SOAH DOCKET NO. 453-05-4470.M5
MDR Tracking No. M5-04-4006-01

DECISION AND ORDER

I. SUMMARY

Texas Mutual Insurance Company (Carrier) appealed the decision of Speciality Independent Review Organization, Inc., an independent review organization (IRO), in Texas Workers' Compensation Commission (TWCC)[1] Medical Review Division (MRD) tracking number M5-04-4006-01, granting partial reimbursement for medical services provided to the Claimant. This decision orders that the Carrier is required to reimburse DFW Pain Center, Inc. (Provider) for the a portion of the contested services.

Administrative Law Judge (ALJ) Ami L. Larson convened a hearing on October 11, 2005. The hearing was concluded and the record closed that day. The Carrier appeared through its representative counsel Patricia Eads. Provider failed to appear.

II. EVIDENCE AND BASIS FOR DECISION

The issue presented in this proceeding is whether the Carrier should reimburse the Provider for disputed services provided between December 31, 2003 and March 11, 2004, and billed under CPT Codes 99213 (office visit), 97530 (therapeutic activities), 95851 (range of motion testing), 97140 (manual therapy), 97116 (gait training) and 97750 (physical performance testing).

The documentary record consists of four exhibits presented by Carrier,[2] including the deposition testimony of Mark Miller, a physical therapist. Additionally, David Alvarado, D.C., testified as an expert witness on behalf of Carrier.

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[1] Effective September 1, 2005, the functions of TWCC were transferred to the newly created Division of Workers' Compensation of the Texas Department of Insurance.

[2] Colored highlights in Carrier's Exhibit A reflect notes by the ALJ and should be disregarded.

Claimant suffered a tibial plateau fracture of his right leg on _____, while he was on the job. He was treated with medication, surgery, passive and active therapies, and rehabilitative services. Diagnostic tests included X-rays, MRI and CT scans. Claimant reported to the emergency room the day of his injury and was unable to return to work.

It should be noted that no Explanation of Benefits forms were admitted into evidence. The only indication of denial codes cited by Carrier to justify its refusal to pay for services is found in the table of disputed services contained in Carrier's Exhibit A.[3]

A. Physical Performance Testing - 97750

Carrier denied payment for the physical performance testing based on its assertion that the charge for this service was included in another billed procedure.[4] In its opening remarks, Carrier addressed this issue by stating that this testing should have been done as part of the office visits since its purpose is to check progress and alter the treatment program accordingly. Carrier failed to meet its burden of proof, however, by failing to offer any evidence to support its position. Therefore, Carrier should reimburse Provider for the cost of the Physical Performance Testing on the dates of disputed services pursuant to the MRD decision.

B. Gait Training - 97116

On ten separate dates of service, gait training therapy was administered to Claimant, billed by Provider, and denied by Carrier.[5] Carrier based on its denial on its assertion that these services were not justified by the available documentation as being medically necessary.[6] It should be noted,

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[3] Carrier's Exhibit A, pages 131-160.

[4] According to the table of disputed services found in Carrier's Exhibit A, Carrier denied these services by citing denial code G, for unbundling

[5] It appears that gait training was initiated by Provider on February 13, 2004, but the first documented date for which this service was billed and denied by Carrier is February 16, 2004**.** The additional dates for which gait training was provided and billed, but payment was denied by Carrier are February 18,20, and 23, 2004, and March 1,3,5,8,10, and 11, 2004.

[6] Carrier cited denial code U, according to the table of disputed services.

however, that on both February 25 and 27, 2004, gait training therapy was provided and billed. Carrier reimbursed Provider for all but 29 cents of the amount requested for gait training services on those dates.[7]

Although Carrier took the position that one-on-one gait training was not shown to be medically necessary, it failed to explain why the documentation, which does address the need for this type of therapy, was insufficient and how this type of training could have been performed in a less supervised setting. Additionally, Carrier's reimbursement for two sessions of gait training seem to imply that these services were medically necessary. Because Carrier failed to meet its burden of proof to show a lack of medical necessity for these services, it should reimburse Provider for gait training therapy provided on the disputed dates.

C. Manual Therapy - 97140

[7] Carrier's Exhibit A, page 140.

Carrier argued that manual, or passive therapy was medically unnecessary on the dates of disputed services and, therefore, should not be reimbursed. Carrier presented the deposition testimony of physical therapist Mark Miller[8] and the live testimony of David Alvarado, D.C., to support its position.

Provider justified his use of these treatments by stating that they address adhesions or spasms, but both Mr. Miller and Dr. Alvarado testified that that there was no indication of the presence of any adhesions or spasms noted in the objective portion of Provider's documentation. Mr. Miller also testified that, even if there were spasms present, the manual therapies provided would not be effective to treat Claimant since he had a deep joint problem and these therapies are relatively superficial.[9]

[8] Carrier's Exhibit B, pages 164 and 165.

[9] Carrier's Exhibit B, page 164.

However, Provider, in his treatment notes, indicated that adhesions and spasms were building up in Claimant's right knee and this was the reason he added specific manual therapies to Claimant's treatment program. Additionally, Mr. Miller's testimony regarding the nature of Claimant's injury and the efficacy of the treatments in dispute is conclusory and insufficient to meet Carrier's burden of proof to show that such services were not medically necessary. It should also be noted that Carrier, in fact, reimbursed Provider for manual therapies provided to Claimant on several dates of service[10] for which Provider's treatment notes are the same as those offered to support the treatment provided on the dates in dispute. This implies that such services were medically necessary and, therefore, Carrier should reimburse Provider for manual therapies performed on the disputed dates.

D. Office Visits - 99213

Carrier argued that the office visits billed in conjunction with each session of physical therapy were excessive and not medically necessary. Additionally, Carrier argued that Provider failed to justify, through documentation, the level of office visit billed. The only evidence presented to address this issue was the testimony of Dr. Alvarado, who stated merely that a lower level office visit could have sufficed. Dr. Alvarado did not explain what is done at each level of office visit or whether there were any components of an office visit that might be necessary and not included in the physical therapy sessions conducted. Carrier failed to meet its burden to show that the office visits provided were not medically necessary. Therefore, Carrier should reimburse Provider for these disputed services.

E. Therapeutic Activities - 97530

In general, Carrier argued that there was insufficient documentation provided to support the medical necessity of one-on-one therapeutic activities prescribed for Claimant on the disputed dates. Carrier, however, reimbursed Provider for at least a portion of all therapeutic activities billed by Provider on each of the disputed dates of service. This implies that one-on-one therapy was

[10] Manual therapy was billed by Provider and reimbursed by Carrier for the following dates of service: February 23, 25, and 27, 2004, and March 11, 2004.

medically necessary. The only question remaining is whether the amount of one-on-one therapeutic activities billed was in excess of what was medically necessary.

On January 5, 9, 12, 14, and 16, 2004, Carrier reimbursed Provider for three units of therapeutic activities and denied reimbursement for the additional one unit billed by Provider for each of those dates. With respect to these dates of service, the MRD decision found reimbursement was appropriate for only three units of therapeutic activities. It is unclear to the ALJ why Carrier is appealing the therapeutic activities on these dates since the MRD decision did not recommend any further reimbursement. For the reasons cited in the MRD and IRO decisions, Carrier should not reimburse Provider for any additional units of therapeutic activities on the above-listed dates.

With respect to the therapeutic activities provided on the remaining dates of disputed services, Dr. Alvarado testified that several of the exercises performed required Claimant to bear weight on his injured leg and were, therefore, contraindicated and should not have been performed pursuant to the orthopedic surgeon's post-operative care instructions.[11] More specifically, Dr. Alvarado stated the standard of care for a fracture of that part of the body calls for no resistance or weight-bearing until the fracture has solidified or calcified. There is no evidence in the record as to when or if the orthopedic surgeon recommended weight-bearing exercises for Claimant. Dr. Alvarado further stated that the number of units already paid by Carrier should have been more than enough for Claimant to learn the exercises and be able to transition to a home exercise program.

Although there is an indication in the orthopedic surgeon's post-operative notes that he intended for Claimant to remain on crutches for two months post-surgery in order to prevent weight-bearing on his right knee, this does not necessarily mean that he intended to rule out limited weight-bearing exercises in physical therapy. At the point where the seemingly weight-bearing exercises were implemented, there is no evidence to show that Claimant was not ready to perform such

[11] Carrier's Exhibit A, page 53.

exercises and, in fact, the physical therapy notes indicate Claimant continued to improve during the course of physical therapy, thereby supporting the appropriateness and medical necessity of the treatment provided.

With respect to the number of units billed for each session of therapeutic activities, the treatment notes reflect the amount of time spent on each type of therapy. Although Dr. Alvarado expresses his opinion that the amounts of time spent were too great and the exercises could have been accomplished in less time, he does not cite any guidelines or specific reasons why he holds his opinion or why the documented length of time for each session was unreasonable and unnecessary.

The ALJ finds that Carrier has failed to meet its burden of proof to show that the units billed by Provider were in excess of what was medically necessary for Claimant and agrees with the IRO that only the number of units actually documented should be reimbursed by Carrier pursuant to the MRD and IRO decisions.[12]

F. Range of Motion Testing - 95851

The MRD and IRO determined that Carrier should not reimburse Provider for the range of motion testing performed. The ALJ is, therefore, unclear as to why Carrier appealed this portion of the MRD and IRO decisions and presented evidence and testimony regarding range of motion testing.

Pursuant to the reasoning of the IRO, the ALJ finds that no reimbursement is required for the disputed range of motion testing.

[12] There are many discrepancies between the number of units billed by Provider and the apparent number of units actually provided according to the treatment notes. Only the number of units documented as actually provided should be reimbursed by Carrier. The MRD and IRO decisions clarify this as well.

III. FINDINGS OF FACT

1. On _____, the Claimant suffered a compensable injury to his right leg, which was diagnosed as a _____ fracture.

2. The Claimant's injury is covered by workers' compensation insurance written for the Claimant's employer by Texas Mutual Insurance Company (Carrier).

3. Claimant was treated with medication, surgery, passive and active therapies, and rehabilitative services.

4. DFW Pain Center, Inc. (Provider) provided post-operative physical therapy treatments to Claimant for his compensable injury.

5. Carrier denied reimbursement to Provider for some of the medical services provided between December 31, 2003, and March 11, 2004, and billed under CPT Codes 99213 (office visit), 97530 (therapeutic activities), 95851 (range of motion testing), 97140 (manual therapy), 97116 (gait training), and 97750 (physical performance testing) on the basis that the treatment was not medically necessary to treat the injury or that it was encompassed in another billed procedure and should not have been billed separately.

6. The Provider timely requested dispute resolution by the MRD.

7. On January 25, 2005, the MRD issued its decision and order adopting the IRO decision concluding that a portion of the disputed expenses should be paid, and the Carrier timely appealed.

8. Carrier failed to submit evidence to show that the disputed services billed under CPT Codes 97116, 97140, 99213, and 97530 were not medically necessary.

9. Carrier failed to submit evidence to show that the disputed services billed under CPT Code 97750 were included in another billed procedure and should not have been billed separately.

10. The Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC) and Independent Review Organization found that the disputed services billed under CPT Code 95851 should not be reimbursed by Carrier.

11. The MRD and IRO found that the disputed services billed under CPT Code 97530 for the dates of service of January 5, 9, 12, 14, and 16, 2004, should not be reimbursed by Carrier.

12. Provider's treatment documentation with respect to the disputed services billed under CPT Code 97530 reflects less time actually spent on therapeutic activities than the amount of time billed by Provider for those services.

13. Carrier is only responsible for reimbursing Provider for the actual number of units reflected in Provider's treatment documentation as stated in the MRD and IRO decisions.

14. TWCC sent notice of hearing to the parties on December 20, 2004. The hearing notices informed the parties of the matter to be determined, the right to appear and be represented by counsel, the time and place of the hearing, and the statutes and rules involved.

15. The hearing on the merits convened October 11, 2005, before Ami L. Larson, Administrative Law Judge. The Carrier appeared through Patricia Eads, attorney. The Provider failed to appear. The record closed that day.

IV. CONCLUSIONS OF LAW

16. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a Decision and Order, pursuant to TEX. LAB. CODE ANN. §413.031 and TEX. GOV'T CODE ch. 2003.

17. The Notice of Hearing issued by TWCC conformed to the requirements of TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

18. Carrier has the burden of proving by a preponderance of the evidence that it should prevail in this matter. TEX. LAB. CODE ANN. §413.031.

19. The medical services provided between December 31, 2003, and March 11, 2004, and billed under CPT Codes 99213 (office visit), 97530 (therapeutic activities), 97140 (manual therapy), and 97116 (gait training) were medically necessary.

20. Reimbursement for the disputed medical services billed under CPT Code 95851 (range of motion testing) should not be required.

21. The disputed physical performance testing billed under CPT Code 97750 should be reimbursed since there is no evidence in the record to support Carrier's basis for denial of payment.

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company is required to reimburse DFW Pain Center, Inc.for the following disputed services provided in treating the Claimant: Physical Performance Testing (97750), Gait Training (97116), Manual Therapy (97140), Office Visits (99213), and only the units of Therapeutic Activities (97530) actually documented in Provider's treatment notes pursuant to the MRD and IRO decisions.

SIGNED December 9, 2005.

AMI L. LARSON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS