DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on April 6, 2011, with the record closing on May 9, 2011, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the findings of Medical Fee Dispute Resolution that the health care provider, is not entitled to $778.32 for dates of service May 12, 2010 through June 4, 2010 (CPT Code 97110) for the compensable injury of _____?

PARTIES PRESENT

In attendance on behalf of the Petitioner/Provider was Dr. AS.
Respondent/Self-Insured Carrier appeared and was represented by RR, attorney.
In attendance on behalf of the employer was LB.
Claimant did not appear and his appearance was waived by the parties.

BACKGROUND INFORMATION

On May 4, 2010 the Self-Insured Carrier pre-authorized post operative physical therapy for the Claimant's compensable lumbar spine injury. Self-Insured Carrier authorized physical therapy three times per week for four weeks. Physical therapy was performed at (Healthcare Provider) from May 12, 2010 through June 4, 2010. The provider billed for three units of exercise under CPT Code 97110 in the amount of $129.72 for each date of service. There were nine dates of service, so the Provider billed for twenty seven units of exercise. The Self-Insured Carrier paid for one unit per day in the amount of $43.24. The total paid to the Provider was $389.16. The other two units per day were denied by the Carrier because there was insufficient documentation of the amount of time spent on each exercise.

The Provider submitted a request for reconsideration and requested that the Self-Insured Carrier reimburse him an additional $778.32 (18 units x $43.24). The Provider's request was denied by the Self-Insured Carrier upon reconsideration. The Self-Insured Carrier's denial was upheld by the Medical Fee Dispute Resolution Officer (MFDRO). The MFDRO decision states that CPT Code 97110 is a timed code billed as one unit per 15 minutes. The MFDRO determined that upon review of the medical notes that the only time documented for therapeutic exercise was ten minutes under cardiovascular treadmill walk and two minutes for knee high steps for a total of twelve minutes for each date of service. The MFDRO found that the documentation submitted did not support the two additional units per date of service and the Provider was not entitled to any additional reimbursement.

Petitioner/Provider challenged the MFDRO decision and requested a Medical Contested Case Hearing (MCCH). A MCCH was held on April 6, 2011 with the record closing on May 9, 2011. The record was held open because the Provider objected to the Respondent's/Self-Insured Carrier's Exhibits. The Provider appeared by phone and did not believe that the copy of the documents that were exchanged by the Respondent/Carrier were the same documents that were being offered into evidence by the Respondent. The Respondent's attorney stated that, as an officer of the court, he swore that they were the same documents. The Provider's objection was overruled. However, a copy of the Respondent's exhibits was mailed to the Provider on April 8, 2011. Provider was advised by the Hearing Officer that if he wished to renew his objections after reviewed the exhibits that he may do so in writing. Provider reviewed the documents and had no objections to the Respondent's exhibits. Both parties submitted written closing arguments and the Medical Contested Case Hearing record closed on May 9, 2011.

DISCUSSION

28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional services rendered on or after May 1, 2008. Rule 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

> Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The Medicare fee guidelines provide specific guidelines for the various types of therapeutic procedures. For CPT Code 97110 (therapeutic exercises) the Medicare fee guidelines states as follows:

> **97110 – (therapeutic exercises) –** Therapeutic exercise to develop strength and endurance, range of motion, and flexibility: active, active-assisted or passive (e.g. treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening). The exercise may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity, or mobility (e.g. degrees of motion, strength grades, and level of assistance). This therapeutic procedure is measured in 15-minute units with therapy sessions frequently consisting of several units.

Provider submitted daily progress notes that document the various therapeutic exercises that were performed on each date of service. All the notes reflect that Claimant performed various lower body stretches, core exercises, cardiovascular exercises, spinal exercises, and lumbar stabilization at each therapy visit. Dr. AS testified that these various exercises take much longer than fifteen minutes to perform. He testified that the documentation of the number of repetitions that were performed is sufficient to establish that Claimant performed therapeutic exercises for the three units of therapy that he billed for each date of service. Dr. AS was of the opinion that the number of repetitions is a quantitative measurement that establishes that the Claimant performed the various exercises for a total of forty-five minutes.

DB testified on behalf of the Respondent. Ms. B testified that she works for (employer name) and she audits bills on behalf of the Self-Insured Carrier. Ms. B performed the audit of the bills at issue in the case. Ms. B testified that she was familiar with the Division rules and the Medicare fee guidelines regarding medical bills for workers' compensation patients. Ms. B agreed with the findings of the MFDRO that only twelve minutes of therapeutic exercises were documented for each date of service. She testified that you could not determine the amount of time spent doing therapy based on the number of repetitions because the amount of time it takes to complete an exercise will vary from person to person. She testified that the medical fee guidelines require that the therapeutic exercises be billed in time units. She stated that because there was only documentation sufficient to establish one unit out of three units for CPT code 97110, Dr. AS was correctly reimbursed by the Self-Insured Carrier and is not entitled to payment for the remaining units.

After considering all of the documentary evidence and testimony presented, Provider did not meet his burden of proof in this matter. Dr. AS did not submit any documentary evidence that indicated the amount of time spent with the Claimant at each physical therapy session. Although Dr. AS testified that the number of repetitions was sufficient evidence of time spent, he did not provide documentary evidence to support his assertion that the number of repetitions of an exercise represents a specific amount of time.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer).

   C. Claimant sustained a compensable injury on _____.

   D. The medical fee dispute resolution officer determined that the Provider is not entitled to reimbursement in the amount of $778.32 for dates of service May 12, 2010 through June 4, 2010.

2. Respondent/Self-Insured Carrier provided to Petitioner/Provider a single document stating the true corporate name of Self-Insured Carrier, and the name and street address of Self-Insured Carrier's registered agent. The document was mailed to the Provider and was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The preponderance of the evidence is not contrary to the decision of Medical Fee Dispute Resolution Findings and Decision rendered on December 7, 2010 that Petitioner/Provider is not entitled to $778.32 for dates of service May 12, 2010 through June 4, 2010 (CPT Code 97110) for the compensable injury of _____ and the Respondent/Carrier is not liable for additional payment.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. (Healthcare Provider) Center is not entitled to $778.32 for dates of service May 12, 2010 through June 4, 2010 (CPT Code 97110) for the compensable injury of _____.

DECISION

(Healthcare Provider) Center is not entitled to $778.32 for dates of service May 12, 2010 through June 4, 2010 (CPT Code 97110) for the compensable injury of _____.

ORDER

Respondent/Self-Insured Carrier is not liable for the fees at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is (**SELF-INSURED)** and the name and address of its registered agent for service of process is:

(NAME)
(ADDRESS)
(CITY), TX (ZIP CODE)

Signed this 17th day of May, 2011.

Jacquelyn Coleman
Hearing Officer