SOAH DOCKET NO. 453-05-4066.M5
MRD NO. M5-04-4212-01

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

DECISION AND ORDER

I. INTRODUCTION

This case presents a challenge by Waco Ortho Rehab (Provider) to portions of a decision by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission)[1] based in part on a determination by an independent review organization (IRO) regarding the medical necessity for specified chiropractic treatments. The IRO found that the insurer, Texas Mutual Insurance Company (Carrier), properly denied reimbursement for some disputed services and should have reimbursed Provider for others. Provider appealed only those portions of the MRD decision that did not recommend reimbursement.

Provider challenged the decision on the basis that the treatment at issue was, in fact, medically necessary, within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision agrees with the MRD findings and decision that no further reimbursement to Provider is required, with the exception of the disputed group therapy services, which should be reimbursed.

[1] Effective September 1, 2005, the duties of the Commission have been transferred to the Texas Department of Insurance, Division of Workers' Compensation.

II. JURISDICTION AND VENUE

No party challenged jurisdiction or venue. Therefore, those matters are set out in the findings and conclusions without further discussion here.

III. STATEMENT OF THE CASE

The hearing in this docket was convened on September 1, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Ami L. Larson presided. Provider was represented by William Maxwell, attorney, who appeared in person. Carrier was represented by attorney Ryan Willett, who was also present at the hearing. Both parties presented evidence and argument at the hearing. In order to allow for the submission of a revised table of disputed services, the record was held open until September 8, 2005, at which time it closed.

The record revealed that on _____, the claimant suffered a compensable injury that produced pain in his lower back and extremities. He continued to work for two weeks before he went to the emergency room as a result of his injury. At that time, he was examined, X-rays were performed, and he was prescribed prescription pain medication. Claimant stopped working on May 27, 2003, and before seeing Provider, he underwent an MRI as well as two weeks of various active and passive physical medicine treatments. Based on the available record, it appears that Claimant did not receive treatment for approximately two months before he presented to Provider on August 12, 2003, for an initial evaluation. Provider then treated Claimant during the period of disputed services from August 13 through November 4, 2003.

When Provider subsequently billed Carrier (the insurer for Claimant's employer) for chiropractic services from August 13 through November 4, 2003, Carrier denied reimbursement for several of the services provided. Carrier's denials of payment were based on various grounds including medical necessity of the disputed treatments, duplicate charges, bundling, and noncompliance with Medicare fee or methodology guidelines. Provider sought medical dispute resolution through the Commission.

The IRO, to which the Commission referred the portion of the dispute, issued a decision on December 17, 2004, regarding the issues of medical necessity and concluded that Provider should be reimbursed for some of the disputed services, but should not for others. The MRD adopted the IRO's decision and addressed on its own those issues in dispute for reasons other than medical necessity. The MRD found that some of those services should be reimbursed, but others should not, and issued a decision incorporating its own findings as well as those of the IRO on December 21, 2004. Provider made a timely request for review before SOAH of the portions of the IRO and MRD decisions that did not recommend reimbursement.[2]

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Provider

Provider presented four documentary exhibits and the testimony of David Bailey, D.C., a principal for Provider, who took issue with the IRO's conclusions regarding the medical necessity of disputed services provided to Claimant. Specifically, Dr. Bailey stated there is no evidentiary basis to support the IRO conclusion that those services were not medically necessary.

Dr. Bailey testified that the treatment he provided to Claimant was appropriate for the musculoskeletal injury from which he suffered. He developed the treatment plan employed based on his expectation that it would yield a positive health outcome for Claimant. Dr. Bailey testified that the services provided were, therefore, medically necessary treatment by definition.

Additionally, Dr. Bailey stated that he has done his own investigation and research regarding one-on-one therapy and believes it yields superior results to any less-supervised setting such as group treatment or home exercise programs. Dr. Bailey discussed two scenarios where he believes one-on-one therapy is appropriate- the "stroke rehabilitation model" and the "performance enhancement model." Under the stroke model, intensive supervision is needed for safety or cognitive concerns. Stroke was not a factor for this claimant. Dr. Bailey testified that under his "performance

[2] The parties stipulated that the services provided on August 12, 2003, were not part of this dispute since the request for medical dispute resolution was not filed timely as to this date.

enhancement model," a patient who does not need direct supervision for safety or cognitive concerns still benefits from the one-on-one supervision because that protocol results in greater and more rapid levels in physical performance, compared to lesser levels of supervision. Consequently, Dr. Bailey testified the one-on-one therapy is always more appropriate because it is more effective.

In addressing the IRO's concerns about this claimant's lack of progress, Dr. Bailey asserted that his burden in determining medical necessity for prospective medical review should not be the same as for retrospective medical review. Retrospective medical review has none of the uncertainty of future outcomes to consider. Dr. Bailey believes it is unfair to hold providers accountable for good results in each patient, when the best medical judgment has been used to determine the medical necessity of their treatment up front with the information available at the time.

Moreover, Dr. Bailey stated, although Claimant's pain levels did not significantly decrease over the course of his treatment, his level of function improved substantially and Claimant was ultimately able to return to work with restrictions, thereby supporting the medical necessity of the treatment he provided.

With respect to the services denied by Carrier for reasons other than medical necessity, Provider argued that Carrier introduced no evidence to support the payment exception codes it cited and MRD did not address the exception codes raised, but denied payment for other reasons with respect to several of the disputed services. Provider argued that, therefore, it should be reimbursed for those services.

B. Carrier

Carrier submitted one documentary exhibit and called David Alvarado, D.C., to testify. Dr. Alvarado stated that, based on his review of the medical records regarding Claimant's treatment history, there is nothing in Provider's notes to justify the need for more than 45 minutes of one-on-one exercise per session or the need for the number of one-on-one therapy sessions provided. He believed that the amount of one-on-one therapy already reimbursed by Carrier was very generous

since there is no evidence that Claimant's injury was ever severe enough to warrant such intensive treatment. Additionally, Dr. Alvarado noted that, by the time Claimant saw Provider for treatment, three months post-injury, Claimant did not have an acute injury and was able to properly perform other exercises in a group setting or at home without problem. He also noted Claimant's pain did not get better notwithstanding the treatment he received.

Specifically, Dr. Alvarado observed that the records show Claimant's treatment did not result in any permanent or significant pain relief, nor did it substantially change his range of motion. He contended the treatment administered by Provider was excessive.

Dr. Alvarado also noted that Dr. Bailey always uses the one-on-one therapy treatment protocol for all of his patients and that it is simply not cost effective as required by the Act. He believes Claimant would have been effectively served by group therapy or home exercises at much less cost.

V. ANALYSIS

A. Medical Necessity

1. One-On-One Supervised Therapeutic Exercises - CPT Code 97110

Although both parties provided credible expert testimony in this case, the ALJ was persuaded by Dr. Alvarado and the IRO findings. Dr. Bailey's policy of providing one-on-one treatment to every patient, regardless of the severity of injury, disregards the need to provide the most cost-effective alternative.

Dr. Bailey's evidence included his own authored research, which quotes a study saying that one-on-one therapy produces "a rapid increase in physical capacity (strength, flexibility, and other measures of human performance) that is intended to allow a safe return to work at the required performance level." He testified that the one-to-one supervision provides better outcomes not reached using lower levels of supervision and opined that Claimant needed this level of therapy to progress. Even if Dr. Bailey's testimony is correct that one-on-one supervision produces the very best results, the ALJ rejects Dr. Bailey's premise that workers' compensation insurance is intended to provide exceptional or the highest level of care at any cost.

A workers' compensation patient is entitled to that treatment equal in cost to similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. *See* TEX. LAB. CODE ANN. § 413.011(b). The goal of the Act and the Commission's rules is to ensure both the quality of medical care and achieve effective cost control. In short, medically necessary care must be both effective and economical. TEX. LAB. CODE ANN. § 413.011(b). Absent some showing that the highest level of care is both the most economical and represents what an arm's-length private payer patient, of average means, would have considered reasonable, use of CPT Code 97110 under a "performance enhancement" standard was not warranted, especially when effective but less costly treatment options were available. Additionally, the record reflects that Claimant was participating in group and home exercises without any difficulties at the same time he was being provided with one-on-one supervised exercises. Provider failed to prove that one-on-one treatment for this injury was medically necessary.

2. Other Services Denied Based on Medical Necessity

Several other disputed services were denied based on medical necessity grounds as well. These services included the following passive therapy modalities: massage therapy,[3] re-freezable cryo packs,[4] consumable TENS supplies,[5] biofreeze,[6] electrical stimulation therapy,[7] chiropractic manipulation - spinal,[8] and mechanical traction therapy - full spine.[9] Dr. Bailey testified that these passive treatments were provided in order to reduce Claimant's pain, swelling, and muscle spasms, and increase his mobility and circulation and that he administered them because he thought they would be beneficial.

[3] CPT Code 97124.

[4] CPT Code 99070-DME#33.

[5] CPT Code 99070-DME #5 or 6.

[6] CPT Code 99070-DME#28.

[7] CPT Code 97139 EU.

[8] CPT Codes 98940 and 98941.

[9] CPT Codes 97012.

The record shows, however, that Claimant's pain was not reduced during the course of this treatment and there is no indication in the record about why or how Dr. Bailey felt that the specific therapies administered would be helpful to Claimant. Dr. Alvarado testified credibly that passive treatment modalities are generally only effective and necessary during an acute stage of an injury, although he stated that it may be reasonable to employ some passive treatment modalities during the initial one to two weeks of therapy in order to develop a treatment plan.

There was no evidence to show that Claimant's injury was acute by the time he sought treatment from Provider, approximately three months post-injury. Carrier already reimbursed or agreed to reimburse Provider for the electrical stimulation and massage therapy through August 22, 2003. Provider failed to meet its burden of proof to show why any of the other passive treatment modalities or any electrical stimulation or massage therapy beyond what Carrier reimbursed were medically necessary.

Accordingly, the undersigned ALJ finds that Carrier should not reimburse Provider for the above-mentioned disputed services since they were not shown to be medically necessary.

The remaining disputed services denied on medical necessity grounds consist of office visits,[10] group therapeutic procedures,[11] and the Delorme muscle testing performed on September 9, 2003.[12]

With respect to the office visits, Provider has failed to show why these visits were necessary in light of the fact that Claimant was regularly seeing the doctor for one-on-one treatment and therapy. The ALJ, therefore, finds that Carrier should not reimburse Provider for the disputed office visits.

Based on the record, it appears that the group therapeutic exercises provided were medically reasonable and necessary to treat Claimant's injury. There is no evidence in the record to indicate

[10] CPT Code 99212.

[11] CPT Code 97150.

[12] CPT Code 97750.

that these services were excessive in scope or duration and, therefore, the ALJ finds that Carrier should reimburse Provider for group therapeutic exercises performed during the period of disputed services.

There is nothing in the record to indicate why Delorme muscle testing was required on September 9, 2003, since Claimant had recently undergone a full evaluation on August 12, 2003. Therefore, the ALJ finds that Carrier should not reimburse Provider for the cost of this testing.

B. Services Denied Based on Grounds Other Than Medical Necessity

A variety of services were denied by Carrier on grounds other than medical necessity. For those services, Carrier cited denial codes "Y",[13] "G",[14] or "D".[15] Since medical necessity was not at issue regarding those services, they were not addressed by the IRO,[16] but rather by the MRD. The MRD reviewed and issued a decision regarding those services. The MRD decision regarding the services denied by Carrier under exception code "Y", however, appear to have been denied by MRD for reasons unrelated to the "Y" code cited by Carrier.

At the hearing, Provider argued strenuously it should prevail and be reimbursed for all of those services since there was no evidence in the record regarding the "Y" code and the MRD did not address that code in its decision. The ALJ disagrees. The Commission is charged with reviewing medical care and ensuring treatments and services are appropriately provided and billed.[17] Although a Carrier is generally prohibited from later raising any new bases for denial that were not initiated

[13] The parties agreed that a "Y" Code is used when a Carrier denies payment based on Medicare Fee or Methodology Guidelines.

[14] "G" stands for "unbundling" and is properly cited when a Carrier denies payment because the charge for a given service was included in another billed procedure.

[15] Code "D" means "duplicate bill" and is used to deny payment where a Carrier has previously processed identical charges.

[16] Carrier denied payment for multiple services based on both the "U" Code as well as an additional non "U" or "V" Code that did not raise the issue of medical necessity. The IRO addressed all disputed services that denied based on medical necessity even if another code was cited as well. The Parties agreed that the medical necessity determination renders moot any other bases for denial by Carrier to the extent that those double-coded services are found to be medically unnecessary by the ALJ.

[17] TEX. LAB. CODE ANN. §§ 413.013 and 413.018.

before the MRD, the Commission is not, nor should it be bound by a Carrier's rationales for denying payment for services.

In this case, MRD did not recommend reimbursement for the "Y" coded services based on a lack of documentation to support the provision of or need for one-on-one therapy. The ALJ agrees with MRD that there is no documentation to support the need for the one-on-one therapy provided beyond the sessions already reimbursed by Carrier.

To the extent that Provider seeks to litigate the specific denial codes raised by Carrier during the SOAH hearing, it is Provider who must bear the burden of proof to show why the disputed services should not be denied for the reasons cited by Carrier through its use of denial codes and corresponding explanations. In this case, Provider presented no evidence regarding Medicare Fee or Methodology Guidelines or duplicate billing and, therefore, Provider cannot and does not meet the burden required to prevail on these issues.

VI. CONCLUSION

Pursuant to the record provided in this case, the disputed group therapy services billed under CPT Code 97150 were shown to be medically necessary and reasonable and should be reimbursed. All remaining disputed services need no further reimbursement for the reasons stated above.

VII. FINDINGS OF FACT

1. On _____, Claimant suffered a compensable injury that produced pain in his lower back and extremities.

2. Claimant continued to work for the two weeks following his injury.

3. Two weeks after his injury, Claimant presented to the emergency room where he was examined, X-rays were performed, and he was prescribed prescription pain medication.

4. Claimant underwent an MRI and received two weeks of various active and passive physical medicine treatments following his emergency room exam.

5. Claimant stopped working on May 27, 2003, due to pain and dysfunction caused by his workplace injury.

6. Claimant presented to Waco Ortho Rehabilitation (Provider) on August 12, 2003, at which time Dr. Bailey performed an evaluation of Claimant.

7. Claimant began receiving chiropractic treatment from Provider on August 13, 2003, and continued this treatment until after November 4, 2003.

8. Provider billed Texas Mutual Insurance Company (Carrier) for chiropractic services from August 13 through November 4, 2003, and Carrier denied reimbursement for several of those services.

9. Carrier's denials of payment were based on various grounds including medical necessity, duplicate charges, and noncompliance with Medicare fee or methodology guidelines.

10. Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission).

11. The Medical Review Division (MRD) of the Commission referred the medical necessity portion of the dispute to an Independent Review Organization (IRO), which issued a decision on December 17, 2004.

12. The MRD incorporated the findings of the IRO and further reviewed those services for which payment was denied on grounds other than medical necessity. The MRD issued its findings and decision on December 21, 2004.

13. Provider timely requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of those portions of the MRD decision that did not recommend reimbursement.

14. The Commission mailed notice of the hearing to all parties.

15. A hearing in this matter was convened on September 1, 2005, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Ami L. Larson, an Administrative Law Judge with SOAH. Provider and Carrier were represented by counsel.

16. During the course of treatment with Provider, Claimant's pain levels did not appreciably decrease.

17. Claimant's injury was not acute by the time he saw Provider for treatment.

18. Passive treatment modalities such as massage therapy, re-freezable cryo packs, consumable TENS supplies, biofreeze, electrical stimulation therapy, chiropractic manipulation therapy and mechanical traction therapy are generally effective only for treatment of acute injuries.

19. Claimant was cooperative with treatment and able to successfully perform exercises in a group setting and on his own at home.

20. The group therapeutic exercises provided to Claimant were medically necessary and reasonable to treat his injury.

21. The expensive and intensive one-on-one services billed under CPT Code 97110 were not reasonable and necessary to treat Claimant's injury.

22. The passive treatment modalities employed were not reasonable and necessary to treat Claimant's injury.

23. The Delorme muscle testing performed on September 9, 2003, was not medically reasonable and necessary.

24. The office visits billed were not reasonable or necessary since Claimant was regularly seeing Provider for one-on-one therapy sessions.

25. Provider failed to present any evidence regarding issues of Medicare fee and methodology guidelines or duplicate billing.

VIII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 413.031.

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

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE (TAC) § 133.305(g) and §§ 148.001-148.028.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Provider, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.14(a).

6. Carrier should reimburse Provider for group therapy sessions billed under CPT Code 97150.

7. The other disputed treatment and services represent health care that was not medically reasonable or necessary under § 408.021of the Act and, therefore, should not be reimbursed.

ORDER

IT IS THEREFORE ORDERED that Texas Mutual Insurance Company should not further reimburse Waco Ortho Rehab for any disputed services other than the disputed group therapy sessions billed under CPT code 97150, which should be reimbursed.

SIGNED November 7, 2005.

AMI L. LARSON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS