SOAH DOCKET NO. 453-05-2106.M5
TWCC MR NO. M5-04-3511-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
WACO ORTHO REHAB ASSOC., **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is a cross-appeal of two decisions: one from an independent review organization (IRO) and the other from the Medical Review Division of the Texas Workers' Compensation Commission (MRD).[1] The IRO found that office visits, therapeutic procedures, group therapeutic procedures, manipulation, massage, tests, traction and supplies from August 1, 2003, through September 29, 2003, were not medically necessary. The MRD reviewed fee disputes and recommended reimbursement in the total amount of $2,078.79, primarily due to inadequate Explanations of Benefits (EOBs). This decision finds that the decision of the IRO should be upheld. The services provided were not medically necessary. This decision further finds that portions of the MRD decision should be upheld. Thus, the Administrative Law Judge (ALJ) orders Texas Mutual Insurance Company (Carrier or Petitioner) to reimburse Waco Ortho Rehab Assoc. (Provider or Respondent) in the amount of $450.79.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Those issues are set out in the Findings of Fact and Conclusions of Law below.

[1] The Texas Workers' Compensation Commission was transferred to the Workers' Compensation Division of the Texas Department of Insurance effective September 1, 2005.

The hearing in this matter convened July 26, 2005, before State Office of Administrative Hearings (SOAH) ALJ Wendy K. L. Harvel. Petitioner was represented by attorney Scott Placek. Respondent was represented by attorney William Maxwell. The hearing concluded and the record closed the same day.

II. DISCUSSION

A. Factual Background

Claimant sustained compensable soft tissue injuries on ___, while working as a teacher's aide. At the time of the injury, Carrier was Claimant's employer's workers' compensation insurance carrier.

Beginning on the date of injury, Claimant underwent physical therapy, chiropractic treatments, and physical medicine modalities at Respondent's clinic. Carrier denied reimbursement for certain services provided between August 1 and September 29, 2003. Provider appealed the denial to the Commission.

The IRO, reviewing medical necessity, upheld Carrier's denial of reimbursement for CPT codes 99215-25 (office visits); 97110 (therapeutic procedures); 98943 (manipulation); 97139-EU (unlisted therapeutic procedures); 97124 (massage); 97750 (physical performance test); 97012 (mechanical traction), and 99070 (supplies and materials) for services provided from August 1, 2003, through September 29, 2003.

The MRD determined that medical necessity was not the only issue to be resolved in the medical dispute. The medical dispute contained services that were not addressed by the IRO.[2] The MRD denied additional reimbursement for CPT code 97110. The MRD also denied reimbursement for CPT code 97750-MT for August 19 and September 30, 2003. The MRD recommended additional reimbursement for the following codes and dates:

[2] Although some of the CPT codes overlap between the IRO and MRD decisions, the dates of service do not overlap. Thus, there are no services that were evaluated both by the IRO and the MRD.

Code	Dates of service	Total amount
97024	June 17, 2003	$21.00
97014	June 18, 2003	$15.00
97265 and 97250	June 19, 2003	$86.00
97150	June 24, 2003; July 2, 9, 11,16, 21, 23, and 28, 2003	$216.00
99080-73	June 25, 2003; October 23, 2003	$30.00
97750-MT	June 27, 30, 2003; July 15, 29, 2003	$1,376.00
99213 and 99212	July 7, 2003 and October 14, 2003	$89.91
95851	August 19, 2003 (5 units) and September 30, 2003 (3 units)	$244.88

B. Legal Standards

The burden of proof is split in this case. Petitioner has the burden of proof with respect to the MRD decision. Respondent has the burden of proof with respect to the IRO decision. 28 TEX. ADMIN. CODE §§ 148.21(h) and (i); 1 TEX. ADMIN. CODE § 155.41. Pursuant to the Texas Workers' Compensation Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a). Health care includes all reasonable and necessary medical

services. TEX. LAB. CODE ANN. § 401.011(19)(A). The IRO was authorized to decide the medical necessity dispute by the Commission's rule at 28 TEX. ADMIN. CODE § 133.308. The Commission's rules contemplate that there may be medical necessity disputes for which there are medical fee components and states the medical fee component will be decided by the MRD. 28 TEX. ADMIN. CODE § 133.305(b). The MRD had authority to decide the fee dispute component of Petitioner's appeal.

C. MRD Decision

1. CPT Code 97110

To bill under CPT Code 97110, the health care provider must provide one-on-one treatment. The MRD denied reimbursement for this code due to inadequate documentation because the SOAP notes do not clearly indicate that one-on-one treatment was performed nor did the Respondent identify the severity of the injury to warrant one-on-one treatment.

As Respondent conceded, billing for one-on-one therapy under CPT 97110 must be justified, the usual reasons being either safety concerns or cognitive impairment (as with a stroke patient), but that neither justification applied to Claimant. But Respondent asserted that the enhanced performance of one-on-one therapy by itself can justify billing under 97110, arguing that billing under CPT 97110 services was justified because Claimant needed individual and constant attention from the therapist to obtain a greater level of performance enhancement.

Respondent's designated representative, David Bailey, D. C., wrote that one-on-one therapy produces "rapid levels of increases in physical performance, as compared to lesser levels of supervision."[3] He testified that the one-to-one supervision provides better outcomes not reached using lower levels of supervision and opined that Claimant needed this level of therapy to progress.

[3] Pet. Ex. 1, at 15.

Carrier's expert, David Alvarado, D.C., testified that most patients need one-on-one therapy initially to learn how to perform exercises. However, after the patient learns how to perform the exercises safely, they can be performed in a group or at home.

The ALJ finds that the MRD's decision with respect to CPT code 97110 should be upheld. Respondent did not document that the Claimant had any need for intensive one-on-one therapy. Therefore, the ALJ finds that no additional reimbursement should be paid.

2. CPT Codes 97024, 97014, 97150, 97750-MT

The MRD found that CPT codes 97024, 97014, 97150, 97750-MT[4] should be reimbursed because the EOB did not provide a sufficient explanation to allow the sender to understand the reasons for the insurance carrier's actions. Carrier denied payment for these services with an F and also indicated, "The procedure exceeds the maximum fee schedule payment for value and or time on a single date of service."[5] The ALJ finds that this explanation provides a sufficient basis for denial. It informs the provider that the provider has exceeded the maximum fee schedule payment. Thus, the ALJ finds that reimbursement for these CPT codes should be denied.

3. CPT Codes 97265 and 97250

The MRD found that neither party submitted EOBs for the services billed under these codes and did not timely respond to request for additional information. Since the Carrier did not provide a valid basis for the denial of this service, MRD recommended reimbursement. In the EOB provided at the SOAH hearing, the EOB indicates denial with a D code, and the additional explanation that the Provider billed for duplicate services on the same date. From reading the EOB, the ALJ cannot determine what duplicate services were billed. Therefore, the ALJ finds that the EOB does not sufficiently state the reason for denial as required by 28 TEX. ADMIN. CODE § 133.304(c). Thus, the ALJ orders reimbursement in the amount of $86.00.

[4] For dates of service June 27, 30, July 15, and 29, 2003.

[5] Pet. Ex. 3.

4. CPT Code 99080-73

The MRD found that the TWCC-73 is a required report and recommended reimbursement in the total amount of $30.00. The ALJ finds that because the TWCC-73 is a required report, the Carrier should reimburse the Provider in the amount of $30.00.

5. CPT Codes 99213 and 99212

The MRD found that these CPT codes should be reimbursed in the amount of $89.91. These items were billed and not paid. Also, the Carrier did not send an EOB to the Provider indicating the reason for denial. The ALJ finds that the Carrier did not provide a valid basis for denial. Therefore, the ALJ agrees with the MRD that the Carrier should reimburse Provider in the amount of $89.91.

6. CPT Code 97750-MT[6]

Carrier denied payment of this code because "Physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." MRD upheld the denial, indicating that an invalid CPT code was used. Provider offered no argument on this issue. The ALJ finds that the Provider failed to bill with the appropriate CPT code since the Provider billed for both medicine and rehabilitation services in the same day. The ALJ agrees with MRD that no reimbursement should be paid for this code.

7. CPT Code 95851

Carrier denied reimbursement for this item, indicating that the wrong health care provider provided the care for Claimant. The MRD decision states that Provider furnished information stating the work was not performed by a physical or occupational therapist. Thus, the MRD recommended reimbursement. The ALJ has not found in the record any indication that these tasks were performed by anyone other than Dr. Bailey. Dr. Bailey wrote the SOAP notes for that day of treatment, and his name appears on the supplementary report included with the SOAP notes.[7] No other health care provider's name appears. Dr. Bailey is a chiropractor and not a physical or occupational therapist. Therefore, based on the evidence in the record, the ALJ finds that Provider is entitled to reimbursement under this CPT code in the amount of $244.88.

[6] For dates of service August 19, 2003 and September 30, 2003.

[7] Pet. Ex. 3.

D. IRO Decision

Claimant began therapy with Provider on June 5, 2003. By August 1, 2003, she was able to perform all duties required in her job. Additionally, there was minimal change in her abilities or pain level after August 1, 2003. Yet, Dr. Bailey continued care through September 29, 2003. Weeks of the same therapy without documented improvement is not justifiable.

The record contained Dr. Bailey's SOAP notes for most dates of service. The SOAP notes indicate that there was no change in pain ratings. The Claimant consistently complained of a pain rating of either a 6/10 or a 7/10 during the entire treatment time frame.[8]

The SOAP notes failed to establish that Claimant made any progress in pain relief from June to September 2003, and as she was already working in August 2003, it cannot be said the treatment was needed to help her return to work.

Documentation establishing a link between the patient's improvement and the treatment is required.[9] Because no improvement was documented after August 1, 2003, Provider's services were not medically necessary beginning on that date.

III. FINDINGS OF FACT

1. Claimant sustained a compensable soft tissue injury on ___, while working as a teacher's aide.

2. At the time of the injury, Texas Mutual Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

3. Between August 1 and September 29, 2003, Waco Ortho Rehab (Provider or Respondent) provided Claimant physical therapy services under CPT code numbers 99215-25, 97110, 97150, 98943, 99211-25, 97139-EU, 97124 97750, 97012, and 99070.

4. Carrier denied payment for services from August 1 through September 29, 2003, based on lack of medical necessity.

[8] Pet. Ex. 1.

[9] *See* 28 TEX. ADMIN. CODE §§ 133.1(a)(3)(E)(i) and 133.105(b)(6).

5. Between June 17 and October 23, 2003, Respondent provided Claimant with services billed under the following CPT codes: 97110 (excluding the dates of service listed in Finding of Fact No. 3), 97750-MT, 97024, 97014, 97265, 97250, 97150, 99080-73, 97750-MT, 99213, 99212, and 95851.

6. Carrier denied payment for the services in Finding of Fact No. 5 for various reasons, including inadequate documentation, improper CPT code, and other reasons for denial.

7. Respondent's appeal of the denial of payment based on lack of medical necessity was decided by the Texas Workers' Compensation Commission's (Commission) designee, an Independent Review Organization (IRO).

8. For those services listed in Finding of Fact No. 3, the IRO upheld Carrier's denial of reimbursement on the basis that the services were not medically necessary. Respondent timely appealed the IRO's decision.

9. For the services mentioned in Finding of Fact No. 5, the MRD issued an order denying payment in part. Petitioner timely appealed the MRD order.

10. The Commission Staff's notice of hearing stated the date, time, and location of the hearing and cited to the legal statutes and rules involved along with a short, plain statement of the factual matters involved.

11. Petitioner and Respondent were represented at the hearing.

12. With regard to performing physical therapy exercises, Claimant did not have any safety or cognitive issues that required one-to-one physical therapy billed under CPT 97110.

13. Physical therapy billed under CPT 97110 was not medically necessary healthcare for Claimant.

14. From June through October, 2003, Claimant reported her pain level as being either a 6 or 7 out of 10.

15. Claimant was already working on August 1, 2003.

16. Between August 1 and September 29, 2003, Claimant's pain levels remained stable.

17. By August 1, 2003, it should have been apparent that the therapies listed in Finding of Fact No. 3 were not reducing Claimant's pain or helping her return to work and thus were not medically necessary.

18. The documentation for CPT code 97110 was inadequate for dates of service June 17, 18, 23, and 24, 2003, and for July 2, 3, 7, 9, 11, 16, 21, 23, 25, and 28, 2003.

19. The Explanation of Benefits (EOB) for CPT codes 97024, 97104, 97150, and 97750-MT

(June 27, 30, July 15, 29, 2003 dates of service) provided a sufficient explanation for the Provider to understand the reasons for denial.

20. Carrier did not provide a valid basis for denial of CPT codes 97265, 97250, 99213, and 99212.

21. The TWCC-73 is a required form and CPT code 99080-73 should be reimbursed.

22. Provider billed an inappropriate CPT code for services billed under 97750-MT on August 19, and September 30, 2003.

23. Provider did not bill for a physical or occupational therapist for CPT code 95851.

IV. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(d) and TEX. GOV'T CODE ANN. . ch. 2003.

3. The IRO was authorized to hear the medical dispute pursuant to 28 TEX. ADMIN. CODE §133.308.

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 § 133.308.

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

6. Petitioner has the burden of proof in this proceeding with respect to the MRD decision. Respondent has the burden of proof in this proceeding with respect to the IRO decision. 28 TEX. ADMIN. CODE §§ 148.21(h) and (i); 1 TEX. ADMIN. CODE § 155.41.

7. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

8. Health care includes all reasonable and necessary medical services. TEX. LAB. CODE ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

9. Under TEX. LAB. CODE ANN. §§ 413.013 and 413.018, the Commission is charged with reviewing medical care and ensuring treatments and services are both appropriate and appropriately billed.

10. The Commission's rules recognize that there may be medical necessity disputes for which there are medical fee components and states the medical fee component will be decided by the MRD. 28 TEX. ADMIN. CODE § 133.305(b).

11. To establish medical necessity, treatment must be shown to be effective through documentation establishing a link between the patient's improvement and the treatment. *See* 28 TEX. ADMIN. CODE §§ 133.1(a)(E)(i) and 133.105(b)(6).

12. CPT Code 97110 is properly billed only when a one-to-one patient to therapist ratio must be maintained due to safety or cognitive issues or because the patient is entitled to that level of care under § 413.011(b) of the Texas Labor Code.

13. Claimant did not qualify for one-to-one physical therapy under CPT 97110.

14. For the services billed between October 2 and December 24, 2003, under CPT 97110 for which no EOBs were sent, Petitioner provided inadequate documentation to support the CPT code and is not entitled to reimbursement.

15. The EOBs for CPT codes 97024, 97104, 97150, and 97750-MT (for dates of service June 27, 30, July 15, 29, 2003) provided a sufficient explanation for the Provider to understand the reasons for denial, pursuant to 28 TEX. ADMIN. CODE § 133.304(c).

16. The Explanation of Benefits (EOB) for CPT codes 97265 and 97250 did not provide a sufficient explanation for the Provider to understand the reasons for denial, pursuant to 28 TEX. ADMIN. CODE § 133.304(c).

17. Carrier did not provide a valid basis for denial of payment of CPT codes 99080-73, 99213, and 99212.

18. Provider billed for an invalid CPT code 97750-MT on dates of service August 19, 2003, and September 30, 2003, pursuant to 28 TEX. ADMIN. CODE § 134.202(b).

ORDER

It is ORDERED that Waco Ortho Rehab (Respondent) is not entitled to reimbursement by

Texas Mutual Insurance Company (Carrier) for services billed for physical therapy between August 1 and September 29, 2003, because those services were not medically necessary. It is further ORDERED that Carrier shall reimburse Respondent in the amount of $450.79.

SIGNED September 23, 2005.

WENDY K. L. HARVEL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS