SOAH DOCKET NO. 453-05-7890.M5
TWCC MRD NO. M5-05-2110-01

SCD BACK AND JOINT CLINIC, LTD., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
AIGCS, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

SCD Back and Joint Clinic, Ltd., (Provider) challenged the decision of the Texas Workers' Compensation Commission (TWCC or Commission)[1] denying reimbursement for office visits and a variety of physical medicine treatments rendered by Provider for the benefit of __(Claimant) between July 7 and October 12, 2004 (the disputed period). On June 21, 2005, the Medical Review Division (MRD) of TWCC determined that the care was not medically necessary, based on the report of Independent Review, Inc., an independent review organization. Provider also challenged adverse fee rulings issued by the MRD, including the conclusion that it failed to adequately document some of its services.[2]

The hearing in this matter convened on March 8, 2006, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra Church presiding. The record closed that day. Provider was represented by William Maxwell, attorney. AIGCS was represented by Steve Tipton, attorney. Notice was proper and jurisdiction was established in this case.

[1] The Commission was abolished effective September 1, 2005, and the functions of the Commission assigned to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC). The Commission's decision was issued on May 12, 2005, and Provider requested a hearing on June 29, 2005. The agency names at the time of the agency's decision will be used for clarity.

[2] At the hearing, Provider withdrew his challenge of the adverse MRD decision on services billed under CPT Code 97750-MT on April 6 and 8, and August 12 and 13, 2004, and also on services billed under CPT Code 971390-EU on March 29-31, April 14 and 30, May 3, 5, 14, 17, 18, and 24, June 2, 3, 7, 10, 11, 15, 23, 24 and 29, July 5, and August 10, 2004. The withdrawn items and the two fee issues in this case comprised all fee issues referred to hearing.

The ALJ concludes that Provider failed to meet his burden of proof to demonstrate that sessions of physical medicine, and related office visits conducted during the disputed period, were necessary to treat Claimant's compensable injury. Provider also failed to meet his burden of proof to show that he documented either the provision of one-on-one physical therapy sessions or that Claimant's condition warranted the provision of one-on-one physical therapy and also the purpose of the analgesic balm dispensed to Claimant. Carrier will not be required to pay any additional reimbursement to Provider for services rendered during the disputed period, for sessions of physical therapy before the disputed period, or for the analgesic balm.

I. DISCUSSION

A. History of the Case

On___, Claimant sustained a sprain/strain injury to his spine from his sacrum to his neck. Provider was reimbursed for treating Claimant for dates from shortly after the injury through mid-2004. Carrier denied payment for all treatments after July 7, 2004, on the grounds that they were not medically necessary. Provider denied some reimbursement for earlier dates on the grounds that Provider had billed improperly or failed to document the service provided (fee issues). The following list summarizes the MRD rulings by category of service, decision rationale, and dates of service.[3]

- Physical medicine treatments denied as medically unnecessary included mechanical traction, therapeutic exercise, group therapeutic procedures, massage therapy, muscle and range of motion testing, and chiropractic manipulation of several regions of Claimant's spine. The treatments at issue in this category were *administered* from July 7 through October 12, 2004, although the MRD decision denied the medical necessity for any treatments after April 19, 2004.

- The durable medical equipment (DME) item denied as undocumented was analgesic balm dispensed on July 19 and September 22, 2004. (CPT Code A9150).

- Reimbursement for sessions of one-on-one physical therapy (CPT Code 97110) were denied on the basis that Provider failed either to document that he had provided therapy on a one-on-one basis on the dates billed or that Claimant's medical condition warranted administration of one-on-one

[3] Subsequent references to the category of cases include *all items in that category*, unless a specific treatment or date of service is individually discussed.

physical therapy.[4] Provider billed for sessions of this therapy conducted on May 4 and on July 6, 9, and 13, 2004.[5]

B. Evidence and Analysis

On___, Claimant's head hit the inside of the cab of a large dump truck when the truck bounced. The loaded truck bed fell when the lifting cylinder failed, causing the entire truck to bounce.[6] Provider began treating Claimant on March 19, 2004. John. R. Wyatt, D. C., diagnosed Claimant as suffering from a grade II sprain/strain of his spine from his sacrum to his neck, cervicocranial syndrome, and myofascial pain syndrome. Dr. Wyatt initiated a home exercise program along with an in-office course of physical therapy, and also referred Claimant for a neurological examination. Claimant was released to work with restrictions on March 19, 2004.[7]

An MRI on April 6, 2004, conducted by Andrew G. Varady, M. D., showed mild spondylosis in the lumbar spine, minimal disc bulges without herniation in the cervical spine, and no finding in the thoracic spine.[8] A neurological examination on May 11, 2004, conducted by Randall Light, M.D., showed Claimant had suffered no injury to his nerves. Dr. Light concluded Claimant's pain was musculoskeletal and recommended continued conservative care.[9]

Provider asserted that the treatments and one-on-one physical therapy were needed to foster gains in Claimant's ability to perform work tasks. He acknowledged that Claimant did not present some of the classic medical factors for one-on-one therapy but contended that Claimant fit the performance enhancement model for supervised therapy. That is, Claimant would improve faster

[4] Carrier had initially denied reimbursement for these services as being billed in excess of the fee schedule or as being insufficiently documented.

[5] The parties were given an opportunity after the record closed to examine what dates of service were paid and in what amounts. As the parties filed no updated table of disputed items, the ALJ used the table introduced at the hearing. Provider Exh. 1, pp. 53-55.

[6] Provider Exh. 2, pp. 40-44.

[7] Provider Exh. 2, p. 45.

[8] Provider Exh. 2, pp. 67-69.

[9] Provider Exh. 2, pp. 76-79.

with closer supervision.[10] Provider also invoked the analogy of the "industrial athlete," a worker who makes demands on his body comparable to that of an athlete. Such a person warrants application of intensive treatment comparable to that given a professional athlete in order to return him to full functioning. Provider stated that muscle testing showed areas of weakness, susceptibility to injury, and joint instability that persisted throughout 2004. Provider also stated that he saw no signs that Claimant was magnifying or exaggerating his symptoms.

In regard to the length of the treatment, Provider asserted that Claimant had suffered an exacerbation of his original injury which kept him off work between April 30 and May 15, 2004.[11] Neither the nature nor the source of the exacerbating event was spelled out in Provider's clinical notes. Provider had part time work in summer 2004 and had returned to full time work by August 3, 2004.[12] Provider took Claimant off duty between September 28 and October 4, 2004.[13] Claimant was returned to work on October 5, 2004, with time restrictions on squatting, stooping, pulling, walking, and climbing.[14]

Provider asserted that his clinical notes showed Claimant's functioning improved between July and October 2004.[15] Claimant reported pain levels of three on a 10-point scale on most days, with occasional increases to levels of five or six on a 10-point scale which subsided within a few days. Provider's staff consistently observed mild to moderate physical symptoms such as muscle tenderness or spasm regardless of reported pain level. The treatments administered were substantially similar throughout the period. The treatment goals and objectives were general in nature, *i.e.*, increase endurance, flexibility, and range of motion. The notes did not identify a specific target level of performance to which the physical therapy was directed.[16]

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[10] Provider Exh. 1, p. 14.

[11] Provider Exh. 1, pp. 71, 75, 93 and 95, 184-186.

[12] Provider Exh. 1, p. 232.

[13] Provider Exh. 1, p. 103.

[14] Provider Exh. 1, pp. 104-107.

[15] Provider Exh. 2, pp. 220-247.

[16] *See,* for example, Provider Exh. 2, pp. 147, 152, 154-162.

Claimant was examined in August 2004 by an orthopedist, Kenneth G. Berliner, M. D., and in September 2004 by physical medicine physician, Steve C. Opersteny, M.D. Dr. Berliner recommended cervical epidural and facet injections with some physical therapy. Dr. Opersteny concurred with the facet injections and recommended that Claimant continue with his home exercise program.[17] It is not clear whether the injections were administered.

Provider's expert, Casey Cochran, D. C., asserted that Provider's treatment notes showed that Claimant made only minimal gains in strength and range of motion after April 2004. He stated that a long course of supervised exercise can reinforce pain behavior and foster doctor dependence. He also contended that some of the muscle testing results showed what is termed "break away" muscle weakness and that test results showed performance levels below those of even a poorly conditioned person. Results that were so at odds with Claimant's known level of physical functioning should have raised questions about the reliability of the patient's subjective reports of his or her condition.

Dr. Cochran concluded that the history of Claimant's gains could not be attributed to physical therapy but were about what one would expect naturally, without intervention or through adherence to a home exercise program. He said that there were no indications from the medical reports that showed a need for ongoing, intensive therapy in the middle and latter part of 2004.

Provider conducted 11 office visits in concert with the physical therapy and physical medicine sessions. Provider challenged the MRD decision ruling against reimbursement for all of the visits. Neither party presented evidence on what frequency of visit might be reasonable for ongoing monitoring of a patient during that period. As Provider considered these visits part of a comprehensive treatment scheme, the ALJ analyzed of them together with the therapy sessions.

Provider's assertion that Claimant needed intensive physical therapy and passive treatments between August and October 2004 in order to treat a sprain/strain of Claimant's spine was not borne out by the clinical treatment records. Claimant made only modest progress in his strength and range of motion and his exercise program was not markedly progressive during those months. Claimant's

[17] Provider Exh. 2, pp. 256B259.

pain levels remained low and Provider's own staff failed to note more than moderate physical symptoms. Also, there is no credible detail concerning the nature or source of the alleged exacerbations or how they harmed Claimant's spine.

Dr. Cochran's testimony regarding the lack of a clear link between any physical gains made by Claimant and the therapy provided was persuasive and supported by the notes on the physical therapy program. Provider's records lacked well-articulated rehabilitation goals for Claimant during this period and failed to demonstrate a clear medical reason why one-on-one therapy was required. Provider's testimony about the rapid progress that closely supervised patients might make was not supported by reports of Claimant's progress, which seemed desultory at best.

In addition, Provider's records failed to demonstrate the reasons for dispensing an analgesic balm on two dates during the period.

C. Summary

Based on the facts and analysis above, the ALJ concluded that Provider failed to meet his burden of proof to show that any of the services rendered, and any of the related office visits, were medically necessary to treat Claimant's compensable injury during the disputed period. Further, Provider did not show that he had documented reasons for the administration of one-on-one physical therapy or for dispensing analgesic balm. Claimant's request for reimbursement for all services rendered during that period is denied.

II. FINDINGS OF FACT

1. On ____(Claimant) sustained a sprain/strain injury to his entire spine when his head hit the inside of the cab of a large dump truck when it bounced because its loaded truck bed fell back on the frame.

2. AIGCS (Carrier) was the responsible insurer.

3. SCD Back and Joint Clinic, Ltd., (Provider) began treating Claimant on March 19, 2004.

4. On March 19, 2004, John. R. Wyatt, D. C., diagnosed Claimant as having a grade II sprain/strain of his spine from his sacrum to his neck, cervicocranial syndrome, and myofascial pain syndrome.

5. Dr. Wyatt initiated physical medicine treatment, including both a home exercise program and in-office therapy.

6. In April 2006, an MRI examination showed mild spondylosis in Claimant's lumbar spine, minimal disc bulges without herniation in his cervical spine, and no abnormalities in his thoracic spine.

7. Claimant suffered no neurological impairment as a result of his injury.

8. Provider administered sessions of physical medicine and physical therapy to Claimant between March 19 and October 12, 2004.

9. Claimant was released to work with restrictions on March 19, 2004, and was taken off work briefly between September 28 and October 4, 2004.

10. On October 5, 2004, Claimant was returned to work with restrictions on squatting, stooping, pulling, walking, and climbing.

11. Between July 7 and October 12, 2004 (the disputed period), Provider administered 19 sessions of physical medicine including, in various combinations, mechanical traction, therapeutic exercise, group therapeutic procedures, massage therapy, muscle and range of motion testing, and chiropractic manipulation of several regions of Claimant's spine.

12. During the disputed period, Claimant conducted 11 office visits in conjunction with the physical medicine and therapy sessions.

13. During the disputed period, Claimant generally reported pain levels of three on a 10-point scale, with occasional spikes to five or six on a 10-point scale, which subsided within a few days.

14. On July 19 and September 22, 2004, Provider dispensed analgesic balm to Claimant, although it did not document the reason for dispensing the balm.

15. Claimant did not have medical or psychological conditions requiring one-on-one physical therapy.

16. Provider administered some physical therapy to Claimant on a one-on-one basis on May 4, July 6, 9, and 13, 2004.

17. Exercises administered by Provider during the disputed period were not progressive, were substantially similar in duration and intensity throughout the period, and were not directed toward a specific rehabilitation or performance target.

18. Claimant's gains in strength, range of motion, and flexibility were comparable to what would be expected over time without treatment or through adherence to a home exercise program.

19. Carrier denied reimbursement for all physical medicine sessions and related office visits conducted by Provider during the disputed period on the basis that they were not medically necessary to treat Claimant's compensable injury.

20. Carrier denied reimbursement for one-one physical therapy sessions conducted by Provider on May 4, and on July 6, 9, and 13, 2004, on the basis that the sessions were either billed above the fee schedule amount or lacked documentation.

21. Carrier denied reimbursement for analgesic balm on July 19 and September 22, 2004, on the grounds it was not sufficiently documented.

22. Provider sought review by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission of Carrier's denials on both medical necessity and fee grounds.

23. On June 21, 2005, the MRD determined that the physical medicine sessions and related office visits during the disputed period were not medically necessary, based on the report of Independent Review, Inc., an independent review organization (IRO).

24. The IRO reviewer concluded that no therapy or physical medicine treatments received after April 2004 were medically necessary to treat Claimant's compensable injury.

25. On June 21, 2005, the MRD determined that Provider had failed to document the either the provision of one-on-one physical therapy or the need for such services on May 4, July 6, 9, and 13, 2004, or the reason for dispensing analgesic balm on July 19 and September 22, 2004, and denied further reimbursement.

26. On June 29, 2005, Provider requested a contested-case hearing on the MRD Decision on both the medical necessity and fee issues.

27. Provider's request was referred to the State Office of Administrative Hearings (SOAH) and accepted for hearing before September 1, 2005.

28. On November 8, 2005, the Texas Department of Insurance, Division of Workers' Compensation issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted.

29. Administrative Law Judge Cassandra Church conducted a hearing on the merits on March 8, 2006, and the record closed that day.

III. CONCLUSIONS OF LAW

1. 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 TEX. LAB. CODE ANN. § 413.031(k), TEX. GOV'T CODE ANN. ch. 2003, and Acts 2005, 79th Leg., ch. 265, § 8.013, eff. Sept. 1, 2005.

2. Provider timely requested a hearing, as specified in 28 TEX. ADMIN. CODE § 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

4. Provider, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41(b), and 28 TEX. ADMIN. CODE§ 148.14(a).

5. Provider failed to meet his burden of proof to show that sessions of physical medicine and related office visits were medically necessary during the disputed period to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LABOR CODE ANN. §§ 401.011(9) and 408.021.

6. Provider failed to meet his burden of proof to show the reasons for dispensing analgesic balm on July 19 and September 22, 2004, in accordance with 28 TEX. ADMIN. CODE §134.201 (1996 Medical Fee Guideline).

7. Provider failed to meet his burden of proof to show that he documented either the provision of one-on-one physical therapy sessions or that Claimant's condition warranted the provision of one-on-one physical therapy sessions on May 4, July 6, 9, and 13, 2004, in accordance with 28 TEX. ADMIN. CODE § 134.201.

ORDER

IT IS ORDERED that all requests by Provider for reimbursement from AIGCS for sessions of physical medicine and related office visits conducted by Provider, for items of durable medical equipment dispensed by Provider between July 7 and October 12, 2004, and for one-on-one sessions of physical therapy conducted on May 4, an on July 6, 9, and 13, 2004, are denied.

SIGNED May 8, 2006.

CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS