SOAH DOCKET NO. 453-04-8259.M5
[MR NO. M5-04-0674-01]

SCD BACK & JOINT CLINIC,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
LIBERTY INSURANCE CORPORATION,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

SCD Back & Joint Clinic (SCD) challenged part of the opinion of the Texas Workers' Compensation Commission's (Commission's)[1] designee, an independent review organization (IRO), and the decision of its Medical Review Division (MRD) that office visits and physical medicine treatment that SCD provided to Claimant__were not medically necessary health care. The Administrative Law Judge (ALJ) finds that the majority of services in dispute were not medically necessary, but that SCD is due reimbursement for certain services denied with the explanation of benefits (EOB) code "D".

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Those issues are set out in the Findings of Fact and Conclusions of Law.

The hearing in this matter convened on May 3, 2005, before State Office of Administrative Hearings ALJ Carol Wood. William Maxwell, an attorney, represented SCD. Kevin Franta, an attorney, represented Liberty Insurance Corporation (Liberty). The case was reassigned to LJ Katherine Smith, who reviewed the entire record. The record closed on May 15, 2006, after briefing and the issuance of two orders requiring additional information.

Claimant sustained an on-the-job injury to her wrists on___. She had carpal tunnel release

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surgery on her left wrist on March 28, 2001, and carpal tunnel release surgery on her right wrist on October 2, 2002. SCD began treating Claimant on October 24, 2002, for the right wrist, as well as for the left wrist, low back pain, and pain in her shoulders. The treatments in dispute were provided from December 6, 2002, to April 7, 2003, and were billed under the following CPT[2] codes: 99213, 99214, and 99215 (office visits); 97014 (electrical stimulation); 97110 (one-on-one physical therapy); 97150 (group therapeutic procedures); 97250 (myofascial release); 97265 (joint mobilization); 95851 (range-of-motion measurements); 99750-MT (muscle testing); and 99080-73 (special reports). Liberty denied reimbursement using the EOB codes "V," lack of medical necessity based on peer review, or "D"for duplicate bill.

The IRO found that the treatments provided beyond February 3, 2003, were not medically necessary. The IRO also made specific findings regarding certain services provided before February 3, 2003. MRD also recommended no reimbursement for the services listed on the last page of its decision because neither SCD nor Liberty submitted the original denial reason other than "D". Liberty did not contest the services that the IRO found were medically necessary.

The following services are no longer at issue because they have been reimbursed by Liberty: office visits billed with CPT code 99213 on December 6, 9, and 11, 2002; office visits billed with CPT code 99213-52 on December 12, 2002, January 21 and February 3, 2003; $12 toward the office visit billed with CPT code 99214-52 on December 17, 2002; one-on-one physical therapy billed with CPT Code 97110 on December 9 and 11, 2002; muscle-testing billed with CPT code 97750-MT-52 on January 23, 2003; and joint mobilization billed with CPT code 97265 on January 29, 2003.

The following two charts set forth the dates of service still in dispute. The first chart includes dates of service that Liberty denied using the denial code "V" and that MRD found were not medically necessary based on the IRO's decision.[3]

Dates of Service	**CPT Codes**
2-10-03	97014

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12-17-02[4]	99214-52
4-1-03	99215-52
2-11-03	99215
12-26-02, 12-27-02, 12-30-02, 1-3-03, 1-6-03, 1-10-03, 1-13-03, 1-15-03, 1-17-03, 1-24-03, 1-27-03, 1-28-03, 2-5-06, 2-6-03, 2-10-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03, 4-7-03	99213-52
12-23-02 (3 units),[5] 1-7-03 (4 units)	97750-MT-52
2-11-03, 4-1-03, 4-3-03	97750-MT
2-11-03, 4-3-03	97750-MT-52
12-17-02	95851
2-11-03, 4-1-03	95851
2-5-03, 2-6-03, 2-10-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03	97250
2-5-03, 2-6-03, 2-10-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03	97265
2-17-03, 2-19-03, 2-20-03, 2-26-03	97110
2-5-03, 2-17-03, 2-19-03, 2-20-03	97150

The following chart setting out the dates of service that Liberty denied using the code "D" is derived from the last page of the MRD's decision.

Dates of Service	**CPT Codes**
1-28-03, 2-24-03, 3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97110
1-29-03, 1-31-03, 3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03, 3-26-03	99213-52
1-29-03	97014
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03, 3-26-03	97265
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03, 3-26-03	97250
3-5-03, 3-17-03, 3-19-03, 3-21-03, 3-26-03	97150

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3-20-03, 3-21-03	97750-MT-52
4/1/03[6]	99080-73

B. SCD's Position

David Bailey, D. C., who was one of Claimant's treating doctors, testified on behalf of SCD. He testified that the treatments in question--the office visits, one-on-one therapeutic exercises, myofascial release, and joint mobilizations--were medically necessary to repair muscles and because Claimant had a complex of injuries and conditions that needed to be monitored. He stated that he used the modifier -52 to indicate that he was charging only a portion of the fee to the wrist injury. Dr. Bailey also provided a written narrative in support of the medical necessity of the treatment provided. Pet. Ex. 2 at P519-552. SCD also asserts that Liberty failed to provide sufficient explanation of its denial codes in violation of 28 TEX. ADMIN. CODE (TAC) §133.304(c) and (k).

Liberty presented the testimony of its expert, Nick Tsourmas, M.D., an orthopedic surgeon who testified that much of the treatments that were provided were excessive and that the medical documentation did not justify the excessive treatment provided. He testified more specifically that he has performed many carpel tunnel releases, and that the treatment plan of October 24, 2002, to provide three physical therapy sessions a week for six weeks was unwarranted because the surgery did not involve the cutting of any muscle tissue, no muscles were affected by the surgery, and there were no complications from the surgery. Dr. Tsourmas also testified that there was no need to provide myofascial release and joint mobilization, which are passive treatments, because there were no complications from the surgery. He agreed with the peer reviewer who stated that no more than four weeks of postoperative care was warranted. Res. Ex. B0031-32. Dr. Tsourmas also testified that billing with CPT code 97110 requires that the physical therapist provide one-on-one, individualized, monitored treatment, which was not required and which was not justified in the record. Once Claimant had been adequately coached, she should have been able to perform the exercises at home. Dr. Tsourmas also noted that Claimant's other injuries would not justify so much treatment to the wrists because those complaints would not hamper the rehabilitation to the right wrist.

Dr. Tsourmas also testified that there was no need for muscle testing because no muscles were affected by the surgery and the treatment notes do not indicate that the muscle testing was used to vary the treatment provided. He testified that billing for daily office visits with CPT Code 99213, which requires a moderate amount of physical examination during the office visit, was excessive because there was no need for daily office visits during the time in question.

D. Analysis

1. Use of "D"EOB Code

As noted previously, the second chart above sets out the dates of service denied by Liberty using the EOB code "D" for duplicate bill. The following chart sets forth the dates of service for which there are other EOBs in the record with the denial code "V." Those services will be considered, therefore, with the services listed on the first chart above.

Dates of Service	CPT Code	Evidence
1-28-03, 2-24-03	97110	Res. Ex. B0018, B0021; Pet. Ex. 3 at P72
1-29-03, 1-31-03, 3-26-03	99213-52	Res. Ex. B0018, Pet. Ex. 3 at P66, P81
1-29-03	97014	Res. Ex. B0018
3-26-03	97265	Pet. Ex. 3 at P81
3-26-03	97250	Pet. Ex. 3 at P81
3-26-03	97150	Pet. Ex. 3 at P81

With regard to the remaining services listed on the second chart, the ALJ notes that there are no other EOBs in the record indicating that the services provided were ever paid or denied based on lack of medical necessity.[7] And, with the exception of the billing of CPT code 97150 on 3-5-03,

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3-19-03, and 3-21-03, which is referred to in the physical therapy notes as kinetics,[8] the ALJ finds that the medical notes indicate that the services billed were provided on those dates.[9]

As SCD argued, when an insurance carrier denies payment on a medical bill, 28 TAC §133.304(c) requires it to provide the correct EOB code and a sufficient explanation to allow the provider to understand the reason for the carrier's action. In this case the use of "D" was apparently all that SCD received, which was insufficient. SCD's remedy for Liberty's failure to provide sufficient explanation for the denial was to seek medical dispute resolution, as it has done in this case. 28 TAC § 133.304(m). Because 28 TAC §133.307(j)(2) bars Liberty from raising lack of medical necessity with regard to the services it denied solely with "D," it is obligated to reimburse SCD for those services, which are listed below:

Dates of Service	**CPT Codes**
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97110
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	99213-52
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97265
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97250
3-17-03	97150
3-20-03, 3-21-03	97750-MT-52
4/1/03	99080-73

2. Lack of Medical Necessity

The following services are still in dispute based on lack of medical necessity.

1-29-03, 2-10-03	97014

[8] There are no physical therapy notes at all for 3-21-03, and Pet. Ex. 1 at P328, P331 indicates no time was allotted to kinetics on 3-5-03 and 3-19-03.

12-17-02	99214-52
4-1-03	99215-52
2-11-03	99215
12-26-02, 12-27-02, 12-30-02, 1-3-03, 1-6-03, 1-10-03, 1-13-03, 1-15-03, 1-17-03, 1-24-03, 1-27-03, 1-28-03, 1-29-03, 1-31-03, 2-5-06, 2-6-03, 2 10-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03, 3-26-03, 4-7-03	99213-52
2-5-03, 2-6-03, 2-10-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03, 3-26-03	97250
2-5-03, 2-6-03, 2-10-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03, 3-26-03	97265
1-28-03, 2-17-03, 2-19-03, 2-20-03, 2-24-03, 2-26-03	97110
2-5-03, 2-17-03, 2-19-03, 2-20-03, 3-26-03	97150
12-23-02 (3 units), 1-7-03 (4 units)	97750-MT-52
2-11-03, 4-1-03, 4-3-03	97750-MT
2-11-03, 4-3-03	97750-MT-52
12-17-02	95851
2-11-03, 4-1-03	95851

Electrical stimulation was billed on January 29, 2003, with CPT code 97014. Because the IRO determined that electrical stimulation was necessary from November 11, 2002, through February 3, 2003, and Liberty did not appeal that decision, SCD is due payment for that date of service. The ALJ also finds that the one-on-one physical therapy provided on January 28, 2003, and billed with CPT code 97110 should be reimbursed because it falls within the time period found reasonable by the IRO. As for the electrical stimulation provided on February 10, 2003, Dr. Bailey provided no evidence in support of that treatment to sufficiently controvert the IRO's decision that such a treatment after February 3, 2003, was not medically necessary.

With regard to the office visits, the IRO found only the visit of December 19, 2002, which was billed with CPT code 99214, to be medically necessary. Otherwise, the IRO found that no evidence supported the "requirement for an expanded evaluation and management service/office visit on each patient encounter . . . , even with a -52 modifier."

When a healthcare provider bills for one of the three highest level office visits, which includes CPT codes 99213, 99214, and 99215, the Commission's rules require the healthcare provider to submit the following: progress or SOAP[10] notes substantiating the care given and the need for further treatment and services, and indicating progress, improvement, the date of the next treatment and services, complications, and expected release date.[11] The 1996 Medical Fee Guideline also sets out necessary criteria when billing with CPT codes 99213, 99214, and 99215.[12]

With those directives in mind, the ALJ finds the testimony of Dr. Tsourmas challenging the billing of daily office visits to be persuasive. Regarding the office visits provided on December 26, 27, 30, 2002, January 3, 6, 10, 13, 15, 17, 24, 27, 28, 29, 31, February 5, 6, 10, 17, 19, 20, 24, 26, March 26 and April 7, 2003, which were billed with CPT code 99213, that coding is not appropriate unless two of the following occur: an expanded problem-focused history, an expanded focused examination, and medical decision-making of low complexity. The SOAP notes document neither an expanded problem-focused history, nor an expanded focused examination. With regard to the office visit of December 17, 2002, which was billed with CPT code 99214-52, that coding requires that two of the following occur: a detailed history, a detailed examination, and medical decision-making of moderate complexity and that the presenting problems are of moderate to high severity requiring that the doctor spend 25 minutes face-to face with the patient. The SOAP notes document neither a detailed history, nor a detailed examination, nor medical decision-making of moderate complexity. Furthermore, Liberty paid for a portion of the office visit. With regard to the office visits of February 11 and April 1, 2003, that were billed with CPT code 99215, that coding requires that two of the following occur: a comprehensive history, a comprehensive examination, and

medical decision-making of high complexity and that the presenting problems are of moderate to high severity requiring that the doctor spend 40 minutes face-to face with the patient. The SOAP notes document neither a comprehensive history, nor a comprehensive examination, nor medical decision-making of high complexity.

With regard to the myofascial release and joint mobilization, Dr. Tsourmas's testimony supports the IRO's decision that those treatments were not necessary beyond February 3, 2003. The same reasoning is also applicable to the one-on-one physical therapy and group therapy provided after February 3, 2003. At that point, as Dr. Tsourmas testified, Claimant should have been performing exercises at home. Although Dr. Bailey presented a study in support of providing intensive one-on-one therapy for at least an hour three times per week, that study concerned treatment to the back. Pet Ex. 2 at P533, fn. 37, P534.

Because Dr. Bailey failed to rebut Dr. Tsourmas's persuasive testimony that muscle testing was not needed for Claimant's wrists because no muscles were involved in the carpal tunnel release surgery, the ALJ finds that the muscle testing billed on December 23, 2002 (3 units), and January 7, February 11, April 1 and 3, 2003, should not be reimbursed. Consistent with the opinions of the IRO and Dr. Tsourmas, the ALJ also finds that the range-of-motion measurements provided on December 17, 2002, February 11 and April 1, 2003, should not be reimbursed.

Over all the ALJ finds that Dr. Bailey's assessment of the treatment plan provided was conclusory, duplicative, and short on details. *See e.g.*, Pet. Ex. 2 at P523, P545. Furthermore, Dr. Bailey's assessment that Claimant benefitted from the program is questionable. Despite her pain-level being a three out of 10 on April 1, 2003, on that same date she was being recommended for chronic pain management, and she continued to get treatment into July 2003, because her pain-level was a six out of 10. Pet. Ex. 2 at P526; Pet. Ex. 1 at P266. Furthermore, it is not clear from the record that any improvement in pain-level was to her right wrist, because the narrative suggests that Claimant's lower back pain was her primary complaint. Pet. Ex. 2 at P519-20.

Concluding that the majority of the care provided in this case was inadequately documented and excessive, the ALJ finds that SCD has failed to meet its burden of proof that the treatments provided Claimant were medically necessary and denies reimbursement of the disputed claims, except for the one-on-one physical therapy provided on January 28, 2003; electrical stimulation

provided on January 29, 2003; myofascial release, joint mobilization, one-on-one physical therapy, office visits provided on March 3, 5, 7, 17, 19, and 24, 2003; group therapy provided on March 17, 2003; muscle testing provided on March 20 and 21, 2003; and a special report provided on April 1, 2003.

III. FINDINGS OF FACT

1. Claimant__ sustained a compensable injury to her wrists on____.

2. She had carpal tunnel release surgery on her left wrist on March 28, 2001, and carpal tunnel release surgery on her right wrist on October 2, 2002.

3. SCD Back & Joint Clinic (SCD) began treating Claimant on October 24, 2002, for her right wrist, as well as for her left wrist, lower back pain, and pain in her shoulders.

4. At the time of the compensable injury, Claimant's employer had workers' compensation insurance coverage with Liberty Insurance Corporation (Liberty).

5. The treatments in dispute were provided from December 6, 2002, to April 7, 2003.

6. The treatments in dispute were billed under the following current procedural terminology (CPT) codes: 99213, 99214, and 99215 (office visits); 97014 (electrical stimulation); 97110 (one-on-one physical therapy); 97150 (group therapeutic procedures); 95851 (range-of-motion measurements); 99750-MT (muscle testing); 97250 (myofascial release); 97265 (joint mobilization); and 99080-73 (special reports).

7. Liberty denied reimbursement using the explanation of benefits (EOB) codes "V," lack of medical necessity based on peer review, or "D" for duplicate bill.

8. SCD appealed to the Texas Workers' Compensation Commission (Commission), which referred the dispute to its designee, an independent review organization (IRO).

9. On June 29, 2004, the Commission's Medical Review Division (MRD) issued a decision based on the IRO's review, which largely found that the treatments provided after February 3, 2003, were not medically necessary.

10. MRD also found that because neither SCD nor Liberty submitted a denial reason other than "D" for several dates of service in dispute listed on the last page of its decision, it could not determine the reason for the denial, and therefore, recommended no reimbursement for those services.

11. SCD timely appealed the MRD's decision on July 21, 2004.

12. On August 19, 2004, the Commission issued the notice of hearing, which stated the date, time, and location of the hearing and cited to the statutes and rules involved, along with a short, plain statement of the factual matters involved.

13. Liberty denied the following dates of service, which are documented with medical records indicating that the services were provided, using only the EOB code "D" and not "V":

Dates of Service	**CPT Code**
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97110
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	99213-52
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97265
3-3-03, 3-5-03, 3-7-03, 3-17-03, 3-19-03, 3-24-03	97250
3-17-03	97150
3-20-03, 3-21-03	97750-MT-52
4/1/03	99080-73

14. Although Liberty denied payment for group therapy/kinetics billed with CPT code 97150 using only the EOB code "D," no medical notes document that group therapy/kinetics were provided to Claimant on March 5, 19, and 21, 2003.

15. The electrical stimulation provided on January 29, 2003, and billed with CPT code 97014 was reasonable medical care.

16. The one-on-one physical therapy provided on January 28, 2003, and billed with CPT code 97110 was reasonable medical care.

17. The remaining treatment provided Claimant was excessive, and the medical documentation does not justify the excessive treatment provided because the carpal tunnel surgery did not involve the cutting of any muscle tissue, no muscles were effected by the surgery, and there were no complications from the surgery.

18. The treatment notes do not document why passive treatments, including joint mobilization and myofascial releases, were being provided four months after the surgery when no complications from the surgery were documented.

19. One-on-one, individualized, monitored physical therapy was not required beyond February 3, 2003, and was not justified in the treatment notes.

20. Once Claimant had been adequately coached, she should have been able to perform the exercises at home.

21. There was no need for muscle testing because no muscles were affected by the surgery and the treatment notes do not indicate that the muscle testing was used to vary the treatment provided.

22. The need for range-of-motion measurements and special reports was not justified in the medical notes.

23. The medical records from the office visits provided on March 7, 10, 11, 17, 18, 19, 26, 27, 28, and 31, which were billed with CPT code 99213, document neither an expanded problem-focused history, nor an expanded focused examination.

24. The medical records from the office visit of December 17, 2002, which was billed with CPT code 99214-52, document neither a detailed history, nor a detailed examination, nor medical decision-making of moderate complexity.

25. The medical notes from the office visits of February 11 and April 1, 2003, which were billed with CPT code 99215, document neither a comprehensive history, nor a comprehensive examination, nor medical decision-making of high complexity.

26. Claimant's other injuries did not justify such extensive treatment to the wrists because those complaints should not have hampered rehabilitation to the right wrist.

IV. CONCLUSIONS OF LAW

1. 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. LABOR CODE ANN.§§ 402.73(b) and 413.031(k) (West 2005), TEX. GOV'T CODE ANN. ch. 2003, and Acts 2005, 79th Leg., ch. 265, §8.013, eff. Sept. 1, 2005.

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

3. SCD had the burden of proof in this proceeding. 28 TEX. ADMIN. CODE (TAC) §§ 148.21(h) and (i); 1 TAC § 155.41.

4. When Liberty denied payment for the services noted in Finding of Fact No. 13 using the "D" explanation of benefits (EOB) code it did not sufficiently apprise SCD of its reasons for denial. 28 TAC 133.304(c); TEX. LABOR CODE ANN. § 408.027(e).

5. Because Liberty provided no basis for denying reimbursement for the dates of service noted in Finding of Fact No. 13 other than "D" it is precluded from raising lack of medical necessity for denying the claim for those dates. 28 TAC § 133.307(j)(2).

6. SCD is due reimbursement from Liberty for the services noted in Finding of Fact No. 13. TEX. LABOR CODE ANN. § 408.021.

7. When a healthcare provider bills for an office visit using CPT code 99213, 99214, and 99215 and for physical medicine treatment, the healthcare provider must submit progress or SOAP notes substantiating the care given and the need for further treatment and services, and indicating progress, improvement, the date of the next treatment and services, complications, and expected release date. 28 TAC §133.1.

8. Use of CPT code 99213 requires that two of the three occur during an office visit--an expanded problem-focused history, an expanded focused examination, and medical decision- § 134.201.

9. Use of CPT code 99214 requires that two of the three occur--a detailed history, a detailed examination, and medical decision-making of moderate complexity--and that the presenting problems are of moderate to high severity requiring that the doctor spend 25 minutes face-to face with the patient. 1996 Medical Fee Guideline, adopted by reference in 28 TAC § 134.201.

10. Use of CPT code 99215, requires that two of the three occur--a comprehensive history, a comprehensive examination, and medical decision-making of high complexity--and that the presenting problems are of moderate to high severity requiring that the doctor spend 40 minutes face-to face with the patient. 1996 Medical Fee Guideline, adopted by reference in 28 TAC §134.201.

11. Based upon Findings of Fact nos. 17-26 and Conclusions of Law nos. 5-8, the treatments provided to Claimant that included office visits, physical therapy, joint mobilization, myofascial release, muscle testing, and range-of-motion measurements were not medically necessary health care under TEX. LAB. CODE ANN. §§401.011 and 408.021(a).

12. Based upon the foregoing findings of fact and conclusions of law, SCD's request for reimbursement should be denied, except for the one-on-one physical therapy provided on January 28, 2003; electrical stimulation provided on January 29, 2003; myofascial release, joint mobilization, one-on-one physical therapy, office visits on March 3, 5, 7, 17, 19, and 24, 2003; group therapy provided on March 17, 2003; muscle testing provided on March 20 and 21, 2003; and a special report provided on April 1, 2003.

ORDER

IT IS THEREFORE, ORDERED that Liberty Insurance Company shall reimburse SCD Back & Joint Clinic for the following services: one-on-one physical therapy provided on January 28, 2003; electrical stimulation provided on January 29, 2003; myofascial release, joint mobilization, one-on-one physical therapy, office visits on March 3, 5, 7, 17, 19, and 24, 2003; group therapy provided on March 17, 2003; muscle testing provided on March 20 and 21, 2003; and a special report provided on April 1, 2003. The remainder of SCD's request for reimbursement in this case is denied.

SIGNED July 10, 2006.

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KATHERINE L. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS