SOAH DOCKET NO. 453-05-8918.M5
TWCC MDR NO. M5-05-1620-01

TEXAS MUTUAL INSURANCE COMPANY, Petitioner	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
SOUTHEAST HEALTH SERVICES, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY

Texas Mutual Insurance Company (Carrier) and Southeast Health Services (Provider) appealed the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC)[1], which ruled on fee issues, and adopted the decision of Texas Medical Foundation, an independent review organization. This decision orders that the Carrier is not required to further reimburse the Provider for the contested services.

The Administrative Law Judge (ALJ) convened the hearing on January 17, 2006. The hearing was concluded and the record closed that day. The Carrier appeared through its representative Bryan Jones, attorney. The Provider failed to appear at the hearing and its appeal is dismissed without further discussion.[2]

II. EVIDENCE AND BASIS FOR DECISION

The issue presented in this proceeding is whether the Carrier should reimburse the Provider for medical services provided between February 3 and June 29, 2004, and billed under CPT Codes

[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] The Provider contested the MRD's denial of reimbursement in the amount of $9,279.47 for CPT Codes 99211 (office visits), 99212 (office visits), 99213 (office visits), 99214 (office visits), 97032 (electrical stimulation), 97016 (vasopneumatic devices), 97139 (unlisted therapeutic procedure), and 97140 (manual therapy). A claim is subject to dismissal for failure to prosecute pursuant to SOAH Rule 1 TEX. ADMIN. CODE § 155.56. The dismissal will become final 20 days from the date of this decision unless the Provider can show good cause for its failure to appear at the hearing.

97110 (therapeutic exercises), 97113 (aquatic therapy), 97150 (therapeutic exercises), 97530 (therapeutic activities), and 97140 (manual therapy). The Carrier argued that none of the medical services provided to the Claimant were medically necessary or reasonably required to treat the compensable injury. The amount in dispute for these CPT Codes is $4,343.61.

The documentary record consisted of two exhibits presented by the Carrier, Exh. 1 (472 pages), and Exh. 2 (25 pages). Additionally, David Alvarado, D.C., testified as an expert witness on behalf of the Carrier.

The Claimant suffered a work-related back injury on___, from repetitive lifting of heavy building materials. His treatment included three surgeries and many sessions of physical therapy. The Claimant was treated by the Provider beginning in January 2004 and continuing to August 2004.

Dr. Alvarado graduated from the Texas Chiropractic College in 1987. His practice is limited primarily to the evaluation and treatment of biomechanical back pain, and consulting services for several insurance carriers.[3] Dr. Alvarado reviewed the Claimant's medical records in preparation for his testimony.

Dr. Alvarado testified that the Provider treated the Claimant with both passive and active care. Regarding CPT Code 97110, he stated that the treatment was not medically necessary because the Claimant had received 272 units of therapeutic exercises prior to February 2004, and that any continuation of this particular care was excessive. Also, Dr. Alvarado stressed that the Claimant was well-versed in the exercises and that one-on-one care was not necessary because there was no documentation indicating that the Claimant had either safety or cognitive issues.

According to Dr. Alvarado, aquatic therapy provides for active exercises in a non-weight bearing setting and transitions the patient to land-based therapy. He stated that the Claimant had 206 units of aquatic therapy prior to the disputed dates of service and continued excessive amounts of this therapy was not medically necessary. Similarly, Dr. Alvarado testified that the Provider failed

[3] Exh. 1, page 408 and 409.

to document in the medical records what therapeutic activities were performed by the Claimant. Thus, in Dr. Alvarado's opinion, the activities were not medically necessary.

Dr. Alvarado testified that it is not appropriate to provide passive therapy for more than six months after an injury. Therefore, the manual therapy provided for the Claimant was, in his opinion, not medically necessary because it was provided long after the appropriate time frame.

The Provider also billed for group exercises. Dr. Alvarado stressed that the medical records contained no explanation to support delivery of this treatment. It was Dr. Alvarado's opinion that the exercises should have been performed in a home setting.

The ALJ concludes the Carrier established that the contested medical services billed under CPT Codes 97110, 97113, 97150, 97530, and 97140 delivered from February 3, 2004, through June 29, 2004, were not medically necessary and reasonably required to treat the Claimant's compensable injury. Dr. Alvarado's testimony was not rebutted by the Provider, due its failure to appear at the hearing. Therefore, the Carrier should not be required to reimburse the Provider for the contested services.

III. FINDINGS OF FACT

1. On___, the Claimant suffered a compensable injury to his back.

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

3. Southeast Health Services (Provider) began treating the Claimant in January 2004, following the Claimant's third back surgery and many sessions of physical therapy delivered by other providers.

4. The Carrier denied reimbursement to the Provider for medical services provided between February 3, 2004, and June 29, 2004, and billed under CPT Codes 97110 (therapeutic exercises), 97113 (aquatic therapy), 97150 (therapeutic exercises), 97530 (therapeutic activities), and 97140 (manual therapy).

5. The Claimant was familiar with the exercises performed at the one-on-one level of treatment.

6. The Claimant did not have either safety or cognitive issues requiring the one-on-one level of treatment.

7. Necessity for delivery of services at the one-on-one level of supervision was not documented in the medical records.

8. Direct one-on-one contact with the treating physician at each session of therapy was not necessary to treat the Claimant's injury.

9. The Claimant could have performed therapeutic exercises in a home-based setting instead of a one-on-one setting.

10. The Claimant had 206 units of aquatic therapy prior to the disputed dates of service and continued excessive amounts of this therapy did not provide relief for the Claimant.

11. The Provider failed to document in the medical records what therapeutic activities were performed by the Claimant.

12. It is not appropriate to provide passive therapy for more than six months after an injury.

13. The Provider timely requested dispute resolution by the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC).

14. On June 29, 2005, in MRD Tracking No. M5-05-1620-01, the MRD issued its decision which ruled on fee issues, and adopted the decision of Texas Medical Foundation, an independent review organization.

15. Both the Carrier and the Provider appealed portions of the MRD decision.

16. The Provider appealed the MRD's denial of reimbursement for CPT Codes 99211 (office visits), 99212 (office visits), 99213 (office visits), 99214 (office visits), 97032 (electrical stimulation), 97016 (vasopneumatic devices), 97139 (unlisted therapeutic procedure), and 97140 (manual therapy).

17. TWCC sent notice of hearing to the parties on October 26, 2005. The hearing notice 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.

18. The hearing on the merits convened January 17, 2006, before Michael J. Borkland, Administrative Law Judge. The Carrier appeared through Bryan W. Jones, attorney. The Provider failed to appear.

IV. CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction related to this matter pursuant to Acts of May 30, 2005, 79th Leg., ch. 265, 2005 Tex. Sess. Law Serv. Ch. 265 (HB7) and 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 TEX. LAB. CODE ANN. § 413.031 and TEX. GOV'T CODE ANN. ch. 2003.

3. Based on Finding of Fact No. 16, the Notice of Hearing issued by TWCC conformed to the requirements of TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. The 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.

5. Based on Findings of Fact Nos. 5 - 12, the services referred to in Finding of Fact No. 4 were not medically necessary.

6. A claim is subject to dismissal for failure to prosecute pursuant to SOAH Rule 1 TEX. ADMIN. CODE § 155.56.

7. Based on Conclusion of Law No. 6, the Provider's appeal of the items referred to in Finding of Fact No. 16 should be dismissed.

8. Based on Findings of Fact Nos. 5 - 12 and Conclusions of Law Nos. 4 and 5, the Carrier should not be required to reimburse the Provider for services billed under CPT Codes 97110, 97113, 97150, 97530, and 97140 beginning February 3, 2004, through June 29, 2004.

ORDER

IT IS, THEREFORE, ORDERED that Texas Mutual Insurance Company is not required to reimburse Southeast Health Services for medical services billed under CPT Codes 97110, 97113, 97150, 97530, and 97140 beginning February 3, 2004, through June 29, 2004, for treatment of the Claimant. Additionally, it is **ORDERED** that the Provider's appeal of CPT Codes 99211, 99212, 99213, 99214, 97032, 97016, 97139, and 97140 is dismissed.

SIGNED February 13, 2006.

MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS