SOAH DOCKET NO. 453-04-3780.M5
MDR NO. M5-03-3229-01

LAWRENCE NEIL SMITH, D.C., Petitioner	§	**BEFORE THE STATE OFFICE**
VS.		OF
INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Respondent		**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

The issue in this case is whether certain chiropractic services rendered from January 27, 2003, through March 26, 2003, should have been reimbursed by the Insurance Company of the State of Pennsylvania (Carrier). The Administrative Law Judge finds Lawrence Neil Smith, D.C. (Provider) is entitled to $70 additional reimbursement.

I. DISCUSSION

The Claimant injured his lower back on ____. In January of 2003, the Provider, the Claimant's treating doctor, began an aggressive treatment program consisting of a variety of active and passive chiropractic modalities. The Carrier denied the services.[1] The Provider requested medical dispute resolution. An Independent Review Organization found that services rendered from March 17, 2004, through June 27, 2003,[2] with the exception of services provided on March 26, 2003,

[1] There were no Explanations of Benefits (EOBs) in the record at the MRD level of review, nor were any provided to the ALJ.

[2] The span of the dates of service reviewed by the IRO and the MRD are not the same; because only the Provider requested a hearing, most of the dates of service reviewed by the IRO are not at issue. This decision focuses on the services reviewed by the MRD, which found certain services should not be reimbursed due to a lack of

were medically necessary to treat the Claimant's compensable injury. In a separate decision, the Medical Review Division found that many of the services provided from January 27, 2003, through March 26, 2003, should not be reimbursed based upon a lack of medical documentation. The Provider requested a hearing of the MRD's findings. The Carrier did not request review of the decision of the MRD or the IRO; therefore, only the documentation of the services, and not their medical necessity, is at issue in this decision.

The MRD found that the documentation was insufficient to support that one-on-one physical therapy was provided on a one-on-one basis, and further, that other services were not adequately documented. Consequently, the MRD concluded reimbursement of $799 out of $2,102 billed was appropriate. At the hearing, the Provider failed to offer any evidence, either through testimony or documentation, substantiating the delivery of the services on the relevant dates of service for which the MRD had found the documentation inadequate. The record contains only the bills for the dates of services in which payment was denied, and no other treatment notes reflecting their delivery. The ALJ, therefore, finds that the Provider has failed to meet his burden of proof to demonstrate the delivery of the services at issue. The ALJ, however, finds that the Provider is entitled to $70 in additional reimbursement for the relevant dates of service in which the MRD ordered payment, as is reflected in the findings of fact.

II. FINDINGS OF FACT

1. The Claimant injured his lower back on ____.

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documentation. The MRD's review was limited to the adequacy of the documentation of the services provided, not their medical necessity.

2. In January of 2003, the Claimant's treating doctor, Lawrence Neil Smith, D.C. (Provider), began an aggressive treatment program consisting of a variety of active and passive chiropractic modalities.

3. The Insurance Company of the State of Pennsylvania (Carrier) denied payment for the services.

4. Based on the Carrier's denial of payment, the Provider requested medical dispute resolution with the Medical Review Division office (MRD) of the Texas Workers' Compensation Commission.

5. An Independent Review Organization found that the services rendered from March 17, 2004, through June 27, 2003, with the exception of services provided on March 26, 2003, were medically necessary to treat the Claimant's compensable injury.

6. In a separate review relating to the adequacy of the documentation, the MRD found that certain services rendered from January 27, 2003, through March 26, 2003, should not be reimbursed because of a lack of documentation.

7. Based on the decision of the MRD, the Provider requested a hearing before the State Office of Administrative Hearings (SOAH).

8. Notice of the hearing was sent March 18, 2004. The notice 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.

9. The hearing was convened on May 27, 2003, with Administrative Law Judge (ALJ) Janet Dewey presiding and representatives for the Carrier and the Provider participating. The record closed on June 4, 2004.

10. On January 31, 2003, the Provider billed for a special report; however, there is no documentation of procedure substantiating the requested amount for reimbursement billed under CPT code 99080-73, for which there is no corresponding maximum allowable reimbursement (MAR) set by the Medical Fee Guideline.

11. The Provider billed for three office visits with manipulations under CPT code 99213-MP for each of the following dates: March 5, 2003, March 7, 2003, March 12, 2003.

12. The Provider billed for nine fifteen-minute units of one-on-one physical therapy under CPT codes 97530, 97112 and 97110 on March 5, March 7, and March 12, 2003. There is no evidence that the therapist worked exclusively with the injured worker for any period of time for which the Provider billed the Carrier using the one-on-one CPT codes 97530, 97112 and 97110.

13. There are no treatment notes or other documentation to verify that physical therapy billed under CPT codes 97530, 97112 and 97110 was provided on March 7, 2003.

14. The MRD ordered the Carrier to reimburse the Provider $236 for services provided on March 5, 2003, and March 12, 2003 ($43 for an office visit with manipulation, and two units of one-on-one therapy ($35 x 2) for each date of service).

15. There are no treatment notes or other documentation to verify that physical therapy billed under CPT codes 97530, 97112 and 97110 was provided on March 14, 2003.

16. There are no treatment notes or other documentation to verify that any traction was provided under CPT code 97012 on March 10, 2003.

17. There are no treatment notes or other documentation to verify that either electrical stimulation (CPT code 97032) or traction (CPT code 97012) was provided on March 26, 2003.

III. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. ' 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003 (Vernon 2000 and Supp. 2004).

2. The Provider timely filed its request for a hearing as specified in 28 TEX. ADMIN. CODE (TAC) ' 148.3.

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

ANN. '' 2001.051-052.

4. The Provider has the burden of proof in this proceeding under 28 TAC ' 148.21(h).

5. The Provider shall use the code 99213 with the modifier -MP when providing an office visit in combination with a manipulation on the day of service. ($48 MAR). Additional manipulations are coded using the code 97261 ($8 MAR). Medical Fee Guideline (MFG), *Medicine Ground Rule,* I.B.2.b.

6. The Provider is entitled to payment of $96 for two office visits with manipulations under CPT code 99213-MP and for four additional manipulations under CPT code 97261 for March 5 and March 7, 2004 in the amount of $32.

7. CPT code 97110 (therapeutic procedure) and 97112 (neuromuscular reeducation) apply only when the doctor or therapist works directly, one-on-one with a patient on that patient's therapy only. If two or more patients are performing the same or different therapeutic exercises in the same setting under the supervision of the therapist or doctor, one-on-one contact does not exist; the group code, CPT code 97150, would apply in this situation. MFG, *Medicine Ground Rule,* I.A.9.b. and I.C.9.

8. The Provider is entitled to payment for four units of group therapy under CPT code 97150 (MAR $27) for physical therapy services provided under CPT codes 97110 and 97112 on March 5 and 7, 2003 in the amount of $108.

9. CPT code 97530 (therapeutic activities)(MAR $35) applies when the doctor or therapist works directly, one-on-one with a patient on that patient's therapy with the use of dynamic activities to improve functional performance. MFG, *Medicine Ground Rule,* I.A.11.A.

10. There is no corresponding group code for services provided under CPT code 97530; it is appropriate to limit the reimbursement to one unit of CPT code 97530 in light of the Provider's failure to demonstrate that these services were provided on a one-on-one basis, on March 5 and March 7, 2003. The Provider is entitled to $70 for services billed under CPT code 97530 on March 5 and 7, 2003.

11. The Provider should have been reimbursed a total of $306 for services provided on March 5 and 7, 2003.

12. Because the MRD has already awarded $236 for services provided on March 5 and 7, 2003,

which has not been contested by the Carrier, the Provider is entitled to an additional $70 in reimbursement under the MFG.

13. The General Instructions in the MFG, III.A. require that for CPT codes without an established MAR specific documentation substantiating the amount requested must be provided.

14. The Provider failed to meet its burden of proof that the other services identified in the findings of fact and provided on March 10, 14, and 26, 2003, were delivered; therefore, the Provider is not entitled to additional reimbursement for these services.

ORDER

IT IS, THEREFORE, ORDERED the Carrier is required to reimburse the Provider an additional $70 for chiropractic services rendered from January 27, 2003, through March 26, 2003.

SIGNED August 2, 2004.

JANET R. DEWEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS