SOAH DOCKET NO. 453-04-0996.M5
TWCC MDR NO. M5-03-0992-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	'	**BEFORE THE STATE OFFICE**
VS.	'	**OF**
SCD BACK AND JOINT CLINIC, LTD., **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Petitioner, Texas Mutual Insurance Company (Carrier), requested a hearing following the Findings and Decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC), acting through Texas Medical Foundation, an Independent Review Organization, ordering reimbursement to SCD Back and Joint Clinic (Provider) for medical services provided to ____ (Claimant). Carrier disputes the IRO's conclusion that these services were medically necessary. The Administrative Law Judge (ALJ) concludes that Carrier has met its burden of proof that some of the one-on-one therapeutic exercises were not medically necessary. The ALJ also concludes that Carrier proved that four of the ten office visits were not medically necessary. Carrier failed to prove that the remainder of the services provided to Claimant between January 3, 2002, and March 14, 2002, were not medically necessary. Accordingly, Carrier should reimburse Provider for these services.

I. PROCEDURAL HISTORY

ALJ Stephen J. Pacey convened the hearing on July 6, 2004, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider was represented by William Maxwell, attorney. Carrier was represented by R. Scott Placek, attorney. At the conclusion of the hearing, the

ALJ required written closing statements. On August 10, 2004, the ALJ ordered the parties to comply with the written closing statement requirement. The written closing arguments were received, but the required disk was not received until September 16, 2004, at which time the record was closed. The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law below.

II. BACKGROUND

Claimant suffered compensable injury on ____, when she exited a truck and twisted her ankle. Her twisted ankle resulted in surgery performed by Dr. Coleman on January 29, 2001.[1] Dr. Coleman performed a peroneal tendon transfer of her ankle, reconstruction of her ankle, and the lateral aspect of her ankle.[2] Provider's treatment of Claimant was complicated when she developed an infection over the incision. Provider ordered a bone scan to ensure that Claimant did not have osteomyelitis, which is a bone infection.

As a result of the injury and the subsequent surgery, Claimant was diagnosed with a right lateral ankle sprain/strain, and myofascial pain syndrome. In an effort to return Claimant to work, Provider planned a regimen of physical therapy to decrease Claimant's pain and increase her range

1 Claimant previously broke her ankle, which resulted in surgery in 1999.

2 In his deposition, William David Defoyd, D.C., testified that the surgery required the removal of a tendon and placing it on another area of the foot in an attempt to make the tendon replicate a ligament.

of motion. On October 25, 2001, Provider submitted a request for reconsideration of Carrier's denial of preauthorization for 18 sessions including services identified by CPT Code 97110 (8 units), and one unit each of 97150, 97250, and 97265 (Carrier's Exh. 2, at 210). Carrier denied this reconsideration request, but approved three sessions for four weeks including one unit of 97110, 97150, 97250, and 97265.[3]

Rather than initiating the preauthorized program, Provider chose to wait until January 3, 2002, to initiate the physical therapy program that Carrier had previously denied. The rule that required preauthorization for physical therapy sessions in excess of eight weeks became non-obligatory January 1, 2002. Provider performed the services in dispute on Claimant from January 3, 2002, to March 14, 2002. Carrier denied reimbursement for the services, and Provider requested medical dispute resolution on Carrier's denial. The MRD granted Provider's request for reimbursement in part, following its review of the decision issued by the IRO. Carrier then requested a hearing on the services found to be medically necessary. Provider did not request a hearing on the other disputed services for which reimbursement was denied.[4]

III. DISPUTED TREATMENTS

In Provider's written closing argument, Provider requests reimbursement for services that the IRO found were not medically necessary. The IRO specifically concluded that myofascial relief (CPT Code 97150), electrical stimulation (CPT Code 97014), and muscle testing (CPT Code 97750MT) were not medical necessary. As Provider did not appeal the IRO decision, these services with their respective CPT Codes are beyond the scope of the SOAH's jurisdiction. Provider asserted that the MRD held in a fee dispute that muscle testing was not global and Provider should be

3 CPT Code 97110 pertains to therapeutic exercises with one-on-one supervision. CPT Code 97150 pertains to group therapeutic exercises. CPT Code 97250 pertains to myofascial release. CPT Code 97265 pertains to joint mobilization.

4 The IRO held that Delorme muscle testing, myofascial release, and electrical stimulation were not medically necessary. Provider did not appeal this decision; therefore, these services are not a part of this SOAH hearing.

reimbursed for this service. For reimbursement, Provider must prevail in both the fee dispute and medical necessity dispute. Provider lost the medical necessity dispute and by not appealing the decision, this particular service is beyond SOAH's jurisdiction. In addition, reimbursement of the $460.00 IRO fee is not a medical necessity question and can not be awarded by SOAH because it is beyond the scope of SOAH's jurisdiction. Each type of service which is properly before SOAH is discussed below.

A. Therapeutic Exercises (CPT Code 97110)[5]

1. Carrier

In his deposition, William David Defoyd, D.C.,[6] conceded that Claimant needed one-on-one therapeutic exercises, but he did not agree that more than one unit per session was medically necessary.[7] Provider usually charged the maximum of eight units for each session attended by Claimant.

Dr. Defoyd explained that CPT Code 97110 is the cognitive time that the patient spends with the health care Provider for instruction or progression of the exercise program. According to Dr. Defoyd, Claimant had 16 hours of one-to-one of instruction prior to surgery. In Dr. Defoyd's opinion, Claimant should have understood how to perform the exercises prior to the time Provider started the new exercise program. He said that the patient does not need a full time Achaperone or valet@ or someone bound to them while performing one-on-one active ankle range of motion

5 Throughout the SOAP notes, the description of the one-to-one exercises is A[t]herapeutic procedure exercises to the ankle to reduce pain, add strength, endurance, range of motion, and flexibility. Aerobic conditioning to increase endurance and tolerance to work tasks. Stretching of myofascial tissues and muscles to increase range of motion and flexibility.@

6 Dr. Defoyd prepared Carrier's response to Provider's request for reconsideration of preauthorization. In his response, Dr. Defoyd preauthorized one unit of one-on-one therapeutic exercises per session.

7 A unit is a 15 minute period. If a Provider performs one-on-one therapeutic exercises for 2 hours, this would equal 8 units. The provider is limited to a maximum of two hours per day.

exercises. Once the person has been instructed and the exercise has been demonstrated, how the exercise should be performed, the person should be able to perform the exercise the next time without supervision. He pointed out that the exercises remained the same every session even though Claimant showed little improvement. This was a minimal type of exercise program that does not require significant one-on- one instruction. He also noted that there were minimal safety issues because most of the exercises were done in a sitting position.

Dr. Defoyd described the goal of rehabilitation as teaching the person to become more independent. He explained that a patient performs certain exercises initially with one-on-one supervision, then, in between visits, the patient continues the exercises. The patient returns to the doctor's office to ensure that the exercises are still properly performed. If the patient is doing well and has improved range and strength, the patient is progressed. Dr. Defoyd asserted that this did not happen to Claimant. Dr. Defoyd indicated that Provider billed for the amount of time Claimant performed the one-on-one exercises, when Claimant was doing essentially the same set of exercises each visit. According to Dr. Defoyd, some of the exercises were not described. Provider described them as Aother exercises performed. Difficulties monitored and adjustments made.@ (Petitioner's Exh. 1, at 111). Dr. Defoyd concluded that this practice was an inappropriate use of CPT Code 97110, and services in excess of one unit were not medically necessary.

2. Provider

David Bailey, D.C., testified at the hearing and by deposition.[8] Dr. Bailey was listed as Claimant's treating doctor, but the SOAP notes indicated that Sam Liscum, D.C., treated Claimant on all but three of the disputed days. (Petitioner's Exh. 1, at 136-155). Dr. Bailey testified that his goal in physical therapy is return the person to the workplace as quickly as possible. To achieve this goal,

8 Dr. Bailey owns SCD Back and Joint Clinic, Ltd.

Dr. Bailey stated that he utilizes aggressive therapeutic exercises, which involve one-on-one therapeutic exercises. Dr. Bailey said that Claimant performed ankle exercises, stretching exercises, range of motion exercises, gait exercises, and exercises of the lumbar spine and lower extremities.

In Dr. Bailey's opinion, one-on-one supervision was not merely for instructional purposes. Dr. Bailey asserted that one-on-one supervision was necessary to monitor the speed, the degree of motion, the angle of motion, the lengths of time, and the number of repetitions. He indicated that supervision adds to the efficacy of the treatment because the therapist understands the goals and knows what should be accomplished. Dr. Bailey compared the difference between one-on-one therapeutic exercises and exercises with no supervision or group supervision to the difference between a soccer coach and a soccer trainer. He noted that the soccer player would improve more quickly with the trainer's one-on-one instructions.

Dr. Bailey also mentioned that one-on-one supervision has two intangible advantages. He said encouragement by a one-on-one therapist usually speeds up the recovery process. One-on-one supervision also is conducive to compliance and completion. He asserted that when patients exercise on their own, they are less likely to comply with instructions and also less likely to complete the therapy.

3. Analysis

Carrier proved by a preponderance of the evidence that Claimant's care should have been limited to three sessions for four weeks including one unit of 97110 per session. The following factors weigh in Carrier's favor: Dr. Bailey's testimony was not persuasive; Claimant had 16 hours of one-on-one supervision of the same therapeutic exercises prior to her surgery; the Claimant's condition did not improve significantly; the exercises did not change when Claimant did not improve;

Claimant should have known how to conduct the exercises; the reasons for the one-on-one physical therapy were either absent from the SOAP notes or contained the same reasons as in previous SOAP notes; and many of the exercises were not described and were defined as Aother exercises.@

Dr. Bailey's testimony was not persuasive for a number of reasons. In Dr. Bailey's deposition, approximately three weeks prior to the hearing, Dr. Bailey did not know Claimant's injury. Carrier asked Dr. Bailey Acould you tell me, what kind of injury [Claimant] (name of Claimant) suffered.@ Dr. Bailey answered Awithout looking at the record, no.@[9] Dr. Bailey might not have known because he was the treating doctor in name only.

Dr. Liscum conducted almost all of Claimant's treatments during the disputed period. In his deposition, Dr. Bailey's testimony was entirely from the notes of Dr. Liscum. Dr. Bailey's reasons for the one-on-one sessions were generic, and could be applied to any patient. The reasons were not tailored to Claimant's specific injury or symptoms. Dr. Bailey had preauthorization for a more limited therapy, but instead of implementing the preauthorized therapy, he waited and instituted his original therapy program on January 3, 2002. This was only two days after the time that preauthorization was no longer required.

Claimant's 16 hours of one-on-one supervision before her surgery consisted of the same type of exercises she performed during the disputed period. She should have known how to do the exercises. Claimant's condition did not improve and her exercises did not change. Claimant did the same exercises over-and-over and yet Provider insists that she needed one-on-one supervision for monitoring and evaluating. Claimant did not need to be monitored and evaluated for every unit of every session for a two-month period. Dr. Defoyd testified that you instruct patients to do the exercise and after a period of time, you monitor and evaluate. Claimant finally left Dr. Bailey's care because she no longer agreed with his recommendations. (Carrier's Exh. 2, at 155).

9 Dr. Bailey's June 18, 2004, deposition at page 9, at lines 19-22. (Provider Exh. 6).

The ALJ agrees with Carrier. Therapeutic exercises were medically necessary, but the one-on-one supervision was only medically necessary for one unit per session.

B. Office Visit (CPT Code 99213)

In a six-week period, Provider charged nine times for an established patient limited office visit. Provider charged for an office visit every time Claimant was present in the clinic, including the tenth charge on Claimant's last visit to the clinic. Dr. Defoyd testified that four of these visits were not medically necessary. Dr. Defoyd asserted that office visits were medically necessary, but not every other day. According to Dr. Defoyd, this CPT Code is an for office visits that include expanded problem-solving history and physical examination, and Carrier did not need to conduct the examination every two or three days. (Provider ' s Exh. 6, at page 74, on lines 10-17). This testimony was not rebutted by Provider. The ALJ agrees with Carrier that only six of the ten office visits were medically necessary.

C. Various CPT Codes (99215-Comprehensive Office Visit, 95851-Range of Motion Testing, 97150-Group Therapeutic Exercises, 97265-Joint Mobilization, and 99080-Copying Charges).

1. Comprehensive Office Visit

This was the first office visit before Provider initiated Claimant's intensive physical therapy program. In Dr. Defoyd's opinion, this was medically necessary, but the documentation did not indicate that a comprehensive office visit was performed. He asserted that it should have been billed as an ordinary office visit (CPT Code 99213). Carrier raised medical necessity as a defense. It can not now raise documentation. The ALJ concludes that Carrier did not fulfil its burden, and Provider should be reimbursed for this comprehensive office visit.

2. Range of Motion Testing

According to Dr. Defoyd, this charge should have been included as part of the ordinary office visit. This service has a separate CPT Code from office visits. It is the ALJ's opinion that only six of the ten office visits were medically necessary, therefore adding other therapies to the office visit is not reasonable. Provider should be reimbursed for its range of motion testing.

3. Group Therapeutic Exercises

Dr. Defoyd said this was medically necessary. Provider should be reimbursed for this service.

4. Joint Mobilization

This was included in Dr. Defoyd's preauthorization approval. Provider should be reimbursed for this service.

5. Copying Charges

Provider charged for copying the medical records that were sent to the designated doctor. The ALJ concludes these charges are proper, and Provider should be reimbursed.

IV. DECISION

Most of Carrier's claims did not oppose the type of service, but rather the frequency of the service. Provider shall be reimbursed for one unit per session of one-on-one therapeutic exercises (CPT Code 97110) three times a week for four weeks, rather than the eight units per session three times a week for nine weeks. Provider shall also be reimbursed for six units of limited office visits (CPT Code 99213), rather than the ten sessions billed.

The ALJ finds the following services to be medically necessary and the Provider shall be reimbursed for these services: CPT Code 99215-Comprehensive Office Visit, CPT Code 95851-Range of Motion Testing, CPT Code 97150-Group Therapeutic Exercises, CPT Code 97265-Joint Mobilization, and CPT Code 99080-Copying Charges.

Some services are not a part of this hearing. The IRO found that Delorme muscle testing (CPT Code 97750-MT), myofascial release (CPT Code 97250), the analgesic balm (CPT Code 99070), and electrical stimulation (CPT Code 97014) were not medically necessary. Provider did not appeal this decision; therefore, these services are not a part of this SOAH hearing

V. FINDINGS OF FACT

1. Claimant suffered a compensable injury, on ____, when she exited a truck and twisted her ankle

2. Texas Mutual Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer when her compensable injury occurred.

3. Claimant's twisted ankle resulted in surgery performed by Dr. Coleman on January 29, 2001.

4. Dr. Coleman performed a peroneal tendon transfer of her ankle, reconstruction of her ankle, and the lateral aspect of her ankle.

5. SCD Back and Joint Clinic's (Provider) treatment of Claimant was complicated when she developed an infection over the incision.

6. As a result of the injury and the subsequent surgery, Claimant was diagnosed with a right lateral ankle sprain/strain, and myofascial pain syndrome.

7. Provider planned a regimen of physical therapy to decrease Claimant's pain and increase her range of motion.

8. On October 25, 2001, Provider submitted a request for reconsideration of Texas Mutual Insurance Company's (Carrier) denial of preauthorization for 18 sessions of physical therapy including services identified by CPT Code 97110 (8 units), and one unit each of CPT Codes 97150, 97250, and 97265.

9. Carrier denied this reconsideration request, but preauthorized three sessions of physical therapy for four weeks including one unit of CPT Codes 97110, 97150, 97250, and 97265.

10. Rather than initiating the preauthorized program, Provider chose to wait until January 3, 2002, when it initiated the physical therapy program that the Carrier had previously denied.

11. The rule that required preauthorization for physical therapy sessions in excess of eight weeks lost effect on January 1, 2002.

12. Provider performed the services in dispute on Claimant from January 3, 2002 to March 14, 2002.

13. Carrier denied reimbursement for the services, and Provider requested medical dispute resolution on Carrier's denial.

14. The Texas Workers Compensation Commission's Medical Review Division (MRD) granted Provider's request for reimbursement in part, following its review of the decision issued by the independent review organization (IRO).

15. Carrier then requested a hearing on the services found to be medically necessary.

16. Provider did not request a hearing on the other disputed services for which reimbursement was denied.

17. Carrier conceded that Claimant needed one-on-one therapeutic exercises, but it did not agree that more than one unit per session was medically necessary.

18. Dr. Bailey was listed as Claimant's treating doctor, but the SOAP notes indicated that Sam Liscum, D.C., treated Claimant on all but three of the disputed days.

19. It was not medically necessary for Claimant to receive treatment on a one-to-one basis for eight units of therapeutic exercises per session from January 3, 2002 to March 14, 2002, for the following reasons:

A. Claimant had 16 hours of one-on-one supervision for the same therapeutic exercises prior to Provider's current therapy regimen.

B. Claimant should have known how to conduct the exercises because of previous instructions.

C. Claimant's condition did not improve significantly, and the exercise plan did not change when Claimant did not improve.

D. The justification for eight units of one-on-one therapeutic exercise was either absent from the doctor's notes or contained the same reasons included in previous doctor's notes.

E. Many of the exercises were not described and were defined as Aother exercises.@

F. No special circumstances were shown indicating that it was medically necessary to conduct more than three sessions for four weeks with one unit of one-on-one supervision.

20. It was medically necessary for Claimant to be limited to three sessions for four weeks including one unit of one-on-one supervision per session.

21. Only six of the ten disputed office visits were necessary because this is an is an expanded problem-solving history and physical examination, and Carrier did not need to conduct the examination every two or three days

22. Carrier failed to prove that the following services were not medically necessary: CPT Code 99215-Comprehensive Office Visit, CPT Code 95851-Range of Motion Testing, CPT Code 97150-Group Therapeutic Exercises, CPT Code 97265-Joint Mobilization, and CPT Code 99080-Copying Charges.

23. The IRO found that Delorme muscle testing (CPT Code 97750-MT), myofascial release (CPT Code 97250), the analgesic balm (CPT Code 99070), and electrical stimulation (CPT Code 97014) were not medically necessary. Provider did not appeal this decision; therefore, these services are not a part of this SOAH hearing

23. On November 10, 2003, notices of the hearing in this case were mailed to Provider and Carrier.

24. The notices 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.

25. On July 6, 2003, SOAH Administrative Law Judge Stephen J. Pacey convened and recessed the hearing in the William P. Clements Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Provider was represented by William Maxwell, attorney, and Carrier was represented by W. Scott Placek, attorney. The record closed September 16, 2004.

VII. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this case, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. ' 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely requested a hearing contesting the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission), as specified in 28 TEX. ADMIN. CODE (TAC) ' 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. ' 2001.052 and 28 TAC ' 148.4(b).

4. Provider has the burden of proving the case by a preponderance of the evidence, pursuant to 28 TAC ' 148.21(h) and (i).

5. Based on the above Findings of Fact and Conclusions of Law, and pursuant to TEX. LABOR CODE ' 408.021(a), Carrier failed to prove that comprehensive office visits, range of motion testing, group therapeutic exercises, joint mobilization, and copying charges disputed were not medically necessary to treat Claimant's compensable injuries.

6. Based on the above Findings of Fact, Carrier did prove that it was not medically necessary for Claimant to receive treatment on a one-to-one basis for eight units of therapeutic exercises per session from January 3, 2002, to March 14, 2002.

7. Based on the above Findings of Fact, Carrier did not prove that three sessions for four weeks including one unit of one-on-one supervision per session was not medically necessary

8. Based on the above Findings of Fact, Carrier did prove that ten office visits were not medically necessary.

9. Based on the above Findings of Fact, Carrier did not prove that six office visits were not medically reasonably.

10. Based on the above Findings of Fact, Provider should be reimbursed according to Conclusions of Law Nos. 5-9.

ORDER

IT IS ORDERED THAT SCD Back and Joint Clinic is entitled to receive reimbursement, according to Conclusions of Law Nos. 5-10, from Texas Mutual Insurance Company for the disputed treatment provided to Claimant from January 3, 2002, through March 14, 2002.

SIGNED November 16, 2004.

STEPHEN J. PACEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS