DOCKET NO. 453-05-3206.M5
MR NO. M5-04-1454-01

TEXAS MUTUAL INSURANCE COMPANY	**§**	**BEFORE THE STATE OFFICE**
V.	**§**	**OF**
NETWORK OF PHYSICIANS MANAGEMENT, INC.	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) challenges the decision of the Independent Review Organization (IRO) granting reimbursement for physical therapy and office visits provided to injured worker__. (Claimant). After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that Carrier has shown that the majority of services billed were not medically necessary. However, certain services were medically necessary and, thus, reimbursable. As set forth below, Network of Physicians Management, Inc. (Provider) is entitled to reimbursement in the sum of $986.

I. BACKGROUND

Claimant suffered a compensable, work-related injury to his knee on ___, while moving furniture on his job. Claimant was diagnosed with an internal derangement to his left knee. Claimant initially received conservative care involving passive and active physical therapies from Provider. When Claimant failed to show adequate improvement, he underwent arthroscopic knee surgery on February 13, 2003. After his surgery, Claimant received additional physical therapy from Provider during the period from March 3, 2003, through July 24, 2003. In this case, the dates of service in dispute are December 17 and 18, 2002, and April 7 through July 24, 2003. Carrier declined to reimburse the treatments, contending they were not medically necessary.

Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission). The matter was referred to an IRO designated by the Commission for the review process. The IRO determined that some of the services were medically necessary treatment for Claimant's compensable injury. Carrier then requested a hearing before the State

Office of Administrative Hearings. The hearing convened on June 27, 2005, with ALJ Craig R. Bennett presiding. Provider appeared through its attorney, Jaime Alvarado. Carrier appeared through its attorney, Patricia Eads. The hearing concluded and the record closed that same day. No parties objected to notice or jurisdiction.

II. DISCUSSION AND ANALYSIS

This case involves a dispute over the necessity of one-on-one therapy billed under CPT Code 97110 and office visits billed under CPT Code 99213. Carrier argues that the pre-surgery services provided on December 17 and 18, 2002, were not necessary because one-on-one therapy was not appropriate two months post-injury; rather, Carrier argues that active therapy should have begun sooner and Claimant should have been doing only home-based exercises by two months post-injury.

Carrier also contends that one-on-one physical therapy provided after April 2, 2003 (*i.e.*, more than six weeks after Claimant's surgery) was not necessary. Carrier asserts that any additional benefits from therapeutic exercises could have been obtained through a home exercise program and should not have required extensive supervision or in-office individual treatment. Further, Carrier alleges that Provider did not adequately document the necessary elements for office visits billed under 99213 and such visits were not necessary at the frequency billed by Provider. In support of its arguments, Carrier presented the testimony of William Defoyd, D.C. and the deposition testimony of Scott Herbowy, a physical therapist.

In response, Provider points out that it provided conservative treatment that allowed Claimant to return to work without the need for work conditioning that had been preauthorized by Carrier. Provider asserts that the medical documentation shows that, prior to his surgery, Claimant had been placed on a home exercise program but still needed one-on-one therapy to improve his gait and ensure proper performance of strengthening tasks. Provider further alleges that, after Claimant's surgery, he needed additional physical therapy to help restore his functioning level and to allow him to return to work. Provider offered the testimony of its principal, Mark Crawford, D.C., to support its contentions.

Ultimately, the ALJ agrees that Carrier has shown that the services billed under CPT Code 97110 were not medically necessary for Claimant after April 2, 2003. The medical and legal authority is clear that CPT Code 97110 is to be used only when the health care provider has worked directly one-on-one with the patient in regard to that patient's therapy alone.[1] In this case, the ALJ finds persuasive the testimony from Dr. Defoyd and Mr. Herbowy that one-on-one therapy should not have been needed more than six weeks after Claimant's surgery. By April 2, 2003, Provider had treated Claimant with one month of one-on-one sessions, three times per week. Claimant's injury was relatively minor and the treatment records show that Claimant was progressing well. As Carrier's expert testimony shows, Claimant should not have continued to need additional one-on-one therapy for an additional extensive period of time. The exercises and activities that Claimant was performing in Provider's office were relatively uncomplicated, and Claimant could have performed them at home or in a group setting. The ALJ is not persuaded by Provider's evidence that the one-on-one treatments should have continued with little change for an additional 24 sessions (along with the 12 sessions that Carrier reimbursed) post-surgery. Accordingly, the ALJ concludes that Provider is not entitled to reimbursement for services billed under CPT Code 97110 after April 2, 2003.

However, the ALJ agrees with Provider that one-on-one therapy in December 2002 was properly provided and medically necessary. After Claimant's injury, Provider chose to provide passive therapy for a longer period of time than that suggested by Carrier's experts, before beginning active therapy. However, Provider did not provide excessive active therapy once it was begun and, given Claimant's continued problems (as reflected by the needed arthroscopic surgery in February 2003), the one-on-one therapy in December appears reasonable. In total, Provider only treated Claimant with six dates of service of active one-on-one therapy before his surgery. Carrier reimbursed four of those, but refused to reimburse the last two.

The ALJ finds that Provider is entitled to reimbursement for those last two dates of service, for a total reimbursement of $280 (eight units at $35 per unit).

Next, the ALJ turns to the disputed office visits. From December 17, 2002, to July 24, 2003, Provider billed Carrier for 26 disputed office visits under CPT Code 99213. Carrier declined to

[1] *See* SOAH Docket No. 453-01-1188.M5 (April 3, 2002)(ALJ Smith); SOAH Docket No. 453-00-2051.M4 (December 1, 2000)(ALJ O'Malley); SOAH Docket No. 453-01-1081.M4 (May 25, 2001)(ALJ Smith); SOAH Docket No. 453-01-1492.M5 (July 23, 2001)(ALJ Cunningham); *see* the American Medical Association's *CPT Assistant*.

reimburse them, contending the office visits were not medically necessary. At the hearing, Carrier argued that office visits were not appropriate at the frequency billed, nor were they adequately supported by documentation. The ALJ considers only whether the office visits were medically necessary, because that is the sole ground on which Carrier initially denied reimbursement. After reviewing the evidence, the ALJ agrees with Carrier that the number of office visits billed were not medically necessary or appropriate. However, the ALJ does find that some of the office visits were appropriate and should be reimbursed.

As noted by Dr. Defoyd, office visits billed under CPT Code 99213 require at least two of the following three components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Carrier notes that Provider billed for an office visit under CPT Code 99213 nearly every time Claimant was given therapy. Carrier argues that there would have been no need for either an expanded problem-focused history or an expanded problem-focused examination every time Claimant received therapy. Therefore, Carrier argues that such billings are excessive and unreasonable. The ALJ generally agrees. However, Dr. Defoyd conceded that, for a patient undergoing ongoing therapy, an expanded office visit may be appropriate every two to three weeks. From reviewing the records, and considering Dr. Defoyd's testimony, the ALJ concludes that office visits on the following dates were medically necessary and appropriate for Claimant's treatment: December 18, 2002; April 16, April 30, May 14, June 2, July 10, and July 24, 2003. The total reimbursement for these dates of service is $336 (seven dates of service at $48 each). Provider is entitled to reimbursement for that amount.

In summary, then, the ALJ finds that Carrier is liable to reimburse Provider $280 for eight units of one-on-one therapy and $336 for seven office visits. Further, at the hearing, Carrier agreed to reimburse Provider for those amounts ordered by MRD that were not addressed by the IRO medical necessity review. In particular, MRD ordered Carrier to reimburse Provider $84 for services billed under CPT Code 99358-52, $160 for services billed under CPT Code 97799-MR, $36 for services billed under CPT Code 95851, and $90 for services billed under CPT Code 99080-73. These amounts are added to the total ordered by the ALJ above, for a total reimbursement of $986. Carrier is ordered to reimburse Provider this amount. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant suffered a compensable, work-related injury to his knee on ___, while moving furniture on his job.

2. Texas Mutual Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for his compensable injury.

3. Claimant was diagnosed with an internal derangement to his left knee.

4. Claimant initially received conservative passive and active physical therapy from Network of Physicians Management, Inc. (Provider).

5. Given Claimant's continued problems, one-on-one therapy in December 2002 was medically reasonable and appropriate for treatment of Claimant's injury.

6. After failing to show adequate improvement, Claimant underwent arthroscopic knee surgery on February 13, 2003.

7. After his surgery, Claimant received additional physical therapy treatments from Provider during the period from March 3, 2003, through July 24, 2003.

8. By April 2, 2003, Provider had treated Claimant with one month of post-surgery one-on-one sessions, three times per week.

9. Claimant's injury was relatively minor and the treatment records show that Claimant was progressing well. The exercises and activities that Claimant was performing in Provider's office were relatively straightforward and uncomplicated, and Claimant could have performed them at home or in a group setting. Accordingly, Claimant did not need additional one-on-one therapy after April 2, 2003.

10. For a patient undergoing ongoing therapy, an expanded office visit may be appropriate every two to three weeks.

11. Office visits on the following dates were medically necessary and appropriate for Claimant's treatment: December 18, 2002; April 16, April 30, May 14, June 2, July 10, and July 24, 2003.

12. In this case, the dates of service disputed by Carrier are December 17 and 18, 2002, and April 7, 2003, through July 24, 2003.

13. Carrier denied reimbursement for the services, contending they were not medically necessary.

14. Provider requested medical dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission), which referred the matter to an Independent Review Organization (IRO).

15. MRD ordered reimbursement on December 1, 2004, based on the IRO physician reviewer's determination that some of the services in issue were medically necessary.

16. On December 22, 2004, Carrier requested a hearing and the case was referred to the State Office of Administrative Hearings (SOAH).

17. Notice of the hearing was sent by the Commission to all parties on March 9, 2005.

18. On June 27, 2005, Administrative Law Judge Craig R. Bennett convened a hearing in this case. Provider appeared through its attorney, Jaime Alvarado. Carrier appeared through its attorney, Patricia Eads. The hearing concluded and the record closed that same day.

19. No parties objected to notice or jurisdiction.

20. At the hearing, Carrier agreed to reimburse Provider for those amounts ordered by MRD that were not addressed by the IRO medical necessity review.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

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

5. Carrier has the burden of proof. 28 TEX. ADMIN. CODE §§ 148.21(h) and 133.308(w).

6. Carrier has shown, by a preponderance of the evidence, that the services billed under CPT Code 97110 after April 2, 2003, were not medically necessary for treatment of Claimant's compensable injury.

7. Carrier has not shown, by a preponderance of the evidence, that the one-on-one therapy provided to Claimant in December 2002 was not medically necessary for treatment of Claimant's compensable injury.

8. Carrier has not shown that the office visits provided to Claimant on December 18, 2002; April 16, April 30, May 14, June 2, July 10, and July 24, 2003, were not medically necessary for treatment of Claimant's compensable injury.

9. Carrier is liable to reimburse Provider the total sum of $986 for: (1) eight units of one-on-one therapy (CPT Code 97110); (2) seven office visits (CPT Code 99213); (3) services billed under CPT Code 99358-52; (4) services billed under CPT Code 97799-MR; (5) services billed under CPT Code 95851; and (6) services billed under CPT Code 99080-73.

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company reimburse Network of Physicians Management, Inc. the sum of $986 plus interest for the specified treatments provided to Claimant.

SIGNED June 29, 2005.

CRAIG R. BENNETT
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS