SOAH DOCKET NO. 453-05-4187.M5
MRD NO. M5-05-0070-01

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

DECISION AND ORDER

I. INTRODUCTION

This case presents a challenge by Waco Ortho Rehab (Provider) to a decision of an independent review organization (IRO) on behalf of the Texas Workers' Compensation Commission (Commission or TWCC)[1] in a dispute regarding medical necessity for chiropractic treatment. The IRO found that the insurer, Texas Mutual Insurance Company (Carrier), properly denied reimbursement for physical therapy that Provider administered to a claimant suffering from lumbar back and right wrist injuries.

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 IRO, finding that no further reimbursement of Provider for the CPT Code 97110 is required, but that a few more minor claims should be reimbursed.

[1] Effective September 1, 2005, the duties of the TWCC have been transferred to the Texas Department of Insurance, Division of Worker's 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 6, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Bill Zukauckas presided. Provider was represented by William Maxwell, attorney, who appeared by telephone. Carrier was represented by Scott Placek, attorney. Both parties presented evidence and argument and the record closed the same day.

The record revealed that in early__, the claimant suffered a compensable injury to his lower back and right wrist, resulting from an attempt to lift a heavy object and put it on a high shelf. He initially went to the emergency room, and then to a medical center where he received one physical therapy treatment. He presented to Provider on September 9, 2003, and received the disputed chiropractic treatment through November 18, 2003.

When Provider subsequently billed Carrier (the insurer for the claimant's employer) for chiropractic services from September 9 through November 18, 2003, Carrier denied reimbursement on the grounds that the treatment had been medically unnecessary. Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on November 9, 2004, concluding that Provider should not receive reimbursement for the disputed services. The IRO presented the following rationale for its decision:

> No evidence was provided showing that the provided treatment actually cured or relieved the effects of the patient's injury, promoted the patient's recovery, or helped the patient return to employment. Temporary relief of pain is not equivalent to relieving the effects of the patient's injury. A report on 12/9/03 indicated the pain was "unresponsive so far to three months of conservative intervention." Patient was diagnosed with sprain/strain of the right wrist and lumbar spine, and he should have

> responded with appropriate treatment in six to eight weeks, but he failed to do so. Multiple referrals to medical specialists in December 2003 indicate that the D.C.'s treatment failed to be beneficial to the patient. An 11/24/03 FCE report indicates that the patient showed multiple limitations regarding lifting, coordination, pushing, pulling, range of motion, as well as severe psychological barriers and increased pain with testing. These results also indicate that the D.C.'s treatment failed to be beneficial to the patient. Based on the records provided for review, the treatment in dispute was over-utilized and inappropriate.

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and, on January 7, 2005, issued its own decision confirming that the disputed services were not medically necessary and should not be reimbursed (except for a few CPT codes). Provider then made a timely request for review of the IRO and MRD decisions before SOAH.

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Provider

Provider presented the testimony of David Bailey, D.C., a principal for Provider, who took issue with the IRO's conclusions in this case. Specifically, Dr. Bailey stated there is no evidentiary basis to support the IRO opinion.

Dr. Bailey testified that claimant was seen within five days after his injury. Although he admitted there was nothing special about claimant's case, he has done his own investigation and research regarding one-on-one therapy and believes it provides superior results to any lesser 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 obviously not a factor for this claimant. Dr. Bailey testified that under his "performance 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 testified 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.

B. Carrier

David Alvarado, D.C., testified for Carrier. He examined medical records and performed a peer review in the case. He testified there is nothing in Provider's notes to validate the need for more than 45 minutes of exercise per day. He noted that of the 140 units of CPT code 97110 billed, that carrier had paid for 85 units. He believed that this was more than generous because claimant's injury had no acute pathology, the claimant needed little or no one-on-one supervision, and the claimant did not get better.

Specifically, Dr. Alvarado noted that the records show claimant's did not result in permanent pain relief, nor did it substantially change his range of motion. He claimed the treatment provided 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

While 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 to 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. In this case, the claimant had only sprain/strain of the right wrist and lumbar spine. The ALJ finds that Provider failed to prove that one-on-one treatment for this injury was medically necessary.

With regard to the other CPT codes discussed in the MRD order dated January 7, 2005, the

ALJ finds that CPT codes 99070, 99070, 97211-25, 98940, 97124, 97139-BU, 98943, 97012, 99212-25, and 97750-MT, shall be paid for the reasons stated and according to the terms of that order. MRD found that CPT Code 97150 should not be paid because the documentation did not list the specific services provided and the number of persons in the group therapy. The ALJ disagrees with that decision and changes it by this order to allow reimbursement. The ALJ finds that the Provider uses that code for group warm-up exercises. Provider's notes indicate there are two or more persons in the group and the ALJ finds that sufficient for the limited purposes used by Provider. If Provider were to use this code for an individual's specific exercise plan, rather than the 97110 Code,[2] more detail about the specific activity and the number of participants in the group should be noted.

VI. CONCLUSION

The ALJ finds that, under the record provided in this case, the medical services at issue billed under CPT Code 97110 need no further reimbursement. All services billed under CPT Code 97150 are shown to be medically necessary and reasonable, and CPT codes 99070, 99070, 97211-25, 98940, 97124, 97139-BU, 98943, 9701299212-25, and 97750-MT, shall be paid for the reasons stated and according to the terms of that order dated January 7, 2005.

VII. FINDINGS OF FACT

1. In early___, claimant suffered injury to his right wrist and lumbar back, which constituted compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. On September 9, 2003, the claimant initially presented to the clinic of Waco Ortho Rehab (Provider), complaining of right wrist and lumbar back pain. The claimant began a therapeutic regimen of supervised exercise and chiropractic modalities that extended through November 18, 2003.

3. Provider sought reimbursement for services noted in Finding of Fact No. 2 from Texas Mutual Insurance Company (Carrier), the insurer for claimant's employer.

4. The Carrier denied some of the requested reimbursement.

[2] The ALJ believes the evidence suggests that would have been the proper amount of supervision of claimant for the majority of his rehabilitation therapy.

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

6. The independent review organization (IRO), to which the Commission referred the dispute, issued a decision on November 9, 2004, finding that the treatment at issue had not been medically necessary, primarily upon grounds that the one-on-one supervised rehabilitation program was excessive for that claimant's injury and not reasonable or necessary.

7. The Commission's Medical Review Division reviewed and concurred with the IRO's findings in a decision dated January 7, 2005, but allowing payment for other services.

8. Provider timely requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.

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

10. A hearing in this matter was convened on September 6, 2005, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Bill Zukauckas, an Administrative Law Judge with SOAH. Provider and Carrier were represented.

11. Provider was unable to show that the expensive and intensive one-on-one services billed under CPT Code 97110 were reasonable and necessary for this claimant with an ordinary sprain/strain of his right wrist and lumbar back.

12. Provider was able to show that all group therapy for this claimant billed under CPT Code 97150 was just used as a warm-up group exercise with two or more persons and substantially complied with the requirement for that code for these first-of-the-day warm-up exercises.

13. Provider was able to show that other codes, specifically CPT codes 99070, 99070, 97211-25, 98940, 97124, 97139-BU, 98943, 9701299212-25, and 97750-MT, were reasonable and necessary and should be paid for the reasons stated and according to the terms of the MRD order for this matter dated January 7, 2005**.**

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. Based upon Finding of Fact No.11, Provider failed to prove that services provided under CPT Code 97110 were medically necessary, therefore, no further reimbursement is warranted.

7. The treatment provided in Finding of Fact Nos. 12 and 13, represents health care medically necessary under § 408.021of the Act.

ORDER

IT IS THEREFORE ORDERED that Waco Ortho Rehab should have no further reimbursement for the major cost component in this matter, CPT Code 97110. It is further ordered that all costs billed under CPT Code 97150 are shown to be medically necessary and reasonable and should be reimbursed, and that CPT codes 99070, 99070, 97211-25, 98940, 97124, 97139-BU, 98943, 9701299212-25, and 97750-MT, shall be paid for the reasons stated and according to the terms of that MRD order dated January 7, 2005.

SIGNED November 2, 2005.

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS