SOAH DOCKET NO. 453-04-1978.M5

TEXAS MUTUAL INSURANCE CO., **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
BARBARA FRACZEK, P.T., **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is an appeal by Texas Mutual Insurance Co. (Petitioner) from a decision of an independent review organization (AIRO@) on behalf of the Texas Workers' Compensation Commission (Commission) in a dispute regarding the medical necessity of physical therapy services. The IRO found that Petitioner improperly denied reimbursement for physical therapy that Barbara Fraczek, P.T., (Respondent) administered between September 9 and 23, 2002, to a claimant suffering from a shoulder and wrist injury.

Petitioner challenged the decision on the basis that the treatment at issue was not, in fact, medically necessary, within the meaning of '' 408.021 and 401.011(19) of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision disagrees, in part, with that of the IRO, finding that reimbursement of a portion of the disputed services should be denied.

JURISDICTION AND VENUE

The Commission has jurisdiction over this matter pursuant to ' 413.031 of the Act. 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 ' 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction or venue.

STATEMENT OF THE CASE

The hearing in this docket was convened on July 19, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Mike Rogan presided. Petitioner was represented by Katie Kidd, Attorney. Respondent appeared by telephone, along with her representative, Cherilyn Johnston. Both parties presented evidence and argument. The record remained open until July 26, 2004, to allow the parties to submit additional documents and comments.[1]

[1] The staff of the Commission formally elected not to participate in this proceeding, although it filed a general AStatement of Matters Asserted@ with the notice of the hearing.

The record revealed that on ___, the claimant suffered a compensable injury to his right shoulder and wrist. Consequently, he underwent surgery on May 30, 2002, for repair of a rotator cuff tear and for manipulation of the wrist. Post-surgical rehabilitation included physical therapy supervised by Respondent, beginning on July 23, 2002, in an effort to increase the strength and range of motion in the injured shoulder and wrist.

Petitioner (the insurer for the claimant's employer) reimbursed Respondent for much of the physical therapy provided to the claimant, However, Petitioner denied reimbursement for services (including office visit, therapeutic procedures, and joint mobilization) that were provided from September 9 through September 23, 2002, on grounds that these services were not medically necessary.

Respondent sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on November 4, 2003, concluding that Petitioner should have reimbursed Respondent for the disputed services. The IRO noted:

> Post operative physical therapy for eight weeks to progress [the patient's] range of motion and strength in the shoulder and wrist was appropriate and medically necessary.

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and, on November 18, 2003, issued its own decision confirming that the disputed services were medically necessary and should be reimbursed. Petitioner then made a timely request for review of the IRO and MRD decisions before SOAH.

THE PARTIES' EVIDENCE AND ARGUMENTS

A. Petitioner

Petitioner presented the testimony of Dr. Nicholas Tsourmas, a Board-certified practitioner in orthopedic surgery, who found the first six weeks of therapy provided by Respondent to be reasonable, but concluded that after September 9, 2002, the claimant should have been beyond the need for passive modalities and joint mobilization to enhance range of motion. Indeed, he asserted, by that date the claimant should have been able to rely on self-directed exercise to advance his rehabilitation B a much less costly alternative than supervised, one-on-one therapy.

In any case, Dr. Tsourmas testified, the services provided to the claimant by Respondent did not really constitute one-on-one therapy, as billed (CPT Code 97110). Citing the testimony of Donna Smith (an assistant physical therapist who performed the immediate supervision of the claimant's therapy on behalf of Respondent), Dr. Tsourmas characterized the disputed services as group-therapy, since Ms. Smith stated that she at times simultaneously directed the workouts of both the claimant and one or more other patients.

Petitioner also presented Mark Miller, a physical therapist who frequently lectures on treating spinal and musculo-skeletal conditions. Mr. Miller agreed that the claimant should have been able to follow a therapy program on his own by September 9, 2002, with perhaps a few minutes of supervision every week or so to evaluate his progress in exercising at home and to adjust the program, as needed. On the other hand, Mr. Miller concluded that joint mobilization (CPT Code 97265) was probably too agressive a technique to have been included in the disputed stage of the claimant's rehabilitation.

B. Respondent

Both Ms. Smith and the Petitioner herself testified that joint mobilization and other passive modalities were needed in the claimant's case to counteract the effect of his having had his arm immobilized in a sling for four to six weeks following surgery. Ms. Smith noted that the mobilization initially administered was Grade 1 B the least intensive level B perhaps advancing to Grade 2 by the end of the disputed therapy.

Both witnesses also stated that the claimant received instruction in performing a home exercise program at the same time that he began supervised post-surgical therapy. Ms. Smith said that the patient's home program was reviewed and coordinated with the supervised therapy program.

While conceding that she probably supervised the active therapeutic exercises of one or more other patients along with the claimant (at least on some occasions), Ms. Smith emphasized that that she provided strictly one-on-one service with respect to the passive modalities applied in the claimant's case.

In closing argument, Respondent contended that the MRD's order in this proceeding barred the insurer from raising any new reasons for denial of reimbursement (*i.e.*, reasons other than the disputed services' lack of medical necessity), in accordance with the Commission's rule at 28 TEX. ADMIN. CODE (ATAC@) ' 133.307(j)(2).

ANALYSIS

Petitioner bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. In the ALJ's view, it has discharged that burden only with respect to the disputed services identified with CPT Code 97110 (for supervised, one-on-one therapeutic activities).

The record presented to the ALJ does not support a basic premise under which the review of this dispute apparently has proceeded up to this point B *i.e.*, it does not indicate that those disputed services recorded nder CPT Code 97110 actually satisfied the definition for that category of services. As noted in reference material from the federal Centers for Medicare and Medicaid Services (submitted by Respondent), Code 97110 treatment does not include simultaneous treatment to two or more patients who may or may not be doing the same activities. Rather, the explanation states:

> If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy, 97150 (untimed).

The testimony of Ms. Smith showed, with reasonable clarity, that she sometimes monitored the therapeutic activities of both the claimant and one or more other patients at the same time. Such activity does not fit in CPT Code 97110, although Respondent reported it under that category. Ms. Smith apparently could not recall her work with the claimant in any detail and did not specify that any of it entailed true one-on-one supervision during the dates of service in dispute. Thus, the ALJ is not able to conclude that any portion of the disputed services billed under CPT Code 97110 was properly categorized.

The ALJ does not believe that disallowance of services for the provider's failure to identify them properly is precluded by 28 TAC ' 133.307(j)(2) or by SOAH's well-established principle (in Commission cases) that only those reasons for denial that are set out prior to a request for dispute resolution may be considered in subsequent review. On the contrary, in an administrative contest of this type, when a provider asserts that certain, specifically identified services were medically necessary, a later showing that the services actually delivered were of a significantly different nature must lead, normally, to a logical assumption that those different services were *not* medically necessary. Certainly, in this case, the Respondent's evidence appeared to be consistently directed at supporting the premise that one-on-one therapy was needed by the claimant and that less-intensive types of therapy B such as home exercise or group therapy B were inadequate for his full rehabilitation. By Respondent's own reasoning and acknowledgment, therefore, services that were represented as CPT Code 97110 but that did not, in fact, measure up to that classification must be regarded as failing to make a reasonable contribution to the patient's recovery.

In addition, the failure to deliver the same services that a provider specifically bills is a deficiency that an insurer realistically may not be able to detect until a late stage in the dispute resolution process B if even then. In this case, Petitioner may not have had any firm basis for questioning whether Respondent actually provided CPT Code 97110 services until Ms. Smith's testimony showed a lack of substantiation for those services. Insurers certainly should not be required to list the provider's inaccuracy of service identification as a speculative reason for denying reimbursement, on the mere chance that such inaccuracy might surface in the subsequent investigation of a dispute.

With respect to disputed services under CPT Code 97265 (joint mobilization), Petitioner did not present a convincing or consistent critique of the IRO's approval of reimbursement. While Dr. Tsourmas suggested that the time for such mobilization had passed by the disputed dates of service, Mr. Miller asserted that such treatment was still premature on those dates, with the claimant's shoulder remaining vulnerable from recent surgery. On cross-examination, Mr. Miller then qualified his testimony to acknowledge that the lowest levels or grades of joint mobilization would probably have been appropriate for the claimant during the relevant period. Ms. Smith later testified that only such mild mobilization (Grade 1, possibly edging into Grade 2) was provided during that time.

Petitioner did not address in any substantive way the disputed services under CPT Code 97213.

CONCLUSION

The ALJ finds that, under the record provided in this case, the disputed medical services reported under CPT Code 97110 have not been shown to be medically necessary. These services were reportedly provided on seven separate dates, with $140.00 billed on each date. Reimbursement for these services should be denied, counter to the previous determination by the IRO.

Petitioner did not show that the other disputed services were unnecessary. These included three sessions under CPT Code 97265, with a total of $192.00 billed, and one visit under CPT Code 97213, with $60.00 billed. Respondent should therefore be reimbursed for these services, in accordance with the IRO's previous determination in this matter.

FINDINGS OF FACT

1. On ___, claimant suffered an injury to his right shoulder and wrist that was a compensable injury under the Texas Worker's Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. The claimant's injury necessitated surgery for repair of a rotator cuff tear and manipulation of the wrist on May 30, 2002.

3. Post-surgical rehabilitation included a program supervised by Barbara Fraczek, P.T., ("Respondent"). Treatment included office visit (CPT Code 97213), joint mobilization (CPT Code 97265), and supervised therapeutic activities (CPT Code 97110).

4. Respondent sought reimbursement for services noted in Finding of Fact No. 3 B including care provided on dates of service from September 9 through September 23, 2002 B from Texas Mutual Insurance Co. ("Petitioner"), the insurer for claimant's employer.

5. Petitioner denied the requested reimbursement for those services associated with dates of service from September 9 through September 23, 2002.

6. Respondent made a timely request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

7. The independent review organization ("IRO") to which the Commission referred the dispute issued a decision on November 4, 2003, and concluded that the services in dispute had been medically necessary to improve claimant's post-surgical range of motion and strength in the shoulder and wrist.

8. The Commission's Medical Review Division ("MRD") reviewed and concurred with the IRO's determination in a decision dated November 18, 2003, in dispute resolution docket No. M5-03-2564-01.

9. Petitioner requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the MRD decision regarding reimbursement.

10. The Commission mailed notice of the hearing's setting to the parties at their addresses on January 5, 2004. The hearing was subsequently continued to a later date, with proper notice to the parties.

11. A hearing in this matter was convened before SOAH on July 19, 2004. Petitioner and Respondent were represented. The record in the proceeding remained open until July 26, 2004, to allow submission of argument and documentation of authorities.

12. Among services noted in Finding of Fact No. 3 that were provided on dates of service from September 9 through September 23, 2002, those billed by Respondent under CPT Code 97110 (for one-on-one, supervised therapeutic activities) did not actually meet the definition for that category, but actually represented group therapy.

13. The services noted in Finding of Fact No. 12 were provided on seven separate dates of service, with $140.00 billed on each date, for total billings of $980.00.

14. With respect to services noted in Finding of Fact No. 3 that were provided on dates of service from September 9 through September 23, 2002, and were billed by Respondent under CPT Codes 97265 (joint mobilization) and 97213 (office visit), Petitioner did not show that the IRO and MRD erred in finding such services to be medically necessary, as noted in Findings of Fact Nos. 7 and 8.

15. The services noted in Finding of Fact No. 14 were provided on four separate dates of service, with total billings of $258.00.

CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ' 413.031.

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

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE ("TAC") § 133.305(g) and §§ 148.001-148.028.

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

5. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC ' 148.21(h).

6. Based upon the foregoing Findings of Fact, those disputed services for the claimant noted in Finding of Fact No. 12 do not represent elements of health care medically necessary under § 408.021of the Act.

7. Based upon the foregoing Findings of Fact, those disputed services for the claimant noted in Finding of Fact No. 14 represent elements of health care medically necessary under § 408.021of the Act.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions in this matter of the IRO, issued on November 4, 2003, and of the MRD, issued on November 18, 2003, were incorrect with respect to the services noted in Finding of Fact No. 12. Reimbursement of Respondent for such services, in the amount of $980.00, should be denied.

9. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions in this matter of the IRO, issued on November 4, 2003, and of the MRD, issued on November 18, 2003, were correct with respect to the services noted in Finding of Fact No. 14. Respondent should be reimbursed by Petitioner for such services, in the amount of $258.00.

ORDER

IT IS THEREFORE, ORDERED that the appeal of Texas Mutual Insurance Co., seeking reversal of the findings and decision of an independent review organization issued in this matter on November 4, 2003, be approved in part and denied in part; that Texas Mutual Insurance Co. shall not be required to reimburse Barbara Fraczek, P.T., for services provided from September 9 through 23, 2002, that were identified with CPT Code 97110; but that Texas Mutual Insurance Co. shall be required to reimburse Barbara Fraczek, P.T., $258.00 for services provided during the same period that were identified with CPT Codes 97213 and 97265, consistent with the prior decision of the independent review organization.

SIGNED August 2, 2004.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS