SOAH DOCKET NO. 453-05-3360.M5
MR DOCKET NO. M5-04-1000-01

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

ADMINISTRATIVE HEARINGS

DECISION AND ORDER

Carl M. Naehritz III, D.C. (Provider) contested the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission)[1] ordering partial reimbursement for treatment provided to Claimant, leaving $3,725.07[2] in dispute for diagnostic radiology, neurology and neuromuscular procedures, physical medicine and rehabilitation, special services and reports, office and other outpatient services, and durable medical equipment provided to Claimant from December 18, 2002, through November 3, 2003. Fidelity & Guaranty Insurance (Carrier) denied reimbursement on the basis that the treatment and services were found by peer review to be medically unnecessary to treat Claimant's compensable injuries, as well as for other reasons set out below.

1 Effective September 1, 2005, the functions of the Commission were transferred to the newly-created Division of Workers' Compensation at the Texas Department of Insurance.

2 Three tables of disputed services are in evidence, containing contradictory information. The ALJ relies on the Table of Disputed Services admitted as Provider's Exh. 1, because it was prepared after Provider compared its original table against Carrier's table, and excluded items that Provider is no longer disputing. The ALJ finds it to be the most accurate table in evidence. In addition, the parties stipulated on the record at the reconvened hearing on January 12, 2006, that Carrier has paid Provider for office visits (CPT Code 99213) provided on October 1 and 29,

The Independent Review Organization (IRO) found that for a six-to-eight week period through February 2003 the modalities used for therapy were indicated due to Claimant's continuing back pain following his September 2002 surgery. However, the IRO reviewer stated that a repeat MRI done in January 2003 suggested more surgical pathology, which was a reason not to continue with non-helpful physical therapy.[3] The IRO reviewer concluded that the continued therapy in this case might have been more harmful than helpful, especially since the patient was not showing improvement.[4]

Based on the review of disputed services within the request, the MRD determined that medical necessity was not the only issue to be resolved. This dispute also contained services that were not reviewed by the IRO, but were reviewed by the MRD. The MRD denied reimbursement for treatment in which the bills had not been stamped "Request for Reconsideration" then re-submitted to Carrier, as well as for other reasons set out below.

The Administrative Law Judge (ALJ) finds Provider proved by a preponderance of the evidence that the disputed treatment and services were reasonable and medically necessary through February 2003, and proved that reimbursement is warranted for some of the disputed services provided from March 2003 through November 2003. Therefore, Carrier is to reimburse Provider the amounts set out in this Decision and Order.[5]

2003, and that those services are no longer in dispute.

3 A January 15, 2003 MRI showed post-surgical changes at L5/S-1 consisting of mild disc space narrowing, right laminectomy and right-sided surgical hardware. There was no recurrent disc herniation, however traction deformity of the right anterolateral thecal sac and involvement of the right S1 nerve root, most likely from post-surgical fibrosis, was noted. There also was seen at L4/5, a compression deformity of the lateral aspect of the thecal sac on the right side, raising the suspicion of fibrotic tissue. *See* June 27, 2003, report by Michael Ranier, M.D. at Carrier's Exh. 9, and Carrier's Exh. 12.

4 Carrier's Exh. 9, at RM-048.

5 *See* Finding of Fact No. 22.

I. PROCEDURAL HISTORY

ALJ Sharon Cloninger convened the hearing on July 25, 2005, in the William P. Clements State Office Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Provider appeared *pro se*. Carrier was represented by W. Jon Grove, attorney. The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law. The hearing concluded and the record closed that same day.

On September 23, 2005, the ALJ re-opened the record for the limited purpose of allowing Provider the opportunity to offer proof that it had requested reconsideration of denied bills into evidence, to present evidence as to why those disputed services should be reimbursed (based on Carrier's reason for denial as stated on the EOBs), and to give Carrier the opportunity to rebut Provider's evidence related to the EOBs. The hearing reconvened on January 12, 2006. Both parties appeared and presented evidence, and the record closed that same day.

II. BACKGROUND

Claimant suffered a compensable injury to his neck and low back on____, when he fell from a four-foot ladder onto concrete.[6] Prior to his compensable injury, Claimant had successful lumbar spine surgery in 1992 involving a unilateral right-sided pedicle screw fixation at L5-S1,[7] and he was asymptomatic until his compensable injury occurred.[8] Following the November 2001 fall, Claimant was diagnosed with an L4-L5 disk herniation. Conservative treatment did not relieve his back pain, so on September 11, 2002, he underwent a left L-4 hemilaminectomy, and left L4-L5 microdiskectomy with foraminotomy with excision of prior fusion.[9]

6 Carrier's Exh. 7, at RM-041; Carrier's Exh. 14, at RM-085.
7 *Id.*, at 23.
8 Carrier's Exh. 9, at RM-048.

Post-operatively, on December 17, 2002, Claimant met with Provider, who is associated with High Point Pain Management, for a pain consultation regarding his continuing low back pain. He told Provider that four epidural steroid injections had not given him any pain relief. Provider found Claimant to have muscle spasms which were partially relieved with Soma and a muscle stimulator.[10]

Provider's treatment of Claimant included intensive physical therapy from December 30, 2002, through October 13, 2003. During that time–on July 22, 2003–Claimant was placed at maximum medical improvement.[11] At least as of June 2003, Claimant was found to have failed back syndrome.[12] As of November 19, 2003, Claimant continued with pain and depression, with no significant relief or improvement from his physical therapy.[13] Claimant has not worked since May 2002 due to his chronic back pain.[14]

III. APPLICABLE LAW

A. Texas Labor Code

An employee who sustains 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: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment. TEX. LAB. CODE § 408.021(a).

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9 Carrier's Exh. 7, at 23-24.
10 Carrier's Exh. 9, at RM-048.
11 Carrier's Exh. 6, at RM-031.
12 Carrier's Exh. 13, at RM-078 through RM-081.
13 Carrier's Exh. 2, RM-10.
14 Carrier's Exh. 9, at RM-048.

B. Submission of bills for reconsideration

The MRD denied reimbursement for some disputed services because there was no evidence that Provider had properly resubmitted bills to Carrier for reconsideration. The MRD decision stated:

> ...neither the requestor nor the respondent submitted copies of EOB's [sic]. Per Rule 133.304(k)(1)(A)[15] the requestor did not clearly mark the reconsideration request "REQUEST FOR RECONSIDERATION" as the rule states, therefore no reimbursement is recommended.[16]

The insurance carrier shall treat a request for reconsideration as an incomplete medical bill under 28 TAC § 133.300 if the request is not submitted in accordance with 28 TAC § 133.304(k). An incomplete medical bill is either to be completed by the insurance carrier, or returned to the healthcare provider indicating what further information is necessary to complete the bill. 28 TAC § 133.300. If the incomplete bills were returned to Provider by Carrier in accordance with 28 TAC § 133.300, and not properly resubmitted by Provider, then Carrier has no further obligation to Provider for reimbursement

IV. DISPUTED TREATMENT AND SERVICES

15 28 TAC § 133.304(k) "If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit the request for reconsideration by facsimile or mutually agreed upon electronic transmission unless the request cannot be sent by those media, in which case the sender shall send the request by mail or personal delivery; the request shall include (1) a copy of the complete medical bill that the health care provider is requesting the insurance carrier to reconsider, (A) clearly marked with the statement "REQUEST FOR RECONSIDERATION."

16 Evidence that Provider resubmitted denied bills stamped "Request for Reconsideration" was admitted at the reconvened hearing.

The following list of disputed services began with Provider's Table of Disputed Services[17] checked against the MRD decision and IRO decision. If an item on Provider's Table of Disputed Services was not addressed either by the MRD or the IRO, it was deleted from the list and not considered by the ALJ.[18]

A. Reimbursement Denied by Carrier with Code V (Unnecessary Treatment with Peer Review)[19]

1. Diagnostic Radiology[20]

a. Spine and Pelvis radiologic examination, one level (CPT Code 72020-WP)

The amount in dispute is $58.58 for the October 13, 2003 service.

b. Spine and pelvis complete, with oblique views (CPT Code 72110-WP)

The amount in dispute is $63.08 for the October 13, 2003 service.

2. Neurology and neuromuscular procedures

a. Manual muscle testing (CPT Code 95831)

The amount in dispute is $116 for the July 30, 2003 service.[21]

b. Range of motion measurements (CPT Code 95851)

17 Provider's Exh. 1.

18 Provider lists CPT Code 97140 for August 12, September 24, and October 13, 2003, but these services were not reviewed by the IRO or addressed by the MRD, so the ALJ will not consider them.

19 Because Provider proved treatment provided from December 18, 2002, through the end of February 2003 was medically necessary, the ALJ is ordering reimbursement for disputed services provided on those dates and denied under Code V.

20 Provider testified that Claimant fell at home when his leg "gave out," so Provider took x-rays to find out if Claimant had suffered a fracture or displacement of hardware in his back. *See also* Carrier's Exh. 14, at RM-092, which states "x-rays today" and Provider's SOAP notes for that date, which state Claimant's "left leg went out from under him." *See also* Carrier's Exh. 11, at RM-072.

21 *See* Medical Fee Guideline (MFG), at 57.

The amount in dispute is $36 for the January 30, 2003 service, and $144 for the July 30, 2003 measurements.[22]

3. Physical Medicine and Rehabilitation

a. Therapeutic procedures (CPT Code 97110)

The amount in dispute is $105 for the July 8, 2003 treatment; $140 for the July 29, 2003 treatment; $140 for the July 30, 2003 treatment; $137.36 for the August 12, 2003 treatment; and $137.36 for the September 24, 2003 treatment.[23]

Under the Medical Fee Guideline, treatment provided under CPT Code 97110 is considered physical medicine care or therapy, and a one-to-one setting is required pursuant to Medicine Ground Rule (I)(A)(9).[24]

b. Neuromuscular re-education of movement (CPT Code 97112)[25]

The disputed amount is $35 for treatment rendered on January 17, 2003; $35 for treatment on July 30, 2003; $35.25 for treatment on August 12, 2003; $35.25 for treatment on September 24, 2003; and $35.25 for treatment on October 13, 2003.[26]

c. Myofascial release/soft tissue mobilization (CPT Code 97250)

The disputed amount is $43 for each date of service–January 17, March 6, and July 29, 2003.[27]

d. Joint mobilization (CPT Code 97265)

22 Provider testified that the July 30, 2003 range of motion testing was medically necessary to check Claimant's progress and status. *See also* MFG, at 57.

23 Provider testified that the therapeutic exercises provide on July 8, July 29, August 12 and September 24, 2003, helped to relieve Claimant's pain.

24 S*ee* MFG, at 59.

25 *Id.*

26 Provider testified that the treatment on March 6, August 12 and September 24, 2003, relieved Claimant's pain.

27 Provider testified that the treatment on March 6 and July 29, 2003, relieved Claimant's pain.

The disputed amount is $43 for treatment on March 6, 2003, and $46 for treatment on July 29, 2003.

e. Therapeutic activities (CPT Code 97530)

The disputed amount is $35 for treatment on January 17, 2003, and $35 for treatment on March 6, 2003. The Medical Fee Guideline describes the treatment under this CPT Code as "Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes."[28]

4. Special Services and Reports

a. Supplies and materials provided over and above those usually provided with the office visit (CPT Code 99070)[29]

The amount in dispute is $85 for supplies provided on December 18, 2002.[30]

B. Payment Denied by MRD Due to Failure of Provider to Request Reconsideration[31]

At the reconvened hearing, evidence was submitted to establish that there had been a proper request for reconsideration for the following treatment and services, some of which were paid in part:

1. Manual muscle testing (CPT Code 95831)

Treatment was provided on January 30, 2003. The amount in dispute is $39.[32]

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28 *Id.*

29 The ALJ sustains Carrier's objection to disputed treatment listed on the updated Table of Disputed Services under CPT Code 99070 for September 17, 2003, because the disputed treatment listed on the originally submitted TWCC 60 for that date is for a cervical collar (CPT Code L0120), which is not the service provided.

30 Provider testified that the traction unit was needed by Claimant for home use. He said reimbursement should be at 100 percent, pursuant to the 1995 MFG.

31 Payment for office visits billed under CPT Code 99213 on October 1, 2003, and October 29, 2003, was denied by the MRD, but the parties stipulated at the January 12, 2006 reconvened hearing that Carrier had reimbursed Provider for these services, and they are no longer in dispute.

2. Therapeutic procedures (CPT Code 97110)

Treatment was provided on July 23, 2003. The amount in dispute is $140. Carrier denied per Code V.

3. Neuromuscular re-education of movement (CPT Code 97112)

Treatment was provided on January 21, March 6, July 23, and July 29, 2003, for $35 on each date.[33]

4. Myofascial release/soft tissue mobilization (CPT Code 97250)

Treatment was provided on July 23, 2003, for $43. Although this treatment is on the original bill, it is not on the bill stamped "Request for Reconsideration."[34]

5. Joint mobilization (CPT Code 97265)[35]

Treatment was provided on January 17 and July 23, 2003. The amount in dispute is $43 for each date. Although this treatment is on the original bill, it is not on the bill stamped "Request for Reconsideration."[36]

6. Supplies and materials (CPT Code 99070)

An innerspring mattress was provided on June 25, 2003, for which there is $210 in dispute, and a chair support on July 23, 2003, for which there is $50 in dispute.

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32 Provider's bill stamped with "Request for Reconsideration" is in evidence, but the Carrier's reason for denial is not in evidence. *See* Provider's Exh. H, admitted January 12, 2006 (to distinguish between Provider's Exh. 2, tabs A-U admitted at the hearing on July 25, 2005.)

33 Carrier denied all except the January 21, 2003 date of service per denial code V. There is no reason in evidence for denial of the January 21, 2003 treatment. *See* Provider's Exh. G, admitted January 12, 2006.

34 Provider's Exh. L, admitted January 12, 2006.

35 The January 17, 2003 date of service as not on the bill stamped "Request for Reconsideration."

36 *Id.*

Carrier denied payment for the June 25, 2003 date of service using Code S, stating "Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided."[37]

Payment for the chair support was denied using Code W9, which states "Unnecessary medical treatment based on peer review. Payment withheld as peer review indicates documentation does not support the treatment to be medically reasonable and/or necessary."[38]

7. Office visit (CPT Code 99213)

Carrier has reimbursed Provider for an office visit on October 1, 2003, and this service is no longer in dispute.[39]

8. Prolonged physician service without direct (face-to-face) patient contact (CPT Code 99358)

Treatment was provided on October 29, 2003, for which $84 is in dispute. Carrier denied payment using Code D, stating "Reimbursement for unilateral or bilateral procedures is being withheld as the maximum number of occurrences for a single date of service or maximum lifetime for the claim has been exceeded."[40]

9. Telephone calls (CPT Code 99372)

Treatment was provided on June 23 and November 3, 2003, for which $23 on each date is in dispute. Carrier denied the June 23, 2003 service using Code 50,

37 Provider testified that reimbursement for the posturepedic mattress should be at 100 percent under TWCC guidelines. *See also* Provider's Exh. K, admitted January 12, 2006.

38 Provider testified that the Healthy Back system helped Claimant a lot in the office, so he prescribed for use at home and in his vehicle. He said the chair support was medically necessary to relieve Claimant's pain. *See* Provider's Exh. L, admitted January 12, 2006.

39 The parties stipulated at the January 12, 2006 reconvened hearing that this service is no longer in dispute.

40 Provider's Exh. O, admitted January 12, 2006.

which states "These are non-covered services because this is not deemed a medical necessity' by the payer. Unnecessary medical treatments or service."[41]

Carrier denied the November 3, 2003 service using Code N, stating "Submitted documentation does not indicate the specific nature of the care that was coordinated and what was decided."[42]

10. Whirlpool equipment (CPT Code E1399)

Treatment was provided on July 23, 2003, for which $495 is in dispute. Carrier denied per Code V.[43]

C. Payment Denied by MRD for Code N (Not Appropriately Documented)

The MRD denied payment on the basis that the submitted documentation for the telephone call (CPT Code 99372) made on June 13, 2003, does not indicate that the treating doctor conferred with an interdisciplinary team comprised of multiple individuals. The amount in dispute is $21.[44]

D. Reimbursement Denied by MRD for Denial Code F (review of the submitted documentation indicates that the service provided is considered within the scope of normal practice)

1. Prolonged physician service without direct (face-to-face) patient contact (CPT Code 99358)

41 Provider testified that he and Claimant discussed how the pain medications were not working, and that Claimant asked Provider to contact Dr. Shaw, who was his pain management doctor, for an appointment. *See also* Provider's Exh. J, admitted January 12, 2006.

42 Provider testified that Claimant had formed a blood clot in his leg, and that he coordinated having Claimant placed on blood thinners. *See also* Provider's Exh. P, admitted January 12, 2006.

43 Provider's Exh. L, admitted January 12, 2006.

44 Provider testified that he and Claimant talked over the telephone about his case, because Claimant was in a lot of pain. Provider said they discussed Claimant's appointment with a pain specialist, and talked about his supplies.

Services were provided on September 29, 2003 (x2) for $168, and October 1, 2003, for $84. The MRD stated that per the Medical Fee Guideline effective August 1, 2003, and the Ingenix Endcoder Pro, CPT Code 99358 is a bundled code, and no reimbursement is recommended.[45]

2. Telephone calls (CPT Code 99372)

This service was provided on January 10, April 15, and April 30, 2003, for $21 on each date.[46]

V. EVIDENCE AND DISCUSSION

At the July 25, 2005 proceeding, Provider testified on his own behalf, called two witnesses, and offered two exhibits, which were admitted. Carrier called one witness and offered 16 exhibits, which were admitted. When the hearing reconvened on January 12, 2006, Provider again testified on his own behalf, and offered Exhibits A through P, which were admitted. Carrier offered three exhibits, which were admitted.

A. Testimony

1. Provider's testimony[47]

Provider testified that he disagrees with the IRO decision because, due to Claimant's failed back syndrome, the disputed physical therapy was helpful to Claimant.

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45 Provider testified that on September 29, 2003, he read reports and records on Claimant that he had received from Claimant's other doctors. He said that he also spent prolonged time on October 1, 2003, reviewing records from one of Claimant's other doctors.

46 Provider testified that on January 10, 2003, he was called by Carrier's nurse case manager to discuss Claimant's case and for approval of the MRI. He said that on April 15, 2003, he spoke with Carrier's representative Robin Albritton regarding the status of Claimant's case, and what supplies had been ordered for him. *See* Carrier's Exh. 14, at RM-088, which is Provider's treatment record documenting the telephone call. On April 30, 2003, a peer review doctor called Provider to go over Claimant's records and the testing that had been done. *See* Carrier's Exh. 14, at RM-090, which is Provider's treatment record documenting the telephone call.

47 Provider's testimony is also inserted as footnotes to relevant treatment and services under the "IV. Disputed Treatment and Services" section of this proposal for decision.

2. Testimony of Lynell Straughter

Lynell Straughter, Provider's office manager, testified that the resubmitted bills and EOBs are in Provider's file, and it is her usual and customary practice to submit them to the MRD when a denial for reimbursement is appealed. She believes she did submit them to the MRD. In the past, if any part of an MRD appeal was incomplete, she was contacted by the MRD and given an opportunity to complete the appeal packet, but the MRD did not notify her that it was missing the EOBs in this case. She said she did not pre-file the resubmitted bills and EOBs for the SOAH hearing because, in her experience, it is not the usual practice to present EOBs at SOAH hearings.

Based on Ms. Straughter's testimony, the ALJ re-opened the record in this case for submission of the EOBs. All but two of the EOBs in dispute were submitted at the subsequent January 12, 2006 proceeding.

3. Testimony of Scott Wallis, D.C.

Scott Wallis, D.C., testified as Provider's expert witness. He said that treatment of Claimant's 2002 compensable back injury was made more difficult by Claimant's 1992 back surgery, which is not compensable. He explained that because Claimant had a second surgery to the same area of his back following the __ injury, his post-surgery treatment fell outside ordinary treatment guidelines. Dr. Wallis said that adhering to treatment guidelines is reasonable when a patient has no significant history of injury, but that more treatment is necessary for a chronic pain patient such as Claimant.

On cross examination, Dr. Wallis testified that his testimony is only related to the

medical necessity of the disputed services. He said periodic review of Claimant's progress every 30 days was necessary to determine if a change in treatment was warranted, and muscle and range of motion testing on January 30, 2003, and July 30, 2003, was required to monitor changes in Claimant's strength and range of motion.

4. Testimony of Michael A. Booth, D.C.

Michael A. Booth, D.C., Carrier's expert witness, testified that Provider's treatment of Claimant from October 2002 through February 2003 was reasonable and medically necessary. He said Provider's treatment of Claimant from March through November 2003 had no beneficial effect and no reimbursement is warranted except for the office visits, which should be reimbursed as part of Claimant's ongoing case management. He said that from March through November 2003, Claimant would have done just as well performing active rehabilitation in a home exercise program with office visits to check his progress every two weeks or monthly.

Dr. Booth explained that the disputed treatment was not consistent with treatment guidelines. He said there is no evidence in the notes he reviewed that Claimant suffered an exacerbation, in which case one or two office visits within one week of the exacerbation would have been appropriate to treat acute symptoms.

On cross examination, Dr. Booth testified that failed back syndrome, such as Claimant has, is difficult to treat and agreed "to a point" that it might take longer to treat and require more care than ordinary back injuries. He explained that a patient with failed back syndrome could experience a higher element of pain and mechanical problems. But he cautioned that active rehabilitation could exacerbate the patient's failed back syndrome symptoms.

B. Documentary Evidence

1. Peer Review by Mike O'Kelley, D.C.[48]

In an October 5, 2003 peer review, Mike O'Kelley, D.C., found that due to Claimant's failed back syndrome, chiropractic care other than prn[49] care was not necessary after Claimant's July 22, 2003 maximum medical improvement (MMI) date.[50] He said if Claimant had an exacerbation, an office visit would be reasonable and necessary for the doctor to document and evaluate Claimant's status.[51] However, Dr. O'Kelley did not find documentation or anything in his discussion with Provider of an exacerbation directly related to work.[52]

Dr. O'Kelley found that passive care was warranted for Claimant for up to four weeks following his September 11, 2002 back surgery, with an end date of October 11, 2002.[53] He also stated that multiple injections such as Claimant had on May 20, 2003, require concurrent active therapy care, but not after Claimant's MMI date of July 22, 2003.[54] He concluded that the end date of chiropractic office visits and manipulations should have been July 22, 2003, short of an exacerbation of Claimant's compensable injury.[55] Dr. O'Kelley reported that he spoke with Provider on October 3, 2003, who told him Claimant did not require any further durable medical equipment and that there was no objective rationale for additional diagnostic testing as of that date.[56]

2. Mark Cwikla, M.D.

48 Carrier's Exh. 6, at RM-030 through RM-035.
49 prn *abbr* [Latin *pro re nata*] as needed; as the circumstances require–used in writing prescriptions. Merriam Webster's Medical Dictionary (1995), p. 557.
50 *Id*., at RM-031.
51 *Id.*, at RM-033.
52 *Id*., at RM-034.
53 *Id*., at RM-032.
54 *Id*, at RM-033.
55 *Id.*
56 Carrier's Exh. 6, at RM-034.

On January 9, 2003, Mark Cwikla, M.D., saw Claimant and concluded there was nothing more to offer him except pain management.[57]

3. Highpoint Pain Management

Mary L. Claire, M.D., and Michael Ranier. M.D., of Highpoint Pain Management, treated Claimant from December 17, 2002, through October 16, 2003.[58] On March 3, 2003, Dr. Claire prescribed pain medication to address Claimant's low back pain.[59] On March 14, 2003, she found Claimant to have chronic low back pain with radicular symptoms and multiple trigger points that were significantly relieved for one week with trigger-point injections.[60]

On April 1, 2003, Claimant complained of a reoccurrence of severe neck pain, headaches, and upper trapezius pain. Dr. Claire assessed him to have chronic low back pain, anxiety and muscle spasms, and depression secondary to chronic pain. She recommended a series of botulism toxin injections into his trigger point areas as soon as possible.[61]

On May 6, 2003, Dr. Claire recommended a series of three lumbar epidural steroid injections to treat Claimant's ongoing low back pain with radicular pattern, and recommended that he continue with medication to treat anxiety, muscle spasms, and neuropathic pain.[62]

Claimant was given trigger point injections on May 20, 2003, and reported almost

57 Carrier's Exh. 7, at RM-036.
58 Carrier's Exh. 9, at RM-048 through RM-065
59 Carrier's Exh. 9, at RM-052.
60 Carrier's Exh. 9, at RM-053 through RM-054, and RM-055.
61 Carrier's Exh. 9, at RM-056.
62 Carrier's Exh. 9, at RM-058.

complete relief of his neck pain and headaches following the injections.[63]

Michael Ranier, M.D., conducted a follow-up pain consultation with Claimant on June 27, 2003.[64] He found Claimant had made very little or any progress since beginning physical therapy in February 2003. Claimant was still ambulating with a straight cane for left leg weakness. Dr. Ranier noted that although Claimant had not reached MMI, Provider had given him a 42 percent whole person rating for his right upper extremity and his spine. Dr. Ranier concluded that Claimant's series of trigger point injections had been successful, and recommended Botox injections, epidural steroid injections, and a pain medication prescription.

On October 16, 2003, Dr. Ranier saw Claimant in a follow-up visit for neck pain.[65] He observed that according to the physical therapy daily note for October 14, 2003, Claimant reported he was still experiencing no relief from his current symptoms, that his stressful home life is having significant impact on his pain levels, and that a fall against a door frame earlier that week caused a significant increase in his symptoms.[66] Dr. Ranier stated that he believes Claimant will be on pain medication for the rest of his life; will be at MMI once he finishes therapy and learns his exercises; and that Claimant needs to see a psychologist because social problems are manifesting physically.

Dr. Ranier also noted that Claimant was making variable progress in regards to the objective measurements taken during his initial evaluation. He stated that Claimant's cervical range of motion as well as his shoulder range of motion was decreasing, but his strength was increasing slightly. Dr. Ranier recommended that because of Claimant's stressful home situation as well as his continued re-injury or aggravation of his symptoms, it might be beneficial to seek

63 Carrier's Exh. 9, at RM-060.
64 Carrier's Exh. 9, at RM-061 through RM-063.
65 Carrier's Exh. 9, at RM-064 through RM-065.

further medical management before continuing with the rest of his physical therapy program.[67]

4. Total Pain Medicine and Anesthesiology

In a June 23, 2003 initial consultation[68] by A. L. Shaw, M.D., Claimant was assessed with depression, anxiety, occipital headaches, failed back syndrome, and lumbar facet arthropathy and lumbar radiculopathy. Dr. Shaw's treatment plan for Claimant included prescription medication and caudal and bilateral lumbar facet injections at the L3-4, L4-5, and L5-S1 levels. Dr. Shaw said the treatment was necessary to reduce the source of Claimant's pain generation and increase his strength and flexibility.

5. Deepak V. Chavda, M.D.

Deepak V. Chavda, M.D., saw Claimant in March and May 2003, and consulted with Provider about Claimant on April 17, 2003.[69] He determined on March 5, 2003, that Provider should continue providing conservative care for Claimant's cervical and thoracic spine. However, he also recommended that Claimant continue pain management medication through Dr. Claire, pain management through High Point Pain Management, and that further evaluation was needed after CT scans and x-rays to determine if surgery or injections should be considered. On May 7, 2003, Dr. Chavda discussed with Claimant that he was not a surgical candidate, and that he should see a pain specialist for medication, sympathetic blocks, or possible spinal cord stimulator. On May 8, 2003, Dr. Chavda spoke with Provider, and they agreed Claimant was probably a candidate for conservative care.

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66 *See* Carrier's Exh. 11, at RM-072.
67 *Id*,. at RM-073.
68 Carrier's Exh. 13, at RM-078 through RM-081.

6. Miguel B. Banta, Jr., M.D.[70]

Miguel B. Banta, Jr., M.D., is an anesthesiologist who specializes in pain control. On Provider's referral, Dr. Banta saw Claimant on April 2 and 23, June 11, and November 19, 2003. He recommended on each visit that Claimant continue therapy with Provider. At the November 19, 2003 visit, Dr. Banta advised Claimant that he needed to protest his MMI rating of 14 percent, because he was more injured than that due to his two back surgeries and persistent radiculitis.[71]

H. ALJ's Analysis and Conclusion

The ALJ finds Provider proved by a preponderance of the evidence that treatment provided to Claimant through February 2003, and denied by Carrier with a "V," was reasonable and medically necessary for post-surgery recovery. Both Provider and Dr. Booth–Carrier's expert witness–testified that disputed treatment rendered to Claimant by Provider through February 2003 was reasonable and medically necessary. The IRO also recommends reimbursement for these services.

Because Claimant suffered from failed back syndrome, which requires more care than is addressed in medical guidelines, and because more treatment is necessary for a chronic pain patient such as Claimant, and because Claimant underwent multiple injections in May 2003,[72] the ALJ finds that some of the disputed treatment and services provided to Claimant by Provider

69 Carrier's Exh. 15, at RM-094 through RM-105.
70 Carrier's Exh. 10, at RM-066 through RM-069.
71 Carrier's Exh. 10, at RM-069.
72 Dr. O'Kelley found that multiple injections, such as those provided to Claimant on May 20, 2003, require concurrent active therapy care, but not after Claimant's MMI date of July 22, 2003. *See* Carrier's Exh. 6, at RM-033. Dr. O'Kelley said the end date of chiropractic office visits/manipulations should have been July 22, 2003, short of an exacerbation of Claimant's compensable injury. *Id.*

after the end of February 2003 should be reimbursed, and some should not.

Overall, the ALJ recommends the following:

- the diagnostic radiology provided on October 13, 2003, in the amount of $58.58 for CPT Code 72020-WP and $63.08 for CPT Code 72110-WP be reimbursed, because Claimant fell at home and x-rays were necessary to determine if he had fractured his leg or if the hardware in his back had shifted.

- range of motion measurements (CPT Code 95851) on January 30, 2003, in the amount of $36 should be reimbursed, because the testing was necessary to ascertain Claimant's progress in physical therapy. Reimbursement is not warranted for the measurements taken on July 30, 2003, because those were taken after Claimant had reached MMI, and there had not been an exacerbation or any other reason to take the measurements.

- therapeutic procedures (CPT Code 97110) on July 8 ($105), July 23 ($140), July 29 ($140), August 12 ($137.36), and September 24, 2003 ($137.36) should be reimbursed, because the treatment relieved Claimant's pain resulting from his compensable injury. Payment is not recommended for the July 30, 2003 date of service because there is no evidence that the treatment on that date relieved Claimant's pain.

- neuromuscular re-education (CPT Code 97112) on January 17 ($35), March 6 ($35), July 23 ($35), July 29 ($35), August 12 ($35.25), September 24 ($35.25), and October 13, 2003 ($35.25) should be reimbursed, because the treatment relieved Claimant's pain. Payment is not recommended for the neuromuscular re-education provided on January 21, 2003, because the Carrier's reason for denial is not in evidence, which prevents the ALJ from determining whether Provider proved payment is warranted. Payment is not recommended for the July 30, 2003 date of service, because there is no evidence that treatment on that date relieved Claimant's pain.
- myofascial release/soft tissue mobilization (CPT Code 97250) on January 17 ($43), March 6 ($43), and July 29, 2003 ($43) should be reimbursed, because the treatment relieved Claimant's pain. Payment is not recommended for the July 23, 2003 treatment, because although the treatment is included on the original bill submitted to Carrier, it is not on the bill stamped "Request for Reconsideration."

- joint mobilization (CPT Code 97265) on March 6 ($43) and July 29, 2003 ($46) should be reimbursed, because the treatment relieved Claimant's pain.

Payment is not recommended for the January 17 and July 23, 2003 treatment, because although the treatment is included on the original bill submitted to Carrier, it is not on the bill stamped "Request for Reconsideration."

- $ therapeutic activities (CPT Code 97530) on January 17 ($35) and March 6, 2003 ($35) should be reimbursed, because the treatment relieved Claimant's pain.

- $ supplies and materials (CPT Code 99070) on June 25, 2003 ($210), for the innerspring mattress, should be reimbursed, because the MFG states reimbursement is based on Documentation of Procedure (DOP), not on a maximum allowable reimbursement (MAR).[73] Reimbursement is warranted for the chair support provided on July 23, 2003 ($50), because its use relieved Claimant's pain.

- $ prolonged physician service without direct (face-to-face) patient contact (CPT Code 99358) on October 29, 2003 ($84) should not be reimbursed, because Provider presented no evidence to contradict Carrier's reason for denial of payment. Reimbursement for prolonged physician service on September 29 and October 1, 2003, is not warranted, because the MFG changed August 1, 2003, rendering this service part of a bundled code.

- $ telephone calls (CPT Code 99372) conducted on June 23, 2003 ($23) and November 3, 2003 ($23) should be reimbursed, because it was medically necessary for Provider to arrange for Claimant to see a pain management doctor on June 23, 2003, and because Provider had to coordinate care for Claimant, who had developed a blood clot in his leg, on November 3, 2003. Reimbursement is not warranted for the telephone call on June 13, 2003, because Provider did not prove he conferred with an interdisciplinary team comprised of multiple individuals, but rather, only spoke with Claimant. Reimbursement is not warranted for telephone calls on January 10 ($21), April 15 ($21) and April 30, 2003 ($21), because Provider did not prove that these conversations were outside the scope of normal practice.

- $ whirlpool equipment (CPT Code E1399) provided on July 23, 2003 ($495) should not be reimbursed, because there is no evidence it was medically necessary to treat Claimant's compensable injury.

Based on the above recommendations, Carrier is to reimburse Provider the amounts listed above.

73 *See* MFG, at page 1-2, and 60.

VI. FINDINGS OF FACT

1. Claimant suffered a compensable injury to his neck and low back___, when he fell from a four-foot ladder onto concrete.

2. Fidelity & Guaranty Insurance (Carrier) was the workers' compensation insurance carrier for Claimant's employer when his compensable injuries occurred.

3. Prior to his compensable injury, Claimant had successful lumbar spine surgery in 1992, involving a unilateral right-sided pedicle screw fixation at L5-S1, and was asymptomatic until his compensable injury occurred.

4. Following the ___ fall, Claimant was diagnosed with an L4-L5 disk herniation. Conservative treatment did not relieve his back pain, so on September 11, 2002, he underwent a left L-4 hemilaminectomy, and left L4-L5 microdiskectomy with foraminotomy with excision of prior fusion.

5. Post-operatively, on December 17, 2002, Claimant met with Carl M. Naehritz III, D.C. (Provider), who is associated with High Point Pain Management, for a pain consultation regarding his continuing low back pain.

6. Provider's treatment of Claimant included intensive physical therapy from December 18, 2002, through November 3, 2003.

7. Claimant suffers from failed back syndrome and chronic pain.

8. Claimant was placed at maximum medical improvement (MMI) on July 22, 2003.

9. As of November 19, 2003, Claimant continued with pain and depression, with no significant relief or improvement from his physical therapy.

10. Claimant has not worked since May 2002, due to his chronic back pain.

11. Provider's treatment of Claimant included the following:

    a. Spine and Pelvis radiologic examination, one level (CPT Code 72020-WP)

       The amount in dispute is $58.58 for the October 13, 2003 service.

b. Spine and pelvis complete, with oblique views (CPT Code 72110-WP)

The amount in dispute is $63.08 for the October 13, 2003 service.

c. Manual muscle testing (CPT Code 95831)

Treatment was provided on January 30 ($39) and July 30, 2003 ($116).

d. Range of motion measurements (CPT Code 95851)

The amount in dispute is $36 for the January 30, 2003 service, and $144 for the July 30, 2003 measurements.

e. Therapeutic procedures (CPT Code 97110)

Treatment was provided on July 8 ($105), July 23 ($140), July 29 ($140), July 30 ($140), August 12 ($137.36), and September 24, 2003($137.36).

f. Neuromuscular re-education of movement (CPT Code 97112)

Treatment was provided on January 17 ($35), January 21($35), March 6 ($35), July 23 ($35), July 29 ($35), July 30 ($35), August 12 ($35.25), September 24 ($35.25), and October 13, 2003 ($35.25).

g. Myofascial release/soft tissue mobilization (CPT Code 97250)

The disputed amount is $43 for each date of service–January 17, March 6, July 23, and July 29, 2003.

h. Joint mobilization (CPT Code 97265)

The disputed amount is $43 for treatment on January 17 ($43), March 6 ($43), July 23 ($43) and July 29, 2003 ($46).

i. Therapeutic activities (CPT Code 97530)

The disputed amount is $35 for treatment on January 17, 2003, and $35 for treatment on March 6, 2003. The Medical Fee Guideline describes the treatment under this CPT Code as “Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional

performance), each 15 minutes."

j. Supplies and materials provided over and above those usually provided with the office visit (CPT Code 99070)

Supplies were provided on December 18, 2002 ($85); an innerspring mattress was provided on June 25 ($210) and a chair support on July 23, 2003 ($50).

k. Office visit (CPT Code 99213)

Carrier has reimbursed Provider for office visits on October 1 and October 29, 2003, and this service is no longer in dispute.

l. Prolonged physician service without direct (face-to-face) patient contact (CPT Code 99358)

Services were provided on September 29 (x2) ($168), October 1($84) and October 29, 2003 ($84).

m. Telephone calls (CPT Code 99372)

Service was provided on January 10 ($21), April 15 ($21), April 30 ($21), June 13 ($21), June 23 ($23) and November 3, 2003 ($23).

n. Whirlpool equipment (CPT Code E1399)

Treatment was provided on July 23, 2003 ($495).

12. Provider requested reimbursement for the treatment and services outlined in Finding of Fact No. 11, which Carrier denied using various denial codes.

13. Provider filed a request for medical dispute resolution with the Texas Workers' Compensation Commission's Medical Review Division (MRD), asking for reimbursement for the above-described services, as well as for other services that are not in dispute in this proceeding.

14. The MRD referred the dispute to an independent review organization (IRO) which issued a decision on June 7, 2004, finding that physical therapy provided to Claimant by Provider from December 18, 2002, through February 2003, was medically necessary, but that treatment provided from March 2003 through November 2003 was not, because the

Claimant did not show improvement. The IRO reviewer stated that in January 2003, a repeat MRI suggested more surgical pathology, another reason not to continue with non-helpful physical therapy.

15. The IRO decision addressed only medical necessity for services provided from December 30, 2002, through October 13, 2003; the MRD addressed additional issues regarding the disputed dates of service.

16. On November 16, 2004, the MRD issued its decision ordering reimbursement for some of the services in dispute in this proceeding and denying reimbursement for others.

17. On November 23, 2004, Provider contested the MRD decision, requesting a hearing before the State Office of Administrative Hearings (SOAH).

18. On February 3, 2005, *a* notice of the hearing in this case was mailed to Provider and Carrier.

19. 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.

20. On July 25, 2005, SOAH Administrative Law Judge Sharon Cloninger convened and recessed the hearing in the William P. Clements Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Provider appeared *pro se*. Carrier was represented by W. Jon Grove, attorney. The hearing reconvened on January 12, 2006. Both parties appeared. The hearing concluded and the record closed that same day.

21. Provider's treatment of Claimant from December 18, 2002, through the end of February 2003 was medically necessary to treat Claimant's post-surgery back pain, and reimbursement is warranted.

22. Reimbursement for the following treatment and services should be as follows:

    a. The diagnostic radiology provided on October 13, 2003, in the amount of $58.58 for CPT Code 72020-WP and $63.08 for CPT Code 72110-WP be reimbursed, because Claimant fell at home and x-rays were necessary to determine if he had fractured his leg or if the hardware in his back had shifted.

    b. Range of motion measurements (CPT Code 95851) on January 30, 2003, in the amount of $36 should be reimbursed, because the testing was necessary to

ascertain Claimant's progress in physical therapy. Reimbursement is not warranted for the measurements taken on July 30, 2003, because those were taken after Claimant had reached Maximum Medical Improvement on July 22, 2003, and there had not been an exacerbation or any other reason to take the measurements.

c. Therapeutic procedures (CPT Code 97110) on July 8 ($105), July 23 ($140), July 29 ($140), August 12 ($137.36), and September 24, 2003 ($137.36) should be reimbursed, because the treatment relieved Claimant's pain resulting from his compensable injury. Payment is not recommended for the July 30, 2003 date of service because there is no evidence that the treatment on that date relieved Claimant's pain.

d. Neuromuscular re-education (CPT Code 97112) on January 17 ($35), March 6 ($35), July 23 ($35), July 29 ($35), August 12 ($35.25), September 24 ($35.25), and October 13, 2003 ($35.25) should be reimbursed, because the treatment relieved Claimant's pain. Payment is not recommended for the neuromuscular re-education provided on January 21, 2003, because the Carrier's reason for denial is not in evidence, which prevents the ALJ from determining whether Provider proved payment is warranted. Payment is not recommended for the July 30, 2003 date of service, because there is no evidence that treatment on that date relieved Claimant's pain.

e. Myofascial release/soft tissue mobilization (CPT Code 97250) on January 17 ($43), March 6 ($43), and July 29, 2003 ($43) should be reimbursed, because the treatment relieved Claimant's pain. Payment is not recommended for the July 23, 2003 treatment, because although the treatment is included on the original bill submitted to Carrier, it is not on the bill stamped "Request for Reconsideration."

f. Joint mobilization (CPT Code 97265) on March 6 ($43) and July 29, 2003 ($46) should be reimbursed, because the treatment relieved Claimant's pain. Payment is not recommended for the January 17 and July 23, 2003 treatment, because although the treatment is included on the original bill submitted to Carrier, it is not on the bill stamped "Request for Reconsideration."

g. Therapeutic activities (CPT Code 97530) on January 17 ($35) and March 6, 2003 ($35) should be reimbursed, because the treatment relieved Claimant's pain.

h. Supplies and materials (CPT Code 99070) on June 25, 2003 ($210), for the innerspring mattress, should be reimbursed, because the MFG states reimbursement is based on Documentation of Procedure (DOP), not on a

maximum allowable reimbursement (MAR).[74] Reimbursement is warranted for the chair support provided on July 23, 2003 ($50), because its use relieved Claimant's pain.

i. Prolonged physician service without direct (face-to-face) patient contact (CPT Code 99358) on October 29, 2003 ($84) should not be reimbursed, because Provider presented no evidence to contradict Carrier's reason for denial of payment. Reimbursement for prolonged physician service on September 29 and October 1, 2003, is not warranted, because the MFG changed August 1, 2003, rendering this service part of a bundled code.

j. Telephone calls (CPT Code 99372) conducted on June 23, 2003 ($23) and November 3, 2003 ($23) should be reimbursed, because it was medically necessary for Provider to arrange for Claimant to see a pain management doctor on June 23, 2003, and because Provider had to coordinate care for Claimant, who had developed a blood clot in his leg, on November 3, 2003. Reimbursement is not warranted for the telephone call on June 13, 2003, because Provider did not prove he conferred with an interdisciplinary team comprised of multiple individuals, but rather, only spoke with Claimant. Reimbursement is not warranted for telephone calls on January 10 ($21), April 15 ($21) and April 30, 2003 ($21), because Provider did not prove that these conversations were outside the scope of normal practice.

k. Whirlpool equipment (CPT Code E1399) provided on July 23, 2003 ($495) should not be reimbursed, because there is no evidence it was medically necessary to treat Claimant's compensable injury.

VII. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this case, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely requested a hearing contesting the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission), as specified in 28 TEX. ADMIN. CODE (TAC) § 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TAC § 148.4(b).

74 *See* MFG, at page 1-2, and 60.

4. Provider, as the petitioner, has the burden of proving the case by a preponderance of the evidence.

5. Based on the above Findings of Fact and Conclusions of Law, and pursuant to TEX. LABOR CODE § 408.021(a), Carrier should reimburse Provider as set out in Finding of Fact No. 22.

ORDER

IT IS ORDERED THAT Fidelity & Guaranty Insurance Company is to reimburse Carl M. Naehritz III, D.C., in the amount set out above for the disputed treatments and services rendered to Claimant from December 18, 2002, through November 3 2003.

SIGNED March 10, 2006.

_____

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS