DOCKET NO. 453-03-3602.M5
TWCC MDR NO. M5-03-1580-01

		BEFORE THE STATE OFFICE
MEDICAL ASSOCIATES,	§	
Petitioner	§	**OF**
	§	
V.	§	
	§	**ADMINISTRATIVE HEARINGS**
ASSOCIATION CASUALTY INSURANCE	§	
COMPANY.	§	
Respondent	§	

DECISION AND ORDER

Medical Associates (Petitioner) seeks reimbursement in the amount of $813.00 from Association Casualty Insurance Company (Carrier) for 11 office visits provided to injured worker___ (Claimant). The Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) adopted the decision of the Independent Review Organization (IRO) and denied reimbursement. Petitioner appealed MRD's decision. After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that Petitioner has not shown by preponderance of the evidence that the 11 office visits were medically necessary treatment for Petitioner's work-related, compensable injury. Therefore, the ALJ denies the request for reimbursement.

I. Background Facts

Claimant suffered a compensable, work-related injury on ___, resulting in pain to her cervical region. Her general care was provided by Dennis L. Lehman, M.D. She underwent a cervical laminectomy and fusion of the cervical vertebrae in 1994 and surgery on her rotator cuff in 1995, performed by Warren Wilson, M.D., and Luiz C. Toledo, M.D., respectively. On May 16, 1996, George Armstrong, M.D., determined that Claimant had reached MMI and assigned her a 19% whole person impairment rating.

Claimant was dismissed from Dr. Lehman's medical care on December 19, 1996. At the request of Dr. Toledo, a functional capacity examination (FCE) was performed at Omega Rehab on January 20, 1997. The results suggested significant functional overlay and symptom magnification. From1997 to date, Claimant remained under the care of Provider for pain in her cervical and lumbar regions and was diagnosed in 1999 with significant psychological issues, including major depression and generalized anxiety disorder. Since 1999, she continues to receive conservative treatment including office visits and pain medications. Carrier denied reimbursement for 11 office visits, involving CPT code 99214 (mid-level office visits), from March to September 2002.

After Carrier denied reimbursement for the 11 dates of service in issue, Petitioner requested medical dispute resolution by the Commission's MRD, which referred the matter to an IRO. The IRO physician reviewer determined that the services were not medically necessary and agreed with Carrier that reimbursement was not appropriate. Based on the IRO determination, MRD issued an order declining to order reimbursement. Petitioner then appealed.

On September 22, 2003, ALJ Sharon Cloninger convened a hearing in this case. Petitioner appeared by telephone. Carrier appeared and was represented by its attorney, Tommy W. Leuders. The hearing concluded and the record closed on that same day. After the record was closed, this case was reassigned to ALJ Tommy L. Broyles for preparation of a decision. The undersigned ALJ has reviewed the entire record and has listened to the tapes of the hearing in preparation of this decision.

II. Analysis

The sole issue in this case is whether the 11 dates of service provided to Claimant between March 6, 2002 and September 18, 2002 were medically necessary to treat her work-related injury. The visits were billed under CPT Code 99214, which is the code for moderately complex office visits involving at least two of the following components: medical decision-making of moderate complexity, a detailed history, and a detailed examination.[1]

Petitioner provided the treatments at issue and testified during the hearing that the office visits were necessary to treat Claimant's pain. He stated that anytime his patients are prescribed narcotic analgesics, office visits are required before the prescriptions will be refilled. He believes any decision to prescribe narcotics is at least of moderate complexity given the required dealings with the state, the workers compensation system, and the possible complications that may arise. He added that complications are increased with a patient who has psychological issues, such as Claimant's depression. Petitioner further believes he provided a detailed history and examination with each of these visits. His records reflect that a questionnaire with over 30 questions was answered by Claimant each time she sought treatment. He believes this established a detailed history. Finally, Petitioner argues that his examinations of Claimant were detailed. He disagrees with any assertion that an examination must be of the patient's entire body to be considered detailed.

It is Respondent's position that none of the required components for a moderately complex office visit were presented in Petitioner's documentation or testimony. Rather, the office visits in question were simply to reissue medications and thus were not appropriately billed under CPT Code 99214. Respondent notes that with CPT Code 99214, a physician typically spends 25 minutes with the patient or the family, which Respondent argues did not happen in these instances. Respondent asserts that Petitioner's medical reports do not indicate a detailed history, that the questionnaires were filled out by the patient before the examinations, and that the examination itself was limited to a brief review of the area of complaint (generally noted only as "tenderness to palpation" on the reports), which is not detailed.

After considering the arguments and evidence presented, the ALJ concludes that Petitioner has failed to establish by a preponderance of the evidence that the treatment in issue was medically necessary. Specifically, the ALJ finds that Claimant's subjective complaints of pain are due in great part to pain magnification and thus may not form the basis for medical necessity. A review of the questionnaires completed by Claimant reveals pain levels at the time of the visits at 8-10 on a scale of 1-10, with 10 being the worst pain possible. This is remarkable given that the medical reports are lacking any indication of physical manifestations of such pain. Moreover, there was evidence of functional overlay and symptom magnification as early as 1997, when the FCE was performed.

[1] One office visit was actually billed at CPT Code 99215, suggesting an even more complex office visit.

Surprisingly, despite these indications of symptom magnification, the medical records contain few notes at all about objective findings or even attempts to objectively evaluate Claimant's reported symptoms. As noted by the peer review doctor: "[B]ased on the medical records provided, there is a lack of documentation of objective physical findings, neurological deficits, (or) objective data to suggest that *any*[2] continued treatment is medically reasonable or necessary."[3]

Moreover, even if some office visits were justified, the evidence suggests moderately complex visits were neither medically necessary nor provided. Instead, two of the three required findings for a moderately complex medical visit were not proven up. There is no evidence of detailed histories or examinations. The histories and objective findings noted in the medical reports are very general, lasting only a couple of sentences which vary very little from visit to visit. As stated by the IRO doctor, Dr. Morris' progress notes are very poorly documented and do not justify a visit with a CPT code of 99214. Rather, the office visits in issue were quick check-ups for refills of medications and should not have been billed under CPT code 99214.

For the reasons identified above, and as set forth in the findings of fact and conclusions of law below, Provider has not shown by a preponderance of the evidence that the treatments in issue were medically reasonable and necessary, nor properly provided according to the Commission's rules. Therefore, reimbursement is denied as to all amounts sought.

III. Findings of Fact

1. ____ (Claimant) suffered a compensable injury to her cervical region on or about ____. At all times relevant herein, Association Casualty Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant.

2. For her injury, Claimant underwent surgery in 1994 and 1995. On May 16, 1996, George Armstrong, M.D., determined that Claimant had reached MMI and assigned her a 19% whole person impairment rating.

3. On January 20, 1997, a functional capacity evaluation was performed at Omega Rehab with evidence of significant functional overlay and symptom magnification.

4. Claimant saw A J. Morris, M.D. (Provider) on the following dates in issue in 2002: 3/6, 4/3, 5/1, 5/13, 5/29, 6/26, 7/24, 8/21, 8/29, 9/5, and 9/18. On each of those dates, Claimant was already an established patient of Provider and the CPT code used was 99214, except for 8/29/02, which was billed at the higher care CPT code of 99215.

5. CPT code 99214 is for a 25-minute office visit with an established patient. It requires at least two of three components: a detailed history, a detailed examination, and medical decision making of moderate complexity.

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[2]Emphasis in original text.

[3]The peer review doctor added that the clinical notes from Dr. Morris have a paucity of any clinical findings or variation from week-to-week to identify the frequency or duration of treatment as medically indicated. He continues that there is little-to-no variation in the subjective complaints of "pain" and the objective complaint□s of spasm. In the peer review doctor□s opinion, "A referral to the TWCC-Compliance and Practices Divisions may be appropriate."

The presenting problems must be of moderate to high complexity.

6. Provider's medical reports do not contain evidence of detailed histories or examinations.

7. Claimant indicates very high levels of pain at each visit; the pain levels are not supported by objective findings in the medical reports.

8. Claimant demonstrated symptom magnification at the time of the office visits in question.

9. The treatments in issue were not medically reasonable and necessary, nor were they properly provided under CPT codes 99214 or 99215.

10. Provider billed Carrier the total sum of $1,053.00 for the 11 office visits and expected a payment of $813.00 in accordance with the medical fee guideline allowance.

11. Carrier denied reimbursement for the office visits on the grounds that they were not medically necessary

12. Provider filed a Request for Medical Dispute Resolution with the Commission, seeking reimbursement for the treatment of Claimant.

13. On May 9, 2003, the Commission's Medical Review Division (MRD) determined that Provider was not entitled to any reimbursement.

14. On May 22, 2003, Provider filed a request for hearing before the State Office of Administrative Hearings (SOAH).

15. Notice of the hearing was sent on June 25, 2003.

16. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

17. The hearing was continued and all parties were notified of the new setting.

18. The hearing was held on September 22, 2003, with Administrative Law Judge Sharon Cloninger presiding and the Carrier and Provider participating. The hearing was adjourned and the record closed the same day.

IV. Conclusions of Law

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act (the Act), specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Petitioner has the burden of proof in this matter. 28 TEX. ADMIN. CODE §148.21(h).

6. Petitioner failed to establish, by a preponderance of the evidence, that the treatments provided on the eleven dates of service in issue were medically necessary for the treatment of Petitioner's work-related injury.

7. Petitioner's request for reimbursement should be denied.

ORDER

IT IS ORDERED that Association Casualty Insurance Company is not required to reimburse Medical Associates for any of the services in issue in this proceeding.

Signed November 17th, 2003.

TOMMY L. BROYLES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS