DOCKET NO. 453-03-1539.M5
[MDR TRACKING NO. M5-02-3272-01]

KENT RICE, D.C., *Petitioner*	§	**BEFORE THE STATE OFFICE**
VS.	§	**OF**
LIBERTY MUTUAL INSURANCE COMPANY, *Respondent*	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Kent Rice, D.C., appealed an Independent Review Organization (IRO) determination upholding a Liberty Mutual Insurance Company (Liberty Mutual) decision denying payment, on the basis of medical necessity, of certain services he provided to an injured worker (Claimant) from August 21, 2001, through December 12, 2001. This proposal concludes that Dr. Rice proved the majority of services were medically necessary and should be paid. Some services were not shown to be medically necessary and should be denied.

I. Procedural History and Jurisdiction

A hearing convened in this case on June 24, 2003, before James W. Norman, Administrative Law Judge (ALJ), at the State Office of Administrative Hearings, 300 West 15th Street, Austin, Texas. Dr. Rice appeared and represented himself. Liberty Mutual appeared and was represented by Charlotte Salter, Attorney. The hearing closed on June 24, 2003.

As there were no issues concerning notice or jurisdiction, those matters are stated in the fact findings and legal conclusions without further discussion here.

II. Discussion

A. Background

1. Factual

The Claimant was injured on_____, while operating an 18-wheel truck inside a shipping yard when another truck struck the right front passenger door of his vehicle. The Claimant suffered injuries to his neck, mid-back, and low-back regions. He presented to Dr. Rice and received treatments and services for more than a year. He stopped treatments and was released to go back to work in 1999. In 2001, he saw Dr. Rice again because of an exacerbation of his condition.

Dr. Rice's cervical spined diagnoses were cervical radiculoneuropathies resulting in myofascitis, associated with muscle spasms, muscle weakness, motion deficits, intersegmental joint dysfunction, complicated by left posterior central disc herniation at C4-5, C5-5 and C6-7, and 50 percent narrowing of the C5 neural formina due to the disc herniation. His lumbar spine diagnoses were lumbar radiculoloneuropathies resulting in myofascitis, associated with muscle spasms, muscle

weakness, intersegmental joint dysfunction, complicated by posterior L3-4 disc bulging, disc herniation at L4-5 and L5-S1, and rostalcaudal subluxation at the L4-S1 neural foramina.

The CPT codes for the disputed services are:

- 99213- office or other outpatient visit for the evaluation and management of an established patient, requiring at least two of the following three key components: an expanded problem-focused history; an expanded problem focused examination; medical decision making of low complexity. Presenting problems are of low complexity, typically requiring 15 minutes of face-to-face time with the patient.

- 99215- office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following three components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Presenting problems are usually of high complexity, typically requiring 40 minutes of face-to-face time with the patient.

- 97012- supervised traction, mechanical.

- 97024-supervised diathermy.[1]

- 99362-medical conference with interdisciplinary team of medical health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes.

- 99090-analysis of information data stored in computers (e.g. ECGs, blood pressures, hematologic data).

2. Legal

An employee who sustains 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: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment. TEX. LABOR CODE ANN. § 408.021. "Health care" includes "all reasonable and necessary medical . . . services." TEX. LABOR CODE § 401.011(19).

[1]Defined as heating of the body tissues due to their resistance to the passage of high-frequency electromagnetic radiation, electric currents, or ultrasonic waves. Tissues may be warmed or coagulated and destroyed. *Dorland's Illustrated Medical Dictionary* (28th ed. 1994) at 462.

B. Scope of Dispute

The ALJ concludes that Liberty Mutual's ground of dispute in this case is limited to denial code U because all the disputed services were denied under that code. Denial code U is defined as "unnecessary treatment without a peer review," meaning the insurer denies payment because it deems the treatment or service to be medically unreasonable or unnecessary or both.

At the hearing, Liberty Mutual argued that the claim should be denied because it did not meet the requirements of Spine Treatment Guidelines (SPTG) subsection (e)(3)(E),[2] requiring documentation for manipulation to show objective or quantitative and continued measures of improvement over time and SPTG subsection (e)(2)(E), requiring manipulations over the minimum appropriate duration.

The primary reason for not considering the SPTG ground for denial is that Liberty Mutual did not assert denial code T (treatment/service falls outside the parameters set in the appropriate Commission guideline) when it denied the claim. The Commission rules at 28 TAC § 133.304(c) require an insurer to provide sufficient explanation of a claim denial to allow a provider to understand its reasons. Several SOAH cases have held an insurer is precluded from later raising a ground for denial it failed to assert before medical dispute resolution.[3] A secondary reason for not considering the SPTG is that the provision cited by Liberty Mutual concerns manipulations and the services represented by the CPT codes in dispute do not appear to involve that type of procedure.

C. Medical Necessity of Services Under Various CPT Codes

Dr. Rice had the burden of proof. He testified generally that the services and treatments he provided were medically necessary. He cited the record at several places,[4] where the patient described either decreased pain or improvement or both. He cited an evaluation by John Dozier, D.C., where the Claimant said the physical therapy and chiropractic care "helped a lot."[5]

Dr. Rice testified as follows concerning some of the disputed CPT codes:

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[2]The SPTG is in former 28 TEX. ADMIN. CODE (TAC) § 134.1001. All the Commission treatment guidelines were abolished effective January 1, 2002. Act of May 25, 2001, 77th Leg., R.S. ch. 1456 § 6.09(b), 2001 Tex. Gen Laws 5188. However, guidelines are sometimes still relied on, in the absence of other standards, as persuasive evidence of appropriate care.

[3]*See* for example, SOAH Docket 453-01-0309.M5 (2001).

[4]Ex. 2 at 33, 53, 54, 79, 87-88, and 90-91.

[5]Ex. 3 at 5.

- CPT code 99213 office visits were necessary as a part of case management, *i.e.*, meeting with the Claimant for an expanded history or examination and to make medical decisions. He cited the fact that Liberty Mutual generally did not deny the actual treatments but unexplicably denied his ability to meet with the Claimant and evaluate his care.

- CPT code 99090 represented the time he spent in reviewing reports from the pain management doctor, Michele Wiggins, M.D., to whom he sent the Claimant for epidural steriod injections.

- CPT code 99362 represented the time he spent in a conference with a Liberty Mutual doctor to monitor the Claimant's care.

Dr. Rice complained that at times Liberty Mutual sometimes paid for the type of service at issue and sometimes denied it. He said it appeared to just randomly deny certain services.

The IRO doctor's opinion and Dr. Rice's response to them are as follows:[6]

- There was no quantitative objective evidence in the records that show improvement in the Claimant's condition. As shown above, Dr. Rice cited several places in the record where his notes said the Claimant reported improvement in his condition, pain relief, or both.

- There were no recommendations for referrals or consideration of other types of treatment. Dr. Rice cited the fact that he referred the Claimant to a pain management specialist for epidural steriod injections.

- There was no suggestion of stopping care for a period of time to see how the Claimant would respond without treatment. Dr. Rice testified the Claimant needed ongoing treatment but said he was able to decrease treatment frequency over time.

- There was some relief from epidural steriod injections but there was no evidence of significant relief from chiropractic care. Dr. Rice challenged the IRO doctor's ability to know the source of the Claimant's relief without seeing him. He asserted the IRO doctor could not differentiate one kind of care from another in this respect. He testified the Claimant had received a full gamut of care, including physical therapy, xanaflex, neurotonin, other prescription medications, anti-inflammatories, kinetic rehabilitation exercises, massage, and manipulations, in addition to the epidural steriod injections.

- There was no objective evidence to support the care during the period in question.

[6]The only substantive expert opinion evidence that the services were not medically necessary was from the IRO review doctor. Liberty Mutual's evidence also contained opinions from John Dozier, M.D., dated December 18, 2001, Mary Lou Skelton, D.C., dated March 12, 1999, and David Richardson, D.C., dated February 11, 1998, and March 2, 1998. Dr. Richardson's and Dr. Skelton's opinions obviously addressed services that pre-dated the ones at issue. Dr. Dozier simply said that any additional medical services after December 18, 2001, would be unnecessary. Ex. 3 at 9.

Dr. Rice maintained there was evidence, as shown above.

In addition to arguing that Dr. Rice did not meet SPTG requirements of providing objective measurements of the Claimant's progress and citing to the above-described peer reviews, Liberty Mutual cited Dr. Rice's reports[7] as showing the Claimant progressed very little under Dr. Rice's care.

D. Analysis

The evidence shows the services described in CPT codes 99213, 99090, and 99362 were medically necessary. In relation to CPT code 99213, Dr. Rice's explanation that he needed to meet with the Claimant to monitor his care and properly evaluate his condition and make medical decisions was convincing. Exhibit 4 shows that Liberty Mutual paid for some but not all office visits. The reason for denying some office visits but not others could have been its belief that it was not necessary for Dr. Rice to see the patient as often as he did. However, there was no expert evidence to that effect and the ALJ is not able to serve as his own expert in reaching to that conclusion.

Dr. Rice's explanation of the 99090 and 99362 CPT code services was also reasonable and persuasive. It was obviously important to spend time reviewing reports from the pain management doctor who gave the Claimant the epidural steroid injections and to spend time conferring with Liberty Mutual's doctor.

In connection with the above-stated conclusion, the ALJ notes that Liberty Mutual generally paid for the actual treatments. Liberty Mutual's evidence and argument at the hearing was directed toward all the treatments/services during the period at issue. Its argument seems to be that since none of the services were necessary, the services at issue were also uneeded. However, the services that were paid for are not at issue in this case-the ALJ must assume Liberty Mutual thought they were justified. The CPT code 99213, 99090, and 99362 services appear to be justified in conjunction with the undisputed services provided.

The ALJ concludes that medical necessity was not shown for the CPT code 99215, 97012, and 97024 services. Dr. Rice did not specifically address those services in his testimony. His general testimony that the services were medically necessary and that the Clamant benefitted generally does not demonstrate that the specific services provided under those CPT codes were necessary. This is particularly true of CPT code 99215, where there was no showing that an extended office visit to discuss complex matters was appropriate.

III. Findings of Fact

[7]Ex. 2 at 7, 30, 57, and 93.

1. Kent Rice, D.C., appealed an Independent Review Organization (IRO) determination upholding a Liberty Mutual Insurance Company (Liberty Mutual) decision denying payment for certain services he provided to an injured worker (Claimant) from August 21, 2001, through December 12, 2001.

2. It is undisputed that Dr. Rice appealed not later than the 20th day after he received notice of the decision.

3. All parties received not less than 10 days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

4. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

5. The Claimant was injured on_____, while operating an 18-wheel truck inside a shipping yard when another truck struck the right front passenger door of his vehicle.

6. The Claimant suffered injuries to his neck, mid-back, and low-back regions.

7. The Claimant received treatment from Dr. Rice until 1999, when he was released to go back to work.

8. In 2001, the Claimant presented to Dr. Rice again because of an exacerbation of his injury.

9. Services or treatments Dr. Rice provided or made available in 2001 included: physical therapy; xanaflex, neurotonin, and other prescription medications; anti-inflammatories; kinetic rehabilitation exercises; massage; manipulations; and epidural steroid injections.

10. Liberty Mutual paid for many of the treatments and services described in Finding of Fact No.

11. Office visits with the Claimant were necessary to monitor the Claimant's condition, for expanded histories or examinations, and to make medical decisions.

12. It was necessary for Dr. Rice to spend time reviewing the reports of the pain management doctor to whom he sent the Claimant for epidural steriod injections.

13. It was necessary for Dr. Rice to confer with Liberty Mutual's doctor concerning care issues with the Claimant.

14. There was insufficient specific evidence to prove the services Dr. Rice provided under CPT codes 99215, 99090, and 99362 were medically necessary.

15. There was no evidence that Dr. Rice's charge for the services at issue exceeded the maximum allowable reimbursement.

IV. Conclusions of Law

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE ANN. §413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

2. All parties received adequate and timely notice of the hearing. TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. Dr. Rice had the burden of proof in this matter. 28 TEX. ADMIN. CODE §148.21(h).

4. Liberty Mutual should pay for the disputed services represented by CPT codes 99213, 99362, and 99090.

5. Dr. Rice did not meet his burden of proving that Liberty Mutual is liable for the disputed services represented by CPT codes 99215, 97012, and 97024.

ORDER

IT IS, THEREFORE, ORDERED that Liberty Mutual Insurance Company pay Kent Rice, D.C., the amount charged plus interest for the disputed services represented by CPT codes 99213, 99362, 99090.

IT IS ORDERED FURTHER Liberty Mutual Insurance Company is not liable for paying for the disputed services represented by CPT codes 99215, 97012, and 97024.

Signed July 8th, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

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JAMES W. NORMAN
Administrative Law Judge