DOCKET NO. 453-05-4452.M5
MR NO. _____

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	
	§	**OF**
ALL STAR CHIROPRACTIC & REHAB,	§	
	§	
Respondent		**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (the Carrier) appeals the decision of the Texas Workers' Compensation Commission (Commission),[1] acting through an independent review organization (IRO), requiring reimbursement of $4,079.56 for mechanical traction, electrical stimulation, therapeutic exercise, chiropractic manipulation, and massage therapy provided to a workers compensation claimant from November 4, 2003 through May 10, 2004. The Administrative Law Judge (ALJ) concludes the Carrier has proven by a preponderance of the evidence that most of the disputed services were not medically necessary. Therefore, the ALJ reverses the decision of the IRO, in part, and finds that reimbursement of only $1,079.95 is required for the disputed services.

I. NOTICE AND HEARING

The hearing convened April 12, 2006, at the hearing facilities of the State Office of Administrative Hearings (SOAH) before SOAH ALJ Kerry D. Sullivan. The Carrier was represented by Katie Kidd. The Respondent, All Star Chiropractic & Rehab, was represented by Jon Schweitzer, D.C. The hearing concluded and the record closed on April 12, 2006.

II. BASIS FOR DECISION

The Claimant was injured on____, when he slipped and fell on his left side, injuring his left shoulder, neck, and chest while performing his duties as a _____. The Claimant's injuries were initially diagnosed as sprain/strain, but it was ultimately determined that he suffered a rotator cuff

[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.

tear and multiple disc herniations. The Claimant received extensive conservative care, including the services in dispute. In addition, his rotator cuff was surgically repaired on February 24, 2004, and he subsequently underwent a cervical fusion operation.

The record in this proceeding consists of approximately 500 pages of the Claimant's medical records and the testimony of two witnesses. Bill DeFoyd, D.C., testified on behalf of the Carrier and Jon Schweitzer, D.C., testified for the service provider. As addressed below, the ALJ is persuaded by Dr. DeFoyd's testimony that most of the services in dispute were not medically necessary.

With the exception of therapeutic exercises, the disputed services generally constituted passive care, which Dr. DeFoyd testified should typically be undertaken soon after an injury or following surgical intervention or any setbacks. According to Dr. DeFoyd, passive care should be used exclusively for no more than two weeks and should decrease over time and be replaced by active therapy. He also stated that passive therapy should constitute no more than 25 per cent of the overall therapy regimen.

Dr. DeFoyd acknowledged that the Carrier should have reimbursed the service provider $1,079.95 in disputed services that it initially denied, and the Carrier stipulated it would make this payment. This amount relates to passive therapy provided immediately following the rotator cuff surgery in February 2004. Dr. Defoyd testified, however, that all of the other disputed services were excessive and not medically necessary. He stated that the remaining services fell outside of the Medicare and Official Disability Guideline, which he viewed as the most generally accepted guidelines for this type of medical care, and that no justification was provided to depart from the usual standard. He also asserted that meaningful assessment of the disputed treatment was hampered by the fact that the Claimant was not provided a functional capacity evaluation from which to measure progress.

Finally, Dr. DeFoyd testified that the active therapy in dispute was not medically necessary in that it was billed under CPT Code 97110, which requires one-on-one attention, whereas only less intensive (and less expensive) group therapy (CPT Code 97150) was required and, in fact, provided.

According to Dr. DeFoyd, one-on-one therapy is required to instruct, problem solve, and where there are safety issues or cognitive difficulties, but that none of these situations were present with the Claimant during the disputed period.

Dr. Schweitzer countered that the results pertaining to the Respondent speak for themselves. He observed that the Respondent returned to full duty with his employer and missed very little time. He also testified that the Respondent was overweight and out of condition, thus requiring service in a more intensive setting than would, perhaps, otherwise be required. He defended the absence of a functional capacity evaluation on the basis that claimants who undertake such evaluations are frequently guarded with respect to their effort, often rendering results questionable. He testified that, instead, he prefers to rely on informal observation of his patients undertaking activities such as taking off their shirt.

The ALJ is persuaded by the testimony of Dr. Defoyd for several reasons. His assessment is consistent with the most widely accepted treatment guidelines, and it appears the Claimant should have been weaned from passive therapy prior to the provision of the services remaining in dispute. The lack of a functional capacity evaluation or other objective assessment of the Claimant's progress militates against deviating from the guidelines. Finally, Dr. Schweitzer's incorrect belief that multiple patients may be supervised while charging for CPT Code 97110 (therapeutic exercise) indicates that Dr. Schweitzer is less familiar with the workers' compensation system in Texas than is Dr. DeFoyd, whom Dr. Schweitzer acknowledged has a well-respected reputation.

Based on the above, the ALJ finds that $1,079.95 should be reimbursed for the originally disputed services, in accordance with Dr. DeFoyd's testimony, but that no additional reimbursement should be required.

III. FINDINGS OF FACT

1. The Claimant suffered a compensable injury on___, when he slipped and fell on his left side, injuring his left shoulder, neck, and chest while performing his duties as a _____.

2. Texas Mutual Insurance Company (the Carrier) is the provider of workers' compensation insurance covering the Claimant for his compensable injury.

3. Respondent All Star Chiropractic & Rehab provided mechanical traction, electrical stimulation, therapeutic exercise, chiropractic manipulation, and massage therapy to the Claimant from November 4, 2003 through May 10, 2004.

4. The Carrier denied the Respondent reimbursement for the services described in Finding of Fact No. 3 on the basis that they were not medically necessary.

5. The Respondent requested medical dispute resolution by the Texas Workers' Compensation Commission, which referred the matter to an Independent Review Organization (IRO).

6. The IRO found in favor of the Respondent with respect to the services in dispute in this proceeding.

7. On February 14, 2005, the Carrier requested a hearing, and the case was referred to the State Office of Administrative Hearings (SOAH).

8. Notice of the hearing was sent on March 7, 2005.

9. The notice contained a statement of the time, place, and nature of the hearing, and the legal authority and jurisdiction under which the hearing was to be held; a reference to the sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

10. The hearing was continued based on an agreed motion of the parties and was ultimately conducted on April 12, 2006. Both the Carrier and the Respondent participated in the hearing.

11. The Claimant's injuries were initially diagnosed as sprain/strain, but it was ultimately determined that the Claimant suffered a rotator cuff tear and multiple disc herniations.

12. The Claimant received extensive conservative care, including the services in dispute. In addition, his rotator cuff was surgically repaired on February 24, 2004, and the Claimant subsequently underwent a cervical fusion operation.

13. Initially disputed services in the amount of $1,079.95 for passive therapy provided immediately following the Claimant's rotator cuff surgery in February 2004 was shown to be medically necessary and was stipulated by the Carrier.

14. The remaining disputed services were not shown to be medically necessary. They fell outside of generally accepted guidelines, and there was inadequate rationale provided to warrant deviation from the guidelines. Additionally, services provided under CPT Code 97110 were not provided in a one-on-one setting as required for reimbursement under that code.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act (the Act), specifically TEX. LABOR CODE ANN. § 413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE §148.3.

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

5. As the petitioner, the Carrier has the burden of proof in this matter. 28 TEX. ADMIN. CODE §148.21(h).

6. The Carrier established that, with the exception of $1,079.95 in initially disputed services stipulated to be reimbursable at hearing, the services in dispute were not medically necessary.

7. The Carrier should be required to reimburse All Star Chiropractic & Rehab a total of $1,079.95 for the services at issue in this proceeding.

ORDER

IT IS ORDERED that the Texas Mutual Insurance Company shall reimburse All Star Chiropractic & Rehab a total of $1,079.95 for services provided to the Claimant from November 4, 2003 through May 10, 2004.

SIGNED May 24, 2006.

KERRY D. SULLIVAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS