SOAH DOCKET NO. 453-05-3361.M5
TWCC MR NO. M5-04-2146-01

COTTON D. MERRITT, D.C., **Petitioner**	**BEFORE THE STATE OFFICE**
V.	**OF**
TEXAS MUTUAL INSURANCE COMPANY **Respondent**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

Cotton D. Merritt, D.C. (Provider) disputes a decision of an independent review organization (IRO) on behalf of the Texas Workers' Compensation Commission (TWCC)/Medical Review Division (MRD) regarding Texas Mutual Insurance Company's (Carrier's) denial of payment for various services provided Claimant from April 30, 2003, through July 18, 2003, including office visits (CPT 99213), therapeutic exercises (CPT 97110), and therapeutic activities (CPT 97530).[1] The IRO/MRD found that with a few exceptions these medical services were not medically necessary to treat Claimant's compensable injury. As set out below, the Administrative Law Judge (ALJ) finds that the disputed medical services provided by Provider from April 30, 2003, to May 12, 2003, were not medically necessary, but the disputed medical services provided from July 9, 2003, to July 18, 2003, were medically necessary.

On ___, Claimant, a 51-year-old female, sustained a compensable injury to her right knee when she slipped and fell twisting her right knee. As a result of the compensable injury, Claimant went to Provider for treatment on April 14, 2003. Provider's diagnosis included a strain and sprain

1 According to Provider and Carrier, the amount in dispute is $980. Carrier's attorney agreed Carrier had not filed a cross appeal challenging the amounts the MRD/IRO had ordered Carrier to pay Provider. Provider agreed that he was only challenging the claims denied as not medically necessary. Those medical services denied by the MRD for being billed in an amount exceeding that permitted by the medical fee guidelines, Provider agreed are not in dispute. Those services include CPT codes 97139-ME, 97035, and 97032 billed on April 15 and 16, 2003, and CPT code 97530 billed on April 18, 22, May 5, July 9 through 14, and July 16, 2003 (only two hours may be billed, not the 2.25 billed by Provider).

of the lateral collateral ligaments with a probable tear of the lateral meniscus and infrapatellar bursitis.[2] The following day, Provider began treating Claimant with conservative care which included physical therapy in conjunction with a home exercise program. When Claimant failed to respond to this treatment, Provider referred Claimant for an MRI.

On April 29, 2003, Claimant had an MRI which showed evidence of a medial meniscal tear and patella chondromalacia.[3] According to Provider, when he received the MRI report, he referred Claimant to a local orthopedic surgeon, Owen Dewitt, M.D., for a surgical consultation. However, Provider continued to provide chiropractic care to Claimant, including physical therapy, through May 12, 2003.[4] On May 13, 2003, Dr. DeWitt evaluated Claimant's right knee and recommended surgical intervention.

On May 30, 2003, Dr. Dewitt performed a medial meniscal repair, chondroplasty of the patella, medial femoral condyle, and tibial plateau on Claimant's right knee. Provider initiated postoperative rehabilitative care on June 18, 2003, and Carrier paid for these postoperative therapeutic activities until July 9, 2003. From July 9, 2003, to July 18, 2003, Carrier denied payment for all rehabilitative services provided Claimant except for one 15-minute unit of therapeutic activities. During this time, Claimant began experiencing periodic locking and catching in her right knee. On August 18, 2003, Dr. Dewitt examined Claimant's knee and referred her for another MRI. Ultimately, Claimant underwent a second knee surgery. However, this occurred outside the dates of service in dispute in this matter and will not be discussed further.

Carrier initially paid for Provider's services to treat Claimant's right knee. However, Carrier denied payment for the medical services provided on April 30, 2003 and May 2 to May 12, 2003, prior to surgery, and for the medical services provided from July 9 to July 18, 2003, following the surgery, with the exception of one 15-minute unit billed for therapeutic activities. Provider maintains these treatments were medically necessary and should have been paid. Carrier disagrees.

Carrier's expert, David Alvarado, D.C., opined that a trial of conservative care lasts twelve

2 Ex. P-1 at 40 and Ex. R-2 at 6.

3 Ex. P-1 at 59.

4 Ex. P-1 at 23-27.

sessions, usually three times a week for four weeks. Provider chose to provide daily care, providing the twelve sessions in just over two weeks. By April 29, 2003, Provider had exhausted this trial period. In addition, by this time the MRI showed that Claimant had a meniscus tear and any further physical therapy was counterproductive because the tear must be repaired first.

Dr. Alvarado's opinion is consistent with the IRO's decision. Once Provider received the MRI report on April 30, 2003, the IRO opined:

> "It was not reasonably necessary or appropriate, and in fact counterproductive to continue 60 minutes of therapeutic exercise, which included full weight-bearing, flexion and extension, squats, lunges and stair-stepping for a patient with credible medical evidence of a meniscal tear and moderate chondromalacia of patella. Upon being made aware of these conditions, the prudent chiropractor would have discontinued those therapeutic exercise activities and arrange for orthopedic surgical consultation post haste."[5]

Following Claimant's knee surgery, Carrier also denied payment for all but one unit of therapeutic activities and care provided to Claimant between July 2 and 18, 2003. According to Dr. Alvarado, Claimant should have been able to do these exercises without one-to-one supervision because Claimant had been doing the same exercises since she first began treatment with Provider. Carrier paid Provider for all the units billed for one-on-one supervision on six occasions prior to July 2, 2003. This, Dr. Alvarado asserts, was more than enough one-on-one supervised therapy and Claimant did not require any more. Instead, Claimant should have been either in a group setting or on a home-based therapy program.

Under cross-examination, Dr. Alvarado conceded that he rarely does postoperative rehabilitation.

Provider had the burden of proof in this matter. Provider established that it was reasonable to provide physical therapy to Claimant until he had received the MRI report. Provider received the report on April 30, 2003, and knew, or should have known, that Claimant had a meniscal tear which required at a minimum a surgical consultation to determine if surgery was needed to repair this tear. Based upon the evidence, the disputed medical services provided by Provider to Claimant on April 30, 2003, and May 2, 5, 7, and 12, 2003, were contraindicated and not medically necessary.

5 Ex. R-1 at 6.

As for the therapeutic activities following Claimant's knee surgery, the evidence supports Provider's assertion that these services were medical necessary. Claimant returned to Provider for post surgical rehabilitation on June 18, 2003. While the exercises were similar to those Claimant had been doing before the surgery, she was again in an acute phase of recovery. The IRO found the therapeutic activities billed from July 9 to July 18, 2003, were not medically necessary. However, the IRO went on to write:

> A reasonable duration of postoperative rehab services or rehabilitation services should have been anticipated by the carrier. The duration for these services should be consistent with the Texas Worker's Compensation lower extremity treatment guidelines and peer review medical literature. [6]

The IRO explained that the lower extremity guidelines allow for up to two months of primary treatment, and the medical literature supports 12 to 16 weeks of structured rehabilitation. Provider had provided Claimant only four weeks of therapeutic activities when Carrier denied payment for all services billed for each date, except one 15-minute unit of therapeutic activities. Provider explained that Claimant was still in the acute phase of rehabilitation and argued that because this course of rehabilitative therapy provided Claimant was consistent with the time specified in both the lower extremity guidelines and the medical literature, Carrier improperly denied these claims. Moreover, Provider maintains that on July 9, 2003, Claimant could not do the exercises in a group setting or at home because she needed to be monitored closely so that incremental changes could be made in her performance and to ensure she did not hurt herself.

Based on the evidence, Provider proved that the disputed medical services provided to Claimant on July 9 through July 18, 2003 for postoperative rehabilitation were provided in a manner consistent with medical literature and were medically necessary. Claimant was still recovering from surgery to her right knee and required Provider's one-on-one supervision to monitor her performance during this acute phase and to make incremental adjustment to how she performed these therapeutic activities. Therefore, the ALJ finds that the disputed medical services provided by Provider to Claimant from July 9 to July 18, 2003, were medically necessary.

6 Ex. R-1 at 6.

II. FINDINGS OF FACT

1. On ___, Claimant sustained a work-related injury to her right knee as a result of her work activities (compensable injury).

2. At the time of Claimant's compensable injury, Claimant's employer's workers' compensation insurance carrier was Texas Mutual Insurance Company (Carrier).

3. On April 14, 2003, Claimant went to Cotton D. Merritt, D.C. (Provider), for treatment of her compensable injury.

4. Provider diagnosed Claimant's right knee as a sprain and strain with a probable tear of the lateral meniscus and infrapatellar bursitis. Provider initiated conservative chiropractic care which included therapeutic exercises in conjunction with a home exercise program.

5. Claimant did not respond to the Provider's conservative treatment and continued to experience pain and locking in her right knee.

6. Provider referred Claimant for an MRI.

7. On April 29, 2003, Claimant underwent an MRI of her right knee that showed evidence of a medial meniscal tear and patella chondromalacia.

8. A surgical consultation was required to determine if surgery was necessary to repair the meniscal tear in Claimant's right knee.

9. Provider referred Claimant to a local orthopedic surgeon, Owen Dewitt, M.D., for a surgical consultation.

10. It was not medically necessary for Claimant to continue participating in therapeutic exercises if surgery were required to repair the meniscal tear in her right knee.

11. Provider continued to provide one-on-one supervision to Claimant during therapeutic exercises through May 12, 2003.

12. On May 13, 2003, Dr. Dewitt examined Claimant and found that her knee would not heal without surgical intervention.

13. On May 30, 2003, Dr. Dewitt performed a medial meniscal repair, chondroplasty of the patella, medial femoral condyles and tibial plateau on Claimant's right knee.

14. Provider began providing postoperative rehabilitative care to Claimant on June 18, 2003, which included therapeutic exercises and activities similar to those she performed before the surgery.

15. Carrier paid for the medical services until July 9, 2003, when Carrier denied the payment for the medical services as unnecessary treatment, except for one 15-minute unit of therapeutic activities billed on each occasion.

16. On July 9, 11, 14, 16, and 18, 2003, Provider provided Claimant with several units of one-

on-one supervision during her therapeutic exercises and activities because Claimant's postoperative condition required constant monitoring to ensure she did the exercises properly and did not harm herself and to make incremental changes while she was exercising.

17. Through July 18, 2003, Claimant required one-on-one supervision because she continued to experience some locking in her right knee and was still in the acute phase of rehabilitation and was not ready to do the exercises independently or in a group setting.

18. Provider filed a request for medical dispute resolution with the Texas Workers' Compensation Commission (TWCC).

19. On November 9, 2004, an independent review organization (IRO) reviewed the medical dispute and found that the disputed medical services were not medically necessary.

20. Based on the IRO's findings, TWCC's Medical Review Division (MRD) declined to order reimbursement to Provider for the disputed medical services provided to Claimant from April 30 to July 16, 2003.

21. After the MRD order was issued, the Provider asked for a contested-case hearing by a State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ).

22. Required notice of a contested-case hearing concerning the dispute was mailed to the parties.

23. On July 28, 2005, SOAH ALJ Catherine C. Egan held a contested-case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Attorney Ryan Willett appeared for Carrier. Provider appeared telephonically and represented himself. The hearing concluded and the record closed on that same day.

III. CONCLUSIONS OF LAW

1. 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 TEX. LABOR CODE ANN. (Labor Code) §§ 402.073(b) and 413.031(k) and TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

3. Based on the above Findings of Fact and Gov't Code § 2003.050 (a) and (b), 1 TEX. ADMIN. CODE (TAC) § 155.41(b) (2004), and 28 TAC §§ 133.308(v) and 148.14(a), Provider has the burden of proof in this case.

4. 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 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. Labor Code § 408.021 (a).

5. Based on the above Findings of Fact and Conclusions of Law, the disputed medical services provided by Provider to Claimant from April 30 to May 12, 2003, were not medically necessary to treat Claimant's compensable injury.

6. Based on the above Findings of Fact and Conclusions of Law, the disputed medical services provided by Provider to Claimant from July 9 to July 18, 2003, were medically necessary to treat Claimant's compensable injury.

ORDER

IT IS ORDERED THAT Cotton D. Merritt, D. C., is not entitled to reimbursement from Texas Mutual Insurance Company for the disputed medical services provided Claimant from April 30, 2003, to May 12, 2003. It is further **ORDERED** that Cotton D. Merritt, D.C., is entitled to reimbursement from Texas Mutual Insurance Company for the disputed medical services provided Claimant from July 9, 2003, to July 18, 2003.

SIGNED September 26, 2005.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS