SOAH DOCKET NO. 453-05-4248.M5
TWCC NO. M5-04-2692-01

THE UNIVERSITY OF TEXAS SYSTEM,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
HEALTH AND MEDICAL PRACTICE,	§	**ADMINISTRATIVE HEARINGS**
Respondent		

DECISION AND ORDER

An Independent Review Organization (IRO) determined that various chiropractic services rendered by Health and Medical Practice (Provider) to Claimant for her compensable injury were medically necessary. The Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission)[1] ordered the University of Texas System (Carrier) to reimburse Provider $6,279.57 for the disputed services. Carrier requested a hearing. This decision finds that the services were not medically necessary, and orders no reimbursement to Provider for them.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

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

The hearing in this matter convened November 1, 2005, at the State Office of Administrative Hearings (SOAH), 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Charles Homer III presiding. Assistant Attorney General Barbara L. Klein appeared for Carrier. Provider was represented by counsel, William Maxwell. As a result of a conference among counsel and the ALJ at the end of the hearing, the procedural record was held open until December 1, 2005, for receipt of briefing and response, if any, on the issue of whether Medicare reimbursement methodology[2] applies to the determination of medical necessity for service dates before

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the newly-created Division of Workers' Compensation at the Texas Department of Insurance.

[2] "Medicare" methodology refers to the guidelines promulgated for this region under the auspices of the federal Centers for Medicare and Medicaid Services, which is commonly abbreviated as "CMS."

August 1, 2003, and whether Carrier's appeal is sufficient to require application of Medicare reimbursement methodology when the MRD apparently failed to do so. Also at the hearing, the parties agreed to confer and submit a printed version of the Medicare-based treatment guidelines applicable to the disputed services rendered after August 1, 2003, the effective date of the 2002 Medical Fee Guideline,[3] for the ALJ's use in the event he found such guidelines to apply to this proceeding.

On January 3, 2006, the ALJ received the hardcopy of the Medicare Guidelines for Physical Medicine and Rehabilitation and for Chiropractic Care,[4] and on January 6 issued an order acknowledging receipt thereof and closing the record. The ALJ takes official notice of the contents of that hardcopy.[5]

II. APPLICABLE LAW

1. Medical Necessity

Whether the requested treatment is medically necessary is determined by reference to TEX. LAB. CODE ANN. (Code) § 408.021(a), which states:

> (a) 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] *Texas Medical Association, et al v. Texas Workers Compensation Commission, et al* 137 S.W.3d 342 (Tex. App. B Austin 2004, no pet).

[4] *Medicare Guidelines for Physical Medicine and Rehabilitation* and *Medicare Guidelines for Chiropractic Care*, Trailblazer Health Enterprises, LLC, (2005). (Internet version printed January 3, 2006)

[5] *Medicare Guidelines for Chiropractic Care* refers on page 3 to a *Medicare Benefit Manual*, because, according to the *Guidelines*, chiropractic services are subject to national regulation for Medicare. The manual was not proffered to the ALJ, but because of the specific circumstances of this case, its use is not required in reaching a decision. For future cases involving services rendered after August 1, 2003, the *Manual* may be necessary, and should be provided to the ALJ not later than at the hearing.

(3) enhances the ability of the employee to return to or retain employment.

At the hearing, the ALJ assigned the burden of proof to Carrier, pursuant to 28 TEXAS ADMINISTRATIVE CODE (TAC) § 148.14(a). Thus, Carrier must prove the disputed services were not reasonably required within the meaning of Code § 408.021(a). As discussed in Part II.B., the statutes and rules adopted there under require consideration of Medicare reimbursement methodologies in determining whether services rendered on and after August 1, 2003, were medically necessary.

B. Appropriate Medical Treatment Guidelines

The parties agree that this proceeding is an appeal of the MRD's findings regarding medical necessity, and nothing else. Carrier asserts that the appropriate standards for determining medical necessity are set according to the "2002 Medical Fee Guideline,"[6] while Provider argues that Carrier did not appeal any portion of the MRD decision except the medical necessity findings, and is therefore precluded from requesting an application of its rules that the MRD did not apply. Provider's analysis would require parties seeking review of an adverse determination to formally plead every errant consideration implicit in the agency's decision being appealed, a position that, to the ALJ's knowledge, is unsupported. Rather, because the hearing is *de novo*, the ALJ is obligated to apply controlling law without regard to whether the agency did so.[7]

It is now settled law that 28 TAC § 134.202 requires application of Medicare reimbursement methodologies to services rendered on and after August 1, 2003, which includes all but two weeks out of 16 weeks of Provider's services. The legally required guideline must be applied in this proceeding, and the ALJ will apply the 1996 Medical Fee Guidelines to services provided before August 1, 2003, and the Medicare methodology to services provided thereafter.[8]

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[6] 28 TAC § 134.202, effective August 1, 2003. See *Texas Medical Association, et al v. Texas Workers Compensation Commission*, above. This rule is referred to as the "2002 Medical Fee Guidelines" and requires use of the Medicare reimbursement methodologies.

[7] This is not to imply that the ALJ is not obligated to follow a reasonable agency interpretation of its own rule. The reason for following current guidelines, not superseded ones, in this proceeding is that there is no question of interpretation: Rule 134.202 is very clear that Medicare guidelines will be used.

[8] On its third page (unnumbered), the MRD decision states that its order of reimbursement is made to Carrier [I]n accordance with the Medicare program reimbursement methodologies for dates of service after August 1, 2003, per

III. THE PARTIES' EVIDENCE AND POSITIONS

A. Claimant's Injury and Treatment

On___, Claimant__ , a 24-year-old female who worked re-shelving books at a college library (___) injured her left elbow (sprain/strain)[9] while using both hands[10] to lift four books. The injury was compensable under the Texas Workers' Compensation Act. Claimant first saw Rachel Salazar, D.C., who worked for Provider, on June 27, and began a course of regular chiropractic therapy with Provider that continued beyond the last date of service in dispute in this proceeding.

From July 16, 2003, through November 11, 2003, Provider rendered the following services, most or all of them on multiple dates, and billed under the codes beside each:[11]

- extremity manipulation (98943)
- therapeutic exercises (97110)
- massage therapy (97124)
- attended electrical stimulation (97032)
- ultrasound (97035)
- therapeutic activity (97530)
- evaluation and management (99212MP)
- evaluation and management (99213MP)
- functional capacity evaluation (97750FC)

Commission Rule 134.202(b).

But this portion follows the medical necessity decision, and in context appears to refer only to fee calculations, and not the IRO's determination of medical necessity, in which the IRO gave no sign that it followed either guideline over the other or that it recognized that August 1, 2003, was significant to its determination. The ALJ accepts Provider's contention, only for the argument's sake, that the MRD and the IRO did not apply Medicare guidelines in determining medical necessity.

[9] Provider Exh. 1, p. 25.

[10] Provider Exh. 1, p. 123.

[11] Carrier Exh. 5, p. 000001-000008.

- motor nerve conduction study (95900)
- sensory nerve conduction study (95904)

On January 6, 2004, Dr. Salazar issued a return to work approval with a zero percent impairment rating.

B. Evidence

Each party offered documents concerning Claimant's prior treatment, evaluations, requests for reimbursement, and Carrier's adverse determinations.

Jarrod Cashion, D.C., testified for Carrier. While he did not disagree with the finding of sprain/strain to the left forearm and elbow, he testified that in order for treatment to be medically necessary, it must be appropriate for and addressed to a specific deficit suffered by the patient, whether that is pain, restricted range of motion, or muscle spasm. Dr. Cashion supported a course of treatment for a sprain/strain such as Claimant's that begins with passive therapy (hot packs, for example) and progresses to active modalities such as exercise. In Claimant's case, such a course should have ended after three weeks from the injury, or on July 15, 2003, according to Dr. Cashion.

Regarding the supervised one-on-one (97110) exercises, Dr. Cashion stated that Provider's documentation failed to describe a target area, the number of repetitions of each exercise, the duration of the exercise, and the patient's response to each exercise session. Because Provider did not address those elements, Provider's documentation is insufficient to support billing under 97110 for the exercises, and does not show their medical necessity, according to Dr. Cashion.

Dr. Cashion testified that Claimant had no post-injury deficit that necessitated either nerve conduction studies or manipulation of the arm. Similarly, Dr. Cashion stated that the massage therapy (97124) was not indicated for Claimant because, after her first exam on June 27, Claimant did not exhibit muscle spasm, the condition which does respond to pressure on the affected muscle. In Dr. Cashion's view, Claimant had no range of motion deficit on her left side, because her left and right arms tested equally.

Dr. Cashion stated that the absence of any significant injury was confirmed by the July MRI, almost a month after her injury. Regarding the nerve conduction velocity (NCV) studies (95000 and 95004), he believed that they were not medically necessary because there was no clinical evidence of a nerve deficit, the assessment of which is the purpose of NCV studies.

On cross-examination, Dr. Cashion discussed Medicare guidelines and how they allow providers to bill under multiple codes in various situations for services rendered in one visit. Dr. Cashion also stated that outcomes have nothing to do with medical necessity under Medicare Guidelines.

Robert O'Neal, D.C., testifying for Provider, asserted that the July 8, 2003, nerve conduction study of Claimant's left arm showed irritation of the elbow, which correlates to Claimant's subjective report of elbow pain. He stated that the follow-up motor nerve study on August 29, 2003, showed ulnar irritation but no axillary irritation, indicating improvement in Claimant's initial condition, and stated that Claimant's ultimate return to work with zero impairment rating demonstrates the medical necessity of Provider's services.

Dr. O'Neal described coding and billing for services under Medicare guidelines, and discussed several instances in which multiple CPT codes may be appropriate for use in a single office visit. He also noted that Medicare guidelines require one office visit per month for re-evaluation of the patient's condition.

Responding to Carrier's cross-examination concerning Claimant's range of motion (which remained the same in both arms and remained at the same extent on each of three functional capacity evaluations over several months), Dr. O'Neal stated that the nerve conduction studies supported his belief that Claimant had a nerve irritation that Provider's treatment helped to improve.

IV. ANALYSIS

Carrier's evidence met its burden of proving that the disputed services were not medically necessary for Claimant. Although the initial treatment of Claimant appears to have been within guidelines, Carrier's evidence, much of it comprised of Provider's records, demonstrated affirmatively that Claimant had no objective findings that would support continuation of either passive or active therapies beyond three weeks. Therefore, Provider should be reimbursed only for services it rendered before July 16, 2005.

Provider's witness Dr. O'Neal testified that Claimant's pain was relieved by the disputed services, and suggested that the pain's aggravation when Claimant returned to work on medium duty necessitated further treatment. Dr. O'Neal cited the NCV studies, while Dr. Cashion's evaluation states that the studies offer "minimal to no objectivity."[12] But Claimant's ultimate return to work with a zero impairment rating was the primary objective support for Dr. O'Neal's opinion that the dispute services were medically necessary.

In different circumstances, a return to work may indeed be evidence probative of medical necessity. But in this case, all the evidence, including the manner in which the accident caused the injury, shows or at least strongly suggests that the injury was minimal. Dr. Cashion testified that such an injury resolves itself over time.

Dr. Cashion's testimony is supported by Claimant's medical record. Her MRI, taken on July 21, 2003, confirmed that Claimant had a "normal" left elbow, that her ligaments, tendons, and neurovascular system the potentially affected area were all normal. The MRI report describes only a "minimal" signal consistent with "subjacent mild peritendinitis" and restates that there is no abnormality within the tendon, and concludes:

> 1) No evidence for ligament, tendon, nor muscular or osseous injury of the left elbow.
> 2) No evidence for biceps tendon tear or injury.
> 3) Minimal linear inflammation deep to the common flexor tendon, compatible with minimal peritendinitis.[13]

[12] Carrier Exh. 5, at p. 000002.

[13] Carrier Exh. 6, p. 000040.

Most persuasive are the notes of Provider's doctor and Claimant's treating doctor, Rachel Salazar:

> (July 30, 2003) This patient has a medical necessity for direct one-on-one patient contact to reduce the current physical impairment which is limiting the patient's ability to engage in normal, pain-free ADL's.
>
> (July 30, 2003) The therapeutic exercises are being implemented to achieve the following short-term goals: restore the patient's ability to perform normal ADL's, and decrease joint pain to allow for quicker improvements in the patients [sic] functional level.
>
> (July 30, 2003) The treatment benefits of ultrasound (97035) will help achieve the following patient goals: improved joint mobility due to softening of adhesive scars limiting normal tissue and joint function, and a reduction of local pain associated with inflammatory tissue changes.
>
> (July 14, 2003) The following deficit areas were identified as *not pertaining directly to the patient's injury* and predominantly due to de-conditioning and long standing habits. "Patient was unable to complete normal activities of daily living in a pain free status. Unable to lift in rotation."[14] (Emphasis supplied.)

Thus, Provider's records state that its treatment of Claimant was for conditions unrelated to her compensable injury. Carrier's evidence highlights the absence of another foundation of medical necessity: treatment for injury-related pain. Reduced to bare essentials, Provider's records of Claimant's treatment reveal that whatever the extent of her injury on June 21, on July 30 Claimant:

> "described mild left forearm pain; a little worse since last visit. This patient also reported symptoms of minimal left arm tingling; this is at the same level of pain [sic] as last time."[15]

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[14] Provider Exh. 1, p. 168. These treatment notes are what might be called the "third version"in that they are a well-organized (by date) and computer-processed (*e.g.*, variable font size) document than the original (hand-inscribed on forms) notes and better than the typed notes that were apparently created from the hand-inscribed. Both earlier versions contain omissions of specifics that render them unintelligible and almost useless as evidence, *i.e.*, "OBJECTIVE FINDINGS: Palpation examination of the left forearm found." (Carrier Exh. 6, at p. 000016.) "gain, OBJECTIVE FINDINGS: Palpation of the left forearm found a level of. Manipulation was evident in the left elbow." (Carrier Exh. 6, at p. 0000119.) These quotations are not aberrant selections from generally consistent notes: they are representative samples.

Carrier, while not objecting to the admission of the earlier versions, argued their lack of reliability and the consequent lack of reliability of the "third version." But as the excerpts show, even standing unchallenged, the third version contains the seeds of this claim's destruction by asserting, as it does, that treatments were being rendered to promote healing of a "minimal" pain and "nominal"tingling.

[15] Carrier's Exh. 6, at 000045.

At her next office visit on August 1 Claimant "described indications of nominal left forearm pain and minimal left arm tingling."[16] Based upon those symptoms, on August 1 Provider wrote the following note and began a course of treatment that ultimately continued until the end of the year 2003:

> [Claimant's] injury is exacerbated with increased activity. She will be placed in a more aggressive physiotherapeutics program to decrease her pain, aid in range of motion, and strengthen the surrounding soft tissue structure.[17]

Thereafter, through the end of 2003 (as far as the ALJ has found in the typed version of the daily notes), "nominal" and "minimal" are the two words used to described Claimant's two symptoms. These records bear out Dr. Cashion's opinion that Claimant, after a short period, had no significant deficits to treat.

The IRO decision commented that:

> [T] diagnoses for this patient have included left forearm sprain/strain and left forearm myofascial pain. . . . [T]his patient's response to treatment was slow. The . . . reviewer also explained that although the patient failed to respond well to the treatment rendered, the treatment was appropriate and medically necessary. Therefore, the . . . reviewer concluded that the [list of all therapies] were medically necessary to treat this patient's condition.[18]

As Provider argues, even such a circular (ineffective treatments mean that "patient's response was slow"and conclusory IRO finding as that cited above is sufficient to relieve Provider of the burden of proving medical necessity on appeal. But Carrier's evidence is sufficient to prove the contrary, and Provider was unable to respond persuasively. Carrier's expert testimony that there was no medical necessity for any of the various treatment modalities provided to Claimant after a very short recovery period is amply supported by Claimant's medical history, including both the objective tests and her own complaints. Dr. O'Neal's testimony, based as it was on his review of Provider's confusing records, could not and did not describe how the extended course of treatment

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[16] Carrier's Exh. 6, at p. 000053. This page, and the other pages reviewed by the ALJ that contain the quoted terms are titled "Daily Notes Report," and are the typed versions of such reports. The Carrier's date stamp on each displays a date approximately two weeks from the office visit recorded, *e.g.*, the October 14, 2003, report (Carrier Exh. 6, p. 147) was received by Carrier on October 29, 2003.

On the other hand, the "third version"of Provider's daily notes previously referred to was apparently prepared for use in this proceeding, substantially later than Carrier's Exh. 6. Most tellingly, the pain described as "nominal" in the Carrier Exh. 6 has been upgraded to "mild" in Provider's Exh. 1, p. 220. The ALJ finds Carrier's Exh. 6 to be more reliable than Provider's Exh. 1 as to daily notes.

[17] Carrier Exh. 6, p. 000049.

[18] Provider Exh. 1, p. 94.

fit Claimant's specific needs, or even what those specific needs were and why they were severe enough to require such a long course of therapy. The history itself is a chronicle of three months of regular therapy while Claimant's condition changed minimally, if at all. Thus Carrier's was by far the preponderance of the credible evidence in this record.

V. CONCLUSION

This record shows beyond a preponderance of the credible evidence that the chiropractic treatment rendered to Claimant from July 16 through November 11, 2003, was not medically necessary for her. Provider should not receive reimbursement for the disputed services.

VI. FINDINGS OF FACT

1. On___, a claimant, ___(Claimant), who worked for self-insured employer University of Texas System (Carrier), suffered a compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. §401.001 *et seq*.

2. As part of the claimant's subsequent treatment, Health & Medical Practice (Provider) provided chiropractic and related services to Claimant from ___, through November 11, 2003 (disputed services).

3. Provider requested from Carrier reimbursement for all services referenced in Finding of Fact No. 2.

4. Carrier denied Provider's claim for reimbursement for the disputed services on the basis of lack of medical necessity.

5. Provider requested the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) for medical dispute resolution with respect to the disputed reimbursement.

7. An Independent Review Organization (IRO) found the disputed services were medically necessary.

8. On January 25, 2005, the MRD issued its decision and ordered Carrier to reimburse Provider $6279.57 for the disputed services.

9. On January 31, 2005, Carrier requested a hearing with the State Office of Administrative Hearings (SOAH).

10. The Commission mailed notice of the hearing to the parties at their addresses on February 24, 2005.

11. This case was referred by the Commission and accepted by SOAH for hearing before September 1, 2005.

12. Claimant injured her left arm when she attempted to lift four large books using both hands.

13. Claimant's injury did not involve more than minimal irritation beneath the common flexor tendon, which itself suffered no tendinitis.

14. Claimant's MRI of July 21, 2003, revealed no injury to tendons, bones, or the neurovascular system of her left arm at the elbow.

15. Claimant had muscle spasm in her left elbow on her June 27, 2003, visit to Provider, but not thereafter.

16. Claimant's range of motion at the elbow was the same on both sides on her June 27, 2003, visit to Provider and was the same at all visits during the rendition of the disputed services.

17. The normal course of sprain/strain injury such as Claimant's is that the injury heals within a few weeks.

18. There is no evidence that Claimant "responded slowly" to the four-month course of therapy that comprises the disputed services.

19. Provider's documentation for services billed under CPT code 97110 did not clearly delineate exclusive one-on-one treatment nor did it identify a level of severity of the injury that is sufficient to overcome Carrier's evidence that one-to-one therapy was not medically necessary for claimant.

20. On and after August 1, 2003, Claimant's symptoms were recorded by Provider as "nominal left forearm pain and minimal left arm tingling."

21. Claimant received chiropractic care from June 27 through July 15, 2003, from Provider.

22. Approximately three weeks of therapy was sufficient for Claimant's injury under the 1996 Medical Fee Guidelines.

23. Approximately three weeks of recovery time is a timeframe consistent with Claimant's clinical presentation on June 27, 2003.

24. Claimant's injury-related condition after July 15, 2003, required no further therapy and treatment to completely resolve itself.

25. Claimant's compensable injury was resolved or so nearly resolved on August 1, 2005, that no further treatment by Provider was medically necessary.

VII. CONCLUSIONS OF LAW

1. At the time this case was referred to SOAH, the Texas Workers' Compensation Commission (Commission) had jurisdiction to decide the issues presented by this proceeding pursuant to§ 413.031 of the Act.

2. The State Office of Administrative Hearings (SOAH) has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. (Labor Code) §§ 402.073(b) and 413.031(k) (West 2005), TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003 (West 2005), and Acts 2005, 79th Leg., ch. 265, § 8.013, eff. Sept. 1, 2005.

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

4. Carrier, the party seeking relief, had the burden of proof in this case, pursuant to 28 TAC §148.21(h).

5. The 2002 Medical Fee Guidelines (28 TAC § 134.202) apply to the disputed services rendered to Claimant on and after August 1, 2003.

6. The Medicare guidelines required to be used by the Commission's 2002 Medical Fee Guidelines require that patient symptoms improve within a "timeframe consistent with the patients [sic] clinical presentation. Medicare Guidelines for Chiropractic Care, Trailblazer Health Enterprises, LLC, 2005. (Internet version printed January 3, 2006), at p. 3.

7. No disputed service provided before August 1, 2003, was medically necessary for Claimant under the 1996 Medical Fee Guidelines.

8. No disputed service provided on or after August 1, 2003, was medically necessary for Claimant under the 2002 Medical Fee Guidelines. 28 TAC § 134.202.

9. Based upon the foregoing Findings of Fact and Conclusions of Law, Carrier should not be ordered to reimburse Provider for the disputed services.

ORDER

IT IS THEREFORE, ORDERED that Carrier, University of Texas System, need not reimburse Provider, Health and Medical Practice for services provided by Provider to Claimant ___. from July 16 through November 11, 2003.

SIGNED January 13, 2006.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE