SOAH DOCKET NO. 453-05-3173.M5
TWCC MR NO. M5-04-2346-01

FIRST RIO VALLEY MEDICAL, P.A., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
TPCIGA for WESTERN INDEMNITY INSURANCE COMAPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

First Rio Valley Medical, P.A. (Petitioner), appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD) based on the decision of its designee, an independent review organization (IRO). The decision upheld Western Indemnity Insurance Company's[1] (Carrier) denial of reimbursement for services provided a workers' compensation claimant (Claimant) on the basis that the services were not medically necessary healthcare. This decision finds that the disputed services were not medically necessary healthcare.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice.[2] Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

[1] Western Indemnity Insurance Company is now an "impaired" company whose TWCC claims are being handled by TPCIGA.

[2] Petitioner initially argued that the matter should have been treated solely as a reimbursement case under 28 TEX. ADMIN. CODE (TAC) § 133.307 because it filed a request for resolution of a medical fee dispute, not a medical necessity dispute, after Carrier failed to respond to a request for reconsideration. However, under the rule at 28 TAC § 13.304(m), a carrier's failure to respond to a request for reconsideration does not waive a dispute over medical necessity, but rather merely gives the requestor grounds to request dispute resolution on medical necessity. Pursuant to 28 TAC §133.305(b), the MRD properly considered Petitioner's request for dispute resolution as being one to determine the threshold issue of medical necessity, so that is the sole dispute in this contested case.

The hearing in this matter convened April 28, 2005, at the State Office of Administrative Hearings, 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Ann Landeros presiding. Petitioner was represented by its owner, Robert Howell, D.C. Attorney Steven Tipton represented Carrier. Commission Staff did not participate in the hearing.

II. DISCUSSION

A. Background Facts

In ___, Claimant sustained an injury to her left leg that was compensable under the Texas Workers' Compensation Act (Act). At the time of the compensable injury, Claimant's employer had workers' compensation insurance coverage with Carrier.

On the date of injury, Claimant underwent surgery to on her left knee. Subsequently, she had three more knee surgeries, the last being on December 18, 2002, when orthopedic surgeon, James Key, M.D., removed two screws that had backed themselves out of a plate and were causing discomfort. Some scar tissue was also excised during that surgery. (Pet. Ex. 1, p. 106).

On February 17, 2003, Dr. Key prescribed four weeks of physical therapy and massages for Claimant's knee. (Pet. Ex. 1, p. 105). He renewed the prescription on March 10, 2003, for another six weeks and added aquatic therapy and electric stimulation. (Pet. Ex. 2, p. 279). Petitioner provided the prescribed therapies.

In dispute in this case are the following services that Petitioner provided Claimant from April 7 to June 2, 2003: electrical stimulation, continuous passive motion, massage, aquatic therapy; and therapeutic exercises. Also disputed are office visits billed throughout the period and psychiatric interview, testing, and assessment of Claimant billed on June 2, 2003.

The IRO reviewer found the physical therapy more than three months post-surgery was not

medically necessary and also disallowed the psychiatric services for that reason. The reviewer further found Petitioner administered too many modalities per session and should not have separately billed the office visits that occurred on the same dates as the therapy sessions. The MRD adopted the IRO decision but awarded Petitioner reimbursement for an office visit on April 24, 2003.

Petitioner timely appealed the IRO findings and MRD decision. Carrier did not cross appeal the MRD's award of reimbursement.

B. Legal Standards

Petitioner has the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) §§ 148.21(h) and (i); 1 TAC § 155.41. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a). Health care includes all reasonable and necessary medical services including a medical appliance or supply. TEX. LAB. CODE ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

Treatment is shown to be effective if documentation establishes a link between the patient's improvement and the treatment. See, 28 TAC §§ 133.1(a)(E)(i) and 133.105(b)(6). The Act requires services be appropriately billed and provide the effective medical cost control required by TEX. LAB. CODE ANN. § 413.011(d).

C. Evidence

1. Petitioner's Evidence

In addition to voluminous documents, Petitioner presented Dr. Howell's testimony. Dr. Howell stated that Claimant was a morbidly obese, diabetic, de-conditioned, sixty-two year old female, whose primary language was Spanish. According to Dr. Howell, these factors all complicated Claimant's post-surgical recovery.

Dr. Howell found that, after the hardware was removed, Claimant's irritated muscles needed strengthening. He also noted that Claimant had symptoms of a mild infection at the surgical site that, along with her diabetes and obesity, complicated her recovery and required an extended period of therapy. He contended Claimant's case was complicated, rejecting the peer reviewers' finding that her injury was a "simple" fracture with an uncomplicated recovery.

Dr. Howell began Claimant's second round of therapy on March 17, 2003, following her March 10th examination by Dr. Key. For the second round, Dr. Howell prescribed the same therapies as Dr. Key, but added continuous passive motion therapy. He denied providing more than three modalities a day to Claimant and stated he billed office visits (CPT 99211 and 99213) on the same dates of service as the therapeutic services to cover overhead expenses.

With regard to billing under CPT 97110 for therapeutic exercises, Dr. Howell explained that the one-to-one therapy was needed because Claimant: (1) had an unstable gait; (2) needed constant instruction in Spanish; (3) had to be observed for injuries due to her diabetic neuropathy; (4) needed to have someone adjust the equipment; and (5) required a constant cardiovascular monitoring. He stated Claimant needed aquatic therapy (CPT 97113) because, due to her obesity, she could not do full weight-bearing exercises and because the warm water improved her circulation.[3]

[3] Although Petitioner introduced a number of articles concerning the benefits of aquatic therapy, the record did not reflect that these were peer review medical journal articles, so no weight was given to that information.

According to Dr. Howell, the passive motion (CPT 97039-CM) and massage therapies (CPT 97124) were to prevent re-formation of scar tissue. He stated the interferential electrical stimulation (CPT 97032) decreased pain and strengthened muscles by inducing contractions.

In April 2003, Dr. Howell reported Claimant was experiencing mild depression related to her physical limitations. (Pet. Ex. 1, p. 3). On June 2, 2003, Petitioner evaluated Claimant's psychological condition for participation in a chronic pain management program and biofeedback sessions. (Pet. Ex. 1, p. 11-27).

2. Carrier's Evidence

Carrier cited to Dr. Key's February 2003 reports for its position that by March 17, 2003, Claimant no longer needed Petitioner's services.

On February 4, 2003, Dr. Key wrote that Claimant's wound was healing "relatively well" and she was walking on the leg without difficulty. On February 18, 2003, his report stated that Claimant was walking on the leg and had full range of motion. He commented she just needed to "work on that scar to get it released so there is not a painful deep tissue line running down to the bone."

On March 6, 2003, Dr. Key reported that Claimant had a revised scar that was pliable at one end and firmly attached to the underlying soft tissue at the other. He wanted her to continue to mobilize the scar "in physical therapy by massage and other attempts at rehabilitation." He also noted a slight redness at one end of the wound that he thought was a skin irritation and, other than that, he thought Claimant was "doing very well." (Carrier Ex. 4).

Carrier argued that there was some significance to the fact that the March 10, 2003, physical therapy prescription bore Dr. Key's stamped signature. Dr. Howell stated he did not know why Dr. Key had not written his signature on that document and did not know if Petitioner solicited the prescription from Dr. Key.

Carrier's expert witness, Bill Timberlake, D.C., testified that he had reviewed Claimant's medical records and found the disputed services were not medically necessary. According to Dr. Timberlake, mobilization of scar tissue can often be accomplished by massage or stretching. Because Claimant did not suffer from orthopedic complications, she should have been able, especially given her extensive prior physical therapy, to perform the necessary therapies herself. He noted Dr. Key found Claimant was walking without difficulty and had full range of motion in the knee in February 2003. Walking, which Claimant was able to do in March 2003, should have been sufficient to loosen the scar tissue, in Dr. Timberlake's opinion.

Dr. Timberlake noted that in various nationally recognized guidelines,[4] clinically based physical therapy has not been shown to be more effective than home-based therapy. He found the records lacked any justification for the office visits, especially because Claimant did not receive concurrent chiropractic care during her therapeutic sessions. He noted that Claimant's pain levels did not change significantly over the course of treatment, which, along with the length of her treatment and excessive use of passive modalities, indicated to him that Claimant's problem was chronicity, not organic pain.

Mild changes in Claimant's subjective pain reports did not indicate improvement but reflected the expected natural history of her healing (the healing that would occur without treatment). Dr. Timberlake believed Claimant's medical records reflected she did not benefit from Petitioner's services and she would have been in the same condition in April 2003 even without treatment.

[4] He cited to the Official Disability Guidelines and the Mercy Center Guidelines.

According to Dr. Timberlake, even if Claimant had a post-operative infection, she would not have needed the extensive therapy Petitioner provided but could have benefitted as much or more from home-based therapy. He did not agree with Dr. Key's decision to prescribe therapy on March 10, 2003.

3. Analysis

Petitioner failed to carry its burden of proof in this matter to show that the services were medically necessary, primarily because the evidence was contradictory about the need for clinically-based services.

Petitioner provided most of its services under a prescription from Dr. Key, the surgeon who operated on Claimant and evaluated her post-surgical progress. In March 2003, despite his positive assessments of Claimant's mobility and range of motion, Dr. Key stated that she still needed therapy to deal with the scar tissue. As the surgeon who evaluated her, Dr. Key was in the best position to judge what Claimant's medical needs were in March 2003, and his opinion is entitled to substantial weight, particularly as there is no reason to believe he had any conflict of interest in prescribing the physical therapy and other services Petitioner provided. However, Dr. Key's prescription for therapy did not by itself establish that Claimant needed the *clinically-based* therapies Petitioner provided.

Petitioner's evidence established that Claimant had diabetes, was obese, and had a limited command of the English language. But none of these factors established that Claimant could not safely perform exercises (walking on a treadmill, working with weights, exercising in a pool) in a group setting or at home.

Dr. Howell's contention Claimant had trouble walking and used a cane was contradicted by Dr. Key's reports that, in February 2003, she was walking without difficulty and had full range of motion. Also, in his own note dated February 24, 2003, Dr. Howell stated the Claimant was not using any devices to help her with her injury. (Pet. Ex. 2, p. 384).

There was no objective evidence that Claimant needed constant cardiovascular monitoring during her workout or that, even if needed, cardiovascular monitoring could not have been done safely in a group setting. Finally, there is no reason to believe that a patient§s limited ability to understand English constituted a cognitive impairment requiring constant, individual attention from a therapist. The record did not support Petitioner's use of CPT 97110 because Claimant had safety or cognitive impairment issues.

Because Claimant had a full range of motion in February 2003, there was no justification for the continuous passive motion therapy from April 2003 forward. With regard to the electrical stimulation, the record did not reflect why Claimant, whose muscles worked well enough for her to walk on the treadmill, perform aquatic exercises, and lift weights, needed this type of additional muscle stimulation.

By the time of the disputed services, Claimant had already had weeks of the same therapies and should have known how to perform the therapies herself. For instance, Petitioner failed to show why Claimant needed a therapist to massage her knee, a body part that is easy reached and manipulated.

Although Petitioner explained the benefits of aquatic therapy for Claimant, it did not establish why Claimant could not perform the aquatic exercises by herself. Dr. Howell's notes reflected that Claimant performed the exercises in the pool with the therapist while he observed and instructed from outside the pool. Petitioner failed to justify the need for both a therapist and Dr. Howell to instruct Claimant's aquatic therapy.

Petitioner's sole justification for charging for office visits was to cover its overhead expenses. The Act and Commission's rules allow providers to charge for *services*–unless incorporated into a service, an overhead expense cannot be legitimately billed under the Act or the Commission's rules. Because Petitioner did not receive office visit services on the disputed dates of service , billing for office visits was improper.

Although Dr. Timberlake opined that Claimant suffered from chronicity brought on by over-treatment with passive modalities, the records did not provide a justification for the psychiatric evaluation, report, and assessment billed. Claimant was assessed to see if she would benefit from biofeedback sessions or a chronic pain management program, not to treat the mild depression she reported to Dr. Howell. Petitioner failed to show why Claimant needed to be assessed for these additional treatments and program.

Petitioner failed to meet its burden of proof that its services to Claimant were medically necessary healthcare, primarily because the services provided were not shown to be rendered in a cost-effective manner or setting. The record did not establish that, from April 7 to June 2, 2003, Claimant needed any clinically-based therapies; that she received office visit services; or that she needed to be evaluated for a chronic pain management program or biofeedback services.

III. FINDINGS OF FACT

1. In ___, Claimant sustained an injury to her left leg that was compensable under the Texas Workers' Compensation Act (Act).

2. At the time of the compensable injuries, Western Indemnity Insurance Company (Carrier) was the workers' compensation insurance coverage insurer for Claimant's employer.

3. Since the date of the disputed services, TPCIGA acquired the right and responsibility to handle Carrier's workers' compensation claims.

4. In December 2002, orthopedic surgeon James Key, M.D., operated on Claimant's knee to removed some displaced hardware and to excise scar tissue.

5. During the time period at issue, Claimant was a sixty-two-year-old, morbidly obese, de-conditioned, diabetic, Spanish-speaking female.

6. On February 17, 2003, Dr. Key prescribed physical therapy and massage for Claimant.

7. Pursuant to Dr. Key's prescription, Claimant received therapy and massages from First Rio Medical, P.A. (Petitioner).

8. On March 10, 2003, Dr. Key reexamined Claimant and prescribed physical therapy, aquatic therapy, electrical stimulation, and massage for Claimant.

9. From April 7 through June 2, 2003, Petitioner provided Claimant with the services described in Finding of Fact No. 6 along with continuous passive motion, office visits, and a psychiatric interview, assessment and report.

10. Despite her obesity, diabetes, limited English, and possible poor cardiovascular health, Claimant did not have either safety or cognitive impairment issues that required one-to-one therapy billed under CPT 97110.

11. Claimant needed massages to loosen up her surgical scars but it was not shown she needed the service from a massage therapist because she could have done her own massages as the knee is a readily accessible body part.

12. Claimant did not receive office visit services on dates of services billed.

13. Claimant could have performed aquatic exercises in a group setting or outside Petitioner's clinic.

14. Because Claimant had a full range of motion in February 2003, there was no justification for the continuous passive motion therapy from April 2003 forward.

15. Claimant, whose muscles worked well enough for her to walk on the treadmill, perform aquatic exercises, and lift weights, did not need electric stimulation therapy for her muscles.

16. Claimant did not need clinically-based therapies from April 7 to June 2, 2003.

17. Petitioner failed to show why Claimant needed a psychiatric evaluation, report and assessment for a chronic pain management program or biofeedback services.

18. After Carrier failed to respond to its requests for reconsideration for reimbursement, Petitioner filed a request for dispute resolution with the Commission that was treated as a request for medical necessity dispute resolution by the Commission's Medical Review Divison (MRD).

19. The MRD referred the dispute to an Independent Review Organization (IRO), which concurred with Carrier's denial. The MRD issued a decision based on the IRO's findings.

20. Petitioner timely appealed the IRO and the MRD decisions.

21. Pursuant to notice of hearing sent by Commission Staff, all parties appeared or were represented at the hearing held April 28, 2005.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (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(d) 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 and 133.308.

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 had the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i); 1 TAC § 155.41.

6. The IRO had authority to review the parties' positions and issue a decision pursuant to the Commission's rules at 28 TAC §§ 133.305 and 133.308.

7. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

8. Health care includes all reasonable and necessary medical services, including a medical appliance or supply. TEX. LAB. CODE ANN. §401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

9. Petitioner failed to establish that the disputed services were appropriately billed and provided in a way that constituted the effective medical cost control required by TEX. LAB. CODE ANN. § 413.011(d).

10. CPT Code 97110 is properly billed only when a one-to-one patient to therapist ratio must be maintained due to safety or cognitive issues or because the patient is entitled to that level of care under § 413.011(b) of the Texas Labor Code.

11. Petitioner is not entitled to reimbursement of the office visits billed concurrently with therapeutic services because no office visit services were documented on those dates.

12. Petitioner's services to Claimant from April 7 to June 2, 2003, were not shown to be medically necessary healthcare.

13. Petitioner is not entitled to reimbursement from Carrier for the disputed services rendered to Claimant from April 7 through June 2, 2003.

ORDER

It is ORDERED that First Rio Medical, P.A., is not entitled to reimbursement from TPCIGA for Western Indemnity Insurance Company for the services provided to Claimant from April 7 through June 2, 2003.

SIGNED May 31, 2005.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS