DOCKET NO. 453-05-5825.M5
TWCC MR NO. M5-05-1695-01

SAN ANTONIO ACCIDENT INJURY CARE, Petitioner	§	BEFORE THE STATE OFFICE
VS.	§	OF
OLD REPUBLIC INSURANCE COMPANY, Respondent	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

The worker's compensation claimant (Claimant) in this case, a funeral director, sustained compensable injuries to her back when she was assisting in carrying a casket. Old Republic Insurance Company (Carrier), citing lack of medical necessity, declined to pay for approximately two months of therapeutic services provided by San Antonio Accident Injury Care (Provider). A reviewer with an Independent Review Organization (IRO) concluded that Provider's services were not medically necessary, except for massage therapy. Provider seeks review of that determination. This Decision and Order determines that the disputed services were not medically necessary for Claimant's treatment and orders no reimbursement.

I. DISCUSSION

A. Procedural History

The hearing was convened on November 28, 2006, before State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ) Charles Homer III. Bill Maxwell, attorney, appeared on behalf of Provider. Scot Schwartzberg, attorney, represented Carrier. The hearing adjourned, and the record closed the same day. No party raised any issue concerning notice or jurisdiction, and those matters are treated only in the Findings of Fact and Conclusions of Law below.

B. Background and List of Disputed Services

Claimant, a 45-year-old woman, was injured on , when she assisted in carrying a casket in the course of her duties as a funeral director. She suffered pain in her lower back and legs, and began therapy with Provider on May 4, 2004. She was also seen by S. Ali Mohamed, M.D., an orthopedic surgeon, who recommended epidural steroid injections (ESIs). Dr. Mohamed performed two ESIs on Claimant that are relevant to this case: the first on July 29, 2004, and the second on September 7, 2004.[1] On office visits of July 7, July 28, August 4, and August 25, Dr. Mohamed also ordered Claimant to follow up with Provider to relieve myofascial pain syndrome and to restore function in the affected area, her lumbar spine.[2]

Claimant underwent therapy with Provider approximately 20 times between May 4 and July 15, 2004. Those sessions are not in dispute in this case, which concerns only those services that Provider rendered to Claimant from July 16 through September 15, 2004, and billed under the following CPT codes:

CPT Code	Service
97110	Therapeutic exercises
97112	Neuromuscular re-education
97116	Gait training
97124	Massage therapy.

Carrier denied reimbursement for these services under denial code V – "unnecessary treatment (with peer review)."

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[1] Provider's Ex. 2, pp. 40-45.

[2] Provider's Ex. 2, pp. 103-110, 114-116.

C. IRO Decision

In a decision dated March 17, 2005, the IRO determined that the disputed services were not medically necessary. The IRO reviewer emphasized with regard to therapeutic exercises that Claimant had already been in therapy for several weeks as of July 16, 2004, and stated:

> According to the orthopedist's notes, there was adequate documentation provided to substantiate the presence of muscular spasms and myofascial pain to support the medical necessity for post-injection massage services.
>
> However, insofar as the therapeutic exercises (#97110) were concerned, there was no evidence to support the need for continued monitored therapy. . . . [T]he provider failed to establish why the services were still required to be performed one-on-one after July 16, 2004. . . .
>
> In terms of the neuromuscular re-education services (#97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate . . . this service. According to a Medicare Medical Policy Bulletin (ref.2), "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular re-education may be reasonable and necessary for Impairments (*sic*) which affect the body's neuromuscular system (e.g. poor . . . balance. . . .)."
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> And with respect to the gait training procedures (97116), the record was also devoid of any reference to gait disturbances or aberrations that would otherwise warrant . . this procedure."[3]

II. EVIDENCE AND ANALYSIS

A. Evidence

Provider's exhibits included office notes, requests for reconsideration, and daily treatment logs as well as extensive medical reports. Carrier offered the Medical Dispute Resolution Request

[3] Carrier's Ex. 1-D, pp. 2-3.

(TWCC - 60) and attachments, explanation of benefits forms (TWCC-62), the IRO decision, peer review reports, and Provider's requests for reconsideration.

The only expert who testified was Richard Alexander, D.C., Claimant's treating doctor with Provider, who testified for Provider. Dr. Alexander emphasized that Claimant, who had stopped working May 4, 2004, returned to work on December 9 of that year, and that Dr. Mohamed was able to discontinue Claimant's ESIs in November 2004. Dr. Alexander referred to the "patient exercise flow sheet" concerning the therapeutic activities,[4] and stated that those pages reflect the exercises that Claimant did, the weights she used, and the number of sets and repetitions of each or the duration where the activity was continuous.

Concerning gait training, Dr. Alexander stated that he used a treadmill for this purpose, and that Claimant showed progress by extending the duration of her activity periods and increasing the speed at which she walked.

On cross-examination, Dr. Alexander agreed that Provider noted in its requests for reconsideration that all its therapeutic exercises were administered in a group setting (97110-GP), and he stated that Provider conducted all its therapy sessions in group settings. He also conceded that Provider's records were inaccurate in many details, such as the treatment codes recorded in the daily treatment logs (SOAP notes) and the amount of time charged, but stressed that the correct codes were used on the DWC-60 forms.

B. Analysis and Conclusion

Provider stresses its reliance on Dr. Mohamed's orders concerning follow-up therapy. It is true, as Provider argues, that no evidence directly refutes Dr. Mohamed's orders. But what is disputed is whether those orders together with other credible evidence demonstrate the medical

[4] Provider's Ex. 1, pp. 46-48.

necessity of the particular treatments that Provider rendered. Neither legally nor factually do Dr. Mohamed's orders provide *carte blanche* for all treatment Provider might render.

Legally, Provider urges that previous SOAH decisions have determined that when a Provider relies in good faith on a prescription and provides the service requested, that Provider's services are medically necessary. But all three cases Provider cites for this proposition are instances where a pharmacy has simply filled a prescription.[5] While there may be a reason for applying such reasoning to pharmacists, it should not apply to treating physicians. When a claimant presents a prescription to a pharmacist, the pharmacist cannot perform a physical examination, take a history, or perform tests. He or she cannot touch the claimant. Therefore, as opposed to a treating physician, the pharmacist must rely on the prescription. The physician, as Dr. Alexander testified, makes his own treatment decisions, at least in the absence of very specific orders.

Factually, as previously noted, Dr. Mohamed's orders state two purposes for the therapy he proposed: treatment of Claimant's myofascial pain syndrome and increasing the function of her lower back. The orders do not themselves indicate a need for either neuromuscular re-education or gait training. Nor does Provider point to a specific physical condition or limitation, such as a neurological deficit or learning difficulty, that would require either therapy. Neither Provider's records nor Dr. Alexander's testimony establish a specific condition and rationale for their necessity. Thus, although the record in this proceeding is apparently much more complete than that before the IRO reviewer, it still provides insufficient evidence to meet Provider's burden of proof regarding services billed under CPTs 97112 and 97116.

Regarding therapeutic exercises, Dr. Alexander stated that Provider renders all therapies, including therapeutic exercises, in a group setting, as reflected in its request for reconsideration, but

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[5] SOAH Docket Nos. 453-02-1056.M5 (March 27, 2002); 453-02-0528.M5 (March 22, 2002); 453-02-0773.M5 (March 19, 2002).

not in its other statements of charges.[6] Although Dr. Alexander testified that therapeutic exercises were appropriate adjuncts to the ESIs and that they were designed to relieve Claimant's myofascial pain syndrome, the exercise flow sheets indicate otherwise. The exercises Claimant performed on August 3, her first therapy session after the her first ESI, are precisely the same as those she performed from July 7 through July 27, 2004, and the intensities are the same except that those on the bicycle and treadmill are reduced by one. Further, the record indicates that Provider charged for therapeutic activities before the first ESI on July 29, and continued to bill for one unit per visit during each date of disputed services.[7]

Dr. Alexander did not testify that he was present with Claimant when the services were provided, or that any person supervised or monitored Claimant one-on-one. CPT Code 97110 designates therapeutic activities that are supervised one-on-one; Dr. Alexander provided no rationale for continued supervision. Thus, although Dr. Mohamed obviously wanted Claimant to pursue some activity with Provider, this record does not support the medical necessity of services billed under 97110. The ALJ cannot re-code services billed incorrectly.

Provider argues that because Carrier offered no testimony to contradict Dr. Alexander's testimony supporting the medical necessity of all disputed services, Provider should prevail on all three services. The SOAH decision cited[8] was a Carrier appeal (hence the burden of proof was on Carrier, not Provider, as here[9]) in which Carrier attempted to rebut Provider's testimony by producing two letters from its employees that cited to two negative medical opinions, but did not produce the opinions themselves.[10] In this case, Dr. Alexander's testimony regarding medical

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[6] Carrier's Ex. 1-B. In this document, Provider noted beside each item billed that "Patient was receiving injections in conjunction with treatment." This was not true before July 29, 2004.

[7] Provider's Ex. 2, pp. 13-18.

[8] SOAH Docket No. 453-01-3581.M2. (September 2001).

[9] *Id.*, p. 3.

[10] *Id.*, p. 6.

necessity was conclusory, did not establish links between the treatment rendered and a condition that required such treatment, and at times contradicted Provider's records. Under these circumstances, the reasoning in the SOAH case Provider cites is inapplicable.

Provider has not established that its services were either ordered by Dr. Mohamed or were otherwise medically necessary for Claimant at any point between July 16 and September 15, 2005.

III. FINDINGS OF FACT

1. The Old Republic Insurance Company (Carrier) is the workers' compensation insurer with respect to the claims at issue in this case.

2. On Claimant sustained compensable injuries to her lower back while she assisted in carrying a casket.

3. Claimant began therapy with San Antonio Accident Injury Care (Provider) on May 4, 2004.

4. Between May 4 and July 15, 2004, Claimant underwent approximately 20 sessions of therapy at Provider under the care of Richard Alexander, D.C.

5. On July 19, 2004, S. Ali Mohamed, M.D., observed that conservative therapy had failed and requested authorization for epidural steroid injections (ESIs).

6. On July 29 and September 7, 2004, Dr. Mohamed administered ESIs to Claimant's lower back.

7. On office visits of July 7, July 28, August 4, and August 25, 2004, Dr. Mohamed ordered Claimant to follow up with Provider to relieve myofascial pain syndrome and to restore function in the affected area, her lower back.

8. From July 16 to September 15, 2004, Provider rendered services for Claimant that it billed under the following CPT codes:

CPT Code	Service
97110	Therapeutic exercises
97112	Neuromuscular re-education
97116	Gait training
97124	Massage therapy.

9. Dr. Mohamed diagnosed Claimant with multiple herniated discs in her lumbar spine.

10. Neither Dr. Mohamed nor Dr. Alexander observed that Claimant's gait was impaired between July 16 and September 15, 2004.

11. Neither Dr. Mohamed nor Dr. Alexander observed that Claimant's balance, coordination, kinesthetic sense, posture, motor skills, or proprioception was impaired between July 16 and September 15, 2004.

12. The exercises and activities Provider prescribed for Claimant were the same before her first ESI as those it prescribed after the ESI.

13. Carrier denied reimbursement for all services rendered under denial code V – "unnecessary treatment (with peer review)."

14. Provider requested medical dispute resolution.

15. In a decision dated March 17, 2005, the Independent Review Organization (IRO) determined that except for the massage therapy services billed under 97124, the disputed services were not medically necessary.

16. On March 22, 2004, the Medical Review Division of the Texas Workers' Compensation Commission (Commission) issued its order based on the IRO decision.

17. Provider requested a hearing; Carrier did not cross-appeal concerning the massage therapy services.

18. Notice of the hearing was issued May 19, 2005.

19. 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.

20. Provider did not establish that Claimant had a specific problem that required neuromuscular re-education.

21. Provider did not establish that Claimant had a specific problem with her gait that required gait training.

22. Provider did not establish that it rendered one-on-one supervised therapeutic activities for Claimant's compensable injury.

23. Provider did not establish that one-on-one supervised therapeutic activities were necessary treatment for Claimant's compensable injury.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter. TEX. LAB. CODE ch. 401 *et seq.* (the Act).

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE § 413.031; TEX. GOV'T CODE ch. 2003.

3. Adequate and timely notice of the hearing was provided in accordance with the Administrative Procedure Act. TEX. GOV'T CODE §§ 2001.051 and 2001.052.

4. Provider has the burden of proof in this matter. 28 TEX. ADMIN. CODE ch.148; TEX. LABOR CODE § 413.031.

5. Provider did not prove by a preponderance of the evidence that any of the disputed services rendered by it were medically necessary treatment for Claimant's compensable injury. TEX. LAB. CODE § 408.021.

6. Based on the above Findings of Fact and Conclusions of Law, Carrier is not required to reimburse Provider for the disputed therapeutic exercises, neuromuscular re-education, or gait training provided to Claimant from July 16 through September 15, 2004.

ORDER

IT IS THEREFORE ORDERED that Old Republic Insurance Company need not reimburse San Antonio Accident & Injury Care for the disputed therapeutic exercises, neuromuscular re-education, or gait training provided to Claimant P.D. from July 16 through September 15, 2004.

SIGNED February 14, 2007.

CHARLES HOMER III
STATE OFFICE OF ADMINISTRATIVE HEARINGS
ADMINISTRATIVE LAW JUDGE