SOAH DOCKET NO. 453-05-4543.M5
TWCC MR NO. M5-05-0434-01

TEXAS MUTUAL INSURANCE COMPANY,	'	**BEFORE THE STATE OFFICE**
PETITIONER	§	
	'	
	'	**OF**
V.	'	
	'	**ADMINISTRATIVE HEARINGS**
PREMIER PHYSICAL THERAPY,	'	
RESPONDENT	'	

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD)[1] to adopt the decision of its designee, an Independent Review Organization (IRO), which granted reimbursement for services provided a workers' compensation claimant (Claimant) by Premier Physical Therapy (Provider). Carrier claimed that the services were not medically necessary healthcare. This decision finds that Carrier should reimburse Provider for the aquatic therapy and office visits provided Claimant but not for physical therapy activities billed under CPT 97530.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice, or venue. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened October 17, 2005, at the State Office of Administrative Hearings, 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Ann Landeros presiding. The record also closed that date. Attorneys Bryan Jones and Patricia Eads appeared for Carrier. Provider's owner, Lee Trujillo, appeared on its behalf. Commission Staff did not participate in the hearing.

1 As of September 1, 2005, the Commission has become a division within the Texas Department of Insurance. Acts of May 30, 2005, 79th Leg., R.S., ch. 265, 2005 Tex. Sess. Law Serv. Ch 265 (HB 7). All citations in this Proposal for Decision are to the applicable statutes and rules as they existed at the time this case was referred to the State Office of Administrative Hearings in March 2005.

II. DISCUSSION

A. Background Facts

In__, Claimant sustained an injury to his knee and shoulder that was compensable under the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN. ch. 401 *et seq*. At the time of the compensable injury, Carrier was the workers' compensation insurer for Claimant's employer. Claimant underwent surgery on his injured knee and shoulder and then had post-surgical physical therapy from Provider.

In March 2004, Claimant was referred to Provider. From May 14 to August 11, 2004, Claimant received aquatic therapy (CPT 97113), along with individual therapeutic exercises (CPT 97530) and office visits (CPT 99213) at Provider's facility. Carrier declined to pay for the services, claiming they were not medically necessary.[2] Upon appeal to the Commission, the IRO reviewer ruled in Provider's favor, stating:

> Physical therapists evaluations document deficits in strength and endurance, but also continued progress to the point where [Claimant] was functional with self-care and ADL [activities of daily living]. The physical therapy treatment was appropriate and medically necessary because of the severe injuries the patient suffered.

Carrier timely appealed the IRO decision.

B. Legal Standards

Carrier 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 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, including a medical appliance or supply. 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). To be entitled to payment from a carrier, a provider must submit a properly coded bill. See 28 TAC " 133.1(a)(3), 133.300, and 133.301. To be entitled to payment from a carrier, a provider must submit a properly coded bill. See 28 TAC " 133.1(a)(3), 133.300, and 133.301

2 During the hearing, Carrier conceded that the disputed office visits billed under CPT 99213 for June 10 and August 11, 2004, were medically necessary and stated those billings would be paid.

C. Evidence and Analysis

Upon referral to Provider in March 2004, Claimant complained his knee and shoulder pain were at a level of 8 out of 10. Due to his inability to bear weight on his right foot, he was wheelchair bound when initially evaluated at Provider's facility. Although he is a diabetic, Claimant's surgical scars were noted as having healed well. From March 8 to April 29, 2004, Claimant had 23 sessions of physical therapy, including electrical stimulation, therapeutic exercises, kinetic activities and use of a TENS unit.

At his April 29, 2004, evaluation, Petitioner reported his pain varied from 3 to 8 out of 10 and he could walk for a few steps for a short period of time. His active range of motion (ROM) in his left shoulder was rated as being within functional limits while his active right knee flexion was at 115 degrees and extension at negative10 degrees. (Prov. Ex.1 at 55). On that date, Claimant's treating physician, Pete Garcia, M.D., prescribed the following physical therapy for him: knee and shoulder rehabilitation programs and aquatic therapy. (Prov. Ex. 1 at 59).

The physical therapist's notes stated that Claimant received 4 units of Aaquatics group@ on the following dates: May 14, 19, 21, 24; June 14, 16, 23, 25, 28; July 2, 8, 15, 19, 20, 22, 26, 27, 29; and August 2, 5, and 9, 2004. For other dates of aquatic therapy between May 14 and August 11, 2004, the notes state the aquatic session was individual therapy. Claimant's non-aquatic physical therapy exercise sessions were all provided on a one-to-one basis.

During his reevaluation on August 11, 2004, Claimant rated his pain at 7 out of 10. While his shoulder ROM was still within functional limits, his active right knee ROM was at flexion 155 degrees, extension negative2 degrees. He was able to walk for 10-15 minutes at a time but needed pain medication to perform his activities of daily living. (Prov. Ex. 1 at 108).

1. Carrier's Evidence and Argument

Carrier's expert witness, David Alvarado, D.C., testified that Provider failed to adequately document the need for therapy, especially aquatic therapy, in a one-to-one setting.

Dr. Alvarado stated that aquatic therapy usually precedes land-based therapy so it was puzzling in this case that Claimant progressed to aquatic therapy after many sessions of land-based

therapy. He conceded that it would be appropriate to regress to aquatic therapy if a patient was

unable to tolerate or was not making adequate progress in land-based therapy.

The medical records showed that Claimant's subjective pain levels actually increased from March to August 2004, which Dr. Alvarado took as evidence that the therapy was not helping Claimant. Dr. Alvarado did not see any evidence that Claimant's diabetes slowed his recovery, as the treating physician noted the surgical scars had healed well

Carrier argued that the increase in Claimant's pain levels showed the services were not medically necessary, because they failed to cure or relieve his pain symptoms. Further, Carrier disputed that Provider was entitled to bill for one-to-one aquatic therapy.

2. Provider's Argument

Provider presented only documentary evidence, consisting of Claimant's medical records, its billings, Carrier's denials, and various other TWCC forms. Provider argued the aquatic therapy was appropriate because Claimant had problems bearing weight on his injured leg. It pointed out that from March to August 2005, Claimant progressed from being wheel-chair bound and unable to bear any weight on his leg to walking with a cane for up to 15 minutes at a time. Provider also cited to an August 2004 functional capacity evaluation that noted Claimant's diabetes complicated his recovery. (Prov. Ex. 1 at 112).

3. Analysis

Carrier failed to meet its burden of proof to show that Provider's services were not medically necessary for Claimant. While Claimant's subjective pain levels may have increased from May to August 2004, his ability to walk improved dramatically. In late April 2004, Claimant could only walk a few steps at a time. In August 2004, he could walk with a cane for up to 15 minutes at a time. The increased activity may account for Claimant's report of more pain, but pain levels alone are not the sole determinant of progressBClaimant's progress in an activity of daily living, such as walking, was strong of evidence that the therapy was efficacious.

To be medically necessary, the therapy just had to tend to relieve Claimant's symptoms. In this case, one symptom was inability to bear weight on the injured leg. After the aquatic therapy and other physical therapy, Claimant could bear weight on the leg. That was sufficient to show the therapy was medically necessary.

However, Carrier did establish that there was inadequate documentation to establish that the individual therapy billed under CPT 97530 was billed under the proper code. That CPT code is defined as one-to-one activity, meaning the patient works alone with a therapist. Such intensive supervision is justified only where the medical records show the patient cannot safely work in a group setting. In this case, the activities consisted of using a treadmill and an unspecified arm exercise machine. There was no documentation that Claimant lacked the cognitive or physical abilities to perform these activities safely. Provider's records did not justify its billing under CPT 97530.

As for Carrier's objection to Claimant receiving individual aquatic therapy, Provider billed all sessionsBwhether group or individualBunder CPT 97113. Carrier failed to show that CPT code requires individual therapy or that there was an alternate code for billing group aquatic therapy. Therefore, Carrier failed to show that the use of CPT 97113 was improper.

Carrier should reimburse Provider for the aquatic therapy and office visits billed between May 14 and August 11, 2004, for but not for the services billed under CPT 97530 during that period.

III. FINDINGS OF FACT

1. In___, Claimant sustained a knee and shoulder injury compensable under the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN, ch. 401 *et seq*.

2. At the time of the compensable injury, Claimant's employer had workers' compensation insurance coverage with Texas Mutual Insurance Company (Carrier).

3. In February 2004, Claimant had surgery on his fractured knee and shoulder.

4. On April 29, 2004, Claimant's range of motion (ROM) in his shoulder was within functional limits and his knee active ROM was flexion 115 degrees and extension 0.

5. On April 29, 2004, Claimant rated the pain from his injuries as varying from 3 to 8 out of 10 and he was able to bear weight on his leg for a couple of steps at a time.

6. On April 29, 2004, Claimant's treating physician, Pete Garcia, M.D., prescribed knee and shoulder rehabilitation and aquatic therapy for Claimant.

7. Premier Physical Therapy (Provider) gave Claimant the rehabilitative exercises, office visits, and aquatic therapy prescribed by Dr. Garcia.

8. From May 14 through August 11, 2004, Claimant received aquatic therapy in both a group

setting and on an individual basis.

9. Provider billed all Claimant's aquatic therapy under CPT 97113, the only code available for aquatic therapy.

10. In August 2004, Claimant rated his pain at 7 out of 10. At that time, he was able to walk for up to15 minutes at a time.

11. Between May and August 2004, Claimant made significant progress in his ability to walk due to his therapy.

12. On June 10 and August 11, 2005, an expanded examination office visit billable under CPT 99213 was appropriate for Claimant.

13. From May 14 through August 11, 2004, Claimant did not suffer from cognitive deficits, physical inability to safely perform physical therapy exercises, or lack of knowledge of how to perform the exercises that would have made one-to-one physical therapy billable under CPT 97530 appropriate.

14. Carrier denied reimbursement to Provider for the physical therapy services rendered Claimant from May 14 through August 11, 2004.

15. Provider's appeal of the denial was considered by the Texas Workers' Compensation Commission's (Commission) designee, an Independent Review Organization (IRO).

16. Carrier appealed the IRO's decision to grant reimbursement to Provider.

17. The Commission Staff sent notice of hearing to the parties that 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.

18. Provider and Carrier were represented at the hearing held October 17, 2005, but the Commission Staff chose not to participate.

IV. CONCLUSIONS OF LAW

1. The Workers' Compensation Division of the Texas Department of Insurance[3] (formerly the Texas Workers' Compensation Commission) has jurisdiction related to 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 matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to ' 413.031 of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T

3 Acts of May 30, 2005, 79th Leg., R.S., ch. 265, 2005 Tex. Sess. Law Serv. Ch 265 (HB 7).

CODE ANN. ch. 2001, and the Commission's rules, 28 TEX. ADMIN. CODE (TAC) " 133.305 and 133.308.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. " 2001.051 and 2001.052.

5. Petitioner had the burden of proof in this proceeding. 28 TAC " 148.21(h) and (i); 1 TAC ' 155.41.

6. The IRO had authority to review the parties' positions and issue a decision pursuant to the Commission's rule at 28 TAC " 133.305 and 133.308.

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, including a medical appliance or supply. 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. To be entitled to payment from a carrier, a provider must submit a properly coded bill. See 28 TAC " 133.1(a)(3), 133.300, and 133.301

10. Provider is entitled to be reimbursed under CPT 99213 for Claimant's office visits occurring on June 10 and August 11, 2004.

11. Provider is not entitled to reimbursement for physical therapy provided Claimant and billed under CPT 97530 because those billings were not properly coded.

12. Provider is entitled to reimbursement for aquatic therapy billed under CPT 97113.

ORDER

It is **ORDERED** that Texas Mutual Insurance Company reimburse Premiere Physical Therapy for services billed under CPT97113 and 99213 provided to Claimant from May 14 through August 11, 2004.

It is further **ORDERED** that no reimbursement is due to Provider for active physical therapy

billed under CPT 97530, provided to Claimant from May 14 through August 11, 2004.

SIGNED November 1, 2005.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS