DOCKET NO. 453-03-3116.M5
[MDR TRACKING NO. M5-03-0132-01]

A. KENT RICE, D.C.	§	**BEFORE THE STATE OFFICE**
	§	
V.	§	**OF**
	§	
CITY OF HOUSTON	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

A. Kent Rice, D.C. (Provider) has appealed a Texas Workers' Compensation Commission (TWCC) Medical Review Division (MRD) order, based on an independent review organization (IRO) review. They found that certain services that he provided to _____ (Claimant) from May 6, 2002, through July 19, 2002 (Disputed Services), were not medically necessary to treat the Claimant's compensable injury. The City of Houston (Employer), which is self-insured, denied reimbursement for the Disputed Services, contending that some were not billed in accordance with the negotiated contract price and that the remaining were not medically necessary.

The total maximum allowable reimbursement (MAR) amount in controversy is $3,925. The Parties agree that the Provider, who did not prevail before the IRO, has the burden of proof. The only disputed issue are:

- What were the negotiated contract prices for the Disputed Services; and
- Were the Disputed Services provided after May 17, 2002, medically necessary?

As set out below, the Administrative Law Judge (ALJ) finds that:

- The negotiated contract price for the Disputed Services is 85 percent of the MAR;
- The Provider should be reimbursed $978.35 for the May 6, 2002, through May 17, 2002, Disputed Services, which is 85 percent of the total MARs;
- Two medical conferences to coordinate activities of patient care when the patient was not present, CPT Code 99362, on May 30 and July 17, 2002, were reasonably medically necessary;
- The Provider should be reimbursed a total of $161.50 for those CPT Code 99362 services, which is 85 percent of the total MAR; and
- The Provider's request to be further reimbursed for the Disputed Services should be denied.

II. DISCUSSION

The Provider began providing care to the Claimant on_____, four days after the Claimant was injured. The Provider furnished chiropractic, physical-therapy, and other services to the Claimant. The services in dispute (Disputed Services) were provided to the Claimant from May 6, 2002, through July 19, 2002.

A. Contract Price

The Employer denied the entire requested reimbursement for the portion of Disputed Services provided from May 6, 2002, through May 17, 2002, maintaining the that the Provider had billed more than the negotiated contract price. However, the Employer did not pay a contract price for those services; it paid nothing. While there was some confusion, the Provider testified that he had agreed with Rockport, an entity which he stated handled contract administration for the Employer, to accept 85-percent reimbursement of the MAR for the Disputed Services. The Employer's attorney was not familiar with Rockport, but there was no evidence to dispute the Provider's testimony on this point.

The ALJ concludes that the Provider should be reimbursed $978.35 for the May 6, 2002, through May 17, 2002, Disputed Services, which equals 85 percent of the total MARs.

B. Medical Necessity

Reports by the IRO and by W. Bryan Woods, D.C., stated that typical standards of care within the chiropractic profession allow for up to eight weeks of conservative care for soft tissue injury like the Claimant's. Dr. Woods also noted that the Commission's former Spine Treatment Guideline provided a similar standard. The Provider argued that the Guidelines have been repealed and were never firm rules. He also contended that each case is different. The Petitioner's statements are correct, but Dr. Woods opinion is still sufficient to suggest that more than eight weeks of care by the Provider is atypical and should be more specifically explained.

Only four months after the injury, there already were indications that the Claimant did not need the Provider's chiropractic and physical-therapy services. The Claimant was also treated by David W. Strausser, M.D., who is an orthoepedist. On December 26, 2001, the Claimant told Dr. Strausser that he had been receiving chiropractic and physical-therapy from the Provider for three months and his symptoms had not significantly improved. Dr. Strausser opinion was that the Claimant's symptoms would most likely persist and not improve with such further conservative treatment. Dr. Strausser believed the Claimant needed an anterior cervical discectomy and fusion with decompression at the fifth and sixth cervical vertebrae (C5 and C6).

Why then was the Provider still treating the Claimant seven to ten months after the injury, when the Disputed Services were provided? The Provider repeatedly asserted that the Claimant needed and was entitled to care, but he did not show why the Claimant needed his care.

The Claimant's pain was not decreasing. The Provider stated that the Claimant's condition cycled between better and worse over time and that the Claimant did not want to have surgery, was still in pain, and needed the Provider's care while he considered the surgery options. However, the Claimant's pain level was five out of ten when he first visited the Provider four days after the injury, a four or five out of ten when he visited Dr. Strausser three months after the injury, and remained at five out of ten throughout the last date of the Disputed Services, ten months after the injury. In short, the Provider's care did not significantly decrease the Claimant's pain.

There was no general improvement in the Claimant's function or decrease in his general level of disability. The Provider testified that the Claimant was not static and stable, which would have required the Provider to find that he had reached maximum medical improvement and assign him an impairment rating. However, the documents show that the Claimant had constant and continuing

levels of problems with his activities of daily living. Even on the day of hearing over 23 months after the injury, the Claimant, still has not been released to return to his former work.

In certain respects, the Claimant's range of motion and muscle capacity, which the Provider testified were related to the spinal injury and nerve function, improved between April 24, 2002, and May 27, 2002. But nearly as many capacities declined, as set out below:

	April 24, 2002	May 27, 2002	Percent change
left elbow flexion	20 lb.	31 lb.	+55
maximum cervical flexion angle	33E	47E	+42
right elbow flexion	28 lb.	38 lb.	+36
right elbow extension	30 lb.	38 lb.	+26
left elbow extension	26 lb.	32 lb.	+23
maximum cervical right lateral flexion angle	27E	33E	+22
right shoulder horizontal adduction	48 lb.	58 lb.	+21
left shoulder horizontal adduction	47 lb.	52 lb.	+11
right shoulder abduction	33 lb.	34 lb.	+3
right hip extension	60 lb.	60 lb.	0
left shoulder abduction	24 lb.	24 lb.	0
left hip extension	58 lb.	57 lb.	-2
left hip adduction	50 lb.	36 lb.	-28
left hip flexion	59 lb.	35 lb.	-41
right hip flexion	61 lb.	34 lb.	-44
right hip adduction	55 lb.	27 lb.	-51
left hip abduction	59 lb.	26 lb.	-56
right hip abduction	59 lb.	25 lb.	-58
sleep disruption	yes	no	

The Provider argued that the Claimant had complications necessitating a longer period of care than would be typical. He noted that the Claimant had to see an orthopedic surgeon for evaluation and pain-management specialists for injections. While it appears there were complications, there is no persuasive evidence that those necessitated continuing chiropractic and physical-therapy services from the Provider.

Even if the chiropractic and physical-therapy services were unnecessary, the Provider testified that, as the Claimant's treating doctor, he needed to continue to oversee the Claimant's care. That oversight included providing referrals, *etc.* He noted that some of the Disputed Services, including at least in part the Claimant's visits to his office, were for administration and diagnostics and not just treatment. With only a few exceptions, however, the Disputed Services were not reasonably necessary for those purposes either.

Certainly none of the physical therapy services were necessary; they had nothing to do with oversight, etc. Moreover, the Claimant generally visited the Provider's office three times per week. Absent detailed and specific evidence, the ALJ cannot reasonably conclude that such frequent visits were needed to coordinate care. Nor can the ALJ reasonably conclude that continuing to analyzing computer data concerning the unnecessary chiropractic and physical-therapy services was reasonably necessary.

That leaves two CPT Code 99362 services–medical conferences to coordinate activities of patient care when the patient was not present–on May 30 and July 17, 2002. Given the undisputed need to coordinate with the orthopedic surgeon and the pain-management provider, the ALJ finds that those services were necessary. Accordingly, the Provider should be reimbursed for a total of $161.50 for those two CPT Code 99362 services, which equals the contracted 85 percent of the MAR. The Provider's request to be further reimbursed for the remaining Disputed Services after May 17, 2002, should be denied.

III. FINDINGS OF FACT

1. _____ (Claimant) sustained a work-related injury on_____, while his employer was City of Houston (Employer).

2. The Employer was self-insured for workers' compensation claims.

3. The compensable injury extended to the Claimant's cervical spine and middle and low back.

4. A. Kent Rice, D.C., (Provider) began treating the Claimant on September 21, 2001.

5. From May 6, 2002, through July 19, 2002, the Provider furnished the following services to the Claimant (Disputed Services):

CPT Code, Service	Dates of Service in 2002
99213, established patient office visit, level 3	5/6, 5/9, 5/10, 5/13, 5/15, 5/17, 5/20, 5/22, 5/24, 5/29, 5/31, 6/10, 6/11, 6/14, 6/17, 6/19, 6/20, 7/15, 7/17, 7/19
97014, electrical muscle stimulation –– Unattended	5/6, 5/9, 5/10, 5/13, 5/15, 5/17, 5/20, 5/22, 5/24, 5/27, 5/29, 5/31, 6/10, 6/11, 6/14, 6/17, 6/19, 6/20, 7/15, 7/17, 7/19
97012, application of a modality to one or more areas; traction, mechanical	5/6, 5/9, 5/13, 5/15, 5/17, 5/22, 5/24, 5/27, 5/29, 5/31, 6/10, 6/11, 6/14, 6/17, 6/19, 6/20, 7/15, 7/17, 7/19

CPT Code, Service	Dates of Service in 2002
97024, active care muscular re-education; diathermy	5/9, 5/10, 5/17, 5/20, 5/22, 6/10, 6/11, 6/14, 7/15, 7/17
A4556, electrodes	5/9
97250, myofascial release/soft tissue mobilization	5/20, 5/31, 6/20
97530, therapeutic activities, use of dynamic activities to improve functional performance	5/6, 5/10, 5/13, 5/15, 5/17, 5/20, 5/22, 5/24, 5/29, 5/31, 6/17
99215, established patient office visit, level 5	5/27
95900, conduction, velocity and/or latency study; motor each nerve	5/27, 5/27
95851, range of motion measurements	5/27, 5/27
99090, Analysis of information data stored in computers	5/30, 6/21
99362, medical conference to coordinate activities of patient care; patient not present (60 minutes)	5/30, 7/17

6. The Provider timely sought reimbursement of the maximum allowable reimbursement (MAR) for the Disputed Services, which totaled $3,925.

7. The Employer denied the entire requested reimbursement for the Disputed Services provided from May 6, 2002, through May 17, 2002, maintaining the that the Provider had billed more than the negotiated contract price.

8. The Provider had agreed with Rockport, an entity that handled contract administration for the Employer, to accept 85-percent reimbursement of the MAR for the Disputed Services.

9. The MAR for the Disputed Services provided from May 6, 2002, through May 17, 2002, totaled $1,151, and 85 percent of that total is $978.35.

10. The Employer denied the entire reimbursement requested for the Disputed Services provided from May 20, 2002, through July 19, 2002, maintaining that they were not medically necessitated by the compensable injury.

11. Typical standards of care within the chiropractic profession allow for up to eight weeks of conservative care, like those provided by the Provider, for soft tissue injuries like the Claimant's.

12. The Provider furnished the Disputed Services to the Claimant seven to ten months after the

injury.

13. Despite being provided chiropractic and physical-therapy services by the Provider since September 21, 2001, by the time the Disputed Services were provided:

- The Claimant's pain had not decreased;
- There was no general improvement in the Claimant's function or decrease in his general level of disability;
- The Claimant had not returned to work; and
- His overall ranges of motion and muscle capacities had not improved.

14. The Claimant needed care from an orthopedic surgeon and a pain-management provider.

15. As the Claimant's treating doctor, the Provider reasonably needed to provide the two CPT Code 99362 services, on May 30 and July 17, 2002, to coordinate the Claimant's care with the orthopedic surgeon and the pain-management provider.

16. The MAR for CPT Code 99362 services is $95.

17. The Provider filed a request for medical dispute resolution with the TWCC, which referred it to the IRO.

18. The IRO reviewed the medical dispute but did not find that the Disputed Services were medically necessary to treat the Claimant's compensably injury.

19. After the IRO decision was issued, the Claimant asked for a contested-case hearing by a State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ).

20. Notice of an August 5, 2003, hearing in this case was faxed to the Parties on June 24, 2003.

21. On August 5, 2003, William G. Newchurch, an ALJ with SOAH held a hearing on this case at the William P. Clements, Jr. Building, 300 W. 15th Street, 4th Floor, Austin, Texas. The hearing concluded and the record closed on that same day.

22. The Employer appeared at the hearing through its Attorney, William Weldon.

23. The Provider telephonically appeared at the hearing and represented himself.

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. (Labor Code) §§ 402.073(b) and 413.031(k) (West 2003) and TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003 (West 2003).

2. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

3. Based on Gov't Code § 2003.050 (a) and (b), 1 TEX. ADMIN. CODE (TAC) § 155.41(b) (2003), and 28 TAC §§ 133.308(v) and 148.21(h) (2002), the Provider has the burden of proof in this case.

4. 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. Labor Code § 408.021 (a).

5. Based on the above Findings of Fact and Conclusions of Law, the Carrier should reimburse the Provider $978.35, which is 85 percent of the MARs, for the Disputed Services provided from May 6, 2002, through May 17, 2002.

6. Based on the above Findings of Fact and Conclusions of Law, the Provider should be reimbursed a total of $161.50 for the CPT Code 99362 services provided on May 30 and July 17, 2002.

7. The Provider failed to show that the remaining Disputed Services that he provided the Claimant from May 20, 2002, through July 19, 2002, were reasonably required by the Claimant's compensable injury.

8. Based on the above Findings of Fact and Conclusions of Law, the Employer should reimburse the Provider $1,139.85, and the Provider's request for further reimbursement for the Disputed Services should be denied.

ORDER

IT IS ORDERED THAT the Employer shall reimburse the Provider $1,139.85 and the Provider's request for further reimbursement for the Disputed Services is denied.

Signed September 22, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

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WILLIAM G. NEWCHURCH
ADMINISTRATIVE LAW JUDGE