of David N. Bailey, D.C.[13] Dr. Bailey was not Claimant's treating doctor but worked in the same clinic and consulted with the treating doctor, Ron Linderman, D.C., concerning Claimant. He testified that the group therapy, one-on-one therapy, massage, and office visits are the types of office visits designed for a muscular-skeletal condition such as Claimant's. Also, at the hearing, Dr. Bailey stated he agreed with Dr. Pearce's deposition testimony that one-on-one therapy is the most efficient and fastest way to get an injured person

[11] Dr. Pearce also indicated that advising patients on the workers' compensation system was not a medical service and inappropriate unless a patient were to ask a specific question. Carrier Ex. C (deposition) at 26.

[12] *See* dates of service on November 14, 2003, November 21, 2003, and November 24, 2003, where Provider charged under both office visits (Code 99212 and 99213) and chiropractic manipulation (Code 98943), with the latter charges not in dispute. Carrier's Ex. C at 194-195.

[13] Dr. Bailey is a Doctor of Chiropractic medicine.

back to work. However, he disagreed that certain services were not medically necessary or that Dr. Linderman failed to change the treatment plan. Overall, Dr. Bailey found that the services provided were reasonable and medically necessary for this particular patient: they were appropriate for Claimant's condition, supported by medical literature, and intended to effect a positive outcome. Dr. Bailey also reviewed the IRO decision and agreed with the IRO's finding that Carrier should be required to pay for chiropractic treatment. But Dr. Bailey disagreed with the IRO's denial of massage therapy from November 17 to December 24, 2003, because Claimant had trigger points of pain and other painful areas affecting the muscles in the knee. He indicated that massage helps for this particular condition.

Responding to Carrier's initial denials concerning the use of Code 97110 (services that require one-on-one supervision), Dr. Baily argued that Claimant needed such supervision because it enhanced performance or provided greater and more rapid levels of increase in physical performance, as compared to lesser levels of supervision. In closing argument, Provider pointed out that the handwritten notes indicate "Pt. [Claimant] is hampered by pain during exercise session however w/motivation he is capable of doing exercises safely, one to one required during entire session."[14] and "Pt. [Claimant] required continued one to one encouragement and supervision during session to properly complete exercises." Concerning the office visit on December 18, 2003, Dr. Baily noted the nine-page detailed narrative report. Concerning other office visits, Dr. Bailey stated that office visits are charged when Dr. Linderman discusses workers' compensation rules and procedures and Claimant's choices concerning future treatement.

III. ANALYSIS

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.

Concerning the treatment for the office visits, supplies, therapeutic exercises, and group therapy, Carrier bears the burden of proving that the factual basis or analytical rationale for the IRO's

[14] Provider's Ex. A at 67 and 70 (Provider notes on November 18 and 24, 2003, respectively).

decision in this case was invalid. The ALJ finds that Carrier met this burden. For the disputed massage therapy, Provider bears the burden of proof. Provider failed to meet that burden.

Pre-Surgery. The evidence demonstrated that the bulk of the *contested* services[15] provided to Claimant before his surgery consisted of 37 units of one-on-one therapeutic exercises, Code 97110 (provided on November 17, 18, 20, 21, 24, and 26, and December 1, 3, 5, 8, and 10, 2003). Pre-surgery, Claimant also received massage and electric stimulation therapy. The Provider knew that Claimant's previous treating doctor had recommended surgery, although Claimant indicated to Provider that he did not want surgery.[16] On the first office visit, Claimant's pain level was at six (with ten being the highest level) and, after the consult, Provider's treatment plan indicated a "trial of home program treatment."[17] However, four days later, with a slightly decreased pain level of five, Claimant began almost daily treatments.[18] The treatment notes fail to indicate why the home program needed to be supplemented with daily in-office chiropractic treatment at that time. In fact, Dr. Pearce's testimony indicated that a meniscus tear with no mechanical locking needs conservative care. Dr. Pearce's opinion was supported by Dr. Alvarado, who stated that the home exercise program had not had a chance to work (he testified that a patient should exercise approximately two weeks before a caregiver should determine the efficacy of such a program). Dr. Alvarado further stated that the intensity of therapy before surgery was excessive.

Moreover, Dr. Pearce could not find a reason for one-on-one sessions beyond an initial couple of sessions designed to show a new patient how to exercise. Dr. Alvarado agreed and noted that there was no proof that one-on-one therapy was effective or cost-effective before surgery. Simply, Provider's notes that one-on-one therapy were needed to provide encouragement and motivation failed to persuade the ALJ that this particular patient needed such intense supervision. The ALJ finds one-on-one therapy provided to Claimant was not "health care reasonably required."

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[15] *See* Carrier's Ex. C at 193-200, which lists only the services in dispute for this case. For example, in addition to the disputed 37 units of therapeutic exercises, Carrier was billed 33 more units of Code 97110, one-on-one therapy, for Claimant during the same period in question. Carrier was also billed during this time period for other chiropractic manipulations, office visits, massage and electric stimulation therapy, which are not in dispute in this case.

[16] Provider's Ex. A at 18.

[17] *Id.* at 20.

[18] *Id.* at 37.

As to the other types of services, there is no persuasive evidence that massage therapy (provided almost daily for two weeks before surgery) was reasonable or necessary. Dr. Pierce testified that massage for a knee injury is not likely beneficial. As a non-treating doctor, Dr. Bailey's general testimony that the overall level of care was reasonable failed to refute Dr. Pierce's opinion as an orthopaedic surgeon that manipulations and massage applied to an inflamed knee may be detrimental.

Concerning electrical stimulation, Dr. Alvarado indicated that treatment notes were insufficient as to where and why the therapy was provided. The ALJ was less persuaded by Carrier's position on these particular treatments, because the notes indicate the electrical stimulation was provided to the right upper calf and right knee for pain modulation or control.[19] Additionally, Dr. Pearce stated that electrical stimulation was a type of conservative care (with ice) that may have benefitted Claimant. However, Dr. Pearce also stated that electrical stimulation is an appropriate treatment when there is atrophy of the quadricep muscle–for which Provider's notes did not indicate the stimulation was used. Because both Dr Pierce and Dr. Alvarado found the overall pre-surgery services provided to Claimant to be excessive and because the treatments did not reduce the overall pain level, the ALJ is not persuaded that electrical stimulation solely for pain relief was shown to be necessary.

In sum, although Provider attempted to argue that Claimant did not want surgery–thus conservative chiropractic care was appropriate–the one-and-a-half to two-hour care given to an inflamed knee was not conservative. Approximately one month after Claimant began this aggressive program, he had knee surgery. The ALJ agrees with Carrier's expert witnesses that the disputed treatment given Claimant pre-surgery was excessive and unnecessary medical treatment.

Post-Surgery. Both Drs. Pearce and Alvarado indicated that the December 22, 2003 muscle testing, which includes the disputed office visit under Code 99213 and charges for tests and forms, was performed on Claimant too soon after surgery. Dr. Pearce explained that muscles are weak after

[19] For example, see notes on 11/22/2203, Provider's Ex. B at 179.

knee surgery, and it is better to test muscle strength towards the end of the injury.[20] Dr. Pearce further stated that Claimant's treatment did not appear to be modified as a result of the December 22, 2003 muscle testing. The evidence fails to support muscle testing of Claimant ten days after surgery; thus, the ALJ finds it appropriate to deny the testing and charges related to those services.

Concerning the four post-surgery electric stimulation treatments provided to Claimant, Provider's notes indicate these treatments were applied to the knee for pain relief. Drs. Pearce and Alvarado testified that electrical stimulation would be appropriate to stimulate atrophied muscles. Dr. Pearce admitted that there was some indication of atrophy, although the notes do not indicate where (to which muscle groups) the stimulation was applied. The ALJ finds that the notes indicate electric stimulation was used for pain relief, not to stimulate atrophied muscles. Thus, the preponderance of the evidence does not support Provider's rationale for post-surgery electric stimulation.

To the extent that post-surgery chiropractic massage and myofacial release treatments are in dispute, Dr. Pearce opined that the knee muscle groups would not need post-surgical massage and that myofacial release is unnecessary because there is no scarring that soon after surgery. Again, the evidence does not support the need for these services.

Services Provided Pre- and Post-Surgery. The ALJ further found troubling the repeated charges for discussions of administrative issues related to legal matters on November 11, 12, 18, and 21, and December 1, 5, 10, 18, and 31, 2003. Provider stated its position as to why one such office visit (December 18, 2003) was necessary in a letter to the Texas Medical Foundation: "The patient office visit reports explain that a conference was held with the patient discussing WC laws and rules that related to questions the patient had concerning the work status report that was issued that day, as part of the role and responsibility of being his treating doctor."[21] In fact, this was the seventh time Dr. Linderman spent 10 to 15 minutes discussing non-medical issues, including "law and rules about

[20] Carrier's Ex. C at 28-29.

[21] Provider's Ex. A at 3.

benefit disputes and the resolution processes . . . the obligations and responsibilities of the carrier, the commission, the treating doctor, and injured worker."[22] Notes documenting this non-medical discussion on various service dates are similar, repetitive, and provide no rationale why Claimant needed this non-medical advice so often. No evidence rebutted the testimony of Drs. Pearce and Alvarado that non-medical advice is a not reasonable and necessary service.

In the ALJ's view, the record in this case fails to demonstrate that Provider's disputed treatment was necessary either before or after Claimant's knee surgery. Rather, the record indicated it is somewhat likely that the treatment was excessive, to the possible detriment of Claimant. Provider should not be reimbursed for the disputed services.

IV. FINDINGS OF FACT

1. On ___, Claimant was standing near a bucket forklift, when the forklift operator raised the bucket, which injured his knee and lifted him off the ground. The injury was a compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. On October 13, 2003, Claimant underwent an MRI, which indicated a bone marrow contusion, posterior horn medial meniscal tear, and small joint effusion.

3. On November 30, 2003, William E. Blair, Jr., M.D., evaluated Claimant, recommended an MRI, and restricted Claimant to clerical work.

4. Dr. Blair re-evaluated Claimant on October 20, 2003, and, based on the October 13, 2003 MRI results, indicated that surgery (arthroscopic evaluation and resection) was warranted.

5. Claimant began receiving chiropractic services from Waco Ortho Rehab Associates, LLC, (Provider) on November 6, 2003.

6. On December 12, 2003, Claimant had surgery to repair his knee.

7. From November 6 through December 31, 2003, Claimant received chiropractic treatment and supplies from Provider for the injury noted in Finding of Fact No. 1.

8. Provider sought reimbursement for chiropractic treatment from Texas Mutual Insurance Company (Carrier), the insurer for Claimant's employer.

[22] For example, see notes at Provider's Ex. A at 53.

9. Carrier denied the requested reimbursement.

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

11. The independent review organization (IRO) to which the Commission referred the dispute issued a decision on August 27, 2004, and concluded that: (1) supplies, therapeutic exercises, group therapy, and office visits for dates of service November 6 through December 31, 2003 had been medically necessary; and (2) massage therapy provided during the same dates were not medically necessary.

12. The Commission's Medical Review Division reviewed and concurred with the IRO's decision in a decision dated November 19, 2004, in dispute resolution Docket No. M5-04-3519-01.

13. Both Carrier and Provider 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.

14. The Commission mailed notice of the hearing's setting to the parties at their addresses on January 20, 2005.

15. On May 23, 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. Carrier was represented by Patricia Iads, and Provider was represented by William Maxwell. The record closed that same day.

16. At the hearing on the merits, Carrier stipulated its agreement to pay for the following services and supplies: the December 18, 2003 office visit, CPT Code 99212; group therapy provided on December 23, 24, and 31, 2003, under Code 97150; and the Biofreeze provided on November 6, 2004.

17. Claimant's injury, referenced in Finding of Fact No. 1, required conservative care.

18. Provider initially recommended a home exercise program on November 6, 2003, but began almost daily intensive chiropractic treatment four days later, when Claimant's pain level had slightly decreased.

19. The contested, pre-surgery chiropractic services at issue in this case provided to Claimant from November 6 through December 10, 2003, was not conservative care.

20. One-on-one therapy provided under Code 97110, was not cost-effective therapy.

21. Massage therapy is not necessary for a meniscus tear in the knee.

22. Claimant's pain levels before surgery fluctuated but did not improve overall.

23. The December 22, 2003 muscle testing was performed on Claimant too soon after surgery.

24. Post-surgery, electric stimulation treatments were not given to Claimant to relieve scarring.

25. Post-surgery, knee muscle groups do not need massage.

26. Discussions of administrative issues related to legal matters is not a reasonable and necessary medical service.

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. Carrier bore the burden of proof as to whether supplies, therapeutic exercises, group therapy, and office visits for dates of service November 6 through December 31, 2003, were medically necessary pursuant to 28 TAC § 148.21(h).

6. Provider bore the burden of proof for whether massage therapy sessions for dates of service November 6 through December 31, 2003, were medically necessary pursuant to 28 TAC § 148.21(h).

7. Based upon the foregoing Findings of Fact, the office visits and treatments for Claimant on November 6 through December 31, 2003, do not represent elements of health care medically necessary under § 408.021of the Act.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions of the IRO and of the MRD were correct in part (as to massage therapy) and incorrect in part (as to the remainder of the contested services).

ORDER

IT IS THEREFORE, ORDERED that the appeal of Texas Mutual Insurance Company seeking denial of reimbursement for supplies, therapeutic exercises, group therapy, and office visits for dates of service November 6 through December 31, 2003, be granted. **IT IS FURTHER ORDERED** that the appeal of Waco Ortho Rehab Associated, seeking reimbursement for massage therapy performed from November 6 through December 31, 2003, be denied.

SIGNED July 21, 2005.

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