SOAH DOCKET NO. 453-05-9074.M5
MDR NO. M5-05-2424-01

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
	§	
VS.	§	**OF**
	§	
	§	
COTTON D. MERRITT, DC	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) sought review of an Independent Review Organization (IRO) decision and resulting order by the Medical Review Division (MRD) of the Texas Worker's Compensation Commission (TWCC). The MRD ordered Carrier to reimburse Cotton Merritt, D.C. (Provider) $10,400.75 for chiropractic services provided by him from June 1, 2004, to January 14, 2005, to an injured worker (Claimant), because the IRO found all of Provider's services rendered to Claimant were medically necessary. This decision finds that some disputed therapies and office visits for which Provider seeks reimbursement were not medically necessary for the treatment of the worker's(Claimant's) injury, and finds that many disputed one-on-one sessions of therapeutic procedures (coded 97110) were not medically necessary. Consequently, this decision concludes that Provider is entitled to reimbursement from Carrier, but not the entire amount ordered by the MRD.

I. STATEMENT OF THE CASE

Administrative Law Judge (ALJ) Charles Homer III convened and closed the hearing in this case on January 24, 2006, at the Austin hearing facility of the State Office of Administrative hearings (SOAH). Attorney Ryan Willett appeared on behalf of Carrier. Provider appeared for himself. Notice and jurisdiction were not disputed, and are addressed in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

A. Medical History and Procedural Background.

Claimant, a 54-year-old lady who worked at ___ of Lubbock, Inc., suffered a compensable injury to her left knee on____, when she was hanging clothes on a rack that toppled over and struck

her left knee. Although her pain was immediate and severe, she was initially given only modified duties and self-care instructions. Later, she was diagnosed by MRI with a left lateral meniscus tear and strain/sprain of the left knee. On March 2, 2004, she underwent arthroscopy by Gaylon Seay, M.D., for the torn meniscus. She had four weeks of post-surgical rehab beginning in mid-April at Lubbock Occupational Health Center.

On May 27, 2004, Provider first examined Claimant and noted that her primary complaint was left knee pain (level eight), that her left patella was misaligned, that she walked with a limp, and that she had grinding and crepitus when she moved the joint. Provider noted that the previous therapy had inappropriately required Claimant to use a StairMaster and stationary bicycle, both of which he considered more likely to have aggravated her injury than to have promoted healing.

Provider also wrote that the anticipated duration of her rehabilitation with his clinic was six to eight weeks.[1] He prescribed a course of various physical therapy modalities including one-on-one supervised therapeutic activities and exercises (97110), neuro-muscular re-education (97112), and manual therapy (97140), which Claimant began on June 1 and ended on August 11, 2004. Therapy did not resolve Claimant's pain, and on September 8, 2004, Dr. Dana Soucy performed a total replacement on Claimant's left knee joint. After home healthcare (with therapeutic exercise) that ended October 13, Provider again began seeing Claimant as a patient on October 19, 2004.

Provider billed Carrier for services provided from May 27 through August 11, 2004, and from October 19, 2004, through January 14, 2005. Carrier reimbursed Provider for some services[2] and denied reimbursement for most as medically unnecessary. Provider requested medical dispute resolution. The reviewing IRO concluded that Provider's services for Claimant from June 1, 2004, through January 14, 2005, were medically necessary for her. In response, Carrier requested this proceeding before SOAH. To clarify the issues, the following table breaks Provider's treatment into two courses (one after each of Claimant's surgeries).

Course 1	continuing	continuing	continuing	continuing	(June 10 only)[3]

[1] Provider Ex. 1, pp. 79-81. Page numbers in Provider's Ex. 1 are incompletely copied on the ALJ's copy, so although the ALJ has attempted to cite them correctly, he cannot be certain any page number from Provider's Ex. 1 cited herein is correct, and has attempted to rely exclusively on Carrier's Ex.1.

[2] Carrier paid for some services whose medical necessity it also denied. (Carrier Ex. 1, pp. 206-208; Carrier Ex. 2).

[3] Carrier Ex. 1, p. 37.

	97110 therapeutic procedures, 5 units of one-on-one supervised per visit	97112 neuromuscular re-education, 2 units per visit	97140 manual therapy, 2 units per visit	99212 office visit, 1 unit per visit	95903 (nerve conduction study) 95904 (reflex study)
Course 2	continuing	continuing	continuing	continuing	January 4, 2005 only[4]
October 19, 2004 - January 14, 2005	97110	97112	97140	99212	99213 (4 units) (office visit for evaluation and management of patient)

B. Summary of Evidence and Argument

1. Carrier

[4] Carrier Ex. 2, p. 6.

In general, Carrier argues that Provider's treatment of Claimant was excessively long and intensive, with no medical necessity for the one-on-one therapy except for (1) certain specified visits that provided instructional benefit to Claimant or for (2) appropriate follow-ups on her progress, including necessary observations of her compliance with a home exercise regimen. Thus, according to Carrier, much of the first course of treatment and nearly all of the second was not reasonable and necessary care for Claimant under Medicare standards, which provide an upper limit of two months for post-injury rehabilitation therapy.[5] Carrier presented testimony from John Pearce, M.D., and David Alvarado, D.C.

Dr. Pearce's testimony emphasized the following aspects of Provider's treatment and Claimant's condition:

- Overall, the treatment sessions of two and one-half and three hours were too long, so long that they risked causing regional pain syndrome or increasing rather than decreasing Claimant's pain after the arthroscopy.

- Agreed with Provider that Claimant should not have been instructed to use a StairMaster during her fist four weeks of therapy after the arthroscopy.

- The one-on-one supervised therapy (97110) charges for October 25, 2004, were medically necessary because Claimant had a new injury (the knee replacement) and likely a new therapist.

- The exercises Provider prescribed after the knee replacement were the same as those prescribed for the first post-surgical therapy in June, and nothing in the patient's record of either treatment course supports one-on-one supervision beyond the Medicare guidelines recommendation of 30-45 minutes per session.

- After the knee replacement, it was reasonable to continue the manual therapies and neuromuscular re-education for 4-6 visits in order to increase Claimant's range of motion and for muscle building, but manual therapy was not medically necessary for a longer time

- Three office visits per week for four weeks, a total of 12 visits, would have been sufficient for Claimant, and thereafter she could have graduated into group exercises, and remained in a group exercise program for 12 - 20 sessions. Group programs often benefit patients by providing rivalries and positive feedback among group members.

[5] *Id.*, p. 223.

- When a patient such as Claimant is not progressing, medically necessary treatment implies that some change should be made to her regimen, but at the January 14, 2005 visit,[6] Claimant was still on the same exercises as in the beginning of her second course of therapy, although she had not displayed significant improvement.

- On cross-examination, Dr. Pearce acknowledged there was some improvement in Claimant's range of motion and decrease in her pain during her first course of treatment with Provider, after the arthroscopy.

Consistent with Carrier's position that many of the disputed services were not medically necessary to treat Claimant's injury, its second expert witness, David Alvarado, D.C., testified as these excerpts show:

- Claimant had 42 units of one-on-one supervised therapeutic exercises with the Lubbock Occupational Health Center (Lubbock) before she first saw Provider, reducing dramatically the amount of one-on-one supervision she should have needed thereafter.

- Claimant's progress at Lubbock was insufficient, and she should have received six to eight units (fifteen minutes is a unit) of one-on-one supervision (97110) with Provider, but no more.

- There was some improvement in Claimant's condition during Provider's first treatment.
- Six units of manual therapy (97140) during the first treatment course are within the Medicare guidelines, and therefore reasonably necessary.
- Six units office visits (99212) during the first treatment course were medically necessary.

- While the exercises Provider prescribed were appropriate for Claimant, the amount of time spent on them, especially under one-on-one supervision, was highly excessive

2. Provider

Provider argues that the IRO correctly analyzed all the data, and that Carrier's testimony at the hearing added nothing and did not amount to the preponderance of evidence needed to reverse the MRD decision in his favor. In testimony, Provider asserted:

- that Claimant suffered a complicated injury and had two separate surgeries from which to recover, both of them requiring therapy as evidenced by her treating physician's (Dr. Soucy's) orders;

[6] Referring to Carrier Ex. 1, p. 189.

- that the four weeks Claimant was in therapy with Lubbock Occupational Health Center should not count towards the two months' suggested for therapy by Medicare guidelines, because the four weeks' therapy was actually counter-productive due to Claimant's using the StairMaster and the stationary bicycle;

- that any post-operative rehab is outside the "norm,"and thus must be evaluated on its own. In particular, Claimant's two surgeries and continued pain illustrate a complicated clinical situation that justified extending both her courses of therapy;

- that changing Claimant's exercise regimen would have regressed her, not helped her; and

- that even slight improvement in a patient's range-of-motion and pain levels can make a big difference to the patient.

III. ANALYSIS AND CONCLUSION

A. Treatment During the Period Beginning June 1, 2004

This decision finds that Claimant initially required more services than Carrier asserts were medically necessary, because of her poor post-surgical recovery and the strong possibility that her therapy before she first saw Provider aggravated her condition. This analysis first discusses the neuromuscular re-education, manual therapy, office visits, and studies provided for Claimant during the first course of treatment, and then addresses the one-on-one supervised therapeutic procedures separately.

1. Therapy and Studies

On April 26, 2004, Dr. Seay (who performed the March 2 arthroscopy) wrote that he was "reluctant to recommend any further intervention until she has had more chance [*sic*] at therapy," but on May 17, noting that Claimant still limped severely despite gait training,[7] he recommended total knee replacement. Dr. Soucy, Claimant's treating physician, differed with Dr. Seay and wanted to "delay this [knee replacement] as long as possible for the time being."[8] Dr. Soucy also wrote on

[7] Provider Ex. 1, p. 98.

[8] Carrier Ex. 1, p. 192.

June 7,"I would like for her to continue therapy."[9] Goals and duration of therapy were left to Provider.

From Providers perspective, on May 27, Claimant presented with the following:

- $ history of abnormal failure to regain ROM in her left knee after arthroscopy; excessive postoperative pain; and
- $ history of four weeks of ineffective and at least potentially harmful therapy.

Provider set up a treatment plan and referred her for evaluation to Dr. Soucy, who in turn ordered:

> June 7, 2004 - I would like for her to continue therapy;[10] and
> June 21, 2004 - Continue therapy to work on range of motion.[11]

Consistent with Medicare guidelines, Provider's initial plan called for six to eight weeks of therapy beginning June 1, or a time that would end by July 12-26.[12] After June 21, according to Dr. Soucy's note, the sole reason for continued therapy was improvement in Claimant's ROM. According to Dr. Pearce, by July 2, 2004, Claimant's left-knee ROM in flexion as measured by Provider had stabilized at 100 degrees, and did not thereafter improve.

Although Carrier urges that reimbursement not be allowed after July 2, because there was no improvement in Claimant's ROM and no change in her therapy after that date, Provider required some reasonable time after that date to continue therapy and observe that it was no longer improving Claimant's condition. In other words, it is not possible to observe that a graph has plateaued at a high value at the first data point that reaches the plateau level.[13]

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[9] *Id.*

[10] Carrier Ex. 1, p. 191-2.

[11] *Id*., p. 192.

[12] *Id*., p. 130.

[13] *Id*., p. 151. Provider could not have known on July 2 that Claimant would not improve further, so it is reasonable to reimburse Provider for a period of time in which Claimant reaches an observable plateau. Certainly this should be true when, as here, that observable plateau remains within the ending date of the initial treatment plan. In this

The focus in Dr. Soucy's two separate notes (both quoted above) changes from general care on June 7 to specific treatment on June 21. After June 21, the sole therapy goal in his mind was increasing Claimant's ROM. Because Claimant's ROM reached 100 degrees on July 2 and remained at that level on each occasion that she was tested through July 21, the ALJ finds that Provider's most of Claimant's treatment was medically necessary through July 21, but thereafter was not. After July 21, Provider could either have changed therapy or referred Claimant back to Dr. Soucy, who, as it happened, performed the total knee replacement about seven weeks thereafter.

Thus, two units of neuromuscular re-education and one of manual therapy for each of Claimant's first six treatments (June 1 - 11) were medically necessary, as were the nerve conduction studies and reflex studies conducted on June 10.[14] After June 11 and continuing through July 21, the single units of manual therapy devoted to increasing joint mobility at each office visit were medically necessary because the aim of one of the two units in dispute at each visit was to increase Claimant's ROM; the total of medically necessary manual therapy (97140) units is six plus 16, or 22 units.

Finally, Carrier concedes that it is reasonable to anticipate that periodic office visits are necessary to monitor Claimant's compliance with the prescribed program and effectiveness of therapy. Based on Carrier's witnesses' testimony and Provider's appropriate concern for Claimant's progress, the three office visits (99212) in Claimant's first week of treatment, one in each of the next two weeks, the June 21st visit, and a final follow-up on August 9 (a total of seven units) were medically necessary; the remainder were not. The chart at the end of this subpart 2 shows the disputed services that were medically necessary for Claimant from June 1 through August 19, 2004.

2. One-on-one supervised procedures and exercises (97110)

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case, that date is July 21, by which time Claimant had shown no improvement after three weeks.

[14] The parties did not contest this service, and there is nothing in the record that compels a conclusion different from the IRO's.

Although little dispute exists that some therapeutic exercises were helpful during this first course of treatment, great controversy exists between the parties over how much one-on-one supervised therapy was reasonable for Claimant. Provider does not dispute that Claimant's exercises were elementary in degree of difficulty and that he kept Claimant on the same exercises with but small increase in weight (from one-half to two pounds) throughout her first course of treatment with him.

Carrier does not dispute that the various exercises that Provider prescribed were appropriate; its contention is that after a short time, Claimant could do them in a group (where she might benefit from the camaraderie and rivalry that arises among members) or do them at home.

But because so many exercises were necessary[15] and because Claimant's initial status was poor and difficult to assess, the ALJ finds that three units of one-on-one supervised activities were medically necessary on each office visit from June 1 through June 11, that for the following three visits two units were medically necessary, and that from June 14 through July 21, one unit at each visit was medically necessary. Thus, the total of medically necessary services coded 97110 is 37 units.

Summarizing; for the first course of treatment, the following services were necessary:

Course 1	continuing	continuing	continuing	continuing	June 10 only)[16]

[15] Carrier Ex. 1, p. 132. Claimant's exercises were: synergy rests stance training, knee flexion exercises prone and supine, walk away exercises, and hamstring curls.

[16] Carrier Ex. 1, p. 37.

June 1-August 19, 2004	97110 one-on-one therapeutic procedures medically necessary: 37 units	97112 neuromuscular re-education medically necessary: 12 units	97140 manual therapy medically necessary: 22 units	99212 office visit medically necessary: 7 units	95900,-03, and -04, (nerve conduction study) 95904 (reflex study)[17] medically necessary: 1 unit each

B. Treatment Course 2: October 18, 2004, through January 14, 2005

This decision finds that relatively few units of each service were medically necessary for Claimant after her second surgery. In contrast to her situation after the first surgery and questionable treatment with another provider, Claimant presented to Provider on October 18 having successfully completed a course of treatment whose appropriateness and benefits are uncontested. During that treatment, she had reached all her goals for the course except for a 25-degree deficit in flexion ROM in her left knee, and she was "proficient" in all exercises. She needed outpatient therapy, for which she had a set of instructions.

1. Duration

After the September 8, 2004 total knee replacement of Claimant's left knee joint, Claimant began a course of therapy with a home healthcare provider that lasted from September 13 - October 8, 2004. On her discharge from home healthcare, Claimant had 80 degrees of ROM in flexing her left knee, an amount which did not meet the goals for her home healthcare of 105 degrees, and she still had swelling and pain in her left knee.[18] But the discharge summary noted the following:

> $ Ther Ex: Pt's HEP [home exercise plan] was discussed and reviewed. *Pt i proficient with all exercises* and has a written HEP to follow. Pt performs HEP x 20 reps active or with red Theraband. (Emphasis added.)

[17] The parties did not contest these services, nor did anything in the record prove that they were not medically necessary.

[18] *Id.*, pp. 124-125.

$ *Pt required min verbal cues for AROM [19]to left knee*. Instructed Pt to continue with written HEP and to take that with her to outpatient therapy appointment next week. Pt is to call HHPT if therapy questions arise. Pt verbalized understanding of instructions. (Emphasis added.)

Under the heading "Prior goals for PT" is listed:

$ . . . 6. AROM left knee of 105 degrees/-5 degrees or better.

And under "Goals Attainment":

> Pt met goals for strength, balance, endurance, gait, and education. Pt partially met goals for ROM.[20]

On October 18, Dr. Soucy wrote: "She needs continued therapy,"[21] a statement that must refer to a continuance of the four weeks' home health care that had already ended on October 8. But Dr. Soucy did not specify why Claimant needed therapy, what specific kind of therapy she needed, or how long he wanted it to continue. At this point, the rationale for more treatment was, according to the home health therapy discharge note, to obtain further outpatient therapy and the scope was to extend her range of motion (she had reached all the other goals, and neither the home health therapy discharge or Dr. Soucy added new ones).

Provider first saw Claimant after the knee replacement on the day after Dr. Soucy wrote his note, October 19, 2004, and again set a plan for a six-to-eight week course of therapy, with maintenance oversight thereafter (that is, therapy was scheduled to terminate sometime between November 30 and December 14, 2004.)[22] According to Provider, the goals were to decrease her current pain level, increase range of motion to a functional level, increase strength and endurance to enable return to work, and instruct the patient on an independent home exercise program.[23] Provider

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[19] AROM is the acronym for "active range of motion."

[20] *Id., pp. 125-126.*

[21] *Id.*, p. 199.

[22] *Id.*, p. 160.

[23] *Id.*, p. 160.

then treated Claimant until at least February 17, 2005, and asserts that all disputed services from October 19, 2004, through January 14, 2005, were medically necessary.

Provider argues that Carrier's preauthorization of a work hardening program for Claimant after his second course of treatment shows that his treatment helped Claimant improve and become a candidate for work hardening. That analysis is flawed in that Claimant's perceived ability to benefit from work hardening approximately six months after her knee replacement may, or may not, have anything to do with therapy that she had between those two events. The record does not demonstrate a causal link between Provider's treatment and Claimant's improvement as it might, for example, if it showed that the intensity and duration of Claimant's exercises significantly increased over time and that her muscle tone improved and pain levels continued to decrease markedly after November 15.

Carrier's witnesses conceded that some therapy (including some supervised therapeutic activities) was medically necessary for Claimant after her knee replacement. From Provider's notes and Claimant's witnesses' testimony, the ALJ concludes that, as of November 15, 2004, Provider's therapy had accomplished the goals he set for it, and that, except for the November 29, 2004, and the January 4, 2005, office visits shown in the chart below, no services provided to Claimant after that date were medically necessary, because she could have accomplished whatever additional improvement in her left knee extension that was desirable and achievable by continuing at home the exercises she had long since mastered.

Carrier has the burden of proof, but proof may come from either party's evidence. Provider's documentation for the transition beyond the originally prescribed six to eight weeks describes no new condition or refractory old condition, except to say that initial conditions are not 100 per cent improved and require more therapy. Such conclusory statements do not rebut Carrier's testimony that there was no specific reason or set of reasons why additional therapy was required.[24] Nor did Provide's testimony augment his records concerning specific reasons for the weeks and months of additional therapy in the second course of treatment.

[24] Tex. Labor Code Ann. ' 408.021(a) A. . . 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) enhances the ability of the employee to return to or retain employment.@

In contrast, Carrier's two witnesses provided persuasive testimony that nothing about Claimant's condition justified either the intensive treatment during the two months beginning October 19 or the intensive one-on-one supervision beyond a very brief initial period. Thus, Provider's long and intensive treatment regimen has little support from any treating physician[25] or peer reviewer. Considering the IRO decision as evidence in Provider's favor, the Carrier's evidence is of greater weight and credibility because Carrier demonstrated how Provider's care exceeded the Medicare standard and showed that there was nothing specific about Claiman's condition after the second surgery that justified the extent and intensity of all of the care Provider rendered to Claimant. But that is not to say that Claimant did not require, as Dr. Soucy and Provider both found, some therapy after the home health care program terminated.

Therefore, the ALJ finds that six sessions of manual therapy provided under code 97140, six office visits coded 99212 (October 25, 27, and 29, and November 8, 15, and 29, 2004), and neuromuscular re-education (97112) provided from October 19 to November 15, 2004, were medically necessary, and all other services provided after October 19, 2004, were not, except for the January 4, 2005, office visit for management and evaluation of Claimant (coded 99213). Likewise, the October 19, 2004, office visit coded 99213 was medically necessary.

2. One-on-one supervised exercises (97110) after the knee replacement

Time necessary for teaching Claimant in October and November the same exercises she performed from June 1 through August 19 should have been minimal. At the hearing, Provider described safety (risk of Claimant's re-injuring herself) and professional liability concerns that argue for supervised therapy. But, as Carrier argues, nothing in Provider's extensive treatment notes relates to those concerns, as would be expected if, for instance, safety concerns were a major reason for continuing one-on-one supervision for so long.

Dr. Alvarado and Dr. Pearce agreed that one office visit after the knee replacement and Dr. Soucy's October 18 recommendation for therapy would be medically necessary, in order to re-establish her exercise regimen and monitor the patient's ability to perform. Dr. Alvarado saw no medical need for continued supervision after that date. Although the ALJ finds his testimony coupled with that of Dr. Pearce compelling on the lack of need for an extended course of supervised activities after the September 8 knee replacement, because of the switchover from the home health care agency and because Claimant's activities of daily life were severely limited after her knee

[25] Dr. Soucy's October 18 request for therapy, cited in the text, is the exception.

replacement, the ALJ finds that two consecutive training sessions at three units coded 97110 were medically necessary. Although it is appealing to further reward Provider for the resources he devoted to Claimant's continuing recovery efforts after November 2004, the ALJ cannot, on this record, find that the supervised exercises were medically necessary, nor can he re-code services.

Therefore, the three units of one-on-one supervised therapeutic exercises billed for each of October 25 and October 27 were medically necessary; all other services coded 97110 after October that date were not.

The following chart sets out those services that were medically necessary during Claimant's second course of treatment with Provider.

Course 2					
October 19, 2004 - January 14, 2005	97110 medically necessary: 6 units	97112 medically necessary: 6 units	97140 medically necessary: 6 units	99212 medically necessary: 6 units	99213 (office visit for evaluation and management of patient) (October 19, 2004, and January 4, 2005 only)[26] medically necessary: 2 units

Reimbursement should be ordered for all services designated as medically necessary in either of the two charts in this Part III; reimbursement for all other disputed services from June 1, 2004, through January 14, 2005, should be denied.

IV. FINDINGS OF FACT

1. Claimant, an employee of ___ Lubbock, Inc., suffered a compensable injury to her left knee on___, when she was hanging clothes on a rack that toppled over and struck her left knee.
2. At the time of Claimant=s injury, her employer held workers= compensation insurance coverage with Texas Mutual Insurance Company (Carrier) that covered Claimant.
3. On March 2, 2004, Claimant underwent arthroscopic surgery for a torn lateral meniscus cartilage in her left knee.

[26] Carrier Ex. 2, p. 6.

4. After the arthroscopic surgery, Claimant had a course of physical therapy at the Lubbock Occupational Health Center, beginning in mid-April 2004 and continuing for approximately four weeks.

5. Cotton D. Merritt, D.C., (Provider) first saw Claimant as a patient on May 27, 2004, when he found that her left patella was misaligned, that she walked with a limp, and that she had grinding and crepitus when she moved the joint.

6. Before seeing Provider, Claimant had inappropriately used a StairMaster and stationary bicycle as part of a treatment regimen.

7. Provider began treating Claimant on June 1, 2004, with the following therapy modalities: one on one supervised therapeutic activities and exercises (coded 97110), neuro-muscular re-education (97112), and manual therapy (97140).

8. On June 7, 2004, James Soucy, M.D., recommended that Claimant continue unspecified Atherapy@ and two weeks later, on June 21, he recommended therapy for Claimant in order to Acontinue to work on range of motion [ROM].@

9. Provider billed Carrier for services provided from June 1, 2004, through August 11, 2004, and from October 19, 2004, through January 14, 2005 (disputed services).

10. On June 1, 2004, Claimant=s ROM in her left knee was 70 degrees flexion.

11. On June 21, 2004, after a June 7 steroid injection into her knee, Dr. Soucy ordered Claimant to continue therapy to increase ROM.

12. On June 21, 2004, Claimant's ROM in her left knee was 80 degrees flexion.

13. Provider's initial treatment plan for Claimant was for treatment to last six to eight weeks, or from June 1 to July 12 - 26, 2004.

14. From July 2 through July 21, 2004, Claimant's flexion ROM as measured by Provider stabilized at 100 degrees and did not thereafter improve.

15. From July 2 through July 21, 2004, Claimant's pain level as measured by Provider had stabilized at three out of ten and did not thereafter improve.

16. On September 8, 2004, Claimant underwent total replacement of her left knee.

17. After her knee replacement, Claimant had a four-week course of therapy at home, provided by a therapist and an assistant working together.

18. On October 18, 2004, Claimant's surgeon for the knee replacement, Dr. Soucy, ordered continued therapy of an unspecified nature and duration.

19. On October 19, 2004, Provider first saw Claimant after the knee replacement, and set a plan for a six-to-eight week course of therapy, scheduled to terminate sometime between November 30 and December 14, 2004.

20. Goals of the course of therapy beginning October 19 were to decrease Claimant's current pain level, increase ROM to a functional level, increase strength and endurance to enable return to work, and instruct the patient on an independent home exercise program.

21. At the end of the four-week course of home therapy, Claimant had met all goals for her home therapy except for a 25-degree deficit in her range of motion.
22. After completion of her home healthcare course of treatment, Claimant was proficient in doing her exercises, and her primary need was to continue her exercises and other therapeutic activities.

23. After an initial office visit for evaluation on October 19, 2004, Provider treated Claimant from October 25, 2004, through January 14, 2005, with the following therapy modalities: one-on-one supervised therapeutic activities and exercises (coded 97110), neuro-muscular re-education (97112), and manual therapy (97140).
24. Provider billed Carrier for office visits (either 99212 or 99213) each time Claimant came to his office for treatment from October 19, 2004, through January 14, 2005.

25. On November 15, 2004, Provider's therapy had accomplished the goals he set for it, in that Claimant's ROM and pain levels had stabilized.

26. After November 15, 2004, Claimant could have accomplished whatever additional improvement in her left knee extension that she desired and was capable of achieving by continuing her exercises at home or in group therapy sessions.
27. Two sessions of three units each of one-on-one supervised exercises and procedures is a reasonably necessary treatment regimen and within Medicare guidelines for a patient recovering from knee replacement surgery without aggravating factors present.
28. Six units of neuro-muscular re-education is a reasonably necessary treatment regimen and within Medicare guidelines for a patient recovering from knee replacement surgery without aggravating factors present.

29. For a patient recovering from knee replacement surgery, it is appropriate under Medicare guidelines to charge for an office visit each of the first three times the patient comes in for treatment, once per week for the following two weeks, and once more in the following two-week period.

30. Six units of manual therapy is a reasonably necessary treatment regimen patient recovering from knee replacement surgery with compromised range of motion but without aggravating factors present.

31. Carrier denied reimbursement for the disputed services as not medically necessary.

32. Provider requested medical dispute resolution before the Texas Workers' Compensation Commission (Commission) based on Carrier denial of reimbursement for services provided from June 1, 2004, though January 14, 2005.

33. The reviewing IRO concluded that the disputed services were medically necessary.

34. Carrier timely requested a hearing before the State Office of Administrative Hearings (SOAH).

35. This case was referred by the Commission and accepted by SOAH for hearing before

September 1, 2005.

36. Notice of the hearing was sent to the parties on September 13, 2005. The notice informed the parties of the date, time, and location of the hearing; a statement of the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

V. CONCLUSIONS OF LAW

1. 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.

2. The hearing was conducted pursuant to GOV'T CODE ch. 2001.

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

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

5. The following disputed services rendered between June 1and July 21, 2004, were reasonably required by the nature of Claimant's injury, and were, therefore, medically necessary. TEX. LAB. CODE ANN. §408.021.

June 1-August 19, 2004	97110 one-on-one therapeutic procedures 37 units	97112 neuromuscular re-education 12 units	97140 manual therapy 22 units	99212 office visit 7 units	95900,-03, and -04, (nerve conduction study) 95904 (reflex study) 1 unit of each

6. The following disputed services provided from October 19 to January 14, 2005 were reasonably required by the nature of Claimant's injury, and were, therefore, medically necessary. TEX. LAB. CODE ANN.§408.021.

October 19, 2004 - January 14, 2005	97110 6 units	97112 6 units	97140 6 units	99212 6 units	99213 (October 19, 2004, and January 4, 2005 only) 2 units

7. Provider is entitled to reimbursement for each of the service units shown in Conclusions of Law No. 6 and No. 7.

8. Provider is not entitled to reimbursement for any disputed service not described as medically necessary in either Conclusion of Law No. 6 or No. 7.

ORDER

IT IS ORDERED that Texas Mutual Insurance Company reimburse Cotton Merritt, D.C., for the following chiropractic services provided from June 1, 2004, to January 14, 2005:

June 1-August 19, 2004	97110 one-on-one therapeutic procedures 37 units	97112 neuromuscular re-education 12 units	97140 manual therapy 22 units	99212 office visit 7 units	95900,-03, and -04, (nerve conduction study) 95904 (reflex study) 1 unit of each

October 19, 2004 - January 14, 2005	97110 6 units	97112 6 units	97140 6 units	99212 6 units	99213 (October 19, 2004, and January 4, 2005 only) 2 units

IT IS FURTHER ORDERED that Texas Mutual Insurance Company need not reimburse Cotton Merritt, D.C., for services provided from June 1, 2004, to January 14, 2005, that are not ordered above in this Order.

SIGNED APRIL14, 2006.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS