SOAH DOCKET NO. 453-05-9684.M5
MDR Tracking No. M5-05-2179-01

ARK-LA-TEX HEALTH CENTER,	§	
PETITIONER	§	**BEFORE THE STATE OFFICE**
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE	§	
COMPANY,	§	**ADMINISTRATIVE HEARINGS**
RESPONDENT	§	

DECISION AND ORDER

Ark-La-Tex Health Center (Petitioner) appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD)[1] to adopt the decision of its designee, an Independent Review Organization (IRO). The IRO upheld Texas Mutual Insurance Company's (Carrier) denial of reimbursement for services Petitioner had provided a workers' compensation claimant (Claimant). Carrier's denial was based on its claim that the services were not medically necessary health care. This decision finds that while the services were medically necessary, only those services that were billed under the proper code are reimburseable.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice, or venue. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened April 24, 2006, at the State Office of Administrative Hearings, 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Ann Landeros presiding. The record also closed that date. Petitioner appeared by and through its principal James Raker, D.C. Attorney Bryan Jones appeared for Carrier. Commission Staff did not participate in the hearing.

[1] On September 1, 2005, the Commission became a division within the Texas Department of Insurance. Acts of May 30, 2005, 79th Leg., R.S., ch. 265, 2005 Tex. Sess. Law Serv. Ch 265 (HB 7). All citations in this Decision and Order are to the applicable statutes and rules as they existed at the time this case was referred to the State Office of Administrative Hearings in August 2005.

II. DISCUSSION

A. Background Facts

In___, Claimant sustained an injury to his back when a chair he was sitting in at his job collapsed. These injuries were compensable under the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN. ch. 401 *et seq.* At the time of the compensable injury, Carrier was the workers' compensation insurer for Claimant's employer.

Dr. Raker has been Claimant's treating doctor since February 2003. Claimant has also been treated by other specialists over the years, including pain management specialist, Bruce Safman, M.D., who monitors Claimant's pain medications.

It is undisputed that, before the contested dates of service in this case, Claimant had received over 80 chiropractic treatments and was over a year post-injury. From April 19 through August 17, 2004, Petitioner provided Claimant with electrical stimulation (CPT G0283), physical exercises (CPT 97110), and chiropractic manipulations (CPT 98942). An MRI revealed disc dessication and bulge without nerve impingement at the L4-5 and L5-S1 levels. Claimant's EMG results showed no abnormalities.

The IRO reviewer sustained Carrier's denial of coverage, stating:

> After 85 visits with the treating chiropractor, the treatment plan had done little to help the claimant's subjective opinion of his pain. . . . Continued and ongoing chiropractic care was not supported by the daily treatment cards and is not supported by current medical protocols. There is no documentation that reveals that the claimant is involved in a home based exercise protocol which would help to continue the claimant's treatment without inducing doctor dependence. The documentation supplied did not objectively support the dates of service nor are they supported by any current medical protocol. (Carrier Ex. 1 at 10).

Petitioner appealed the MRD order denying reimbursement.

B. Legal Standards

Petitioner has the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) §§ 148.14; 1 TAC §155.41.

Pursuant to the Act, an employee who has sustained 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 cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. §408.021(a).

Health care includes all reasonable and necessary medical services, including a medical appliance or supply. TEX. LAB. CODE ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31). To be entitled to payment from a carrier, a provider must submit a properly coded bill. See 28 TAC §§ 133.1(a)(3), 133.300, and 133.301

C. Evidence and Analysis

1. Evidence

Dr. Raker testified on behalf of Petitioner. Carrier presented the testimony of its expert witness, chiropractor David Alvarado. Both parties introduced various medical records and Petitioner presented the first page of various medical abstracts of unknown provenance (apparently obtained off the internet).[2]

a. Petitioner

Dr. Raker testified that Claimant is able to function with a combination of pain relievers and intermittent chiropractic care to treat symptom exacerbation. According to Dr. Raker, Claimant had just such a flare-up in July 2004, which is why Claimant received multiple sessions in July and August 2004.

The medical records showed that in the six months preceding the period at issue in the case,

[2] The ALJ was unable to give these articles much, if any, weight, as their provenance was not clear.

Claimant had the following number of sessions with Petitioner for the same services in dispute here: five in October 2003; three in November 2003; two in December 2003; one in January 2004; one in February 2004; and none in March 2004. From April through June 2004, Claimant received one session a month. Claimant had five sessions from July 1 through August 17, 2004. (Carrier Ex. 1 at 68-69).

Claimant credits the medication and Petitioner's services with enabling him to work, which he has been able to do almost continuously since his injury. In April 2005, he wrote:

> If it wasn't for Dr. Raker I would be flat on my back taking pain medications everyday. I come into Dr. Raker's office for adjustments only when I cannot tolerate the back pain. Dr. Raker has kept me at my job. (Pet. Ex. 1 at 26).

As Dr. Raker explained, he documented the sessions on a chart called the travel card. That chart recorded the date, the targeted area and symptom (e.g. "neck pain/spasms"); the treatment and rated the range of motion and symptom by spine level. The chart also noted that therapeutic exercises and electric stimulation were performed along with the manipulations. (Carrier Ex. 1 at 69). Dr. Raker pointed out that from the time of the flare-up in July until the end of the disputed period, Claimant's subjective rating of his back pain were reduced in four out of the seven categories rated on the chart and did not increase in the other categories.

With regard to billing for physical exercises under CPT 97110, which requires a one-to-one patient-to-therapist ratio, Dr. Raker claimed he would check periodically to see that Claimant was performing his home-based exercises correctly. He did not mention that Claimant had any cognitive or physical impairment that interfered with performing physical therapy exercises in a group setting.

b. Carrier

Carrier's expert, David Alvarado, D.C., testified that the disputed services constituted excessive care for a patient more than a year post-injury. Prior to this period, Claimant had already had over 80 sessions of chiropractic care. The recognized chiropractic guidelines state the typical recovery needs a maximum of 18 visits. In his opinion, the manipulations should have had

maximum effect long before the 85th chiropractic session.

Dr. Alvarado found Petitioner's documentation lacked a treatment plan, documentation of a course of home-based exercises, or indications that Claimant suffered from inflammation or muscle spasm that would justify use of electrical stimulation. In his evaluation, Claimant's significant pain relief came from medications, not Petitioner's services.

Dr. Alvarado criticized Petitioner for providing physical therapy services under CPT code 97110. Not only should Claimant have graduated to a home-based exercise program before April 2004, but Dr. Alvarado found no documentation justifying the use of the one-to-one level of therapeutic instruction. Although Petitioner listed treatment for five parts of the body on the travel card, Dr. Alvarado did not see five separate diagnosis that would justify those body parts being treated. He noted Dr. Safman had not mentioned a mid or cervical back problem in his reports. (Carrier Ex. 1 at 20-29).

In general, Dr. Alvarado thought the length and intensity of Claimant's treatment indicated a degree of doctor dependency. He thought the reported injury had had ample time to resolve itself and found no documentation of medical necessity for the disputed treatments.

2. Analysis

The record established Claimant suffers from back pain that he is usually able to control with medications, but which occasionally intensifies to the point he needs additional care. The evidence further established that he receives pain relief from these flare-ups from Petitioner's manipulations, electric stimulation, and physical exercises. Treatment that relieves pain is medically necessary healthcare under the Act. The record lacked any indication, other than the fact that this treatment occurred more than a year post-injury, that Claimant suffers from doctor dependency or has received excess treatment. The fact that Claimant has missed almost no work and seeks Petitioner's care only as needed rebutted Carrier's speculation that he is doctor-dependent.

With regard to the level of care administered, the record lacks sufficient documentation to justify Petitioner's use of CPT 97110 for one-to-one therapy for Claimant. That billing code is to be used primarily where safety is an issue, such as when a physical or cognitive impairment makes group sessions unsafe. The evidence did not establish that Claimant had impaired cognitive or physical abilities that would have made performing exercises in a group setting dangerous. Dr. Raker testified that he billed under CPT 97110 because he was checking to make sure Claimant was performing his home-based exercises properly but the records showed this instruction took place as often as every other visit. As there was no explanation for the need for this frequency of instruction, the use of CPT 97110 was not shown to be justified.

Petitioner established that the treatments provided Claimant from April 19 through May 17, 2004, were medically necessary in that they tended to relieve pain derived from the compensable injury. However, the services billed under CPT 97110 were not coded correctly and Carrier is not liable for incorrectly coded bills. Carrier should reimburse Petitioner only for the manipulations and electrical stimulations provided.

III. FINDINGS OF FACT

1. In___, Claimant sustained a compensable injury to his back while at work.

2. At the time of the injury, Claimant's employer had workers' compensation insurance coverage with Texas Mutual Insurance Company (Carrier).

3. James Raker, D.C., who was Claimant's treating physician, works at and is a principal of Ark-La-Tex Health Center (Petitioner).

4. As a result of his compensable injury, Claimant suffers from back pain that is controlled with pain medication except for occasion flare-ups, when Claimant seeks treatment from Dr. Raker.

5. From April through August 2004, Dr. Raker treated Claimant for back pain that could not be satisfactorily controlled with medication alone.

6. From April 19 through August 17, 2004, Claimant received manipulations (CPT 98942), physical exercises (CPT 97110), and electrical stimulation (CPT G0283) from Petitioner.

7. Claimant received pain relief from Dr. Raker's treatments.

8. From April through August 2004, Claimant received multiple sessions of one-to-one instruction from Dr. Raker on how to perform the physical therapy exercises.

9. It was safe to instruct Claimant on how to perform the exercises in a less intensive setting.

10. Carrier denied payment for the services listed in Finding of Fact No. 6 based on lack of medical necessity.

11. Petitioner's appeal of the denial of payment based on lack of medical necessity was decided by the Texas Workers' Compensation Commission's (Commission) designee, an Independent Review Organization (IRO), which upheld the denial.

12. Petitioner timely appealed the denial.

13. The Commission Staff's notice of hearing stated the date, time, and location of the hearing and cited to the legal statutes and rules involved along with a short, plain statement of the factual matters involved.

14. Petitioner and Carrier were represented at the hearing.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction over this matter pursuant to the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN. §413.031.

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

3. The IRO was authorized to hear the medical dispute pursuant to 28 TEX. ADMIN. CODE (TAC) §133.308.

4. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TAC §133.308.

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

6. Petitioner had the burden of proof in this proceeding. 28 TAC§§ 148.14; 1 TAC § 155.41.

7. Pursuant to the Act, an employee who has sustained 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 cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

8. Health care includes all reasonable and necessary medical services. TEX. LAB. CODE

ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

9. Under TEX. LAB. CODE ANN. §§ 413.013 and 413.018, the Commission is charged with reviewing medical care and ensuring treatments and services are both appropriate and appropriately billed.

10. CPT Code 97110 is properly billed only when a one-to-one patient to therapist ratio must be maintained due to safety or cognitive issues .

11. Claimant did not qualify for one-to-one physical therapy under CPT 97110.

12. A carrier does not have to pay an incomplete medical bill and a bill that uses the wrong CPT code is considered an incomplete medical bill. 28 TAC § 133.1(a)(3)(C) and 133.304.

13. For the services billed between April 19 and August 17, 2004, under CPT 97110 Petitioner billed under an inappropriate CPT code and is not entitled to reimbursement.

14. Claimant received pain relief from the manipulations (CPT 98942) and electrical stimulation (CPT G0283) provided by Petitioner and those services were medically necessary healthcare that Carrier should reimburse.

ORDER

It is ORDERED that Ark-La-Tex Health Care Center (Petitioner) is not entitled to reimbursement by Texas Mutual Insurance Company (Carrier) for services billed under CPT 97110 from April 19 through August 17, 2004, because those services were not billed under the proper CPT code. It is further ORDERED that Petitioner is entitled to reimbursement from Carrier for the services provided to Claimant from April 19 through August 17, 2004, under CPT codes 98942 and G0283 because those services were medically necessary.

SIGNED May 22, 2006.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS