SOAH DOCKET NO. 453-05-4163.M5
TWCC MR NO. M5-04-4243-01

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
VS.	§	
	§	
NEW HELP CLINICS, P.A.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Petitioner, Texas Mutual Insurance Company (Carrier), requested a hearing following the Findings and Decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC), acting through Texas Medical Foundation, an Independent Review Organization (IRO), ordering reimbursement to New Help Clinics, P.A. (Provider) for medical services provided to ___ (Claimant) from August 26, 2003, through February 13, 2004. The IRO also found the services from February 14, 2004, through May 26, 2004, were not medically necessary. Carrier partially disputes the IRO's conclusion that these services were medically necessary. Provider did not challenge the IRO's decision.

The Administrative Law Judge (ALJ) concludes that Carrier has met its burden of proof that the services were not medically necessary, except for the services that Carrier agreed to pay. The Carrier has agreed to pay for the following disputed services[1] on the dates indicated:

1. August 26, 2003: CPT Code 99211 and one (1) unit of CPT Code 97110.
2. August 28, 2003: One (1) unit of CPT Code 97110, two (2) units of CPT Code 95831, and one (1) unit of CPT Code 95851.
3. September 2, 2003: CPT Code 99213 and one (1) unit of CPT Code 97110.
4. September 4, 2003: CPT Code 99213 and one (1) unit of CPT Code 97110.

1, **The disputed services in this case include CPT Code 97110 (therapeutic exercises, one-to-one), CPT Code 97112 (neuromuscular reeducation), CPT Code 99213 (office visit), CPT Code 99211(office visit), CPT Code 98940 (manipulation), CPT Code 97140 (manual therapy), and CPT Code 97124 (massage therapy).**

5. September 5, 2003: CPT Code 99213 and one (1) unit of CPT Code 97112.
6. September 9, 2003: CPT Code 99213 and one (1) unit of CPT Code 97110.
7. September 12, 2003: CPT Code 99211 and one (1) unit of CPT Code 97110.
8. September 16, 2003: Three (3) units of 95831, one (1) unit of CPT Code 95851 and CPT Code 99071.
9. October 13, 2003: A supplemental payment for one (1) unit of CPT Code 98940 [an additional $0.34].
10. December 3, 2003: One (1) unit of CPT Code 95851, CPT Code 97140, CPT Code 97124 and CPT Code 99080-73.
11. December 4, 2003: CPT Code 97124.
12. December 5, 2003: CPT Code 97124.
13. December 8, 2003: CPT Code 97124.
14. December 9, 2003: CPT Code 97124.
15. February 10, 2004: CPT Code 99080-73.
16. February 23, 2004: CPT Code 99080-73.

In Provider's list of disputed services, it listed the following services that have already been paid by Carrier:

17. August 26, 2003: CPT Code 97112.
18. October 8, 2003: CPT Code 98940.
19. October 22, 2003: CPT Code 98940.
20. December 3, 2003: CPT Code 97112 and 97035.
21. December 4, 2003: CPT Code 97140, 97112 and 97035.
22. December 5, 2003: CPT Code 97140, 97112 and 97035.
23. December 8, 2003: CPT Code 97140, 97112 and 97035.
24. December 9, 2003: CPT Code 97140, 97112 and 97035.
25. December 11, 2003: CPT Code 97110.
26. December 12, 2003: CPT Code 97110.

I. PROCEDURAL HISTORY

ALJ Stephen J. Pacey convened the hearing on March 31, 2005, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared *pro se*. Carrier was represented by Timothy Riley, attorney. At the conclusion of the hearing, the ALJ required written closing statements. On May 2, 2004, the ALJ received the closing statements and closed the record.

The record was reopened June 20, 2005, because Provider's disputed services reflected that the services were denied on the basis of a peer review that indicated the services were not medically

necessary.[2] There was not a peer review in the record, so the ALJ contacted the parties and requested that the Carrier either send the peer review or a representative sample of EOBs indicating that reimbursement was denied for a reason other than V code. The EOBs were sent and revealed denial on the basis of an U code. When asked why the denied services were incorrectly coded, the Provider said that the information is sent to a billing service company , and the company coded the disputed service denials incorrectly. The record was closed June 22, 2005. The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law below.

II. BACKGROUND

Claimant suffered a compensable injury on ___, when he was involved in a traffic accident. Claimant was thrown forward and back on impact, but he did not lose consciousness or suffer immediate pain. Later in the day, Claimant began to experience the gradual onset of headaches, neck pain, and low back pain. Extensive one-to-one therapy was provided in the form of CPT Codes (Code) 97110 and 97112.[3] Before the first date in dispute, Claimant had received 20 units of Code 97110 and 11 units of Code 97112. Provider continued treatments until Claimant underwent rotator cuff surgery on November 25, 2003. Provider resumed treatments on December 3, 2004, and continued treating Claimant until May 26, 2004.

Provider performed the disputed services to Claimant from August 26, 2003, to May 26, 2004. Carrier denied reimbursement for the services, and Provider requested medical dispute resolution on Carrier's denial. The MRD granted Provider's request for reimbursement in part, following its review of the decision issued by the IRO. The IRO concluded that the services rendered from August 26, 2003, to February 13, 2004, were medically necessary, and the services rendered from February 14, 2004, to May 26, 2004, were not medically necessary. Carrier then requested a hearing on the services found to be medically necessary. Provider did not request a hearing on the other disputed

2 Medically unnecessary with peer review is marked with a "V" code, whereas medically unnecessary without peer review is marked with a "U" code.

3 Code 97110 describes therapeutic exercises with one-to-one participation, and Code 97112 describes neuromuscular reeducation.

services, therefore, the range of services in dispute with regard to medical necessity is August 26, 2003, to February 13, 2004. At the hearing, David Alvardo, D.C., testified that some of the disputed services were medically necessary, and Carrier has agreed to reimburse for those previously listed services.

III. ANALYSIS

As noted above, Carrier did not claim that all treatments were medically unnecessary, rather, Carrier argued that the number of the treatments were excessive, and the evidence, such as SOAP notes, did not justify the necessity of many of the medical treatments. In reference to Code sections 97710 and 97112, Carrier asserted that the SOAP notes did not clearly delineate exclusive one-on-one treatment nor did Provider identify the severity of the injury to warrant exclusive one-to-one therapy. The ALJ agrees with Carrier's observations.

Provider admitted that the therapeutic exercises billed by his billing service as Code 97110 could have been conducted one-to-one or in a group of two or three. In addition to uncertainty of whether the exercises were performed one-to-one, Dr. Alvarado testified that the exercises were not of a type that would require continuing one-to-one supervision and that there was nothing about the patient's condition that would require it. He noted CPT Code 97110 should only be reimbursed where the ratio of patient to therapist is one-to-one and one-to-one is necessary.[4] The disputed one-to-one therapeutic exercises were not medically necessary.

It is the ALJ's opinion that the medical necessity for the services coded as CPT Code 97140, CPT Code 97124, and CPT Code 98940 was not established in the record.[5] It was impossible to

4 The arguments regarding Code 97110 also extend to the services billed as Code 97112 (neuromuscular reeducation) which is also a therapeutic procedure which can be performed in a one-to-one setting, in a group, or on one's own once properly instructed.

5 Dr. Alvarado also testified that the procedures being performed were not adequately documented in the medical records.

determine who performed the procedures, what type of procedures were performed, where the procedures were performed, and the results of the procedures performed. In this case, the "who" is especially important because the Provider testified that he employed technicians and the Provider was not present for at least 40 days, raising the question of who performed the services on each day the Provider was not present. For each of the days he was not present, Provider billed for each of the three Codes, as he did for almost every day within the disputed period. These three disputed treatments were not medically necessary.

Medical necessity is not the end of the story. Even if the ALJ found that the procedures were medically necessary, the Provider would not prevail because Provider's billing statements are not credible. Provider attributes the inconsistencies in the treatment charges and treatment codes to his billing service. The errors in billing are so flagrant that it is impossible for the ALJ to determine if a service was rendered and if so, whether it was properly coded. The following are examples:

a. For each service in the list of disputed services, Provider reported the reason for Carrier's denial was a peer review, when the EOBs revealed the services were denied on the basis of unnecessary medical without peer review.

b. Provider testified that therapeutic exercises that were billed one-to-one could have been two-or-three-to-one. Again Provider blamed his billing service.

c. Provider did not see Claimant on forty occasions when the billings reflected an office visit on each occasion.

The ALJ also has problems with the billings that were not therapeutic exercises. Manipulation, manual therapy, and massage therapy are not typically modalities that a technician performs, and yet, these modalities were consistently billed when the SOAP notes indicated that Provider did not see the Claimant. It appears that Provider's billing service fabricated many of the charges making it impossible for the ALJ to make any decision concerning the disputed services.

The ALJ concludes that except for the services Carrier has agreed to pay, the disputed services were not medically necessary. The ALJ further concludes that much of Provider's evidence is not credible. For these reasons, Carrier does not have to reimburse Provider for any of the disputed services, except those noted earlier in this decision

IV. FINDINGS OF FACT

1. Claimant suffered compensable injury to his neck and shoulder on ___, when he was involved in a traffic accident.

2. Texas Mutual Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer when his compensable injury occurred.

3. Extensive one-to-one therapy was provided in the form of CPT Codes (Code) 97110 and 97112.

4. Before the first date in dispute, Claimant had received 20 units of Code 97110 and 11 units of Code 97112.

5. New Help Clinics, P.A. (Provider) commenced the disputed services on August 26, 2003, and continued treatments until Claimant underwent rotator cuff surgery on November 25, 2003.

6. Provider resumed disputed treatments on December 3, 2004, and continued treating Claimant until May 26, 2004.

7. Carrier denied reimbursement for the services, and Provider requested medical dispute resolution on Carrier's denial.

8. The MRD granted Provider's request for reimbursement in part, following its review of the decision issued by the IRO.

9. The IRO concluded that the services rendered from August 26, 2003, to February 13, 2004, were medically necessary, and the services rendered from February 14, 2004, to May 26, 2004, were not medically necessary.

10. Carrier requested a hearing on the services found to be medically necessary.

11. Provider did not request a hearing on the other disputed services, therefore, the range of services in dispute with regard to medical necessity is August 26, 2003, to February 13, 2004.

12. Provider's SOAP notes did not clearly delineate exclusive one-on-one treatment nor did Provider identify the severity of the injury to warrant exclusive one-on-one therapy.

13. Provider admitted that the therapeutic exercises billed by his billing service as Codes 97110 and 97112 could have been conducted one-to-one or in a group of two or three.

14. The exercises were not of a type that would require continuing one-to-one supervision, and there was nothing about the patient's condition that would require it.

15. The medical necessity for the services coded as Codes 97140, 97124, and 98940 were not established because it was impossible to determine who performed the procedures, what type of procedures were performed, where the procedures were performed, and the results of the procedures performed.

16. Provider's billing statements are not credible because of the inconsistencies in the treatment charges and treatment codes.

17. The following are examples of billing errors contained in Provider's list of disputed services:

a. For each service in the list of disputed services, Provider reported the reason for Carrier's denial was a peer review, but the EOBs revealed the services were denied on the basis of unnecessary medical without peer review.

b. Provider testified that therapeutic exercises that were billed one-to-one could have been two-or-three-to-one.

c. Provider did not see Claimant on forty occasions when the billings reflected that he had an office visit with Claimant on each occasion.

18. On February 16, 2005, notices of the hearing in this case were mailed to Provider and Carrier.

19. The notices 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.

20. ALJ Stephen J. Pacey convened the hearing on March 31, 2005, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Provider appeared *pro se.* Carrier was represented by Timothy Riley, attorney. At the conclusion of the hearing, the ALJ required written closing statements. On May 2, 2004, the ALJ received the closing statements and closed the record. On June 20, 2005, the record was reopened to receive additional evidence, and the record was closed June 22, 2005.

V. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this case, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Carrier timely requested a hearing contesting the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (the Commission), as specified in 28 TEX. ADMIN. CODE (TAC) § 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TAC § 148.4(b).

4. Carrier has the burden of proving the case by a preponderance of the evidence, pursuant to 28 TAC § 148.21(h) and (i).

5. Based on the above Findings of Fact and Conclusions of Law, and pursuant to TEX. LABOR CODE § 408.021(a), Carrier proved that except for those services Carrier agreed to pay, the services rendered from August 26, 2003, to February 13, 2004, were not medically necessary to treat Claimant's compensable injury.

6. Based on the above Findings of Fact, Carrier proved that Provider's treatment charges and treatment coding were not credible.

7. Based on the above Findings of Fact, Provider should not be reimbursed for the disputed services, except those services that the Carrier agreed to pay.

ORDER

IT IS ORDERED THAT except for services that Carrier agreed to pay, New Help Clinics, P.A., is not entitled to receive reimbursement from Texas Mutual Insurance Company for the disputed treatment provided to Claimant from August 26, 2003, through February 13, 2004.

SIGNED August 3, 2005

STEPHEN J. PACEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS