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SOAH DOCKET NO. 453-05-4086.M5
MRD DOCKET NO. M5-05-0823-01

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

DECISION AND ORDER

Cotton D. Merritt, D.C., ("Petitioner") challenged the decision of an independent review organization ("IRO") on behalf of the Texas Workers' Compensation Commission ("Commission")[1] in a dispute regarding the medical necessity of chiropractic therapy. The IRO found that the insurer, Texas Mutual Insurance Company ("Respondent"), properly denied reimbursement for some of the physical therapy and related services that Petitioner provided to a claimant between November 20, 2003, and February 6, 2004.

Petitioner challenged the decision on the grounds 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 that of the IRO, finding that reimbursement of Petitioner for the disputed services should be denied.

I. JURISDICTION, NOTICE, AND VENUE

The Commission (or its successor agency) has jurisdiction over this matter pursuant to § 413.031 of the Act. The State Office of Administrative Hearings ("SOAH") has jurisdiction over

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

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. No party challenged jurisdiction, notice, or venue.

II. STATEMENT OF THE CASE

The hearing in this docket was convened and adjourned on November 8, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge ("ALJ") Mike Rogan presided. Petitioner represented himself and appeared by telephone. Respondent was represented by Ryan Willett, Attorney. Both parties presented evidence and argument.[2]

The record revealed that on ___, the claimant suffered a compensable injury to his cervical spine. In consequence, he underwent surgical fusion at the C5/6 level of the spine on December 10, 2002. After the surgery, the claimant received little or no rehabilitative therapy for almost a year, until finally seeking such treatment from Petitioner on November 20, 2003. Petitioner administered therapy for the patient through February 6, 2004. Respondent (the insurer for the claimant's employer) subsequently denied reimbursement for much of this service, prompting Petitioner to seek medical dispute resolution through the Commission.[3]

The IRO to which the Commission referred the dispute issued a decision on December 16, 2004, concluding that some of the disputed services were not medically necessary –

[2] The staff of the Commission (or its successor agency) formally elected not to participate in this proceeding, although it filed a general "Statement of Matters Asserted" with the notice of hearing.

[3] Petitioner denied all services at issue on grounds that they were medically unnecessary (*i.e.*, denial code "V" - indicating a conclusion based upon peer review.).

i.e., all neuromuscular re-education (CPT Code 97112); all manual therapy (CPT Code 97140) in excess of one unit provided per date of service; and all services provided after January 23, 2004.[4]

The IRO stated its rationale as follows:

> [Claimant] would be entitled to a trial of care for at minimum of two weeks to determine if therapy would be beneficial in improving his condition. Due to the chronicity of this condition as the surgery was approximately one year prior to starting therapy, this timeframe may be extended. . . .
>
> By 01/23/2004, [claimant] had 12 visits of active care and did not have a significant improvement in his condition and had seemingly plateaued. . . . Guidelines suggest a 25 percent improvement in condition to indicate further care is necessary. Objective measurements do not substantiate this level of improvement from examination on 11/20/03 through 1/23/04.
>
> It does appear that two times per week may have been a case of underutilization where one would expect three times per week to encourage functional gains. Additionally, there were gaps in care through the holiday season that may have prevented [claimant] from achieving or maintaining functional gains. . . .
>
> Guidelines supportive of this recommendation are the Council of Chiropractic Physiological Therapeutics & Rehabilitation Guidelines, Mercy Conference Guidelines and Rand Consensus Panel. Therapy recommendations are derived utilizing Rehabilitation for the Postsurgical Orthopedic Patient, Maxey and Magnusson, Mosby 2001.

The Commission's Medical Review Division ("MRD") confirmed the IRO's decision in a separate decision dated January 13, 2005. Petitioner then made a timely request for review of the IRO and MRD decisions before SOAH, seeking reimbursement for all services billed but not approved in this case.

At the SOAH hearing, however, Petitioner withdrew his contention that Respondent should have approved or reimbursed any services under CPT Code 97112. The focus of this contested case

[4] The IRO also found the other disputed services in this case to be medically necessary. Respondent did not challenge these findings, and reimbursement for these other services is accordingly not at issue.

was thus narrowed to CPT Code 97140 services (in excess of one unit provided per date of service) and all services provided after January 23, 2004.

III. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Petitioner

Petitioner, a licensed chiropractor, testified that Medicare guidelines allow up to an eight-week trial run of physical therapy, which typically would encompass 18 to 24 visits by the patient. In the claimant's case, however, only 12 visits were completed between November 20, 2003, and January 23, 2004, because of holiday interruptions and the claimant's need to travel a significant distance (about 30 miles) to the clinic.

Nonetheless, Petitioner stated, the claimant did achieve a 25-percent improvement over the first two months of his physical therapy, contrary to the IRO's analysis. In terms of overall impairment, the claimant went from a rating of 12 percent on November 20, 2003, to a rating of 8 percent on January 23, 2004, based upon deficiencies in range of motion ("ROM") for the cervical spine. The claimant's rating thus improved by one-third during this period, and he achieved a like improvement - to a rating of 4 percent - by February 6, 2004.

Moreover, Petitioner asserted, the eight-week limit in the Medicare guidelines applies only in the absence of "neurologic compromise." In this case, such neurological impairment existed, in the form of persisting radiculopathy experienced by the claimant. According to Petitioner's clinical notes, the patient's radiculopathy did not really begin to subside until February 2, 2004.

In response to questions about the claimant's need for protracted one-on-one supervision during his therapy, Petitioner testified that chronic pain syndrome and other loss of function had set in during a year of neglect, between the claimant's surgery and his beginning therapy, and these circumstances necessitated such supervision.

B. Respondent

Respondent presented the testimony of David Alvarado, D.C., who, after reviewing case records, concluded that the IRO correctly found that the claimant failed to show an objectively measured 25-percent improvement during his first two months of therapy. Examining the patient's recorded performance from November 20, 2003, through January 23, 2004, Dr. Alvarado noted that the claimant registered the following percentages of improvement in measurements of ROM:

* Flexion	17 percent
* Extension	0 percent
* Rotation	20 percent
* Right bend	17 percent
* Left bend	33 percent

These results average out to between 15 and 20 percent, he added - which was not, in his view, sufficient to justify continuing the disputed therapy beyond January 23, 2004.

Dr. Alvarado also objected to Petitioner's comparison of successive impairment ratings as a means of gauging the extent of the claimant's improvement during therapy. Impairment ratings are not, in themselves, objective measurements of condition, he contended, but rather represent conventionalized calculations or extrapolations from such measurements, providing a generalized view of a patient's relative physical functionality

The specific type of treatment administered by Petitioner in this case also drew Dr. Alvarado's criticism. He asserted that no need existed for one-to-one supervision of the claimant's therapeutic exercises (CPT Code 97110), at least after a short initial period of instruction. The record, he said, reflects none of the reasons that would justify such close supervision - such as complexity of exercises, constant changes in the therapeutic program, significant threat that the

patient might sustain injury during the program, or some other need for constant monitoring or assessment of the patient. Rather, by January 23, 2004, the claimant's progress in therapy had reached a plateau, and he readily could have been shifted to a unsupervised home-exercise program.

Dr. Alvarado agreed that difficulties in traveling to the clinic or in adhering to a treatment schedule during holidays could interfere with a patient's normal progress in therapy. However, he concluded that, in this case, the initial two months of therapy provided a reasonable period in which to fully assess the propriety of further therapy, even taking into account the perhaps lower-than-optimal number of treatment sessions administered during that time.

Dr. Alvarado also acknowledged that the claimant suffered some neurological compromise, which could alter the normal application of the guidelines pertaining to appropriate periods of physical therapy.

IV. ANALYSIS

Both parties presented credible expert testimony, reflecting plausible differences of opinion about the propriety of the services in dispute. However, Petitioner bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. He has not discharged that burden, in the ALJ's view.

Medicare guidelines cited by both parties in this case state the following:

> It is expected that patients undergoing rehabilitation therapy for musculoskeletal injuries in the absence of neurologic compromise will transition to self-directed physical therapy within two months. [This principle] recognizes variability in strength, recovery time, and the ability to be educated, and allows for a recertification for additional therapy, as long as adequate medical documentation by the supervising physician is recorded in the medical record and the patient continues to demonstrate progress. It is expected that at the two-month interval those patients undergoing will be transitioned to fully self-directed care modalities directed towards mobilization and strengthening. Only the more refractory cases requiring additional therapy are expected to continue beyond this point and additional documentation of necessity and medical certification by the supervising physician is required.

While this provision allows for some flexibility, it is rather emphatic in declaring that only "more refractory" cases should entail more than two months of physical therapy. The ALJ does not believe that Petitioner has shown this to be one of those "more refractory" cases, nor has he presented evidence of additional documentation or "recertification" to satisfy the guidelines. Although the record indicates that the claimant suffered some "neurologic compromise," it provides little or no explanation as to how that condition affected the structure or timing of the claimant's prescribed therapeutic regimen. Petitioner also failed to rebut with any specificity the declaration of the IRO that its decision on the disputed services was in accord with various applicable guidelines for chiropractic quality and practice.

The ALJ also concludes that Dr. Alvarado has offered a more valid analysis than Petitioner of how to quantify changes in the objective measurements of the claimant's condition. While the ROM test results cited by Dr. Alvarado are unequivocally "objective measurements" of the patient's condition (as referred to in the IRO decision), the impairment ratings cited by Petitioner are more accurately described as derivations from such objective measurements - which also incorporate various complex assumptions about the extent to which the affected portion of the body contributes to the overall physiological functionality of the patient.

Petitioner provided no specific, concrete explanation for utilizing one-to-one supervision in CPT Code 97110 therapeutic exercises, rather than some less intensive mode of therapy.

Moreover, the parties simply did not specifically address, to any substantive degree, the CPT Code 97140 services raised by the IRO.

V. CONCLUSION

The ALJ finds that, under the record provided in this case, the disputed medical services (*i.e.*, CPT Code 97140 services in excess of one unit provided per date of service, as well as all services provided from January 26 through February 6, 2004) were not shown to be medically necessary. Reimbursement for these services should be denied, accordingly, as initially determined by the IRO.

VI. FINDINGS OF FACT

1. On ___, claimant suffered an injury to his cervical spine that was a compensable injury under the Texas Worker's Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. The claimant's injury ultimately necessitated surgical fusion at the C5/6 level of the spine on December 10, 2002.

3. Cotton D. Merritt, D.C., ("Petitioner") provided the claimant a variety of post-surgical chiropractic therapies and related medical services on dates of service from November 20, 2003, through February 6, 2004.

4. Petitioner sought reimbursement for services noted in Finding of Fact No. 3 from Texas Mutual Insurance Company ("Respondent"), the insurer for claimant's employer.

5. Respondent denied the reimbursement for much of the service billed by Petitioner.

6 Petitioner made a timely request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

7. The independent review organization ("IRO") to which the Commission referred the dispute issued a decision on December 16, 2004, concluding that some of the disputed services were not medically necessary - *i.e.*, all neuromuscular re-education (CPT Code 97112); all manual therapy (CPT Code 97140) in excess of one unit provided per date of service; and all services provided from January 26 through February 6, 2004.

8. The MRD reviewed and concurred with the IRO determination noted in Finding of Fact No. 7, in a decision dated January 13, 2005 (dispute resolution docket No. M5-05-0823-01).

9. Petitioner requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the IRO and MRD decisions, insofar as they denied reimbursement for disputed services.

10. The Commission mailed notice of the setting of a hearing to the parties on February 9, 2005. Upon information that Respondent failed to receive the initial notice, SOAH issued proper notice to the parties of a rescheduled hearing.

11. A one-day hearing in this matter was convened before SOAH on November 8, 2005. Petitioner and Respondent were represented.

12. Under applicable Medicare guidelines, patients undergoing rehabilitation therapy for musculoskeletal injuries should progress to self-directed physical therapy within two months, except in "more refractory" cases.

13. Petitioner has not shown the claimant's case to be one of those "more refractory" cases requiring therapy in excess of that noted in Finding of Fact No. 12.

14. Therapeutic services provided to the claimant on January 26, 2004, and thereafter were not consistent with the time limitations noted in Finding of Fact No. 12.

15. During the two-month time period noted in Finding of Fact No. 12, claimant did not exhibit a 25 percent improvement in condition, as shown by objective measurements, in order to substantiate a need for further therapeutic care.

16. Petitioner did not rebut the declaration of the IRO, in the decision noted in Finding of Fact No. 8, that its decision on the disputed services was in accord with applicable guidelines for chiropractic quality and practice.

VII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (or its successor agency, the Texas Department of Insurance) 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. ADMINISTRATIVE 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. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

6. Based upon the foregoing Findings of Fact and Conclusions of Law, the disputed treatments for the claimant noted in Finding of Fact No. 7 do not represent elements of health care medically necessary under § 408.021of the Act.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the IRO's findings and decision in this matter, issued on December 16, 2004, were correct; Petitioner's request of reimbursement for disputed services in this case should be denied.

ORDER

IT IS THEREFORE, ORDERED that Texas Mutual Insurance Co. should not reimburse Cotton D. Merritt, D.C., for medical services provided from January 26 through February 6, 2004, nor for any neuromuscular re-education services (CPT Code 97112), nor for any manual therapy (CPT Code 97140) in excess of one unit provided per date of service - in accordance with the findings and decision of an independent review organization issued in this matter on December 16, 2004.

SIGNED December 6, 2005.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS