SOAH DOCKET NO. 453-05-4456.M5
TWCC MDR NO. M5-04-2433-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
BOYD CHIROPRACTIC CENTER, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

Texas Mutual Insurance Company (TMIC) timely requested a hearing to contest the January 20, 2005 Findings and Decision of the Texas Workers' Compensation Commission (Commission). The Commission relied upon a November 16, 2004 decision of Specialty Independent Review Organization, Inc., an Independent Review Organization (IRO). The Commission granted reimbursement for certain chiropractic treatment services and denied reimbursement for other chiropractic treatment services provided by Boyd Chiropractic Center[1] (Provider) to injured worker__ (Claimant) from April 2, 2003, through September 15, 2003. In addition, the Commission ordered reimbursement for certain chiropractic services for which there was a fee dispute. Because the Provider did not timely submit to the Commission disputed treatments for April 2-4, 2003 dates of service, the Commission did not review those dates of service and denied reimbursement. In addition, because Provider did not request a contested case hearing with respect to adverse Commission findings, those findings are not reviewed in this Decision and Order.[2]

[1] The name of an employee of Boyd Chiropractic, Sylvia Garza, was deleted, by Order, from the style of the docket so as to correctly identify the parties.

[2] Provider did not request a hearing to contest the following services deemed not medically necessary: (1) CPT Code 97012-mechanical traction, for dates of service April 10, May 14, 15, 19, 21, 22, 28, 29, 30, and June 2; (2) CPT Code 97265-joint mobilization, for dates of service April 7, and May 8 and 28; (3) CPT Code 97250-myofacial release,

The chiropractic services in dispute in this docket are: (1) CPT Code 97012-mechanical traction, for dates of service April 9 and 15; (2) CPT Code 97014-electrical stimulation, for dates of service April 9, 10 and 15; (3) CPT Code 97250-myofacial release, for dates of service April 9, 10 and 15; (4) CPT Code 99213-office visit, for dates of service April 9, 10, 15, May 15, 19, 21, 22, 28, 29, June 9 and 25;[3] (5) CPT Code 99214-office visit, for date of service June 2;[4] (6) CPT Code 97122-manual traction, for date of service April 10; (7) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service May 8 and 12 (four units), May 14, 19, 21 and 22 (three units);[5] (8) CPT Code 97112-neuromuscular re-education, for date of service May 8; and (9) CPT Code 98940-manipulation, for date of service August 13.

With respect to the services for which there was a fee dispute, the Commission awarded Provider reimbursement for the following: (1) CPT Code 99080-73, a work status report for date of service May 21;[6] (2) CPT Code 97112-neuromuscular re-education, for dates of service April 24 and 28; (3) CPT Code 97540[7] for date of service May 1; and (4) CPT Code 99214-25-office visit report, for date of service September 15. The Commission denied reimbursement for (1) CPT Code 99080-73, a work status report for date of service April 14; and (2) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service April 24, 28, and May 1 (five units), and May 2 and 5 (four units).

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for dates of service May 14, 15, 19, 21, 22, 28, 29, 30 and June 2; (4) CPT Code 97010-hot and cold packs, for dates of service April 9 and 15; (5) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service May 22 (one unit), May 15, 19 and 21(two units), May 28 and 29 (five units) and May 30 and June 2 (four units); (6) CPT Code 97112-neuromuscular re-education, for dates of service May 14, 15, 19, 21, 22, 28, 29, 30, and June 2; and (7) CPT Code 98940-manipulation, for date of service September 15.

[3] During the hearing on the merits, TMIC agreed to reimburse Provider for previously disputed office visits on May 19, 28, June 9 and 25.

[4] During the hearing, TMIC agreed to reimburse Provider for this service.

[5] During the hearing, TMIC agreed to reimburse Provider for one unit of service on May 19.

[6] During the hearing, TMIC agreed to reimburse Provider for this service.

[7] Fitting the Claimant with a durable medical device.

After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that some but not all of the disputed services provided by Provider were reasonable, medically necessary and should be paid and that Provider should be reimbursed for all of the fee dispute claims.

The hearing convened on October 10, 2005, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Katie Kidd represented TMIC. James T. Boyd, D.C., appeared for Provider. Dr. Boyd and David Alvarado, D.C., testified. The hearing concluded and the record closed that day. Neither party objected to notice or jurisdiction.

Claimant suffered a work-related injury to his lower back on___. Claimant was initially treated at San Benito Medical Associates, Inc., and received spinal injections. Claimant presented to Dr. Boyd on April 2, 2003, for an evaluation. The injury was diagnosed as a lumbosacral sprain/strain. Treatments began on April 3, 2003, and continued through June 9, 2003. Claimant had additional office visits or treatments from Provider on June 25, August 13, and September 15, 2003. Claimant was initially returned to work with restrictions on April 18, 2003, and was returned to work without restrictions on June 9, 2003.

Dr. Alvarado and Dr. Boyd disagreed about the correct interpretation of the radiological report. Dr. Boyd argued the radiological report indicated instability in the spine, while Dr. Alvarado it did not. Dr. Alvarado also opined that if the spine was unstable, the care that was provided was contraindicated. The ALJ concludes there was no significant instability in Claimant's spine.

With respect to the need for CPT Code 97110 one-on-one supervised therapy, Dr. Boyd contended the one-on-one supervised exercise was necessary to reduce the risk of injury and litigation, while TMIC contended the exercises could have been done safely in group therapy or as a home exercise after an initial period of instruction and training in the exercises.

Therapeutic exercises began on April 21. TMIC paid for four units of exercise on April 21, 23, and May 7. There is no showing Claimant had any difficulty understanding or safely performing the exercises. The ALJ concludes, while Dr. Boyd's desire to reduce the risk of litigation is understandable, there is no medical necessity for one-on-one supervised exercise activity on the disputed dates of service.

Dr. Alvarado generally took issue with office visits and services being provided five times per week versus three times per week. Claimant first visited Provider on Wednesday, April 2 and was also seen on that Thursday and Friday. Provider's intake notes indicate Claimant's pain ranged from 6 to 10 on a 10-point scale.[8] By Wednesday of the following week, April 9, Claimant indicated he was 60% improved but still had a sore back and occasional pain radiating down his legs. On April 16, Claimant described himself as 75% improved, with sore back muscles but no pain. By April 23, Claimant's pain ranged from 1-3.

For the period April 7 through April 23, 2003, three office visits are in dispute-April 9, 10 and 15. While TMIC reimbursed Provider for office visits on April 7, 8, and 11, it denied reimbursement for the April 9 and 10 office visits, and the services provided on those days, as medically unnecessary. Dr. Alvarado testified the standard of care is three office visits per week for four to six weeks. Because Claimant progressed satisfactorily and without complications, he found no need for more than three office visits per week during the time in question.

In summary, Dr. Alvarado did not dispute the overall period during which care was rendered or, in general, the type of care rendered during that period. Nor did he take issue with Claimant's progress or the outcome of Dr. Boyd's treatment regimen. Dr. Alvarado did take issue with the intensity or frequency of the care rendered during the period. As such, it was both Dr. Alvarado's and TMIC's general position that if an office visit was not medically necessary, then care rendered

[8] On the 10-point scale, 10 is extreme pain and 0 is no pain.

during that office visit that was also not medically necessary. Conversely, if the office visit was medically necessary then, with the exception of items such as one-on-one supervised exercise, the care delivered during the office visit was medically necessary.

The daily treatment notes reflect Claimant's progress during the week of April 7-11. As of April 9, Claimant indicated he still had some pain radiating into his legs. By April 10, however, there is no longer any mention of radiating pain. The radiating pain medically justified one additional office visit, April 9, during the week of April 7-11.[9] Thereafter, only three office visits per week were medically necessary through May 15, approximately one month from the date Claimant was returned to work with restrictions. Thus, Provider is also entitled to reimbursement for the May 15 office visit. By May 15, Claimant described his condition as 85% improved and his pain as minor and transient. After May 15, 2003, Claimant's condition was unremarkable and only one office visit per week to monitor Claimant's condition was medically necessary. Thus, the office visits on May 21, 22 and 29 were not medically necessary.

TMIC contended the mechanical traction treatments for dates of service April 9 and 15 were not medically necessary. TMIC contended the manual traction treatment for date of service April 10 was not medically necessary. As previously discussed, the office visits for April 10 and 15 were not medically necessary. Therefore, the services rendered on those dates were not medically necessary. The April 9 treatment was in issue because TMIC challenged the medical necessity of the office visit, and, therefore, all services provided on that date. As noted previously, the April 9 office visit was medically necessary as were all disputed treatment services provided during that office visit.

The disagreement with respect to CPT Code 97112 neuromuscular re-education focused on whether Claimant's exercises were primarily for neuromuscular integrity and training or therapeutic exercises used to strengthen and stabilize the lumbar spine. TMIC contended the gym ball and

[9] In addition, the services provided on April 9 were medically necessary.

wobble board exercises primarily served the latter objective. The evidence demonstrated the treatments served both purposes. Thus, TMIC failed to meet its burden and Provider is entitled to reimbursement. The only date of service in issue denied by TMIC for medical necessity is May 8. TMIC paid for CPT Code 97112 neuromuscular re-education both prior to and after May 8. The service was medically necessary. The April 24 and April 28 dates of service were challenged in a fee dispute based on the documentation. Provider adequately documented provision of the service.

TMIC challenged the Commission's Decision on the May 1 fee dispute for CPT Code 97540 through Dr. Alvarado's testimony that it was not the appropriate CPT Code for fitting the electrical stimulation equipment for Claimant or that it was not appropriate for the treating doctor to invoice for such instruction since it was typically done by the supplier of the durable medical equipment. The Commission determined the daily treatment notes supported the service billed. TMIC's evidence on this issue was equivocal and insufficient to meet its burden of proof.

TMIC denied reimbursement for CPT Code 97014-electrical stimulation for dates of service April 9, 10, and 15. As previously discussed, the services provided on April 10 and 15 were not medically necessary while the services provided on April 9 were medically necessary.

TMIC denied the office visit report, CPT Code 99214-25, of September 15, 2003, based on documentation and reduction to the Maximum Allowable Reimbursement (MAR). The documentation was sufficient to support delivery of the service at the MAR of $92.30 ordered by the Commission.

TMIC denied reimbursement for CPT Code 97250-myofacial release, on dates of service April 9, 10 and 15. As previously discussed, the services provided on April 10 and 15 were not medically necessary while the services provided on April 9 were medically necessary.

TMIC failed to present evidence proving that CPT Code 98940-manipulation, for date of service August 13 was not medically necessary.

Overall, TMIC proved by a preponderance of the evidence that the following treatment services were not medically necessary: (1) CPT Code 97012-mechanical traction, for date of service April 15; (2) CPT Code 97014-electrical stimulation, for dates of service April 10 and 15; (3) CPT Code 97250-myofacial release, for dates of service April 10 and 15; (4) CPT Code 99213-office visit, for dates of service April 10, 15, May 21, 22, and 29; (5) CPT Code 97122-manual traction, for date of service April 10; and (6) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service May 8 and 12 (four units), May 14, 21 and 22 (three units), May 19 (two units).

TMIC failed to prove by a preponderance of the evidence that the following disputed treatments were not medically necessary: (1) CPT Code 97012-mechanical traction, for date of service April 9; (2) CPT Code 97014-electrical stimulation, for date of service April 9; (3) CPT Code 97250-myofacial release, for date of service April 9; (4) CPT Code 99213-office visit, for dates of service April 9, May 15; (5) CPT Code 97112-neuromuscular re-education, for date of service May 8; and (6) CPT Code 98940-manipulation, for date of service August 13.

TMIC failed to meet its burden of proof with respect to the services for which there was no medical necessity dispute but there was a fee dispute and for which the Commission awarded Provider reimbursement: (1) CPT Code 97112-neuromuscular re-education, for dates of service April 24 and 28; (3) CPT Code 97540-medical device fitting, for date of service May 1; and (4) CPT Code 99214-25-office visit report, for date of service September 15.

TMIC agreed to reimburse Provider for the following services at the hearing on the merits: (1) CPT Code 99213-office visit, for dates of service May 19, 28, June 9 and 25; (2) CPT Code

99214-office visit, for date of service June 2; (3) CPT Code 97110-therapeutic treatment with one-on-one supervision, for date of service May 19 (one unit); and (4) CPT Code 99080-73, a work status report for date of service May 21.

II. FINDINGS OF FACT

1. __ (Claimant) suffered a work-related injury to his lower back on__.

2. All dates of disputed services are in 2003.

3. The chiropractic services in dispute in this docket are: (1) CPT Code 97012-mechanical traction, for dates of service April 9 and 15; (2) CPT Code 97014-electrical stimulation, for dates of service April 9, 10 and 15; (3) CPT Code 97250-myofacial release, for dates of service April 9, 10 and 15; (4) CPT Code 99213-office visit, for dates of service April 9, 10, 15, May 15, 19, 21, 22, 28, 29, June 9 and 25; (5) CPT Code 99214-office visit, for date of service June 2; (6) CPT Code 97122-manual traction, for date of service April 10; (7) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service May 8 and 12 (four units), May 14, 19, 21 and 22 (three units); (8) CPT Code 97112-neuromuscular re-education, for date of service May 8; and (9) CPT Code 98940-manipulation, for date of service August 13.

4. During the hearing on the merits, Texas Mutual Insurance Company (TMIC) agreed to reimburse Boyd Chiropractic Center (Provider) for previously disputed CPT Code 99213 office visit for dates of service May 19, 28, June 9 and 25; CPT Code 99214 office visit for date of service June 2; and one unit of CPT Code 97110 therapeutic treatment with one-on-one supervision on May 19.

5. Provider did not request a hearing to contest those portions of the Commission's Decision that were adverse to it. Provider was denied reimbursement for the following services as not medically necessary: (1) CPT Code 97012-mechanical traction, for dates of service April 10, May 14, 15, 19, 21, 22, 28, 29, 30, and June 2; (2) CPT Code 97265-joint mobilization, for dates of service April 7, and May 8 and 28; (3) CPT Code 97250-myofacial release, for dates of service May 14, 15, 19, 21, 22, 28, 29, 30 and June 2; (4) CPT Code 97010-hot and cold packs, for dates of service April 9 and 15; (5) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service May 22 (one unit), May 15, 19 and 21(two units), May 28 and 29 (five units) and May 30 and June 2 (four units); (6) CPT Code 97112-neuromuscular re-education, for dates of service May 14, 15, 19, 21, 22, 28, 29, 30, and June 2; and (7) CPT Code 98940-manipulation, for date of service September 15.

6. With respect to the services for which there was a fee dispute, the Commission awarded Provider reimbursement for the following: (1) CPT Code 99080-73, a work status report for date of service May 21; (2) CPT Code 97112-neuromuscular re-education, for dates of service April 24 and 28; (3) CPT Code 97540-medical device fitting, for date of service May 1; and (4) CPT Code 99214-25-office visit report, for date of service September 15. The Commission denied reimbursement for (1) CPT Code 99080-73, a work status report for date of service April 14; and (2) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service April 24, 28, and May 1 (five units), and May 2 and 5 (four units).

7. During the hearing on the merits, TMIC agreed to reimburse Provider for the fee dispute arising from the CPT Code 99080-73 work status report for date of service May 21.

8. Claimant was initially treated at San Benito Medical Associates, Inc., and received spinal injections.

9. On April 2, 2003, Claimant presented to James T. Boyd, D.C., at Provider for an evaluation. The injury was diagnosed as a lumbosacral sprain/strain. Treatments began on April 3, 2003, and continued through June 9, 2003.

10. Claimant had additional office visits or treatments from Provider on June 25, August 13, and September 15, 2003. Claimant was initially returned to work with restrictions on April 18, 2003, and was returned to work without restrictions on June 9, 2003.

11. There was no significant instability in Claimant's spine.

12. With respect to the need for CPT Code 97110 one-on-one supervised therapy, Dr. Boyd used one-on-one supervised exercise to reduce the risk of injury and litigation.

13. Therapeutic exercises began on April 21. TMIC paid for four units of exercise on April 21, 23, and May 7.

14. Claimant had no difficulty understanding or safely performing the exercises.

15. The exercises could have been done safely in group therapy or as a home exercise after an initial period of instruction and training in the exercises.

16. There is no medical necessity for one-on-one supervised exercise activity on the disputed dates of service.

17. TMIC did not dispute the overall period during which care was rendered or, in general, the type of care rendered during that period.

18. TMIC did not take issue with Claimant's progress or the successful outcome of Provider's treatment regimen.

19. TMIC took issue with respect to Provider's frequency of care, including office visits.

20. Claimant first visited with Provider on Wednesday, April 2 and was also seen on that Thursday and Friday. Provider's intake notes indicate Claimant's pain ranged from 6 to 10 on a 10-point scale, with 10 being extreme pain and 0 being no pain.

21. By Wednesday of the following week, April 9, Claimant was 60% improved but still had a sore back and occasional pain radiating down his legs.

22. On April 16, Claimant was 75% improved, with sore back muscles but no pain.

23. By April 23, Claimant's pain ranged from 1-3.

24. TMIC reimbursed Provider for office visits on April 7, 8, and 11.

25. TMIC denied, as medically unnecessary, reimbursement for the April 9 and 10 office visits, and the services provided on those days.

26. Because Claimant progressed satisfactorily and without complications, TMIC reimbursed Provider for three office visits per week during the initial trial of care.

27. As of April 9, Claimant still had some pain radiating into his legs.

28. By April 10, the radiating pain had ceased.

29. The radiating pain medically justified one additional office visit during the week of April 7-11.

30. In addition, the services provided on April 9 were medically necessary.

31. Thereafter, only three office visits per week were medically necessary through May 15, approximately one month from the date Claimant was returned to work with restrictions. Thus, Provider is also entitled to reimbursement for the May 15 office visit.

32. TMIC's evidence that it was not the appropriate CPT Code and that it was not appropriate for the treating doctor to invoice for such instruction since it was typically done by the supplier of the durable medical equipment was equivocal and insufficient to meet its burden of proof

33. After May 15, 2003, Claimant's condition was unremarkable and only one office visit per week to monitor Claimant's condition was medically necessary.

34. The office visits on May 21, 22 and 29 were not medically necessary.

35. TMIC denied Provider reimbursement for the mechanical traction treatments for dates of service April 9 and 15 as not medically necessary.

36. TMIC denied Provider reimbursement for the manual traction treatment for date of service April 10 as not medically necessary.

37. Because the office visits for April 10 and 15 were not medically necessary, the services rendered on those dates were not medically necessary.

38. The April 9 office visit was medically necessary as were all disputed treatment services provided during that office visit.

39. The CPT Code 97112 neuromuscular re-education exercises were used for neuromuscular integrity and training and as therapeutic exercises used to strengthen and stabilize the lumbar spine.

40. The only date of service in issue denied by TMIC for medical necessity is May 8. TMIC paid for CPT Code 97112 neuromuscular re-education both prior to and after May 8. The service was medically necessary.

41. The April 24 and April 28 dates of service for CPT Code 97112 were challenged in a fee dispute based on the documentation.

42. Provider adequately documented provision of the CPT Code 97112 service for dates of service April 24 and 28.

43. The provision of CPT Code 97540 services on May 1 to fit the electrical stimulation equipment was adequately documented.

44. TMIC denied reimbursement for CPT Code 97014-electrical stimulation for dates of service April 9, 10, and 15.

45. The services provided on April 10 and 15 were not medically necessary while the services provided on April 9 were medically necessary.

46. The documentation was sufficient to support delivery of CPT Code 99214-25-office visit report, on September 15, 2003, based on the reduction to the Maximum Allowable Reimbursement (MAR).

47. TMIC denied reimbursement for CPT Code 97250-myofacial release, on dates of service April 9, 10 and 15.

48. The CPT Code 97250 services provided on April 10 and 15 were not medically necessary while the services provided on April 9 were medically necessary.

49. TMIC failed to present evidence proving that CPT Code 98940-manipulation, for date of service August 13 was not medically necessary.

50. TMIC timely requested a hearing to contest the January 20, 2005 Findings and Decision of the Texas Workers' Compensation Commission (Commission). The Commission relied upon a November 16, 2004 decision of Specialty Independent Review Organization, Inc., an Independent Review Organization (IRO). The Commission granted reimbursement for certain chiropractic treatment services and denied reimbursement for other chiropractic treatment services provided by Provider to injured worker Claimant from April 2, 2003, through September 15, 2003. In addition, the Commission ordered reimbursement for certain chiropractic services for which there was a fee dispute. Because the Provider did not timely submit to the Commission disputed treatments for April 2-4, 2003 dates of service, the Commission did not review those dates of service and denied reimbursement.

51. Provider did not request a contested case hearing with respect to adverse Commission findings.

52. On February 14, 2005, TMIC requested a hearing before the State Office of Administrative Hearings (SOAH).

53. The Commission issued a notice of hearing on March 7, 2005.

54. The notice of hearing contained: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held; (3) a reference to the particular sections of the statutes and rules involved; and (4) a short, plain statement of the matters asserted.

55. The hearing convened on October 10, 2005, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Katie Kidd represented TMIC. James T. Boyd, D.C., appeared for Provider. Dr. Boyd and David Alvarado, D.C., testified. The hearing concluded and the record closed that day.

III. 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. The party requesting the contested case hearing has the burden of proof.

6. Because TMIC failed to prove by a preponderance of the evidence that the treatment services provided were either not reasonable or not medically necessary, Provider is entitled to reimbursement from TMIC for the following disputed treatment services provided to Claimant: (1) CPT Code 97012-mechanical traction, for date of service April 9; (2) CPT Code 97014-electrical stimulation, for date of service April 9; (3) CPT Code 97250-myofacial release, for date of service April 9; (4) CPT Code 99213-office visit, for dates of service April 9, May 15; (5) CPT Code 97112-neuromuscular re-education, for date of service May 8; and (6) CPT Code 98940-manipulation, for date of service August 13.

7. Because TMIC proved by a preponderance of the evidence that the following treatment services were either not reasonable or not medically necessary, Provider is not entitled to reimbursement from TMIC: (1) CPT Code 97012-mechanical traction, for date of service April 15; (2) CPT Code 97014-electrical stimulation, for dates of service April 10 and 15; (3) CPT Code 97250-myofacial release, for dates of service April 10 and 15; (4) CPT Code 99213-office visit, for dates of service April 10, 15, May 21, 22, and 29; (5) CPT Code 97122- manual traction, for date of service April 10; and (6) CPT Code 97110-therapeutic treatment with one-on-one supervision, for dates of service May 8 and 12 (four units), May 14, 21 and 22 (three units), May 19 (two units).

8. Because TMIC failed to meet its burden of proof, Provider is entitled to reimbursement for the following treatment services for which there was no medical necessity dispute but there was a fee dispute and for which the Commission awarded Provider reimbursement: (1) CPT Code 97112-neuromuscular re-education, for dates of service April 24 and 28; (3) CPT Code 97540-medical device fitting, for date of service May 1; and (4) CPT Code 99214-25-office visit report, for date of service September 15.

ORDER

THEREFORE IT IS ORDERED that Texas Mutual Insurance Company reimburse Boyd Chiropractic Center, together with any applicable interest, for the following chiropractic treatment services provided to injured worker__ (1) CPT Code 97012-mechanical traction, for date of service April 9; (2) CPT Code 97014-electrical stimulation, for date of service April 9; (3) CPT Code 97250-myofacial release, for date of service April 9; (4) CPT Code 99213-office visit, for dates of service April 9, May 15; (5) CPT Code 97112-neuromuscular re-education, for date of service May 8; and (6) CPT Code 98940-manipulation, for date of service August 13; (7) CPT Code 97112-neuromuscular re-education, for dates of service April 24 and 28; (8) CPT Code 97540-medical device fitting, for date of service May 1; and (9) CPT Code 99214-25-office visit report, for date of service September 15. **IT IS FURTHER ORDERED** that Texas Mutual Insurance Company reimburse Boyd Chiropractic Center, together with any applicable interest, for the following treatment services it agreed, at the hearing on the merits, to reimburse: (1) CPT Code 99213-office visit, for dates of service May 19, 28, June 9 and 25; (2) CPT Code 99214-office visit, for date of service June 2; (3) CPT Code 97110-therapeutic treatment with one-on-one supervision, for date of service May 19 (one unit); and (4) CPT Code 99080-73, a work status report for date of service May 21. All relief not expressly granted herein is DENIED.

SIGNED December 9, 2005.

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HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS