SOAH DOCKET NO. 453-05-4125.M5
TWCC MR NO. M5-04-4164-01

PATRICK R. DAVIS, D.C., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
LIBERTY MUTUAL FIRE INSURANCE COMPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case concerns the medical necessity of medical services and durable medical equipment provided by Petitioner Patrick R. Davis, D.C., to J.H., a workers' compensation claimant (the Claimant) from September 2, 2003, through December 19, 2003. The amount in dispute is $12,255.13. The Administrative Law Judge (ALJ) finds some services provided from November 17 through November 24, 2003, were medically necessary. He finds the remainder of the disputed services either were not necessary or were not submitted for reimbursement. The ALJ concludes Dr. Davis should be reimbursed an additional $1,007.90.

I. FACTUAL AND PROCEDURAL HISTORY

The Claimant sustained injuries to her neck, right shoulder, mid-back, right elbow, and right wrist in a work-related automobile accident on ___. She began conservative chiropractic treatment with Dr. Davis on March 24, 2003. An EMG on May 15, 2003, revealed carpal tunnel syndrome on the right (moderately severe) and traumatic radial tunnel syndrome on the right (severe). On June 17, 2003, the Claimant underwent a right radial tunnel release and a right carpal tunnel release. She resumed treatment with Dr. Davis on July 21, 2003.

The treatments and services provided by Dr. Davis included the following:

Description	CPT Code
manual therapy (15-minute units)	97140
neuromuscular reeducation	97112
electric muscle stimulation	97032
therapeutic procedures (one-on-one supervision)	97110
analgesic supplies	99070
chiropractic manipulation	98943
ultrasound	97035
therapeutic activities	97530
complex office visit	99215
neuromuscular stimulator	E0745
durable medical equipment	E1399

The workers' compensation carrier, Liberty Mutual Insurance Company (LMIC) declined to reimburse Dr. Davis for treatments provided from August 4, 2003, through December 19, 2003. After unsuccessfully requesting reconsideration, Dr. Davis, on August 6, 2004, filed a request for medical dispute resolution with the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission).[1] The MRD referred the medical necessity issues to an Independent Review Organization (IRO). The IRO found the services provided on August 11 and 22 and September 2, 5, 8, 10, 12, 15, and 16 were medically necessary, although it limited CPT code 97110 to two units per treatment session. It found the services provided after September 16, 2003, were not medically necessary.

The MRD itself reviewed some services for which reimbursement had been denied for reasons other than medical necessity. It ordered reimbursement for CPT Code 97040 for eleven dates of service and for CPT code E0745 for one date of service. It denied reimbursement of CPT Code 98943 for eleven dates of service in August 2003 because of lack of documentation.[2] It also denied reimbursement for all services provided on December 4, 2003, because it found no evidence

[1] Under legislation effective September 1, 2005, the Texas Workers' Compensation Commission was abolished and its functions transferred to the Division of Workers' Compensation at the Texas Department of Insurance (TDI).

[2] Dr. Davis subsequently provided that documentation and LMIC agreed to pay for those services. See Petitioner's Ex. A.

that Dr. Davis had submitted those bills for reimbursement or that Explanations of Benefits (EOBs) had been provided.

Dr. Davis filed a timely request for a hearing before the State Office of Administrative Hearings (SOAH)[3] for the remaining amount in dispute, $12,255.13. After proper and timely notice, the hearing was held September 7, 2005, before ALJ Henry D. Card. Both parties participated in the hearing. The hearing was adjourned, and the record closed, the same day.

II. DISCUSSION

A. Burden of Proof

Under 28 TEX. ADMIN. CODE § 148.14(a), the Petitioner has the burden of proof in hearings, such as this one, conducted pursuant to TEX. LAB. CODE ANN. § 413.031.

B. December 4, 2003, Services

The record does contain documentation that services were provided on December 4, 2003.[4] However, as stated by the MRD, it contains no indication that those services were actually submitted to LMIC for reimbursement as required by the Commission's rules. The ALJ concludes Dr. Davis did not prove he should be reimbursed for the services provided on December 4, 2003.

C. Medical Necessity Issue

In reaching his decision on medical necessity, the IRO reviewer relied on *Official Disability Guidelines Treatment in Workers' Compensation*, 2004 edition.[5] The reviewer determined that physical therapy for up to 20 visits for a ten-week period was reasonable and necessary after the June

[3] LMIC did not request a hearing on the portions of the IRO and MRD decisions favorable to Dr. Davis.

[4] Respondent's Ex. A.

[5] Despite the title, these guidelines were not officially adopted by the Commission and have not been adopted by TDI.

27, 2003, surgery. The reviewer ordered additional reimbursement based on that determination. The reviewer further stated that six therapy sessions were reasonable after the October 22, 2003, nerve transposition surgery. The reviewer found that no more than two units of one-on-one therapeutic procedures (CPT Code 97110) were reasonable and necessary per session and that topical creams (CPT Code 99070) were not medically necessary and could be purchased over-the-counter.

The IRO decision and MRD decision ordered reimbursement for services provided through September 16, 2003, although they limited reimbursement for CPT Code 97110 to two units per session.[6] They did not order reimbursement for any therapy conducted after the October 22, 2003, surgery, for reasons that are not clear from the record.

LMIC's expert witness, Nick Tsourmas, M.D., testified that the Claimant's two surgeries were ordinary and uneventful and that nothing about her injury or post-operative status warranted treatment in excess of the usual levels. He stated that post-operative therapy is rare for carpal tunnel or radial tunnel release, but certainly no more than two weeks of therapy is warranted. He considered the one-on-one therapy allowed by the IRO to be more than adequate to observe the Claimant and educate her about the proper way to perform any rehabilitative exercises. Dr. Tsourmas testified that his opinion was supported not only by the *Official Disability Guidelines*, but also by the guidelines of the American College of Occupational and Environmental Medicine.

Dr. Tsourmas testified that the October 22, 2003, transposition of the ulnar nerve would require three weeks without motion, but would require little or no subsequent therapy. He further stated there was no indication whatsoever for either neuromuscular reeducation (CPT Code 97112) or chiropractic manipulation (CPT Code 98943).

Dr. Davis contended the guidelines, which by definition are general in nature, did not address the Claimant's specific condition. He pointed out that the Claimant continued to have pain after the treatments allowed by LMIC and that she eventually improved under his care. He provided detailed

[6] That limitation affects CPT Code 97110 services provided after September 2, 2003.

treatment notes. He advanced several reasons for continuing one-on-one sessions with the Claimant, including the need to avoid complicating or regressing her injuries, the need to monitor her medical disabilities and performance, the need to motivate and encourage the Claimant, and the need to observe and adjust her program as required.[7]

Although Dr. Davis proved he believed in the efficacy of his treatment program, he failed to prove its medical necessity for the Claimant. Dr. Davis asserted that the Claimant's specific condition warranted this program, but the evidence did not show how her situation differed from the situations addressed by the guidelines and why those general procedures should not have been followed in this case. The fact that she eventually improved does not prove the treatment program was necessary, because the guidelines and Dr. Tsourmas' testimony stated she would have improved with a home exercise program and the passage of time.

The ALJ found Dr. Tsourmas convincing on the specific issues of neuromuscular reeducation and chiropractic manipulation. Dr. Davis' records and testimony did not establish the need for those treatments. Moreover, Dr. Davis did not persuade the ALJ that the extensive one-on-one supervision he provided was necessary. Again, the evidence showed that less one-on-one supervision, combined with home exercise, would have been equally effective in treating the Claimant's condition.

The IRO reviewer and Dr. Tsourmas apparently disagreed on whether any therapy was needed after the October 22, 2003, nerve transposition surgery. Dr. Tsourmas did not express certainty on the subject, however, and he agreed that the *Official Disability Guidelines*, on which the IRO reviewer relied, were credible and widely recognized. The ALJ finds six sessions of therapy were medically necessary after that second surgery. Therefore, in general, Dr. Davis should be reimbursed for services provided on November 17,18, 19, 20, 21, and 24, 2003. The ALJ also finds, however, that neuromuscular reeducation (CPT Code 97112) and chiropractic manipulations (CPT Code 98943) were not medically necessary. He further finds that only two units of one-on-one supervised therapeutic procedures (CPT Code 97110) were necessary per session. Dr. Davis' records

show that the analgesic supplies at issue (CPT Code 99070) were used in the office to assist the

[7] Petitioner Ex. A at 4.

Claimant in tolerating the active procedures. Therefore, the ALJ finds those supplies to have been medically necessary.

The following services were medically necessary:

Date of Service	CPT Code	Description	Amount
11/17/2003	99215	complex office visit	$ 143.78
	E1399	durable medical equipment	32.00
	97140	manual therapy	32.55
	97032	electric muscle stimulation	19.89
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/18/2003	97140	manual therapy	32.55
	97035	ultrasound	14.93
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/19/2003	97140	manual therapy	32.55
	97140	manual therapy	32.55
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/20/2003	97140	manual therapy	32.55
	97140	manual therapy	32.55
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/21/2003	97140	manual therapy	32.55
	97032	electric muscle stimulation	19.89
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/24/2003	97140	manual therapy	32.55
	97035	ultrasound	14.93
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
Total			$1,007.90

Dr. Davis should be reimbursed for those services. The remaining services were not medically necessary and reimbursement should be denied.

III. FINDINGS OF FACT

1. ___ (the Claimant) sustained injuries to her neck, right shoulder, mid-back, right elbow, and right wrist in a work-related automobile accident on ___.

2. The Claimant began conservative chiropractic treatment with the Petitioner, Patrick R. Davis, D.C., on March 24, 2003.

3. An EMG of the Claimant on May 15, 2003, revealed carpal tunnel syndrome on the right (moderately severe) and traumatic radial tunnel syndrome on the right (severe).

4. On June 17, 2003, the Claimant underwent a right radial tunnel release and a right carpal tunnel release.

5. The Claimant resumed treatment with Dr. Davis on July 21, 2003.

6. The treatments and services provided by Dr. Davis included the following:

Description	CPT Code
manual therapy (15-minute units)	97140
neuromuscular reeducation	97112
electric muscle stimulation	97032
therapeutic procedures (one-on-one supervision)	97110
analgesic supplies	99070
chiropractic manipulation	98943
ultrasound	97035
therapeutic activities	97530
complex office visit	99215
neuromuscular stimulator	E0745
durable medical equipment	E1399

7. The workers' compensation carrier, Liberty Mutual Insurance Company (LMIC), declined to reimburse Dr. Davis for treatments provided from August 4, 2003, through December 19, 2003.

8. After unsuccessfully requesting reconsideration, Dr. Davis, on August 6, 2004, filed a request for medical dispute resolution with the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission).

9. The MRD referred the medical necessity issues to an Independent Review Organization (IRO).

10. The IRO found the services provided on August 11 and 22 and September 2, 5, 8, 10, 12, 15, and 16 were medically necessary, although it limited CPT code 97110 to two units per

treatment session.

11. The IRO found the services provided after September 16, 2003, were not medically necessary.

12. The MRD itself reviewed some services for which reimbursement had been denied for reasons other than medical necessity. It ordered reimbursement for CPT Code 97040 for eleven dates of service and for CPT code E0745 for one date of service. It denied reimbursement of CPT Code 98943 for eleven dates of service in August 2003 because of lack of documentation. It also denied reimbursement for all services provided on December 4, 2003, because it found no evidence that Dr. Davis had submitted those bills for reimbursement or that Explanations of Benefits (EOBs) had been provided.

13. Dr. Davis subsequently provided the documentation for CPT Code 98943 for the eleven dates of service in August 2003, and LMIC agreed to pay for those services.

14. Dr. Davis filed a timely request for a hearing before the State Office of Administrative Hearings (SOAH) for the remaining amount in dispute, $12,255.13.

15. Notice of the hearing was sent to the parties February 10, 2005.

16. 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.

17. The hearing was held September 7, 2005, before ALJ Henry D. Card. Both parties participated in the hearing. The hearing was adjourned, and the record closed, the same day.

December 4, 2003, Services

18. The record contains documentation that services were provided on December 4, 2003.

19. The record contains no indication that the December 4, 2003, services were actually submitted to LMIC for reimbursement as required by the Commission's rules.

Medical Necessity Issue

20. Physical therapy for up to 20 visits for a ten-week period was reasonable and necessary after the June 27, 2003, surgery. The IRO reviewer ordered additional reimbursement based on that determination.

21. Six therapy sessions were reasonable after the October 22, 2003, nerve transposition surgery.

22. No more than two units of one-on-one therapeutic procedures (CPT Code 97110) were

reasonable and necessary per session.

23. The Claimant's two surgeries were ordinary and uneventful; nothing about her injury or post-operative status warranted treatment in excess of the usual levels.

24. There was no indication whatsoever for either neuromuscular reeducation (CPT Code 97112) or chiropractic manipulation (CPT Code 98943).

25. The fact that the Claimant eventually improved does not prove the treatment program was necessary.

26. The analgesic supplies at issue (CPT Code 99070) were used in the office to assist the Claimant in tolerating the active procedures, and therefore were medically necessary.

27. The following disputed services were medically necessary:

Date of Service	CPT Code	Description	Amount
11/17/2003	99215	complex office visit	$ 143.78
	E1399	durable medical equipment	32.00
	97140	manual therapy	32.55
	97032	electric muscle stimulation	19.89
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/18/2003	97140	manual therapy	32.55
	97035	ultrasound	14.93
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/19/2003	97140	manual therapy	32.55
	97140	manual therapy	32.55
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/20/2003	97140	manual therapy	32.55
	97140	manual therapy	32.55
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/21/2003	97140	manual therapy	32.55
	97032	electric muscle stimulation	19.89

	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
11/24/2003	97140	manual therapy	32.55
	97035	ultrasound	14.93
	97110	therapeutic procedures (2 units)	68.68
	99070	analgesic supplies	15.00
Total			$1,007.90

28. The remaining disputed services were not medically necessary.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

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

3. Under 28 TEX. ADMIN. CODE § 148.14(a), the Petitioner has the burden of proof in hearings, such as this one, conducted pursuant to TEX. LAB. CODE ANN. § 413.031.

4. Dr. Davis should be reimbursed $1,007.90 for the medically necessary disputed services described in Finding of Fact No. 27.

5. Dr. Davis should not be reimbursed for the remaining disputed services.

ORDER

IT IS, THEREFORE, ORDERED that Liberty Mutual Insurance Company reimburse Patrick R. Davis, D.C., $1,007.90, plus applicable interest, for the services in dispute in this proceeding.

SIGNED November 3, 2005.

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS