SOAH DOCKET NO. 453-05-3364.M5
TWCC MDR NO. M5-04-3521-01

JCMLR, P.A. (ALAMO HEALTHCARE), Petitioner	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
TEXAS MUTUAL INSURANCE COMPANY, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

JCMLR, P.A. (Alamo Healthcare), the Provider, appealed the decision of Texas Medical Foundation, an independent review organization (IRO), in Texas Workers' Compensation Commission (TWCC)[1] Medical Review Division (MRD) tracking number M5-04-3521-01, denying reimbursement for medical services provided to the Claimant. This decision orders that Texas Mutual Insurance Company, the Carrier, is not required to reimburse the Provider for the contested services.

The Administrative Law Judge (ALJ) convened the hearing on September 8, 2005. The hearing was concluded and the record closed that day. The Provider appeared through its representative Alan Tysinger, attorney, and the Provider appeared through its representative Jessica Allen, attorney.

[1] Effective September 1, 2005, the functions of TWCC were transferred to the newly created Division of Workers' Compensation of the Texas Department of Insurance.

II. EVIDENCE AND BASIS FOR DECISION

The issue presented in this proceeding is whether the Carrier should reimburse the Provider for medical services provided from June 17, 2003, through August 22, 2003, and billed under CPT Codes 99213 (office visit), 99212 (office visit), 99211 (office visit), 97012 (mechanical traction), 97116 (gait training), 97010 (hot or cold packs), 97035 (ultrasound), 97112 (neuromuscular re-education), 97110 (therapeutic exercises), 97250 (myofascial release), 97265 (joint mobilization), 99080 (special reports), and 94760 (oxygen saturation, single determination). The Carrier argued that none of the contested medical services provided to the Claimant were medically necessary or reasonably required to treat the compensable injury. The parties asserted that approximately $2,330 is in dispute.

The documentary record consisted of one exhibit presented by the Provider, Exh. 1 (260 pages), and four exhibits submitted by the Carrier, Exh. 1 (335 pages), Exh. 2 (44 pages), Exh. 3 (91-page deposition of Robert C. Lowry, M.D.), and Exh. 4 (17-page deposition of Spiro Ioannides, D.C.).[2] Additionally, Jarrod Mitchell Cashion, D.C., testified as an expert witness on behalf of the Carrier, and Rick Ball, a dispute analyst, testified for the Carrier.[3] The Provider did not offer oral testimony at the hearing, relying solely on the documentation submitted in its exhibit.

The Claimant, a 42-year-old man, suffered an injury to his lower back on___, while working as a grounds keeper.[4] He was initially seen by a company physician, Susan Allen, D.O., who prescribed medications, physical therapy, and return to light duty work. The Claimant's condition

[2] Drs. Lowry and Ioannides are employed by the Provider.

[3] The testimony of Rick Ball established that the Carrier's file did not contain a request from the Provider for the Claimant's participation in either a work conditioning or a work hardening program. Delivery of these services was not an issue appealed by the Provider and, therefore, was not an issue in this proceeding. Hence, Mr. Ball's limited testimony is not summarized in this Decision and Order.

[4] C. Exh. 1, p. 4.

did not improve, and on December 20, 2002, he began seeing Dr. Ioannides, who performed an initial

evaluation and diagnosed the Claimant with lumbar disc syndrome, lumbar sprain/strain, restricted range of motion, and muscle spasms. The Claimant was treated by Dr. Ioannides with a variety of physical medicine modalities and a rehabilitation program.[5]

The Provider pointed to specific medical records to support its claim of medical necessity:

1. An electromyogram performed on February 5, 2003, revealed chronic multilevel radicular syndrome at the L4, L5, and S1 levels, without acute denervation changes. The reviewer believed that the patient was a good candidate for surgical consultation if no improvement of muscle strength or pain syndrome followed physical therapy.[6]

2. The Claimant was diagnosed with disc pathology consisting of herniated disc at L3-L4 and L4-L5.[7] A CT scan of the lumbar spine performed on May 7, 2003, showed disc herniation at the L3-L4 and L4-L5 levels.[8] On the same date, a lumbar myelogram revealed grade 1 spondylolisthesis at L3-L4, spinal stenosis at L4-L5 with narrowed disc space, and narrowed discs at both the L3-L4 and L4-L5 levels.[9]

3. A designated doctor examination performed on August 12, 2004, found that the Claimant suffered from a lumbar sprain without evidence of radiculopathy and that he was continuing to receive therapy to his lower back.[10] The Provider argued that progress notes from August 2003 showed that the Claimant's pain level had decreased.[11]

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[5] C. Exh. 1, p. 112.

[6] C. Exh. 1, p. 127.

[7] C. Exh. 1, p. 163.

[8] C. Exh. 1, p. 149.

[9] C. Exh. 1, p. 150.

[10] C. Exh. 1, pp. 128 - 130.

[11] C. Exh. 1, pp. 326 - 330.

Dr. Cashion has been licensed as a chiropractor in Texas for 10 years. In preparation for his testimony, he reviewed the Claimant's medical records and the depositions of the treating physicians.

Dr. Cashion testified that reasonable physical therapy for a diagnosis of sprain/strain is six visits for two weeks, with an additional 20 visits if improvement is shown. He stated that the treatment provided for the Claimant was not medically necessary because there was neither objective functional improvement nor subjective improvement. Dr. Cashion referred to various pages of the medical records, which showed that the Claimant's range of motion did not improve and actually decreased during the Provider's treatment.[12] Additionally, Dr. Cashion identified pages from the medical records verifying that the Claimant did not report subjective improvement of pain level from the Provider's treatment.[13]

Further, Dr. Cashion testified that the Claimant's sprain/strain injury should have resolved by early 2003 because a lumbar strain is primarily a pulled muscle with inflammation.[14] Additionally, he explained that CPT Code 97110 requires one-on-one supervision, which was not provided because Dr. Ioannides admitted in his deposition that the therapist involved was supervising other patients at the same time he was supervising the Claimant.[15] Dr. Cashion concluded by stating the contested services were not medically necessary in his opinion.

The ALJ concludes the Provider failed to prove that the contested medical services were medically necessary and reasonably required to treat the Claimant's compensable injury. The deposition testimony of Dr. Ioannides confirmed that treatment billed at the one-on-one level of supervision was delivered in a group setting. Further, the testimony of Dr. Cashion established that

[12] C. Exh. 1, pp. 246, 252, 260, 266, 295, 307, 315, and 322.

[13] C. Exh. 1, pp. 287, 292, 300, 302, 303, 326, 327, 328, and 330.

[14] He admitted that a severe sprain/strain may have disc involvement.

[15] C. Exh. 4, p. 14.

that it was necessary for the Claimant to show improvement for the treatment to continue after the first several weeks for a lumbar strain/sprain injury, and the extended treatment of the Claimant did not produce either subjective or objective improvement.

III. FINDINGS OF FACT

1. On___, the Claimant suffered a compensable injury to his lower back.

2. The Claimant's injury is covered by workers' compensation insurance written for the Claimant's employer by Texas Mutual Insurance Company, the Carrier.

3. JCMLR, P.A. (Alamo Healthcare), the Provider, began treating the Claimant on December 20, 2002, for a diagnosis of lumbar sprain/strain, back spasms, restricted range of motion, and lumbar disc syndrome.

4. The Carrier denied reimbursement to the Provider for medical services provided between July 17, 2003, and August 22, 2003, and billed under CPT Codes 99213 (office visit), 99212 (office visit), 99211 (office visit), 97012 (mechanical traction), 97116 (gait training), 97010 (hot or cold packs), 97035 (ultrasound), 97112 (neuromuscular re-education), 97110 (therapeutic exercises), 97250 (myofascial release), 97265 (joint mobilization), 99080 (special reports), and 94760 (oxygen saturation, single determination) on the basis that the treatment was not medically necessary to treat the injury.

5. Treatment billed at the one-on-one level of supervision was delivered in a group setting.

6. The Claimant's injury was a lumbar sprain/strain with nothing to indicate major disc injury.

7. The physical therapy delivered by the Provider was reasonable for only two weeks unless the Claimant showed improvement.

8. The extended treatment of the Claimant did not produce either subjective or objective improvement.

9. The Provider timely requested dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC).

10. On October 8, 2004, in MRD Tracking No. M5-04-3521-01, the MRD issued its decision adopting the independent review organization decision concluding that the disputed services were not medically necessary, and the Provider timely appealed.

11. TWCC sent notice of hearing to the parties on February 3, 2005. The hearing notice informed the parties of the matter to be determined, the right to appear and be represented by counsel, the time and place of the hearing, and the statutes and rules involved.

12. The hearing on the merits convened September 8, 2005, before Michael J. Borkland, Administrative Law Judge. The Provider appeared through Alan Tysinger, attorney. The Carrier appeared through Jessica Allen, attorney.

IV. CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction related to this matter pursuant to Acts of May 30, 2005, 79th Leg., R.S., ch. 265, 2005 Tex. Sess. Law Serv. Ch 265 (HB 7) and TEX. LAB. 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 TEX. LAB. CODE ANN. §413.031 and TEX. GOV'T CODE ANN. ch. 2003.

3. Based on Finding of Fact No. 11, the Notice of Hearing issued by TWCC conformed to the requirements of TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

4. The Provider has the burden of proving by a preponderance of the evidence that it should prevail in this matter. TEX. LAB. CODE ANN. §413.031.

5. Based on Findings of Fact Nos. 5 - 8, the services referred to in Finding of Fact No. 4 were not medically necessary.

6. Based on Findings of Fact Nos. 5 - 8 and Conclusion of Law Nos. 4 and 5, reimbursement for the disputed medical services should not be required.

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company is not required to reimburse JCMLR, P.A. (Alamo Healthcare) for disputed services provided for treatment of the Claimant.

SIGNED November 3, 2005.

MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS