DOCKET NO. 453-05-7321.M5
MDR Tracking No. M5-05-1935-01

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE ' **
Petitioner	§	
VS.	§	**OF**
ABILENE HEALTHCARE AND INJURY CLINIC,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company, Petitioner, requested a hearing to contest an Independent Review Organization (IRO) decision that certain services provided by Abilene Healthcare and Injury Clinic, Respondent, to an injured worker, Claimant, were medically necessary and to contest a decision by the Texas Workers' Compensation Commission Medical Review Division, MRD,[1] that certain other services Respondent provided should also be paid.[2] This decision concludes that Petitioner proved the services found by the IRO to be medically necessary were not necessary and that it should not be required to pay for some of the other services MRD ordered paid.

I. PROCEDURAL HISTORY

A hearing was held on February 1, 2006, before the undersigned Administrative Law Judge (ALJ) at the State Office of Administrative Hearings, Austin, Texas. Petitioner appeared and was represented by its counsel, Ryan T. Willett. Respondent did not appear and was not represented. Petitioner submitted evidence from which a reasonable inference could be drawn that Respondent received notice of the hearing. The ALJ concluded the preponderant evidence indicated that Respondent received notice. There were no other notice or jurisdictional issues. Jurisdictional and notice matters are addressed in the findings of fact and conclusions of law.

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

[2] Respondent did not request a hearing to contest the portion of the IRO/MRD decision concluding that a majority of the services that were the subject of medical dispute resolution were not medically necessary.

II. DISCUSSION

1. Background

Claimant was an ___ worker who injured his back in an accident on____, when he lifted a large iron plate. He received therapy in 1998 after his injury. He continued to have low back pain with lateralizing pain to his right leg. He presented to Respondent on September 4, 2003, with back and bilateral extremity symptoms. He eventually underwent a spinal fusion and laminectomy on March 30, 2004, at the L5/S1 spinal level.

The services in dispute on the issue of medical necessity include office visits, CPT code 99213, on September 8, 2003, September 9, 2003, November 11, 2003, and December 4, 2003; two units of manual therapy, CPT code 97140, per date of encounter for a maximum of three encounters per week from September 4, 2003, through October 4, 2003, and from December 15, 2003 through January 15, 2004; two encounters per week of manual therapy from October 4, 2003, through October 21, 2003, and on March 17, 2004; and two units of manual therapy on November 13, 2003, and December 4, 2003.

Other payments MRD ordered include services under: CPT codes 76800, 76880, and 99213 on October 23, 2003; CPT code 97530 on October 27, 2003; CPT code 97530 on October 29, 2003; CPT code 97530* on October 30, 2003; CPT code 97112* on December 18, 2003; CPT codes 97112,* 97124,* 97140,* and 99214* on December 22, 2003; CPT code 97112 on January 5, 2004; CPT code 97112 on January 7, 2004; CPT code 99214 on January 8, 2004; and CPT code 99140 on February 23, 2004. Petitioner waived its dispute of the services that are shown with asterisks.

The IRO issued its determination on August 10, 2004. The IRO doctor's rationale included the following:

> The patient has failed previous treatment interventions, and apparently suffered a worsening of his condition in September 2003. Subsequent MRI in December 2003 provided evidence all of a deterioration in this patient's condition in the form of a frank disc herniation/protrusion.
>
> The patient was treated in multiple applications modalities, mostly manual therapies all of which would seem to be duplicative in nature.

> Unfortunately, the records all appear to be of the computerized, "canned" variety. They are repetitious, contain minimally clinically useful information and do not show significant progress/substantive change in treatment. There is no objective benchmarking of patient status in terms of re-evaluations/assessment. Unfortunately this provides precious little clinical insight as to the patient's status, his progression or improvement/response to care.
>
> The documentation also fails to outline exactly what type treatments were administered, aside from simply listing that the treatments were "administered or performed to the lumbar region." There is no rationale or indication as to why massage would be different from manual therapy or exactly what type or form of neuromuscular reeducation was provided. It is hard to understand exactly what type of "manual traction" could be performed to the lumbar spine and how this would also differ from manual therapy. There is absolutely no indication as to the rationale for multiple applications of each modality.
>
> At best, considering the fact of this patient was suffering from increased symptomatology, two units of manual therapy is all that can be supported, provided the documentation at hand.
>
> The same limiting argument is provided for multiple applications of therapeutic activities/group activities. There is no documentation provided as to exactly what type of exercises were performed, also without any exercise logs showing progression or improvement in terms of endurance/repetitions/weight etc. Again, considering this patient's condition, all that can be supported is three units of exercises per encounter date.

Employees have a right to necessary health treatment under TEX. LABOR CODE ANN. §§408.021 and 401.011. Section 408.021(a) provides, "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment." Section 401.011(19) of the Labor Code provides that health care includes "all reasonable and necessary medical . . . services."

As Appellant, Petitioner had the burden of proof.[3]

[3] 1 TEX. ADMIN. CODE (TAC) §155.41; 28 TAC §148.14.

B. Petitioner's Evidence and Arguments

William D. Defoyd, M.D., testified on behalf of Petitioner. Dr. Defoyd is a board-certified chiropractic orthopedist who has taught a variety of courses to licensed chiropractors. He testified he agreed with the IRO doctor's rationale, but thought the ultimate conclusion that some services were medically necessary contradicted the rationale. He cited the IRO doctor's statement that "[a]t best," certain types of services can be supported. He argued the IRO doctor's duty is not to say what can be considered medically necessary at best, but what is actually medically necessary.

A reason Claimant did not need extensive manual therapy, in Dr. Defoyd's opinion, was the outcome did not justify the service. He noted Claimant's subjective pain rating at five on a one-to-ten scale with ten the highest on September 4, 2003, and the same rating on March 17, 2004, the last day of disputed service. He said the ratings fluctuated over that period, from a low of two to a high of ten.[4] He pointed out that there was no objective improvement shown in the records and asserted that successful treatment does not ordinarily end with a need for surgery.

Dr. Defoyd cited Respondent's diagnosis as including lumbar disc disorder with myelopathy.[5] He testified this diagnosis is completely erroneous. He said myelopathy is an extremely urgent condition that demands immediate surgery. The condition involves the Cauda Equina nerve roots, where the spine stops. It causes bowel and bladder problems, ordinarily an inability to walk and, at times, total numbness.

Dr. Defoyd cited Respondent's records as including neuromuscular reeducation (NMR) as part of Claimant's treatment.[6]

He asserted there was no need for NMR because there was no evidence of any neuromuscular deficit.

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[4] Ex. 1 at 197, 318.

[5] See Ex. 1 at 196 *et seq.* Respondent also diagnosed lumbar muscle spasm, lumbar vertebra subluxation, and sacroiliac segmental dysfunction.

[6] See Ex. 1 at 197 and many of the following dates of treatment.

In Dr. Defoyd's opinion, there was no need for manual therapy for six months. He said manual therapy at the beginning of treatment can be useful to decrease pain and to increase mobility, but applicable guidelines indicate it does not take that long to prepare a patient for exercise. He maintained it is necessary to see examination findings on the response to manual therapy to know whether it was efficacious.

Dr. Defoyd cited Medicare guidelines as authority that only 25 percent of total therapy time should be passive.[7] He said the predominant therapy in this case, manual therapy, was passive.

A primary reason for Dr. Defoyd's opinion that the services were medically unnecessary was the absence of medical records to support their need. He said the records do not describe Claimant's five-year history between his injury and present illness. These records should have included how he was treated previously and his response to therapy, adequate records on examination results, and an adequate description of the treatments provided. He pointed out that there are different types of manual therapy and maintained it is not entirely clear what was provided. He said Respondent used exactly the same wording to describe treatments over the service period, including misspellings and breaks in lines.

According to Dr. Defoyd, office visits (CPT code 99213) are justified as initial assessments and as reevaluations. He said there was no need for reevaluations shown in the records.

Dr. Defoyd said the CPT 99213 code description requires at least two out of three of the following: an expanded problem-focused history; an expanded problem-focused examination; and low-complexity medical decision making. He maintained the records do not show the office visits met those criteria. He also said the office notes also do not demonstrate that Respondent covered the required areas for examinations, including, among others, range of motion, strength, and reflex testing.

As indicated above, in addition to the services the IRO found to be medically necessary, MRD ordered Petitioner to pay for services under CPT codes 76800, 76880, and 99213 on October 23, 2003; CPT code 97530 on October 27, 2003; CPT code 97530 on October 29, 2003; CPT code

[7] Ex. 1 at 379, 389.

97112 on January 5, 2004; CPT code 97112 on January 7, 2004; CPT code 99214 on January 8, 2004; and CPT code 99140 on February 23, 2004.[8]

Petitioner pointed out that MRD ordered payment for services on October 23, 2003, October 27, 2003, and October 29, 2003, based on its conclusion that Petitioner did not provide EOBs for those services. Petitioner cited portions of its records to show that it did provide the EOBs. Petitioner proved that it provided EOBs on October 27, 2003, and October 29, 2003, as shown on page 164 of Exhibit 1. However, Petitioner did not introduce all of its pre-filed pages into evidence, including pages 70 and 71 concerning purported EOBs for October 23, 2003.

Petitioner cited MRD's rationale for concluding that other services should be paid because Petitioner audited the wrong CPT code. It pointed out that the IRO nonetheless concluded that the services were medically unnecessary and that Respondent did not request a hearing to contest that determination. It contended it should not be required to pay for services determined to be medically unnecessary whether or not the correct CPT code was used in auditing. Petitioner identified the following services as included in this category: CPT code 97112 on December 18, 2003, December 22, 2003, and January 7, 2004; CPT code 97124 on December 22, 2003; CPT code 97140 on December 22, 2003, and February 23, 2004; and CPT code 99214 services on December 22, 2003, and January 8, 2004. However, Petitioner waived its contest of services provided on December 18, 2003, and December 22, 2003.

C. Analysis

Based on the following considerations, the ALJ concludes Petitioner proved the services the IRO found to be medically necessary were not medically necessary.

- The therapy was not beneficial. Eventually, Claimant needed surgery for his infirmity. Claimant's subjective pain rating was five on a one-to-ten scale with ten the highest on September 4, 2003, and the same rating on March 17, 2004, the last day of disputed service. There was no objective improvement shown in the records. Successful treatment does not ordinarily end with the need for surgery. Although the necessity of medical services should be determined on a prospective basis when the

[8] Petitioner also ordered Petitioner to pay for services under CPT code 97530 on October 30, 2003; CPT code 97112 on December 18, 2003; and CPT codes 97112, 97124, 97140, and 99214 on December 22, 2003, but, as previously indicated, Petitioner waived its dispute of those services. Petitioner will be ordered to pay for those services.

services began, a lack of improvement over a long period of treatment is probative evidence that the provider's judgment at the time the services began was faulty and that the treatment was unnecessary.

- $ Claimant was mis-diagnosed. Claimant was not suffering from myelopathy, which is an extremely urgent condition demanding immediate surgery that can involve bowel and bladder problems, an inability to walk, and total numbness. Thus, at least in part, Respondent partially treated Claimant for a condition he did not have.

- $ One of the services Respondent provided was neuromuscular reeducation (NMR). However, there was no need for NMR because there was no evidence of any neuromuscular deficit.

- $ Applicable Medicare guidelines limit passive therapy to 25 percent of total therapy time. The predominant therapy in this case was passive.

The ALJ did not consider the absence-of-documentation issues described by Dr. Defoyd because Petitioner did not cite the absence-of-documentation denial code N as a reason for denying the claim.

With regard to the services MRD ordered paid, the ALJ concludes that Petitioner should pay for the services for which it waived its dispute. This includes CPT code 97530 on October 30, 2003; CPT code 97112 on December 18, 2003; and CPT codes 97112, 97124, 97140, and 99214 on December 22, 2003.

With regard to the services for which MRD ordered payment because there was no EOB, the ALJ concludes that Petitioner should be ordered to pay for CPT codes 76800, 76880, and 99213 on October 23, 2003, because Petitioner did not prove it provided an EOB on that date. However, Petitioner should not be ordered to pay for services it proved it did provide an EOB. This includes services under CPT code 97530 on October 27, 2003, and October 29, 2003.

Petitioner should not be ordered to pay for services which MRD concluded it incorrectly audited because the IRO found those services were medically unnecessary. This does not include services on December 18 and 23, 2003, because Petitioner waived its dispute of those services. Petitioner should not be required to pay for services under CPT codes 97112 on January 7, 2004; 97140 on February 23, 2004; and 99214 on January 8, 2004.

IV. FINDINGS OF FACT

1. The injured worker, Claimant, was an ___ worker who injured his back in an accident on____, when he lifted a large iron plate.

2. Claimant received therapy in 1998 after his injury, but continued to have low back pain with lateralizing pain to his right leg.

3. Claimant presented to Abilene Healthcare and Injury Clinic, Respondent, on September 4, 2003, with back and bilateral extremity symptoms.

4. Claimant eventually underwent a spinal fusion and laminectomy on March 30, 2004, at the L5/S1 spinal level.

5. The services in dispute on the issue of medical necessity include office visits, CPT code 99213, on September 8, 2003, September 9, 2003, November 11, 2003, and December 4, 2003; two units of manual therapy, CPT code 97140, per date of encounter for a maximum of three encounters per week from September 4, 2003, through October 4, 2003, and from December 15, 2003 through January 15, 2004; two encounters per week of manual therapy from October 4, 2003, through October 21, 2003, and on March 17, 2004; and two units of manual therapy on November 13, 2003, and December 4, 2003.

6. Other services that the Texas Workers' Compensation Commission Medical Review Division (MRD) ordered Petitioner to pay include: CPT codes 76800, 76880, and 99213 on October 23, 2003; CPT code 97530 on October 27, 2003; CPT code 97530 on October 29, 2003; CPT code 97530 on October 30, 2003; CPT code 97112 on December 18, 2003; CPT codes 97112, 97124, 97140, and 99214 on December 22, 2003; CPT code 97112 on January 5, 2004; CPT code 97112 on January 7, 2004; CPT code 99214 on January 8, 2004; and CPT code 99140 on February 23, 2004.

7. It is undisputed that Petitioner requested a hearing to contest the IRO and MRD decisions not later than 20 days after receiving notice of the decision.

8. All parties received not less than 10 days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

9. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

10. At the hearing, Petitioner waived its dispute of the following services: CPT code 97530 on October 30, 2003; CPT code 97112 on December 18, 2003; CPT codes 97112, 97124, 97140, and 99214 on December 22, 2003.

11. The services determined by the IRO to be medically necessary were not medically necessary.

a. The therapy was not beneficial, as indicated by the fact that Claimant needed surgery for his infirmity; Claimant's subjective pain rating was five on a one-to-ten scale with ten the highest on September 4, 2003, and the same rating on March 17, 2004, the last day of disputed service; there was no objective improvement shown in the records; and successful treatment does not ordinarily end with the need for surgery.

b. Claimant was mis-diagnosed as suffering from myelopathy, an extremely urgent condition demanding immediate surgery that can involve bowel and bladder problems, an inability to walk, and total numbness.

c. One of the services Respondent provided was neuromuscular reeducation (NMR), but there was no need for NMR because there was no evidence of any neuromuscular deficit.

d. Although Medicare guidelines limit passive therapy to 25 percent of total therapy time, the predominant therapy in this case was passive.

12. Petitioner provided an explanation of benefits (EOB) for certain services MRD ordered to be paid based on its conclusion that no EOB was provided.

13. The services referenced in Finding of Fact No. 12 are services under CPT code 97530 on October 27, 2003, and October 29, 2003.

14. Petitioner did not prove that it provided an EOB for certain other services MRD ordered paid based on its conclusion that no EOB was provided.

15. The services referenced in Finding of Fact No. 14 are services under CPT codes 76800, 76880, and 99213 on October 23, 2003.

16. Certain services that MRD concluded Petitioner incorrectly audited and for that reason should pay were not medically necessary.

17. The services referenced in Finding of Fact 16 are services under CPT codes 97112 on January 7, 2004; 97140 on February 23, 2004; and 99214 on January 8, 2004.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. All parties received adequate and timely notice of the hearing. TEX. GOV'T CODE ANN. §2001.052.

3. Petitioner has the burden of proof. 1 TEX. ADMIN. CODE (TAC) §155.41; 28 TAC §148.14(a).

4. Petitioner should pay for services under the following CPT codes on the following dates: CPT codes 76800, 76880, and 99213 on October 23, 2003; CPT code 97530 on October 30,

2003; CPT code 97112 on December 18, 2003; and CPT codes 97112, 97124, 97140, and 99214 on December 22, 2003. TEX. LAB. CODE ANN. §§ 401.011 and 408.021.

5. Petitioner should not be required to pay for any other disputed services.

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company pay Abilene Healthcare and Injury Clinic for services under the following CPT codes on the following dates: CPT codes 76800, 76880, and 99213 on October 23, 2003; CPT code 97530 on October 30, 2003; CPT code 97112 on December 18, 2003; and CPT codes 97112, 97124, 97140, and 99214 on December 22, 2003.

IT IS ORDERED FURTHER that the claim by Abilene Healthcare and Injury Clinic against Texas Mutual Insurance Company for payment of disputed services other than the ones ordered paid above be, and the same is hereby, denied.

SIGNED March 8, 2006.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS