SOAH DOCKET NO. 453-05-3064.M5
TWCC MR NO. M5-04-4239-01

SCD BACK & JOINT CLINIC, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
BRYAN ISD, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

SCD Back & Joint Clinic (Petitioner) appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD) based on the findings of its designee, an independent review organization (IRO). The IRO found that certain physical therapy passive modalities and supplies provided a workers' compensation claimant (Claimant) were not medically necessary healthcare, upholding a denial of reimbursement by the Bryan Independent School District (BISD). The MRD's decision, interpreting the IRO's findings, denied payment for certain physical therapy exercises billed under CPT 97110, for which the Carrier never issued explanations of benefits (EOB), as being improperly billed. This decision and order finds the passive modalities were not shown to be medically necessary for Claimant and the services billed under CPT 97110 should not be reimbursed because they were improperly billed.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

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

The hearing in this matter convened April 19, 2005, before State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ) Ann Landeros. Petitioner was represented by attorney William Maxwell. Attorney Nick Bray represented Respondent. The Commission Staff did not participate in the hearing. After receipt of written closing arguments, the record closed June 6, 2005.

II. DISCUSSION

A. Factual Background

Claimant sustained a compensable injury to his back on__while working for BISD. At the time of the injury, BISD was self-insured for workers' compensation insurance. In August 2003, Claimant's treating physician, John Wyatt, D.C., who works in Petitioner's clinic, diagnosed Claimant's compensable injuries as lumbar and thoracic strain and sprain and myofascial pain syndrome.

Beginning in August 2003, Claimant underwent physical therapy, chiropractic treatments, and physical medicine modalities at Petitioner's clinic. BISD denied reimbursement for certain services provided between October 2 and December 17, 2003. Petitioner appealed the denial to the Commission. The IRO reviewer wrote:

> There appears to be some documentation supporting the use of active exercise and functional testing services (97110, 97150, and 97750) during the period in dispute. Office visit re-assessments including manipulation (99211, 99212 and 98940) also appear to be at reasonable levels for evaluation and management with appropriate clinical follow-up decision making. However, medical necessity for these ongoing passive modalities (97012, 97139, 97024, A4595 and 97124) are not supported by available documentation and generally accepted standards of care.

Thus, the IRO upheld BISD's denial of reimbursement for CPT codes 97012 (mechanical traction); 97139 (electric stimulation billed as an unlisted service); 97024 (diathermy); A4595 (electrical stimulation supplies); and 97123 (massage therapy) provided between October 2 and December 17, 2003.

The parties disputed how many of the services rendered under CPT 97110 were covered by the IRO's findings. Petitioner claims the IRO found all CPT 97110 services medically necessary while BISD asserts that only those services denied under the "U" code were included in the IRO's findings.

For many of the dates of service, the record lacked an explanation of benefits (EOB).[1] The MRD interpreted the IRO's decision as approving reimbursement for CPT 97110 only for those dates of service where an EOB was provided (and the denial code "U" was used). For dates of service billed under that code without an EOB (from September 8 through December 24, 2003), the MRD declined to order reimbursement, stating:

> The IRO reviewed . . . exercise therapy [97110] . . . rendered from 10-02-03 through 12-17-03 that were denied based upon "U."
>
> The IRO determined codes 97110 (therapeutic exercises) . . . were medically necessary.
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> Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity was not the only issue to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.
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> Review of CPT code 97110 dates of service 09-08-03 through 12-24-03 (14 DOS) revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor submitted proof of resubmission or convincing evidence of carrier receipt of reconsideration resubmission via USPS. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of documentation of this code both with respect to medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission
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> requirements for proper documentation. The MRD declines to order payment for

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[1] The following definitions are found in 28 TAC § 133.1(a):

(6) Explanation of benefits--The information an insurance carrier sends to the required parties when it makes payment or denies payment on a medical bill, and that includes, when it has reduced or denied payment on the bill, an explanation of all the reason(s) for the reduction and/or denial.

(12) Payment exception codes--The Commission-mandated codes insurance carriers use to identify the general rationale for reducing or denying payment for a properly completed medical bill.

(13) Reconsideration--The second review an insurance carrier shall perform of a health care provider's medical bill or preauthorization request, in response to the health care provider's request for the second review.

(17) Upcoding--Using a diagnosis or billing code that does not best represent the injured employee's actual condition or the treatment or service actually performed.

code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

B. Legal Standards

Petitioner has the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) §§ 148.21(h) and (i); 1 TAC § 155.41. Pursuant to the Texas Worker's Compensation Act (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 TAC § 133.308.

C. CPT 97110

Petitioner claimed the MRD lacked authority to change or interpret the IRO decision, which it asserted clearly found medical necessity for all dates of service billed under CPT 97110. Carrier asks that the MRD's denial of reimbursement for CPT 97110 services lacking an EOB be upheld. The only dates of service at issue in this case are those for which no EOB was filed. CPT 97110 was not the appropriate billing code for those services, which should not be reimbursed.

1. Scope of this Appeal

Carrier did not cross appeal the IRO's findings or the MRD decision regarding CPT 97110 services for which it issued an EOB (with "U" denial code), so those dates of service are definitely not part of this appeal. With regard to the CPT 97110 services for which there were no EOBs, Petitioner had a right to seek medical dispute resolution once BISD failed to take final action on the bill by timely paying it or sending an EOB.[2]

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[2] The Commission's rule at 28 TAC § 133.304 states that a carrier shall take final action on a medical bill not later than the 45th day after the date the carrier received the complete bill. Final action consists of: (1) payment in full; (2) denial of the charge; or (3) requesting reimbursement for overpayment. The rule also requires the carrier to send to the provider, along with the payment or denial, an EOB using the Commission's codes and providing sufficient information for the provider to understand the reasons for the carrier's actions. If the carrier has not taken final action by the

Petitioner claims there is an issue as to whether the IRO's decision included billings for CPT 97110 services that lacked an EOB and whether the MRD had authority to change the scope of the IRO's findings. In fact, the IRO merely decided medical necessity, a condition precedent for ordering reimbursement. The MRD declined to order reimbursement because it found Petitioner had failed to meet another condition precedent for reimbursement documentation that the appropriate CPT code was billed.

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. In essence, the MRD reviewed the IRO decision in terms of a fee dispute. 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 TAC § 133.305(b). The MRD had authority to decide the fee dispute component of Petitioner's appeal. The fee dispute issue was tried by agreement when the parties presented evidence and argument on that issue at the contested case hearing.

Petitioner's stated rationale for billing CPT 97110 on the 14 dates of service for which there was no EOB was without basis in the Act or the Commission's rules. Those services were not appropriately billed because, at the very least, they were not shown to have provided the effective medical cost control required by TEX. LAB. CODE ANN. § 413.011(d).

2. No "Performance Enhancement" Justification

For the dates of service at issue in this case, Petitioner was not entitled to bill under CPT 97110.

As Petitioner 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 justifications applied to Claimant. But Petitioner asserted that the enhanced performance

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28th day after a provider sent a request for reconsideration, the provider may seek medical dispute resolution on the medical necessity.

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."

Petitioner's designated representative, David Bailey, D. C., wrote that one-on-one therapy produces "a rapid increase in physical capacity (strength, flexibility, and other measure of human performance) that is intended to allow a safe return to work at the required performance level." 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. (Pet. Exh. 3, p. 380.)

Regarding BISD's failure to supply an EOB, the rule at 38 TAC § 133.307(j)(2) precludes consideration of a rationale for a denial of benefits unless that rationale is communicated to the provider prior to the request for dispute resolution. However, workers' compensation insurance is not intended to provide exceptional or the highest level of care possible. A workers' compensation patient is entitled to that treatment equal in cost to similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. See TEX. LAB. CODE ANN. § 413.011(b). The goal of the Act and the Commission's rules is to ensure both the quality of medical care and to achieve effective cost control. In short, medically necessary care must be both effective and economical.

Petitioner failed to show that Claimant, if paying out of pocket for physical therapy exercises, could or would have paid for care at the 97110 level. Absent some showing that the highest level of care is both the most economical and the level a private pay or patient would have received, use of CPT 97110 under a "performance enhancement" standard was not warranted, especially when effective but less costly treatment options were available.

The MRD correctly denied payment for the services billed under CPT 97110 because those services were billed under an inappropriate CPT code. A carrier does not have to pay an incomplete medical bill and a bill that uses an inappropriate CPT code is considered an incomplete medical bill. 28 TAC §§ 133.1(a)(3)(C) and 133.304.

D. Remaining CPT Codes

Claimant began therapy with Petitioner in late August 2003. As of early September 2003, his pain level stabilized at a 4 or 5 out of 10 and no further progress in pain reduction was documented for the disputed dates of service.[3] Weeks of the same therapy without documented improvement is not justifiable.

The record contained Dr. Wyatt's SOAP notes for most dates of service. With regard to the services listed above, a typical SOAP note stated:

> [Claimant] reports pain was an 8 on a scale of 1 to 10. . . . [He] notes the pain is always present. He is using ice 1 to 3 times per day with significant pain relief . . . The patient reports his current work status is full time work. Today, the patient is experiencing more severe pain episodes. He notes he is not having much improvement. The patient is using heat 1 to 3 times per day with good relief. . . . Chiropractic manipulation treatment, using various indicated techniques to the following spinal regions: thoracic and lumbar. Intersegmental traction to the back of the neck, mid back, and low back to increase mobility and circulation, and to reduce pain. Deep tissue therapy as vibratory massage and percussion (minimum 8 minutes) to the back of the neck, mid back, and low back and related soft tissues for reduction of pain, swelling, muscle spasms, and tenderness. Sensory level electrical stimulation therapy to the back of the neck, mid back, and low back pain for pain modulation or control. Diathermy (deep heat therapy) to the back of the neck, mid back, and low back to increase circulation and decrease irritability of soft tissue. . . E1399: Consumable TENS Supplies: A supply of TENS patches were provided. Re-usable, self-adhesive electrodes were supplied to the patient to carry out the application of Interferential/Electrical Stimulation therapy. These electrodes will require replacement when they fail to regain their adhesive quality or the stimulation intensity changes. . . .Claimant responded with an immediate post-treatment decrease in symptoms. . . . [SOAP note for 9-4-03] (Pet. Ex. 1, p. 44).

With regard to these services, these comments are repeated essentially verbatim in the SOAP notes for all dates of service except that on September 9, 2003, Claimant reported his pain level was at a 5 out of 10 and it varied from 4 to 5 out of 10 from that point forward. Claimant received almost daily therapy during the workweek so his progress or lack thereof quickly should have been apparent.

Without documented improvement, by October 2, 2003, Claimant's therapy could no longer

[3] Claimant reported his pain at 2 on December 19 and 0 on December 22, 2003. (Pet. Ex. 2, p. 85). The sudden drop in pain scale occurred after Claimant missed several sessions of therapy due to an allergic reaction, raising a doubt about the connection between the pain reduction and the therapy.

be considered medically necessary.

The SOAP notes failed to establish that Claimant made any progress in pain relief from September 9 to December 17, 2003, and as he was already working full time in October 2003, it cannot be said the treatment was needed to help him return to work. The notes do establish that Claimant was getting significant pain relief from the cold and heat packs he used at home and that any relief afforded by the clinical therapies was extremely short-lived as on the following treatment day, Claimant had the same complaints and pain levels.

Documentation establishing a link between the patient's improvement and the treatment is required. See 28 TAC §§ 133.1(a)(3)(E)(i) and 133.105(b)(6). Because no improvement was documented after September 9, 2003, Petitioner's services were not medically necessary on October 2, 2003. As Claimant had been receiving almost daily treatments, on October 2, 2003, his failure to improve should have been obvious. The services billed under 97012 (mechanical traction); 97139 (electric stimulation billed as an unlisted service); 97024 (diathermy); A4595 (electrical stimulation supplies); or 97123 (massage therapy) were not medically necessary on October 2, 2003.

III. FINDINGS OF FACT

1. Claimant sustained a compensable injury to his back on___, while working for Bryan Independent School District (BISD).

2. At the time of the injury, BISD was self-insured for workers' compensation insurance.

3. In August 2003, Claimant's treating physician, John Wyatt, D.C., who works at SCD Back & Joint Clinic (Petitioner), diagnosed Claimant's compensable injuries as lumbar and thoracic strain and sprain and myofascial pain syndrome.

4. In August 2003, Claimant started therapy with Petitioner that included mechanical traction, electric stimulation, diathermy, and massage therapy.

5. Between September 8 and December 24, 2003, Petitioner provided Claimant physical therapy services that were billed under CPT 97110.

6. For fourteen of the dates of services mentioned in Finding of Fact No. 5, BISD denied payment but never sent explanation of benefits (EOBs) to Petitioner.

7. Between October 2 and December 17, 2003, Petitioner provided Claimant with services billed under the following CPT codes: 97012 (mechanical traction); 97139 (electric

stimulation billed as an unlisted service); 97024 (diathermy); A4595 (electrical stimulation supplies); and 97123 (massage therapy).

8. BISD denied payment for the services listed in Finding of Fact No. 7 based on lack of medical necessity.

9. Petitioner'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).

10. For those services listed in Finding of Fact No. 7, the IRO upheld BISD's denial of reimbursement on the basis that the services were not medically necessary. Petitioner timely appealed the IRO decision.

11. For the services mentioned in Finding of Fact No. 5, the MRD issued an order denying payment based on failure to show the proper code was billed. Petitioner timely appealed the MRD order.

12. 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.

13. Petitioner and BISD were represented at the hearing but the Commission Staff chose not to participate.

14. 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.

15. Petitioner failed to show that, if paying for therapy himself, Claimant would have paid for the equivalent of therapy billed under CPT 97110.

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

17. From September 9 through December 17, 2003, Claimant reported his pain level as being either a 4 or 5 out of 10.

18. Claimant reported no or only very transient pain relief from the passive modalities listed in Finding of Fact No. 7.

19. Any pain relief Claimant obtained from the passive modalities listed in Finding of Fact No. 7 was too transient to constitute a meaningful improvement in the naturally occurring symptoms of his compensable injury.

20. Claimant was already working on October 2, 2003.

21. Between September 9 and December 17, 2003, Claimant's pain levels remained stable.

22. By October 2, 2003, it should have been apparent that the therapies listed in Finding of Fact No. 7 were not reducing Claimant's pain or helping him return to work and thus were not medically necessary.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction over this matter pursuant to the Texas Workers' Compensation Act (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 § 413.031(d) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The IRO was authorized to hear the medical dispute pursuant to 28 TEX. ADMIN. CODE (TAC) § 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 TAC § 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 had the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i); 1 TAC § 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. A workers' compensation patient is entitled to that treatment equal in cost to similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. See TEX. LAB. CODE ANN. § 413.011(b).

10. 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.

11. The Commission's rules recognizes 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 TAC § 133.305(b).

12. By presenting evidence on the services listed in Finding of Fact No. 5, the parties tried the MRD decision by agreement.

13. 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 TAC §§ 133.1(a)(E)(i) and 133.105(b)(6).

14. 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.

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

16. Petitioner is not entitled to reimbursement for the services provided to Claimant between October 2 and December 24, 2003, (97012-mechanical traction; 97139-electric stimulation billed as an unlisted service; 97024-diathermy; A4595-electrical stimulation supplies; and 97123-massage therapy), because those services were not shown to be medically necessary healthcare.

17. A carrier does not have to pay an incomplete medical bill and a bill that uses the wrong CPT code is considered an incomplete medical bill. 28 TAC § 133.1(a)(3)(C) and 133.304.

18. Petitioner failed to show that Claimant, if paying out of pocket for physical therapy exercises, could or would have paid for care at the 97110 level.

19. For the services billed between October 2 and December 24, 2003, under CPT 97110 for which no EOBs were sent, Petitioner billed under an inappropriate CPT code and is not entitled to reimbursement.

ORDER

It is ORDERED that SCD Back & Joint Clinic (Petitioner) is not entitled to reimbursement by Bryan Independent School District for fourteen dates of service billed under CPT 97110 between September 8 and December 24, 2004, because those services were not billed under the proper CPT code. It is further ORDERED that Petitioner is not entitled to reimbursement for the services provided to Claimant between October 2 and December 17, 2003, under the CPT codes 97012, 97139, 97024, A4595, and 97123 because those services were not medically necessary.

SIGNED June 17, 2005.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS