SOAH DOCKET NO. 453-04-4750.M5
TWCC MDR NO. M5-04-0138-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	:	**BEFORE THE STATE OFFICE**
V.	:	**OF**
CENTRAL DALLAS REHAB, **Respondent**	:	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Petitioner) requested a hearing on the findings and decision of the Texas Workers' Compensation Commission's designee, an independent review organization (IRO), in MDR Docket Nos. M5-04-0188-01 and M5-04-0138-01 (consolidated), that granted certain reimbursement to Central Dallas Rehabilitation (Respondent) for physical therapy services and office visits provided to workers' compensation (Claimant). Petitioner denied certain reimbursements primarily on the ground that not all the services billed were reasonable and medically necessary healthcare. This decision and order finds that some, but not all, of the disputed services were reasonable and medically necessary for Claimant.

I. FACTUAL AND PROCEDURAL HISTORY

Claimant reported a compensable, work-related injury to his right elbow, head, neck and back when he fell backward and struck his head on a brick wall on ___. That day, Claimant visited Dr. Laura Sharratt, D.O., at Concentra Medical Centers (Concentra) who determined that he had no loss of consciousness and mild dizziness at the time of injury. Dr. Sharratt determined at the time of the examination that Claimant had suffered a head contusion and mild cervical strain although his cervical range of motion was normal. On May 1, 2003, Claimant returned to Concentra complaining of discomfort in the back of his neck, headache and ringing in his ears. At that time, Dr. Rudolf Flasdick determined that his cervical range of motion was normal but noted tenderness. On May 5, 2003, Claimant was examined at Concentra by Dr. Robert Stuart and was found to be improving with minimal residual headache, full range of motion and no tenderness or spurling. That day, Claimant was returned to work without restrictions with a diagnosis of face and scalp contusion, olecranon bursitis and a concussion. Claimant visited Dr. Stuart again on May 13, 2003, complaining of an elbow contusion and elbow swelling as a result of the fall, but no significant head symptoms were reported.

On May 15, 2003, Claimant visited Respondent, and for the first time reported his pain as constant and intense. Claimant complained of neck pain, headaches, mid-back pain, elbow, forearm and finger pain. Respondent observed that Claimant's cervical range of motion was decreased in several respects and that he reported neck pain during movement. To resolve these issues, Respondent developed a treatment plan to decrease muscle pain, increase joint function and cervical range of motion. Respondent referred Claimant to Dr. Crawford Sloan, M.D., for a second opinion.

Although Dr. Sloan observed a normal cervical range of motion in Claimant, the doctor also noted headache and elbow cellulitis.

The Respondent treated Claimant during June and July of 2003. Petitioner, as the workers' compensation insurance carrier for Claimant's employer, declined to reimburse certain of Respondent's treatments, contending principally that they were not medically necessary. Based on the Consolidated Table of Disputed Services, the total amount in dispute is $4,355.00.

In response to Petitioner's denial of reimbursement, Respondent sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission). The matter was referred to an IRO designated by the Commission for the review process. There were two IRO/MRD reviews. For the period June 3, 2003 through July 11, 2003, the MRD determined that the Respondent was entitled to reimbursement on some of the requested charges, but found others were not medically necessary (M5-04-0138-01). For the period July 8, 2003 through July 30, 2003, the MRD determined that the Respondent was entitled to reimbursement for all of the disputed services (M5-04-0188-01). Petitioner then requested a hearing before the State Office of Administrative Hearings (SOAH). The hearing convened on July 29, 2004, with ALJ Nancy Lynch presiding.[1] Respondent appeared telephonically through its attorney, Scott Hilliard. Petitioner appeared through its attorney, R. Scott Placek. The hearing concluded that day and the record closed finally on November 15, 2004. No parties objected to notice or jurisdiction. Under 28 TEX. ADMIN. CODE (TAC) §148.21(h), the Petitioner has the burden of proof in hearings, such as this one, conducted pursuant to TEX. LAB. CODE ANN. §413.031.

II. DISCUSSION AND ANALYSIS

The bulk of this case involves a dispute over the necessity of various physical therapy treatments following Claimant's injury. The services in issue involve one-on-one therapy (CPT Code 97110), therapeutic activities (CPT Code 97530), range of motion (CPT Code 95851), physical evaluation/management (CPT Code 99213), myofascial release (CPT Code 97250), joint mobilization (CPT Code 97265), manual traction (CPT Code 97122), medical record copies (CPT Code 99080) and muscle testing (CPT Code 97750-MT).

1. Disputed Services

As an initial matter, the Consolidated Table of Disputed Services includes those charges for which the MRD denied payment to Respondent in M5-04-0138-01. Those denied charges, however, are not before the ALJ in this case because the Respondent filed no appeal. As a result, only the charges which the MRD ordered to be paid are considered in this decision (M5-04-0138-01 and M5-04-0188-01).[2] Hereafter, Adisputed services@ refers only to the charges listed in the Consolidated Table of Disputed Services that the MRD ordered Petitioner to pay.

2. The Passive Treatment Period

[1]ALJ Travis Vickery presided over a post-hearing telephone conference and drafted this decision.

[2] Nevertheless, the undersigned ALJ agrees with the MRD in its denial of Respondent's recovery of the charges detailed in M5-04-0138-01.

The bulk of the disputed services in this matter involves: (1) whether office visits and one-on-one training, treatment and monitoring were medically necessary beyond a reasonable training period; and (2) whether the exercise regimen was necessary or effective. The ALJ first addresses the second issue. Much evidence centered on Claimant's range of motion. Petitioner argues that the disputed services were unnecessary because, by the time Respondent first saw the Claimant, he had already been seen by three doctors at Concentra who all agreed that his range of motion was normal, that he had no head symptoms other than mild headaches and that his condition was improving as early as May 13, 2003. Claimant visited Respondent on May 15, 2003 and received his first diagnosis of a reduced range of motion and Aconstant and intense@ pain. Yet, the findings of the very physician to whom Claimant was referred by the Respondent, Dr. Sloan, were consistent with the Concentra doctors' findings that Claimant's range of motion was normal.

While the Respondent's range of motion findings were inconsistent with every other physician the Claimant visited in May of 2003, one thing is clear: after the workplace injury Claimant suffered from headaches, neck, back and elbow pain. On July 21, 2003, Dr. Fernando Mallou, M.D., found the Claimant to be at MMI with a 9% whole person impairment rating. Dr. Mallou noted that an MRI of the brain showed changes compatible with migraine, and that Claimant suffered from neck discomfort in varying intensities throughout the day. Regardless of range of motion, or the varying reports of the degree of his pain,[3] there is adequate evidence that Claimant was indeed suffering headaches, neck, back and elbow pain prior to and during Respondent's treatment. Based on the evidence of Claimant's pain, Respondent's treatment of the affected areas was appropriate and warranted within limits.

Respondent developed a passive treatment program which began with passive modalities on June 5, 2003, and progressed to active treatment on or about July 10, 2003. The treatment program contemplated four weeks of passive modality treatments three times a week and a progression to active treatment thereafter. Petitioner approved Respondent's passive modalities [range of motion (CPT Code 95851), myofascial release (CPT Code 97250), joint mobilization (CPT Code 97265), manual traction (CPT Code 97122)] from the beginning of Claimant's treatment on June 5, 2003, through late June of 2003. Petitioner denied passive treatment beyond June 26, 2003, as either failed therapy or therapy which had exhausted its effectiveness.

Based on the testimony of Dr. William DaFoyd, D.C., Petitioner's expert witness, the ALJ finds that four weeks is a reasonable amount of time to conduct passive modalities and denies Respondent recovery for passive treatments beyond July 2, 2003. In light of this, the ALJ concludes that Respondent is entitled to recover for services related to myofascial release (CPT Code 97250), joint mobilization (CPT Code 97265) and manual traction (CPT Code 97122) for June 30, 2003; and manual traction and joint mobilization for July 2, 2003. This is a total of two units at a reimbursement of $35 per unit, and a total of three units at a reimbursement of $43 per unit for a total reimbursement of $199 for services billed under CPT Codes 97250, 97265 and 97122. Otherwise, Petitioner is not required to reimburse any other services billed under those CPT Codes.

3. One-on-One Treatment and Office Visits

[3] The ALJ notes that the records reflect that the Claimant spoke little English which may account for variations in his responses about the degree of his pain.

The next area of dispute is whether Respondent's one-on-one treatments and office visits were medically necessary. Petitioner contends that the therapeutic exercises (CPT Code 97110) provided to Claimant between June 19, 2003, and July 30, 2003 were unnecessary. Through the expert testimony of Dr. DaFoyd, Petitioner demonstrated that the exercises Respondent developed for Claimant during the passive treatment plan were simple enough that, once learned they required no one-on-one attention.

The ALJ agrees that Petitioner has shown that the majority of disputed services billed under CPT Code 97110 were not medically necessary for Claimant between June 19, 2003 and July 30, 2003.[4] The medical and legal authority is amply clear that CPT Code 97110 is to be used only when the health care provider has worked directly one-on-one with the patient in regard to that patient's therapy alone.[5] As Petitioner's expert testimony shows, Claimant should not have continued to need an entire hour of one-on-one therapy after initially learning the exercises and that the exercises billed under 97110 should have been easy for the Claimant to duplicate at home or in group therapy.

Respondent asserts that the one-on-one treatment was necessary because Claimant suffered from a head injury, experienced dizziness and nausea, and needed motivation. However, the evidence indicates that Claimant was motivated and able to complete all of his exercises. Second, although Claimant suffered a head injury and apparently related symptoms, the record does not reflect the injury as severe or of the type that would require monitoring while Claimant was engaged in such exercise. Because Claimant was motivated, was properly performing his exercises, and was progressing, he should have been able to perform his exercises on his own at home or as part of a group at Respondent]s office, and should not have needed Respondent's extensive one-on-one attention beyond an initial learning and monitoring phase.

Through July 10, 2003, it would have been appropriate for Respondent to be with Claimant for one unit of one-on-one treatment just for purposes of instruction on exercises to be performed that day, although not every day. In light of this, and the services for which Respondent has already received compensation, the ALJ concludes that Respondent is entitled to recover only one unit of one-on-one therapy (billed under CPT Code 97110) for each of the following dates of service in issue during the passive period of care: June 30, July 2 and July 7, 2003. This is a total of 3 units at a reimbursement of $35 per unit, for a total reimbursement of $105 for services billed under CPT Code 97110 through July 10, 2003. Otherwise, Petitioner is not required to reimburse any other services billed under CPT Code 97110 through July 10, 2003.

4. The Transition to Active Care

In the July 9-10, 2003, time frame the Respondent testified that he moved the Claimant into an "active" phase of care. This entailed teaching the Claimant new exercises and monitoring his progress. From July 14 though July 30, 2003, the Claimant visited Respondent's office three consecutive days a week for three weeks. On each day, Respondent billed an office visit (CPT Code

[4] The therapeutic exercise dated July 10, 2003, is not included in the disputed services before the ALJ because the MRD denied Respondent's recovery for this charge and Respondent filed no appeal.

[5] *See* SOAH Docket No. 453-01-1188.M5 (April 3, 2002)(ALJ Smith); SOAH Docket No. 453-00-2051.M4 (December 1, 2000)(ALJ O Malley); SOAH Docket No. 453-01-1081.M4 (May 25, 2001)(ALJ Smith); SOAH Docket No. 453-01-1492.M5 (July 23, 2001)(ALJ Cunningham); *see* the American Medical Association's *CPT Assistant*.

99213) followed by four units each of therapeutic exercise (CPT Code 97110) and therapeutic activities (CPT Code 97530). The visits occurred on the following dates: July 14, 15, 16, 21, 22, 23, 28, 29 and 30, 2003.[6] Petitioner denied Respondent's recovery of all billings on those dates.

Since Respondent was transitioning Claimant to a more active exercise regimen, the ALJ believes that an office visit (CPT Code 99213) on the first and last day of the first week of the new exercise scheme was appropriate. Thereafter, only one office visit per week was appropriate to assess and evaluate the Claimant's condition and progress, for a recovery of four office visits during the active exercise time frame at $48 per visit for a total reimbursement of $192 for services billed under CPT Code 99213 from July 14-30, 2003.

Likewise, the ALJ believes the impact of the new exercises on Claimant's therapy entitles Respondent to recover for one unit of CPT Code 97110 during each day of the first week of the new active phase of care (July 14, 15 and 16, 2003) and for one unit on the first day of the following two weeks of care (weeks beginning July 21 and July 28, 2003). This is a recovery of 5 units for the period July 14 through July 30, 2003 at a reimbursement rate of $35 per unit for a total reimbursement of $175 for services billed under CPT Code 97110.

As for the recovery of therapeutic activities billed under CPT Code 97530 during the active phase of Claimant's care, the ALJ reviewed the Petitioner's Table of Disputed Services to determine how Petitioner reimbursed Respondent during the training stage of the Claimant's passive care. From June 5 through June 18, 2003, Petitioner reimbursed Respondent for one hour of therapeutic exercise billed under CPT Code 97110 for each of the ten days of service. Thereafter, Respondent was permitted recovery for only one unit for each day of the following week. According to the Petitioner's expert witness, the rationale for these reimbursements was that the Respondent should have been afforded an opportunity to teach the Claimant new exercises and monitor his progress for the first two weeks, but thereafter Claimant should have been able to perform the exercises himself or with minimal supervision.

The ALJ finds this rationale persuasive and applicable to the new series of therapeutic activities introduced in the active care session billings beginning on July 14, 2003. The ALJ concludes that Respondent is entitled to recover for all of the therapeutic exercises (billed under CPT Code 97530) for the first two weeks of the active phase of care and for one unit on each day remaining through July 30, 2003. This is a total of 27 units at a reimbursement of $35 per unit, for a total reimbursement of $945 for services billed under CPT Code 97530 through July 30, 2003. Otherwise, Petitioner is not required to reimburse any other services billed under CPT Code 97530 through July 30, 2003.

5. Miscellaneous Disputed Charges

From June 3, through July 10, 2003, the Petitioner denied a number of charges on the ground that they were Aglobal" to an office visit for which Respondent had been reimbursed. In particular,

[6] The ALJ reconciled the Consolidated Table of Disputed Services and the Providor's Table of Disputed Services (Petitioner's Exhibit 1 at TMI 334-337) and determined that Petitioner did not reimburse Respondent for any services on July 23, 2003. Although this denial was not reflected on the Consolidated Table of Disputed Services, the ALJ treats it as an inadvertent omission and includes the date within the purview of this decision.

Petitioner denied range of motion charges (CPT Code 95851) on June 3, June 18 and July 8, 2003 as global to reimbursed office visits. In addition, Petitioner denied a July 10, 2003, charge for muscle testing (CPT Code 97750) on the same grounds. The ALJ finds that the charges should be paid because the Commission's 1996 Medical Fee Guideline provides that range of motion testing and muscle testing are not global to the office visits.[7] The Petitioner should reimburse Respondent for three dates of service of range of motion billed at $72 per day (CPT Code 95851) for a total of $216. Petitioner should reimburse Respondent for one unit of muscle testing (CPT Code 97750MT) billed at $86.

Finally, Petitioner denied Respondent's charge of $13 on July 11, 2003 for Amedical record copies" billed under CPT Code 99080 for lack of documentation. As Respondent offered no documentation to rebut Petitioner's evidence of lack of documentation, the ALJ finds that it was properly denied and Petitioner need not reimburse Respondent for the July 11, 2003 charge billed under CPT Code 99080.

In conclusion, the ALJ finds that Respondent is entitled to additional reimbursement of $1,918, which includes $199 for services billed under CPT Codes 97250, 97265 and 97122, $280 for services billed under CPT Code 97110, $192 for services billed under CPT Code 99213, $945 for services billed under CPT Code 97530, $216 for services billed under CPT Code 95851 and $86 for services billed under CPT Code 97750MT. Petitioner is ordered to reimburse Respondent for these amounts. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant ___ suffered compensable, work-related injuries to his right elbow, head, neck and back when he fell backward and struck his head on a brick wall on ___.

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

3. As a result of his fall, Claimant suffered a concussion, a head contusion, mild cervical strain, headaches, olecranon bursitis, and neck, back and forearm pain.

4. On May 15, 2003, Claimant first visited Respondent and from June 3, 2003 through July 30, 2003, Respondent treated Claimant.

5. Petitioner declined to reimburse certain of Respondent's treatments, contending principally that they were not medically necessary.

6. Based on the Consolidated Table of Disputed Services, the total amount in dispute is $4,355, although the total amount denied by Petitioner was $6,178. The disputed services involve one-on-one therapy (CPT Code 97110), therapeutic activities (CPT Code 97530), range of motion (CPT Code 95851), physical evaluation/management (CPT Code 99213), myofascial release (CPT Code 97250), joint mobilization (CPT Code 97265), manual traction (CPT Code 97122), medical record copies (CPT Code 99080) and muscle testing (97750MT).

[7] Medical Ground Rule (IV)(A)(1).

7. Respondent sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission).

8. The matter was referred to an IRO designated by the Commission for the review process. There were two IRO/MRD reviews. For the billing period June 3, 2003 through July 11, 2003, the MRD determined that the Respondent was entitled to reimbursement on some of the requested charges but found others were not medically necessary (M5-04-0138-01). For the period July 8, 2003 through July 30, 2003, the MRD determined that the Respondent was entitled to reimbursement for all of the disputed services (M5-04-0188-01).

9. Petitioner then requested a hearing before the State Office of Administrative Hearings SOAH).

10. On April 29, 2004, notice of the hearing in SOAH Docket No. 453-04-4750 was sent to all parties by the Commission.

11. On May 12, 2004, notice of the hearing in SOAH Docket NO. 453-04-5223 was sent to all parties by the Commission.

12. On June 2, 2004, the two dockets were consolidated under the lead docket number 453-04-4750 and notice of the consolidated hearing was sent to all parties by SOAH.

13. The hearing convened on July 29, 2004, with ALJ Nancy Lynch presiding. Respondent appeared telephonically through its attorney, Scott Hilliard. Petitioner appeared through its attorney, R. Scott Placek. The hearing concluded and the record initially closed when the Consolidated Table of Disputed Services was filed with SOAH on August 16, 2004.[8]

14. No parties objected to notice or jurisdiction at the July 29, 2004 hearing.

15. One unit of each service of myofascial release (CPT Code 97250), joint mobilization (CPT Code 97265), manual traction (CPT Code 97122) on June 30, 2003, and one unit each of manual traction and joint mobilization for July 2, 2003, was reasonable and medically necessary for treatment of Claimant's compensable injury. This is a total of two units at a reimbursement of $35 per unit, and a total of three units at a reimbursement of $43 per unit for a total reimbursement of $199.

16. One unit of one-on-one therapy (billed under CPT Code 97110) for each of the following dates of service in issue during the passive period of care was reasonable and medically necessary for treatment of Claimant's compensable injury: 6/30, 7/2 and 7/7. This is a total of 3 units at a reimbursement of $35 per unit, for a total reimbursement of $105 for services billed under CPT Code 97110 through July 10, 2003.

[8] ALJ Nancy Lynch retired after the hearing and before issuing a decision. ALJ Travis Vickery presided over a post-hearing telephone conference on November 8, 2004 and reopened the record primarily for argument on services rendered between July 10, 2003 and July 30, 2003. The record was re-opened for briefing until November 15, 2004. ALJ Vickery drafted this decision.

17. From July 14, 2003, through July 30, 2003, Respondent transitioned Claimant to a more active exercise regimen. As a result, an office visit (CPT Code 99213) was reasonable and medically necessary for treatment of Claimant's compensable injury on the first and last day of the first week of the new exercise scheme to assess and evaluate the Claimant's condition and progress, and for one day on each week following. This is a total of four office visits during the active exercise time frame for a reimbursement of $192 for services billed under CPT Code 99213 from July 14 through July 30, 2003.

18. The impact of the new exercises on therapeutic exercises made reasonable and medically necessary one unit of CPT Code 97110 during each day of the first week of the new active phase of care (July 14, 15 and 16, 2003) and for one unit for the first day of the following two weeks of care (weeks beginning July 21 and July 28, 2003). This is a recovery of 5 units for the period July 14 through July 30, 2003 at a reimbursement rate of $35 per unit for a total reimbursement of $175 for services billed under CPT Code 97110.

19. All of the therapeutic exercises (billed under CPT Code 97530) for the first two weeks of the active phase of care and one unit on each day remaining through July 30, 2003, was reasonable and medically necessary for treatment of Claimant's compensable injury. This is a total of 27 units at a reimbursement of $35 per unit, for a total reimbursement of $945 for services billed under CPT Code 97530 through July 30, 2003. Otherwise, Petitioner is not required to reimburse any other services billed under CPT Code 97530 through July 30, 2003.

20. All of the range of motion testing was improperly denied as global (billed under CPT Code 95851). This is a total of 3 dates of service at a reimbursement of $72 per day, for a total reimbursement of $216 for CPT Code 95851.

21. One date of service of muscle testing was improperly denied as global (billed under CPT Code 97750MT). The reimbursement for this service is $86.

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, 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. Petitioner has the burden of proof. 28 TEX. ADMIN. CODE '' 148.21(h) and 133.308(w).

6. Petitioner has shown, by a preponderance of the evidence, that all but 2 units of treatment provided to Claimant and billed under CPT Code 97265 were not medically necessary for treatment of Claimant's compensable injury.

7. Petitioner has shown, by a preponderance of the evidence, that all but 2 units of treatment provided to Claimant and billed under CPT Code 97122 were not medically necessary for treatment of Claimant's compensable injury.

8. Petitioner has shown, by a preponderance of the evidence, that all but 1 unit of treatment provided to Claimant and billed under CPT Code 97250 were not medically necessary for treatment of Claimant's compensable injury.

9. Petitioner has shown, by a preponderance of the evidence, that all but 8 units of treatment provided to Claimant and billed under CPT Code 97110 were not medically necessary for treatment of Claimant's compensable injury.

10. Petitioner has shown, by a preponderance of the evidence, that all but 4 units of treatment provided to Claimant and billed under CPT Code 99213 were not medically necessary for treatment of Claimant's compensable injury.

11. Petitioner has shown, by a preponderance of the evidence, that all but 27 units of treatment provided to Claimant and billed under CPT Code 97530 were not medically necessary for treatment of Claimant's compensable injury.

12. Petitioner has not shown, by a preponderance of the evidence, that the services provided to Claimant and billed under CPT Codes 95851 and 97750-MT were global to other charges.

13. Petitioner has not shown by a preponderance of the evidence that it is entitled to reimbursement for items billed under CPT Code 99080 on July 11, 2003.

14. Petitioner is liable to Respondent for a total reimbursement of $1,918, which includes $199 for services billed under CPT Codes 97250, 97265 and 97122, $280 for services billed under CPT Code 97110, $192 for services billed under CPT Code 99213, $945 for services billed under CPT Code 97530, $216 for services billed under CPT Code 95851 and $86 for services billed under CPT Code 97750MT.

ORDER

Texas Mutual Insurance Company shall reimburse Central Dallas Rehabilitation a total of $1918 for the services and testing in dispute in this proceeding.

SIGNED November 29, 2004.

TRAVIS E. VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS