DOCKET NO. 453-05-0519.M5

ATLANTIS HEALTHCARE CLINIC,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ARCH INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This is a dispute over reimbursement for services performed for an injury suffered by Claimant while in the course and scope of his employment. The Administrative Law Judge (ALJ) concludes that certain of the disputed services should be reimbursed for Carrier's failure to issue timely Explanation of Benefits; and certain disputed services should not be reimbursed, because Atlantis Healthcare Clinic (Provider) failed to meet its burden to prove medical necessity for those disputed services.

I. FACTUAL AND PROCEDURAL HISTORY

Claimant suffered a work-related injury to his lower back on ___. On December 20, 2000, Claimant visited Provider and saw Marcos S. Rodriguez, D.C. Dr. Rodriguez performed an initial evaluation and the Claimant received a wide range of treatment from the Provider through November 13, 2001.[1]

Arch Insurance Company (Carrier), the Claimant's provider of workers' compensation insurance, disputed Claimant's entitlement to services, stating the 'E' code on certain Explanation of Benefits (EOBs). On January 22, 2002, the Provider filed this dispute with the Texas Worker's Compensation Commission (Commission). On December 19, 2002, the Commission's Hearings

[1] The final date which appears on the table of disputed services is October 26, 2001.

Division issued a Decision and Order (Decision) finding that the Claimant's injury was compensable, but that any work-related disability ended on May 15, 2001. At the Carrier's request, a peer review was conducted and found that no services were reimbursable beyond early February, 2001 (Peer Review). Thereafter, on February 19, 2003, the Carrier issued new EOBs stating the 'V' code. On August 18, 2004, the Commission's Medical Review Division (MRD) denied certain of Provider's requested reimbursements stating that 'No properly filed EOB was submitted by either the requestor or respondent.'

Provider filed timely requests for hearing before the State Office of Administrative Hearings (SOAH) on August 31, 2004. The Commission issued a notice of hearing in this matter on September 23, 2004. A hearing was held on April 4, 2005, before ALJ Travis Vickery. Provider and Carrier participated in the hearing, which was adjourned the same day. The record closed on April 25, 2005, after each party filed post-hearing briefing.

II. ANALYSIS

As an initial matter, the ALJ notes that evidence was offered almost exclusively by the Provider. This is not surprising since the Provider bears the burden of proof in this proceeding. Nevertheless, very little of the evidence actually explains *why* treatment was medically necessary, much less why such treatment was necessary for the length of time it was conducted. The testimony offered at the hearing dealt primarily with whether the Carrier had failed to fulfil its duty with respect to its EOBs. Almost no explanation of the services themselves was offered, nor were the Peer Review's findings addressed. Finally, although the ALJ requested a consolidated table of disputed services, the Provider's April 12, 2005 brief did not include a table of disputed services although one was offered and admitted in evidence at the hearing. The Carrier, however, filed a table of disputed services with a total of $13,882.40 in disputed services (Table of Disputed Services).

1. Entitlement

The Provider raised the issue of Carrier's submission of two sets of EOBs in this case. Carrier's initial set of EOBs denied reimbursement based exclusively on the 'E' denial code. The E code raised the issue of 'entitlement' to treatment or compensability of the Claimant's injury. Compensability is a predicate issue and requires a hearing, which was conducted. On December 19, 2002, the Commission's Hearings Division issued its Decision, finding that 'Claimant sustained a compensable injury on or about ___, and had disability only for the period December 20, 2000 through May 15, 2001.' The Decision became final and unappealable on or about January 23, 2003. The ALJ lacks the authority to review or disturb the Decision.

On January 16, 2003, the Peer Review of the disputed services was issued. The Peer Review found:

> . . . the injury was a lumbar strain/sprain superimposed upon preexisting degenerative changes in the spine . . . [a] short trial of physical therapy and chiropractic care would be reasonable at three times a week for up to approximately six weeks. *In my opinion, an end treatment date should have been reached after eighteen sessions of physical therapy and chiropractic care. By February, 2001, the claimant should have been discharged to a home program . . . [t]here was no medical necessity for any work hardening or work conditioning program, in my opinion*. This claimant underwent an extensive amount or treatment for what appeared to be no more than a soft tissue injury . . . [e]ven the examination by Dr. Laughlin on 01/04/01 did not reveal any significant orthopedic findings. The claimant did have some decreased range of motion in the lumbar spine and some muscle spasms and tenderness. However, Lasegue's test was negative and Patrick's test was negative. The neurological examination was intact. *This was no more than a soft tissue injury . . . [t]he chiropractor performed a number of computerized studies, which were all totally <u>unnecessary</u> and would be considered unreasonable*.[2]

Based on the Peer Review, on January 31, 2003, the Carrier issued new EOBs stating the 'V' denial code -- challenging the medical necessity of the disputed services based on peer review. Although the Provider complains that this is improper, the ALJ notes that Carrier's initial E code denial required a compensability decision, before other issues could be determined. Only after the

[2] Provider's Ex. 1 at 99-102, underlined emphasis in original, other emphasis added.

Decision was issued establishing the existence of, or lack of compensability could the Carrier issue new EOBs.

2. The Carrier's Missing EOBs

It is unclear from Carrier's briefing whether it deemed the new EOBs necessary. Regardless, it was appropriate to do so - as long as the new EOBs matched the original EOBs for dates and services. That is, so long as the Carrier preserved each denial of service by challenging it under the E code in its original EOBs, it was appropriate to issue a new, corresponding EOB denying that service under the V code once the Decision and Peer Review were rendered. Based on the Provider's testimony, and the EOBs in evidence, this was not the case. There are no original EOBs denying services under the E code for the dates February 21, March 9, 12, 13,[3] and April 2 through September 17, and October 26, 2001. Based on this lack of evidence, the issue of medical necessity was simply not preserved for these dates.

The carrier has 45 days after its receipt of a medical bill to respond and provide a denial code and rationales on an EOB. 28 TEX. ADMIN. CODE (TAC)§ 133.304(a). 28 TAC § 133.304(a) states the deadline for a carrier to submit the EOB:

> . . . an insurance carrier shall take final action on a medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill.

28 TAC § 133.304(c) requires that:

> *At the time* an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier *shall* send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits *shall include the correct payment exception codes* required by the Commission's instructions, and *shall* provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s) . . . [t]he insurance carrier *shall* maintain documentation of the date it sent the explanation of benefits, and *shall* either maintain a copy of the explanation of benefits or be able to

[3] The Provider contends that there were no EOBs for services dated March 20, 2001, but the ALJ located them at pages 46 and 47 of Provider's Exhibit 1.

electronically reproduce it. (Emphasis added).

The time limit and the mandatory language of 28 TAC § 133.304(c) and TEX. LAB. CODE § 408.027(d) makes clear the Carrier has a duty to provide a denial code and understandable reasons for denial within 45 days. If there are no timely EOBs in evidence, then the Carrier has failed to properly preserve the issue of medical necessity. The ALJ is aware of Carrier's reference to 25 Tex. Reg. 2123 (March 10, 2000),[4] but that citation does not apply here as the Commission's comment pertained to a carrier's reimbursement for non-compensable injuries - clearly not the case here as determined in the Decision. The Carrier is ordered to reimburse the Provider for disputed services rendered under CPT Codes 97545 WH, 97546 WH, 99213, 97750, 97265, 97250, 95851 and 97122 on February 21, March 9, 12, 13, and April 2 through September 17, and October 26, 2001. The ALJ finds that Provider is entitled to additional reimbursement of $8,271.80[5] for these services, and the Carrier is ordered to reimburse the Provider for this amount.

3. Medical Necessity

As explained above, the medical necessity review excludes services rendered under CPT Codes 97545 WH, 97546 WH, 99213, 97750, 97265, 97250, 95851 and 97122 on February 21, March 9, 12, 13, and April 2, through September 17, and October 26, 2001, as those dates of service were not challenged in accordance with the Commission's rules. It is the Provider's burden in this case to prove medical necessity. While the Provider did produce a number of documents reflecting services *rendered*, there is little evidence explaining *why* the services were medically necessary. The sole witness on behalf of the Provider was R. Todd Petersen, D.C, C.C.S.P., A.T.C., L.A.T. Dr. Petersen also presented Provider's case at the hearing. Significantly, Dr. Rodriguez, the initial diagnosing and treating chiropractor, did not testify -- nor did any of the other treating chiropractors,

[4] Carrier's Post-Hearing Brief at 3-4.

[5] As stated earlier, the parties did not file a single consolidated table of disputed services. These numbers were derived by adding the amounts in the Disputed Services column of each date and service for which reimbursement is ordered.

specialists or therapists reflected in the documents. The result is a distinct lack of evidence on medical necessity.

The ALJ analyzed the disputed services in two groups: non-work hardening (from February 5, 2001 through March 9, 2001, and September 26, 2001 through October 12, 2001), and work hardening (March 14, 2001 through March 30, 2001). The non-work hardening period will be analyzed first. During this period, the Provider rendered services under CPT Codes 99213, 97265, 97250-59, 97122, 97750-MT, 95851, and 97110 (Non-Work Hardening Services).

1. Non-Work Hardening Services

On the first date of service, February 5, 2001, Dr. Rodriguez noted that '[Claimant]'s condition has stayed about the same since his last visit to the clinic,' and that he was progressing well.[6] The Claimant's pain was rated one on an analog pain scale of zero to ten. During treatment, on February 26, 2001, the pain increased to two until February 27, 2001. On February 28, 2001, the pain dropped back down to one and stayed there until work hardening began on March 12, 2001. After work hardening ended and the Claimant was released to return to work, he visited the Provider occasionally through October 2001, reporting pain ratings from 1 through 4.

Throughout the non-work hardening treatment period, there are various notes on tenderness, spasms, pain, discomfort and progress (which is usually the same and yet progressing).[7] Each treatment and procedure is explained, but what the documentation lacks is the necessary nexus between Claimant's specific condition and the treatments. Most, if not all of the explanations, are identical throughout the documents. There is no explanation of progress expected and achieved. Nor is there an articulation of alterations to the treatment plan as a result of progress, such as new exercises, transition to group therapy or home exercises. Basically, the documents state what

[6] Provider's Ex. 1 at 148.

[7] Provider's Ex. 1 at 148 B 168; and range of motion testing at 243-348.

happened and how it affects the Claimant, but there is no adequate explanation of *why* those particular services were medically necessary to treat claimant's specific condition.

While the ALJ is not bound by the Peer Review, it was admitted in evidence and sheds light on the lack of solid explanations for the medical necessity of all disputed services throughout 2001:

> This was no more than a soft tissue injury. Up to eighteen sessions of physical therapy and chiropractic care would have been reasonable . . . [t]he chiropractor performed a number of computerized studies, which were all totally unnecessary and would be considered unreasonable . . . [i]n my opinion, an end treatment date and maximum medical improvement should have been by February, 2001.[8]

In the absence of an explanation to the contrary, the ALJ agrees not only that the end treatment date should have been in February, but that the Provider failed to meet its burden to prove that any of the Non-Work Hardening Services were medically necessary. The Provider is not entitled to reimbursement for any of the Non-Work Hardening Services.

2. Work Hardening

None of the work hardening or work hardening-related services or testing were medically necessary.[9] Work hardening began on March 12, 2001, and extended through May 15, 2001. During that period, the Provider billed services under CPT Codes 97545, 97546, 97750 and 99213 (Work Hardening).

At the beginning of Work Hardening, the Claimant's body biomechanics were good; his pain during exercises was minimal; his social interaction was good; his effort was maximum and his endurance was good. Strength and pain were listed as his limiting factors.[10] There is no other

[8] Provider's Ex. 1 at 99-102, underlined emphasis in original.

[9] Provider cited to the pre-authorization for work hardening. There is only one work hardening pre-authorization letter in evidence dated May 1, 2001, authorizing services from May 7, 2001, through May 20, 2001. There are no dates in the Table of Disputed Services for this date range, however, so the issue is moot.

[10] Provider's Ex. 1 at 169.

evidence of why Work Hardening was necessary B if in fact those findings even support a need for Work Hardening. The applicable Medicine Ground Rules describe work hardening as:

> A highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the persons served to return to work. Work hardening programs are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker . . . [w]ork hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks . . .[11]

Based on the definition of work hardening, it is fatal to Provider's recovery that there exists no evidence of the mandatory treatment plan,[12] no reasoned justification for Work Hardening, no interdisciplinary approach, no mandatory psychological component (other than generic statements regarding cognitive skills exercises performed), and extremely limited mandatory evidence of the Claimant's response to treatment.[13] While there are some 44 pages of clinical notes, followed by functional capacity evaluations and range of motion tests, the generic and repetitive statements in the clinical notes simply do not support the most fundamental of elements necessary to prove the need for Work Hardening -- much less the specific types of information one would expect as a result of a thoughtful review of the Claimant's need, performance and response to the treatment. The Provider will not be reimbursed for Work Hardening, nor for any related testing or services. This finding covers all services from March 14, 2001, through March 30, 2001.

In conclusion, the Carrier is ordered to reimburse the Provider for disputed services rendered under CPT Codes 97545 WH, 97546 WH, 99213, 97750, 97265, 97250, 95851 and 97122 on February 21, March 9, 12, 13, and April 2 through September 17, and October 26, 2001, in the amount of $8,271.80. The ALJ finds that the Provider is not entitled to additional reimbursement for any of the remaining Disputed Services billed under CPT Codes 99213, 97265, 97250-59, 97122,

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[11] 1996 Texas Worker's Compensation Commission Medical Fee Guideline, Medicine Ground Rules I. E p. 37.

[12] *Id.*

[13] 1996 Texas Worker's Compensation Commission Medical Fee Guideline, Medicine Ground Rules II. E p. 38.

97750-MT, 95851, 97110, 97545, 97546, and 97750. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant ___ suffered compensable, work-related injuries to his lower back on ___.

2. Claimant's compensable disability ended on May 15, 2001.

3. Arch Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for his compensable injury.

4. On December 20, 2000, Claimant presented to Atlantis Healthcare Clinic (Provider) for evaluation and treatment.

5. Marcos S. Rodriguez, D.C., a clinician for the Provider, performed an initial evaluation of the Claimant, who received a wide range of treatment from the Provider through November 13, 2001.

6. Provider began treatment of Claimant on December 20, 2000.

7. On May 16, 2001, Provider released Claimant to return to work.

8. Provider treated Claimant from February 5, 2001, through October 26, 2001 (the disputed services).

9. Carrier declined to reimburse Provider's treatments (disputed services), contending first that the Claimant's injury was not compensable and later that the Provider's services were not medically necessary.

10. Based on the Table of Disputed Services, the total amount in dispute is $13,882.40. The disputed services involve CPT Codes 99213, 97265, 97250-59, 97122, 97750-MT, 95851, 97110, 97545, 97546 and 97750.

11. Carrier initially denied reimbursement for the Disputed Services on the explanation of benefits (EOB) using the denial code E, which stands for entitlement.

12. The Texas Workers' Compensation Commission (Commission) Hearings Division's Decision and Order (Decision) was issued on December 19, 2002.

13. The Decision found that Claimant suffered a compensable injury on ___, but that the compensable disability ended on May 15, 2001.

14. At the Carrier's request, a peer review was conducted and on January 16, 2003, the peer review was issued and found that no services were reimbursable beyond February, 2001, as they were not medically necessary (Peer Review).

15. After the Commission Hearings Division's Decision, and the Peer Review, Carrier denied reimbursement for the Disputed Services and issued a new set of EOBs using the denial code V, which stands for medically unnecessary treatment (with peer review).

16. Provider sought medical dispute resolution through the Commission.

17. On August 18, 2004, the Commission's Medical Review Division (MRD) denied certain of Provider's requested reimbursements stating that neither the Provider nor the Carrier submitted properly filed EOBs.

18. On August 31, 2004, the Provider requested a hearing before the State Office of Administrative Hearings (SOAH).

19. The Commission issued a notice of hearing in this matter on September 23, 2004.

20. The hearing convened on April 4, 2005, with ALJ Travis Vickery presiding. Provider appeared telephonically through its representative, R. Todd Petersen, D.C. Carrier appeared through its attorney, Steven M. Tipton. The hearing concluded and the record closed on April 25, 2005.

21. No parties objected to notice or jurisdiction.

22. Carrier failed to issue EOBs for the dates February 21, March 9, 12, 13, April 2 through September 17, and October 26, 2001, within 45 days after its receipt of Provider's medical bills for those dates.

23. Provider failed to show that the remainder of the disputed services were medically necessary to treat Claimant's compensable injury. The remainder of the disputed services were rendered from February 5, 2001 through February 20, February 26 through March 5, March14 through March 30, and September 26 through October 12, 2001, under CPT Codes 99213, 97265, 97250-59, 97122, 97750-MT, 95851, 97110, 97545 and 97546.

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, 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 (TAC) ch. 148.

3. The request for a hearing was timely made pursuant to 28 TAC §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. Provider had the burden of proof in this matter under a preponderance of the evidence standard. 28 TAC §§ 148.21(h), (i) and 1 TAC § 155.41(b).

6. Claimant sustained a compensable injury on ___.

7. When an insurance carrier makes or denies payment on a medical bill, the carrier must issue an EOB with a correct payment exception code and a sufficient explanation to allow the sender (provider) to understand the reason for the carrier's action.

8. Carrier failed to issue EOBs for the dates February 21, 2001, March 9, 12, 13, April 2 through September 17, and October 26, 2001, within 45 days after its receipt of Provider's medical bills for those dates. The Carrier's denial of reimbursement for the disputed services on these dates was legally inadequate as it failed to deny reimbursement in compliance with the Commission's rules.

9. Because Carrier never denied reimbursement in compliance with the Commission's rules for the dates February 21, 2001, March 9, 12, 13, April 2 through September 17, and October 26, 2001, Carrier is required to provide reimbursement for those dates.

10. Carrier is liable to Provider for a total reimbursement of $8,271.80 for services billed under CPT Codes 97545 WH, 97546 WH, 99213, 97750, 97265, 97250, 95851 and 97122.

11. Provider failed to meet its burden to prove that the remainder of the disputed services were medically necessary. The remainder of the disputed services were rendered from February 5, 2001 through February 20, February 26 through March 5, March14 through March 30, and September 26 through October 12, 2001, under CPT Codes 99213, 97265, 97250-59, 97122, 97750-MT, 95851, 97110, 97545 and 97546.

12. Provider is denied reimbursement for the remainder of the disputed services rendered from February 5, 2001 through February 20, February 26 through March 5, March14 through March 30, and September 26 through October 12, 2001, under CPT Codes 99213, 97265, 97250-59, 97122, 97750-MT, 95851, 97110, 97545 and 97546.

ORDER

Arch Insurance Company shall reimburse Atlantis Healthcare Clinic a total of $8,271.80 for the services in dispute in this proceeding.

SIGNED on June 24, 2005

TRAVIS VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS