SOAH DOCKET NO. 453-05-0211.M5
MR NO. M5-04-2465-01

TEXAS MUTUAL INSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
	§	**OF**
	§	
MTR MANAGEMENT	§	
C/O FT. WORTH INJURY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (TMIC) seeks review of a decision by the Texas Workers' Compensation Commission (Commission), acting through an independent review organization (IRO), in a dispute regarding the medical necessity of physical medicine treatments provided to Claimant ___ This decision finds that MTR Management (MTR) should be reimbursed $1008.50 for 11 sessions of joint mobilization, 18 office visits, and 3 sessions of neuromuscular re-education.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The hearing convened on March 30, 2005, at the facilities of the State Office of Administrative Hearings, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Katherine L. Smith presided. TMIC was represented by Tim Riley, an attorney. MTR was represented by Albert M. Daniel, III, D.C. The record closed the same day. Neither party challenged the adequacy of notice or jurisdiction.

II. BACKGROUND

Claimant suffered a compensable injury on ___, when he slipped into a hole and fractured his left ankle and metatarsal. Claimant underwent surgery on ___, at which time five screws were inserted into his left ankle. Claimant received physical therapy from June 13 to July 17, 2002, at Arlington Memorial Physical Therapy. Res. Ex. 1 at 117. Claimant sought treatment from

Dr. Daniel. Dr. Daniel began treating Claimant on August 9, 2002. Claimant underwent surgery on June 5, 2003, to remove the metal hardware.

TMIC denied reimbursement for services that Dr. Daniel provided to Claimant from April 10 to November 3, 2003, based on lack of medical necessity. Of those disputed services, the IRO found that the following were not medically necessary: joint mobilizations and myofascial release provided from April 10 to May 30, 2003; therapeutic exercises provided from April 10 through May 8, 2003; office visits provided on April 14, 21, and 22 and May 5, 2003; office visits with manipulations provided on April 29 and May 13, 2003; and manual therapy provided from August 11 to October 27, 2003. The IRO found that the remainder of the services were medically necessary. The IRO decision was issued on August 5, 2004. TMIC appealed the decision. The services in dispute are listed on Attachment A.

III. ANALYSIS

TMIC presented the testimony of William DeFoyd, D.C., its expert witness, who testified that the treatments were excessive and that the medical documentation did not justify the excessive treatments provided. Dr. Daniel testified that additional treatment was required because Claimant did not progress with the removal of the hardware and to help Claimant regain as much function as possible.

When a healthcare provider bills for one of the three highest level office visits, which includes billing with CPT code 99213, and for physical medicine treatment, the Commission's rules require the healthcare provider to submit the following: progress or SOAP[1] notes substantiating the care given and the need for further treatment and services and indicating progress, improvement, the date of the next treatment and services, complications, and expected release date.[2]

[1] Subjective/objective/assessment/plan.

[2] 28 TEX. ADMIN. CODE ' 133.1(a)(3)(E)(i).

With this directive in mind, the ALJ finds that much of the testimony of William DeFoyd, D.C., challenging the adequacy of the documentation and the necessity of the disputed treatments to be persuasive.

A. Therapeutic Exercises

At issue are 29 one-hour sessions of one-on-one therapeutic exercises provided from May 12 to November 3, 2003. According to Dr. DeFoyd, the use of CPT code 97110 to bill for therapeutic exercises requires the healthcare provider to provide exclusive and direct, one-on-one physical therapy to the patient. Dr. DeFoyd testified that the records in this case do not indicate that exclusive one-on-one therapy was provided for one hour of treatment. Dr. DeFoyd testified further that the

therapy Claimant received did not require a care-giver's constant attendance. The only time an hour of one-on-one therapy would be needed is early on in the treatment, or if a patient is having cognitive difficulties, or when new treatments are being introduced. During the remainder of the time, Claimant should have been performing the exercises in a group setting or at home.

Dr. Daniel testified that continuing the one-on-one supervision was necessary because he was not seeing results with Claimant and to ensure Claimant was performing the exercises correctly because of his level of pain. In response, Dr. DeFoyd testified that if Claimant was not motivated to perform the exercises himself, something else needed to be tried. Dr. DeFoyd also testified that the medical notes did not document that the exercises were producing pain and that if they were, they should have been changed. Dr. Defoyd also noted that April 10, 2003, was Claimant's 95th visit with Dr. Daniel and by that time he had had more than 300 15-minute units of one-on-one physical therapy that was apparently not providing much help. Dr. DeFoyd also noted that initiating the same ineffective treatment post-operatively was not appropriate without an evaluation regarding its effectiveness.

As pointed out by Dr. DeFoyd, the treatment notes documenting the physical therapy provided are sparse and do not indicate that one-on-one physical therapy was being provided for one hour. Furthermore, it certainly is questionable whether one-on-one supervision was needed while Claimant walked on a treadmill and exercised on a stationary bike. In addition, the treatment notes do not document how Claimant responded to the therapy, do not document that Claimant was not responding, and do not indicate how the therapy was being modified in response to Claimant§s pain or lack of progress. If Claimant was not progressing as well as Dr. Daniel had hoped or expected, he had an obligation to state why he was continuing to provide the same, apparently ineffective treatment over and over again.

B. Office Visits

With regard to the office visits that were billed using CPT code 99213-MP, Dr. DeFoyd testified that the medical notes do not justify 99213 billing because they do not reflect expanded problem solving or that re-evaluation occurred. Dr. DeFoyd also pointed out that it was improper to bill for manipulation therapy and joint mobilization on the same date because manipulation therapy duplicates joint mobilization. Dr. Defoyd also criticized the medical records for not stating what type of mobilizations and manipulations were performed. Reference was made only to the left ankle.

With regard to the dates in dispute, the ALJ notes that the dates of the joint mobilizations generally do not duplicate the dates of office visits with manipulations. And because the IRO disallowed the joint mobilizations of April 10, 24, May 1, 20, 22, and 30, 2003, the office visits with manipulations billed on those dates either as 99211-MP or 99213-MP need to be considered independently.

To bill using 99213 requires that two of the following take place during the office visit: an expanded, problem-focused history; an expanded, problem-focused examination; or medical decision making of low complexity. As Dr. DeFoyd stated, the medical notes from the office visits of April 17, May 1, 8, 12, 20, 22, 28, and June 3, 2003, billed as 99213, document neither an expanded, problem-focused history, nor an expanded, problem-focused examination. They are sparse, virtually identical, and the same as those for office visits billed as 99211. Furthermore, the medical records of the office visits of May 1, 20, 22, 28, and June 3, 2003, which were also billed with MP, contain no reference to manipulations being performed.

Although the medical records of the office visits of April 10 and 24, May 30, and August 11 and 26, 2003, billed as 99211-MP provide no indication that manipulations were performed, there is evidence that a basic office visit was provided on those dates. The use of CPT code 99211 only requires that five minutes of evaluation and management occur during the office visit. Because TMIC provided no evidence disputing the efficacy of those office visits, the ALJ finds that reimbursement for those 5 visits, as well as the 13 other office visits of August 25 to November 3, 2003, billed as 99211, for which there are treatment notes, is appropriate.

C. Joint Mobilizations

Because the IRO found that the joint mobilizations provided after the surgery from June 24 to July 31, 2003, were medically necessary and because TMIC did not present evidence controverting the medical necessity of that treatment, the ALJ finds that the 11 sessions billed during that time were medically necessary.

D. Neuromuscular Re-education

At the hearing, TMIC stated that the neuromuscular re-education services of October 2, 7, and 9, 2003, that the IRO found to be medically necessary are not in dispute. The ALJ finds no basis for that assertion. The services, which were billed as 97112-59, are listed on the table of disputed services at Pet. Ex. 1 at 180 and 219. Furthermore, Res. Ex. 1 at 96, 100, and 102 indicate that the service was provided. Because the IRO found that the neuromuscular re-education services of

October 2, 7, and 9, 2003, were medically necessary and because TMIC did not present evidence controverting the medical necessity of that treatment, the ALJ finds that the 3 sessions billed were medically necessary.

E. Conclusion

Accordingly, TMIC is required to reimburse MTR for the office visits of April 10, 24, May 30, August 11, 25, 26, 28, September 5, 8, 11, 30, October 2, 6, 7, 9, 27, 28, and November 3, 2003, billed under CPT codes 99211 and 99211-MP. TMIC is also required to reimburse MTR for the neuromuscular re-education provided on October 2, 7, and 9, 2003, billed under CPT code 97112-59, and the joint mobilizations performed on June 24, 30, July 2, 10, 15, 17, 21, 22, 24, 29, and 31, 2003, billed under CPT code 97265, for a total of $1008.50.

IV. FINDINGS OF FACT

1. Claimant ___suffered a compensable injury on ___, when he slipped into a hole and fractured his left ankle and metatarsal.

2. At the time of the injury, Claimant's employer had workers' compensation insurance coverage with Texas Mutual Insurance Co. (TMIC).

3. Claimant underwent surgery on ___, at which time five screws were inserted into his left ankle.

4. Albert M. Daniel, III, D.C., began treating Claimant on August 9, 2002.

5. Claimant underwent surgery on June 5, 2003, to remove the screws.

6. Reimbursement was sought from TMIC for services provided to Claimant from April 10 to November 3, 2003.

7. TMIC found the treatments provided to be not medically necessary and denied reimbursement.

8. MTR Management (MTR) requested medical dispute resolution at the Texas Workers' Compensation Commission (Commission).

9. In a decision issued by the Commission's Medical Review Division on August 5, 2004, an independent review organization (IRO) to which the Commission referred the dispute found that approximately two weeks of pre-surgical and eight weeks of post-surgical rehabilitation treatments were medically necessary.

10. On August 26, 2004, TMIC requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review of the IRO's decision.

11. On September 16, 2004, the Commission issued the notice of the hearing, which stated the date, time, and location of the hearing and cited to the statutes and rules involved, and provided a short, plain statement of the factual matters involved.

12. The hearing convened on March 30, 2005, at 300 W. 15th St., Austin, Texas.

13. Using CPT code 97110, Dr. Daniel billed for 29 one-hour sessions of one-on-one therapeutic exercises provided to Claimant from May 12 to November 3, 2003.

19. The use of CPT code 97110 to bill for therapeutic exercises requires the healthcare provider to provide exclusive and direct, one-on-one physical therapy to the patient.

20. The treatment notes documenting the one-on-one therapeutic exercises are sparse and do not indicate that exclusive one-on-one therapy was provided for one hour of treatment.

21. The treatment notes do not document how Claimant responded to the physical therapy and do not indicate how the therapy was being modified in response to Claimant lack of progress.

22. The therapy Claimant received did not require a care-giver's constant attendance.

23. Initiating the same ineffective treatment post-operatively was not appropriate without an evaluation regarding its effectiveness.

24. The treatment notes from the office visits of April 17, May 1, 8, 12, 20, 22, 28, and June 3, 2003, billed as CPT code 99213, document neither an expanded, problem-focused history, nor an expanded, problem-focused examination. They are sparse, virtually identical, and the same as those from office visits billed as 99211.

25. The treatment notes of the office visits of May 1, 20, 22, 28, and June 3, 2003, which were also billed with MP, contain no reference to manipulations being performed.

26. The use of CPT code 99211 for billing only requires that five minutes of evaluation and management occur during an office visit.

27. The treatment notes of the office visits of April 10, 24, May 30, August 11, and 26, 2003, billed as CPT Code 99211-MP and the office visits of August 25, 28, September 5, 8, 11, 30, October 2, 6, 7, 9, 27, 28, and November 3, 2003, billed as CPT code 99211 indicate that a basic office visit was provided on those dates.

28. The IRO found that the joint mobilizations performed on June 24, 30, July 2, 10, 15, 17, 21, 22, 24, 29, and 31, 2003, billed under CPT code 97265, were medically necessary.

29. The IRO found that the neuromuscular re-education services of October 2, 7, and 9, 2003, were medically necessary.

V. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to the Texas Workers§ Compensation Act (the Act), TEX. LAB. CODE ANN. § 413.031.

2. 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.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'TCODE ANN. §§ 2001.051 and 2001.052.

4. 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) §§ 148.1-148.28.

5. Under TEX. LABOR CODE § 408.021(a)(1), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed that cures or relieves the effects naturally resulting from the compensable injury.

6. TMIC had the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (I); 1 TAC § 155.41.

7. The 29 sessions of one-on-one therapeutic exercises provided to Claimant from May 12 to November 3, 2003, were not medically necessary healthcare.

8. The office visits of April 17, May 1, 8, 12, 20, 22, 28, and June 3, 2003 billed either as 99213 or 99213-MP, were not medically necessary health care.

9. The April 10, 24, May 30, August 11 and 26, 2003, office visits billed as 99211-MP and 13 other office visits of August 25 to November 3, 2003, billed as 99211, were medically necessary health care.

10. The 11 sessions of joint mobilizations provided to Claimant from June 24 to July 31, 2003, were medically necessary health care.

11. The neuromuscular re-education services of October 2, 7, and 9, 2003, were medically necessary health care.

12. Based upon the foregoing Findings of Fact and Conclusions of Law, TMIC's petition is granted, except for the treatments outlined in Conclusions of Law Nos. 9 through 11.

ORDER

IT IS THEREFORE, ORDERED that TMIC shall reimburse MTR $1008.50, plus interest for the services found to be medically necessary health care.

SIGNED May 17, 2005.

KATHERINE L. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS