MICHAEL MCGARRAH, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
LIBERTY MUTUAL INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Liberty Mutual Insurance Company as carrier for Southwestern Bell Telephone Company (Carrier) denied reimbursement on the basis that the treatment of Claimant rendered by Michael P. McGarrah, D.C. (Provider) was not medically necessary. Provider appealed from the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission) denying reimbursement for services that were provided to Claimant between April 23 and June 20, 2003. The Administrative Law Judge (ALJ) finds that the disputed one-on-one treatment modalities and office visits were not medically necessary and that Provider is not entitled to reimbursement for those services, but that the services rendered to Claimant and billed under CPT codes 97014, 97250, and 97112 were medically necessary for Claimant and Provider is entitled to reimbursement for them.

I. PROCEDURAL HISTORY

An IRO decision of June 18, 2004, determined that none of the disputed services were medically necessary, because no clinical evidence supported continuation of passive modalities and strengthening activities beyond April 15, 2003. The IRO also determined that a June 20, 2003 office visit coded as a Level III new patient office visit was not medically necessary. Provider timely requested a hearing.

ALJ Charles Homer III convened the hearing on April 28, 2005, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider was represented by Leslie R. Casaubon, attorney. Carrier was represented by Kevin Franta, attorney. The parties did not contest notice or jurisdiction, and those issues are addressed in the Findings of Fact and Conclusions of Law below. Michael McGarrah, D.C., testified for Provider, and Bernie McCaskill, M.D. testified for Carrier. Each party submitted documents, all of which were admitted into evidence.

II. INJURY AND TREATMENT

Claimant suffered a compensable injury on ___, when he slipped and fell as he attempted to attempted to retrieve a tool from the back of a truck. After striking the truck, he fell onto the ground and stuck his hands or wrists in the fall. At the time of the injury, he felt back pain and also pain in his left wrist. He saw a doctor two days after the fall and reported ankle, hip, and shoulder injuries, and then began seeing Jack Pedersen, D. C. Doctor Pedersen treated Claimant sporadically from December 2002 through March 2003 for his back: the parties disagree about whether Dr. Pedersen treated Claimant for his wrist injuries. Dr. Pedersen referred him to Michael P. McGarrah, D.C., (who had performed an independent medical examination [IME] on Claimant February 26, 2003)

for further treatment for his wrists,[1] both of which were diagnosed with stenosing tenosynovitis, a form of tendinitis. Between April 1 and June 20, 2003, Claimant visited Dr. McGarrah's office 35 times.[2] Of those 35 sessions, only those from April 23 through June 20, 2003, are in dispute in this proceeding.[3]

Additionally, Claimant saw Stephen J. Troum, M.D., a hand surgeon, on May 5 and May 28, 2003; both times Claimant received cortisone injections to his wrists for pain.[4] At the end of Dr. McGarragh's treatment, and about three weeks after his second steroid injections, Claimant reported improvement and returned to work. Reviewing Claimant's history in October 2003, Gilbert Salazar, M.D., noted that Claimant had responded nicely to conservative therapy and has returned to work.[5]

III. ANALYSIS AND DISCUSSION

The preponderance of the evidence does not support Provider's contention that all of the disputed services were medically necessary. But the evidence shows that, more likely than not, Provider's treatments rendered under CPT codes 97014 (electrical stimulation of muscles, 97250 (myofascial release), and 97112 (neuromuscular reeducation) were medically necessary and did, in fact, help Claimant recover from his wrist injuries and return to work.

Carrier argued that Claimant's wrists and hands had been treated via chiropractic care shortly after his injury: previous unsuccessful conservative treatment weighs against an expectation that further such treatment would improve Claimant's condition or symptoms related thereto. But prior failed therapy at one clinic does not conclusively prove that the same or similar therapy when provided by another[6] caregiver is not medically necessary. Indisputably, Claimant's wrists had not improved significantly and consistently under Dr. Pedersen's care, but did improve enough to allow Claimant return to work during Dr. McGarragh's treatment, and in fact Claimant did return to work.[7] In addition, Dr. Salazar's evaluation on October 13, 2003,[8] is credible (being from an uninterested

[1] Carrier's Exhibit A, pp. 10, 11, and 19.

[2] Provider's Exhibit A, p. 67.

[3] Provider withdrew fee issue for dates of services April 21 and April 28, 2003, according to the MRD.

[4] Carrier's Exhibit A, p. 19; Provider's Exhibit A, pp. 29, 40.

[5] Carrier's Exhibit A, at p. 54. Carrier's Exh. A, pp. 52-54 is a report of an independent medical examination (IME) required by worker's compensation rules.

[6] Both parties produced and discussed evidence concerning whether Jack Pedersen, D.C., treated Claimant for his wrist injuries before Provider did. The ALJ consulted the Medical Fee Guidelines (AMFG@) (Texas Worker's Compensation Commission Medical Fee Guidelines 1996) and in particular the Medicine Ground Rules (MFG, pp. 31-62) and has found nothing to support a conclusion that prior unsuccessful therapy is conclusive evidence against the medical necessity of additional therapy of the same or similar kind, regardless of who renders the additional therapy. The record supports the conclusion that Dr. Pedersen did, in fact, treat Claimant in January and February 2003. But that finding does not preclude a finding that Dr. McGarrah's subsequent treatment of Claimant was medically necessary.

[7] Provider's Exh. A, p. 67.

[8] Id., pp. 52-54. This exam and report together constituted an independent medical examination (IME) required by worker's compensation.

party) and persuasive on the effectiveness of the disputed services. Dr. Salazar wrote that He [Claimant] has responded nicely to conservative care and has returned back to work[9].

Dr. McGarrah referred Claimant to an orthopedist, Dr. Troum, who gave Claimant steroid injections to his wrists on May 5 and May 28, 2003. According to Dr. McCaskill's testimony, Dr. Troum's steroid injections are considered, at least by medical doctors such as doctors McCaskill and Troum, to be part of conservative therapy. Thus Dr. Salazar's evaluation covers one of three cases: Dr. Salazar might have been considering only the injections, Provider's treatment in conjunction with the injections, or even Provider's treatment alone. There is no way to know, but two of the three cases support Provider's position. To be probative of an ultimate fact issue, a fact must only be such that after learning that fact, the fact-finder is more likely to believe that the ultimate fact issue is as the evidence suggests. Additionally, if Dr. Salazar believed that it was only the steroid injections that helped Claimant, he could have noted that specifically. He did not do so.

Carrier strongly disputed Provider's position that Dr. Jack Pedersen did not treat Claimant for wrist injuries. Provider pointed to an October 13, 2003 letter from Dr. Pedersen in which Dr. Pedersen wrote to whom it may concern that he did not treat Claimant Aspecifically for the wrists. Dr. Pedersen added that We attempted home therapy, but it failed.[10] That letter, taken literally, contradicts Dr. Pedersen's treatment records, which do reveal sporadic and cursory treatment of the wrists: a splint, home exercises, and possibly a Theraband session.

When Claimant saw Provider for an IME on February 26, 2003, Claimant had no complaints other than his wrists and stated that his pain had been getting worse for the previous three weeks.[11] Finally, after several no-shows during Dr. Pedersen's treatment, Claimant attended his sessions with Dr. McGarrah regularly, an indication that Claimant perceived that the sessions were indeed helping him. The preponderance of the evidence is that Provider had a reasonable expectation that his treatment would benefit Claimant as contemplated by the Worker's Compensation Act (Act), and that the treatment did in fact benefit him. Therefore, the electrical muscular stimulation, neuromuscular reeducation, and myofascial release rendered by Provider to Claimant from April 23 through June 20, 2003, were medically necessary for him. Supporting this conclusion is Dr. Salazar's evaluation on October 13, 2003, in which he found that Claimant was still back at work, and had minimal loss of strength in both wrists.[12]

Regarding services billed under CPT codes 97110 and 97530 (one-on-one supervised therapeutic procedures and activities, respectively), there is little or no evidence in either Dr. McGarragh's testimony or his SOAP notes about why one-to-one supervision was required on any occasion. Dr. McGarragh testified generally that all his services for Claimant were medically necessary and effective, and one could infer that Claimant may on his first visit have needed instruction, but there is nothing in the record so stating, and Claimant had received therapy from Dr. Pedersen before he saw Dr. McGarragh. Nor is Claimant's first visit for therapy with

Dr. McGarrah (April 1, 2003) in dispute here. Patient safety should not be a concern in wrist therapy.

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[9] Id., p. 54.

[10] Provider's Exhibit A., p. 66.

[11] *Id*., at pp. 13-16.

[12] Carrier's Exhibit A, pp. 49-50, 52-54.

Dr. McCaskill testified that one-on-one therapy was absolutely not medically necessary based upon Claimant's condition when he was treated by Dr. McGarragh. In order to be reimbursed, services billed under CPT codes 97110[13] and 97530[14] must be rendered in a one-on-one manner and that method must be medically necessary for Claimant. The ALJ may not re-code those services to an appropriate level. The evidence does not support a finding of medical necessity for services described by CPT codes 97110 and 97530.

Concerning services rendered for Claimant and billed by Provider under CPT code 99213, Dr. McGarragh's testimony was, again, only a general statement that every medical service he provided to Claimant was medically necessary. The treatment records in evidence do not, so far as the ALJ can determine, offer more specifics. Dr. McCaskill, on the other hand, testified that it is inappropriate to bill an expanded office visit described by CPT code 99213 for a patient who is in the office only for therapy. The MFG states that CPT 99213 involves an expanded problem focused history or examination or medical decision-making of low complexity that typically requires 15 minutes of time in the office with the patient.[15] Nor should office visits be billed under CPT code 99213 more often than every two weeks.[16] Provider's records of his treatment of Claimant reveal no compliance with those guidelines, nor do they support reimbursement sought for office visits under CPT code 99213. Claimant's last visit to Provider is billed under 99203, which is the CPT code for a new patient billing; nothing in the record supports examination or taking a full medical history of Claimant on his last visit to Provider.

Provider's services as electrical muscular stimulation (97014), neuromuscular reeducation (97112), and myofascial release (97250) rendered by Provider to Claimant from April 23 through June 20, 2003, were medically necessary for him, and Carrier should reimburse Provider for those, and only those, services. The remaining disputed services (one-on-one supervised therapeutic procedures and activities coded 97110 and 97530), and office visits to address expanded evaluation or history, or to make moderately complex medical decisions(99213) were not medically necessary for Claimant, and Carrier should not be required to reimburse Provider for them.

IV. FINDINGS OF FACT

1. Claimant suffered a compensable injury on ___, when he slipped and fell attempting to retrieve a tool from his truck. He injured his back, shoulder, and both wrists.

2. Liberty Mutual Insurance Company (Carrier) provides workers' compensation insurance covering Claimant's compensable injuries.

3. After Carrier denied as medically unnecessary the claims by Michael McGarrah, D.C. (Provider) for reimbursement for certain services rendered to Claimant, Provider requested

[13] For the purposes of the Medical Fee Guideline, treatment provided under CPT Code 97110 is considered physical medicine care or therapy, and a one-to-one setting is required by Medicine Ground Rule (I)(A)(9) (MFG, pp. 31-32.)

[14] MFG, p. 59.

[15] *Id.*, Evaluation/management Ground Rules, at p. 19.

[16] Id., Medicine Ground Rules, at p. 31.

medical dispute resolution through the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD).

4. The disputed services are office visits (CPT 99213), one-on-one supervised therapeutic procedures (CPT 97110), one-on-one therapeutic exercises and activities (CPT 97530), electrical stimulation (CPT 97014), myofascial release (CPT 97250), and neuromuscular reeducation (CPT 97112) provided from April 23 through June 20, 2003.

5. An IRO decision of June 18, 2004, determined that none of the disputed services were medically necessary because treatment prior to the disputed dates was a sufficient course of therapy and had not achieved significant improvement.

6. The MRD issued a decision dated July 16, 2004, which found that none of the disputed services Provider rendered to Claimant from April 23 through June 20, 2003, were medically necessary.

7. On August 10, 2004, Provider requested a hearing in response to the MRD decision and the case was referred to the State Office of Administrative Hearings (SOAH).

8. The Commission sent notice of hearing to all parties September 3, 2004.

9. 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.

10. Claimant began treatment of his compensable injuries in December 2002 with Dr. Pedersen, who treated Claimant primarily for his back complaints but also attempted to immobilize at least one of Claimant's wrists.

11. Claimant's wrist pain, wrist strength, and diminished range of motion did not improve under Dr. Pedersen's care, and Dr. Pedersen referred Claimant to Provider for further treatment of his wrists.

12. At Dr. Pedersen's referral, Claimant began a course of therapy sessions three times per week with Provider on April 1, 2003.

13. Provider treated Claimant only for pain and limited range of motion in his wrists.

14. In the absence of significant improvement, an accepted range within the workers' compensation treatment community for the duration of such therapy is six to twelve visits. If the patient improves within that time, more sessions are warranted.

15. Goals for Provider's therapy were to increase Claimant's strength in his wrists as well as to decrease his pain and return him to full-time work.

16. Claimant showed sustained improvement in strength and at least intermittent improvement in pain levels after beginning his treatment with Dr. McGarrah on April 1, 2003.

17. Claimant's forearm and wrist strength continued to improve under Dr. McGarrah's care.

18. Claimant continued his therapy with Provider from April 1 through June 20, 2003, for a total of 35 sessions.

19. Provider's SOAP notes concerning Claimant's treatment between April 23 and June 20, 2003, do not show any reason specific to Claimant that would require continuous one-on-one supervision of his exercises and therapeutic procedures.

20. Provider's disputed services for Claimant billed under CPT codes 97110, 97530, and 99213 and rendered to Claimant from April 23 through June 20, 2003, were not medically necessary.

21. On April 1, 2003, and continuing thereafter until June 23, 2003, both Dr. Pedersen and Provider had a reasonable medical expectation that additional therapy with Provider would, more likely than not, benefit Claimant by reducing the pain and limited range of motion resulting from his wrist injuries and increasing the strength in his wrists and forearms.

22. Claimant benefitted from the treatments and therapies provided from April 23 through June 20, 2003, in that he gained strength in his wrists and his pain levels decreased.

23. On October 13, 2003, Claimant was still back at work, and had minimal loss of strength in both wrists.

V. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to TEX. LAB. CODE ANN. § 413.031.

2. Provider timely appealed the MRD decision of July 16, 2004, that denied him reimbursement for the services disputed in this proceeding.

3. 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 Texas Worker's Compensation Act and TEX. GOV'T CODE ANN. ch. 2003.

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

5. Under TEX. LABOR CODE § 408.021(a)(1), 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 that cures or relieves the effects naturally resulting from the compensable injury.

6. Provider had the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) §§ 148.21(h) and 133.308(w); 1 TAC § 155.41.

7. Provider's disputed services billed under CPT codes 97014, 97250, and 97112 and rendered to Claimant from April 23 through June 20, 2003, were medically necessary.

8. Based on the foregoing Findings of Fact and Conclusions of Law, Provider is entitled to reimbursement for services he rendered to Claimant from April 23 through June 20, 2003,

and billed under CPT codes 97014, 97250, and 97112, but is not entitled to reimbursement for services he rendered to Claimant during the same period and billed under CPT codes 97110, 97530, and 99213.

ORDER

It is **ORDERED** that Liberty Mutual Insurance Company reimburse Michael McGarrah, D.C., for all disputed services coded 97014, 97250, and 97112, and rendered to Claimant from April 23 through June 20, 2003. It is further **ORDERED** that the request of Michael McGarrah, D.C., for reimbursement for all other disputed services rendered to Claimant be, and the same is hereby, denied.

SIGNED June 27, 2005.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS