SOAH DOCKET NO. 453-04-2255.M4

SCD BACK & JOINT CLINIC, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
AMERICAN HOME ASSURANCE COMPANY, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

SCD Back & Joint Clinic (Back & Joint) requested a hearing to contest a Texas Workers' Compensation Commission (Commission) Medical Review Division (MRD) decision concluding that certain physical medicine procedures or activities (services) provided to an injured worker (Claimant) should not be paid because they exceed the maximum time allowed for a physical medicine session as stated in the Commission-adopted 1996 Medical Fee Guideline (MFG). American Home Assurance Company (American Home) agreed with the MRD decision and contended that the services were medically unnecessary for other reasons. On two bases, the Administrative Law Judge (ALJ) concludes that American Home should pay for the services: the time limits cited by MRD and American Home as the reason for denying the claim do not apply to the services at issue; and American Home is precluded from raising the additional matters asserted for denying the claim because they were not raised prior to Back & Joint's request for medical dispute resolution.

A hearing convened on July 5, 2004, before ALJ James W. Norman at the State Office of Administrative Hearings, Austin, Texas. William Maxwell represented Back & Joint. Steven M. Tipton represented American Home. There were no contested issues of notice or jurisdiction. The record closed at the end of the hearing on July 5, 2004.

A. Background

The Claimant sustained a work-related injury on ___, after which he presented to Sam Liscum, D.C., and Back & Joint. He was diagnosed with neck sprain/strain, right forearm sprain/strain, left knee sprain/strain, right rotator cuff sprain/strain, laceration of the right ear, and myofascial pain syndrome.

The disputed services occurred between March 27, 2002, and April 17, 2002, and consisted of the following: nine joint mobilizations (CPT code 97265), eight myofascial releases (CPT code 97250), seven group therapeutic procedures (CPT code 97150), and two electrical stimulations (CPT code 97014). The maximum allowable reimbursement for the services was $950.00.

B. Issues

1. Whether Disputed Services Were Subject to MFG Time Maximums

This case centers in part on a disputed interpretation of the following portion of the MFG:

> A physical medicine session is defined as any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541). The maximum amount of time allowed per session is two hours. If additional time is required to complete the treatment rendered in a session, a maximum of one additional hour may be allowed. DOP [documentation of procedure] is required for time exceeding the two-hour maximum. Two sessions are allowed per day for the first week of the acute phase of the injury. Thereafter, only one session per day is allowed.[1]

American Home argued that the provision's language is unambiguous on its face and clearly limits the amount of time per session involving CPT code 97010-97039, 97110-97150, and 97220-97541 services to no more than two hours unless an additional hour is justified by documentation.[2]

Back & Joint cited several SOAH decisions concluding that un-timed services (including the disputed services in this case) are not subject to the two-hour maximum.[3] Back & Joint also maintained that training seminars put on by the Commission have taught that the two-hour time limit does not apply to un-timed services.[4]

Within the context of a long series of SOAH decisions that un-timed services do not count against the two-hour time limit in the quoted rule, the ALJ adopts Back & Joint's position. Construction of a statute or rule by an administrative agency charged with its enforcement is entitled to serious consideration so long as the construction is reasonable and does not contradict the plain language of the statute. If the agency's interpretation is consistent with the language and purposes of the language, it is ordinarily accepted even if other reasonable interpretations exist. *Westcott Communications, Inc. v. Strayhorn*, 104 S.W. 3d 141, 146-147 (Tex. App.Austin 2003, writ den.).

The ALJ adopts the following reasoning by ALJ Kilgore on the issue of ambiguity:

> . . . . the ALJ disagrees with the carrier's assertion that the rule is clear. While the rule does explicitly reference both timed and untimed codes, it does so in its first sentence which relates to the limit on the number of codes that can be billed for a session, not to the two-hour limit. The ambiguity in the language of the rule primarily arises out of the use of the phrase "time allowed." In most contexts, this

---

[1] MFG, p. 32, Medicine Ground Rules, I.A.10.a.. 28 TEX. ADMIN. CODE (TAC) ' 134.201.

[2] Neither party contended that the extra-hour exception applied.

[3] Docket Nos. 453-01-2175 (ALJ Card); 453-01-1216.M5 (ALJ Sullivan); 453-01-3056.M5 (ALJ Harvel); 453-01-3234.M4 (ALJ Cloninger); 453-01-3441.M4 (ALJ Ramos); and 453-02-2778.M4 (ALJ Kilgore). One earlier decision concluded that the two-hour-time limit applied. Docket No. 453-99-1216.M5 (ALJ Landeros).

[4] It was not clear whether the seminars were meant to state the Commission's view or simply to say how SOAH has ruled on the issue.

> phrase would be unambiguous. The Medical Fee Guideline for workers' compensation billing, however, draws a distinction between services that are billed according to units of time and those that are not. In this setting, a rule imposing a time limit on reimbursement for medical services can give rise to legitimate questions about whether, and how, such a limit is meant to be imposed on services that are not billed according to time. . . .
>
> Timed and un-timed procedures relating to this case are shown at page 59 of the MFG.

2. Whether American Home May Assert Other Grounds for Concluding the Services Are Medically Unnecessary

American Home cited SOAH precedent[5] and Medicare policies saying it is inappropriate to bill for myofascial release, soft tissue manipulation, and joint mobilization together because they are essentially the same procedure. Citing the fact that it paid for chiropractic manipulation on each date of the disputed services, American Home argued that it was medically unnecessary to perform joint mobilization and myofascial release at the same time.

American Home also argued that the services were medically unnecessary for a third reason. It pointed out that the Claimant's pain scores from March 27, 2002, through April 17, 2002, began at only two out of ten (with ten the highest) and reduced to one out of ten.[6] It contended it is common knowledge that soft tissue injuries often resolve by themselves over time. It argued that under these circumstances, the services were not medically necessary.

Back & Joint maintained that American Home is precluded from asserting these grounds for a lack of medical necessity because it did not do so in its EOBs.

The ALJ agrees with Back & Joint's contention. American Home's explanation for each denial of the disputed services was (U) [unnecessary treatment without peer review]. This charge is in excess of the maximum recommended amount/time for the service rendered. A sufficient explanation of the reason for a denial is required by 28 TEX. ADMIN. CODE ' 133.304(c). Commission Rule 133.307(j)(2) says a reason for denial not provided to the provider before a request for medical dispute resolution may not be considered. In this case, to accept American Home's argument that its previously unexpressed grounds for denying the claim should be considered in lieu of or in addition to its expressed reason for denial, would be to effectively sanction a deception to both Back & Joint and the MRD, in violation of the above-cited rules.

II. FINDINGS OF FACT

1. A worker (Claimant) sustained a work-related injury on ___, after which he presented to Sam Liscum, D.C., and SCD Back & Joint Clinic (Back & Joint).

[5] Docket Nos. 453-04-1811.M5 (ALJ Borkland); 453-03-1483.M5 (ALJ Rusch); 453-01-2006.M5 (ALJ Dewey).

[6] Ex. 1 at 3-13.

2. The Claimant was diagnosed with neck sprain/strain, right forearm sprain/strain, left knee sprain/strain, right rotator cuff sprain/strain, laceration of the right ear, and myofascial pain syndrome.

3. Back & Joint filed a claim with American Home Assurance Company (American Home), the workers' compensation insurance carrier for Claimant's employer, for the following services provided from March 27, 2002, through April 17, 2002:

    1. nine joint mobilizations (CPT code 97265);

    2. eight myofascial releases (CPT code 97250);

    3. seven group therapeutic procedures (CPT code 97150); and

    4. two electrical stimulations (CPT code 97014).

4. The maximum allowable reimbursement for the services described in Finding of Fact No. 3 is $950.00.

5. American Home denied the claim described in Finding of Fact No. 3 with the following explanation: (U) [unnecessary treatment without peer review]. This charge is in excess of the maximum recommended amount/time for the service rendered.

6. Back & Joint requested medical dispute resolution before the Texas Workers' Compensation Commission (Commission).

7. In an order issued on December 5, 2003, the Commission's Medical Review Division upheld American Home's denial based on its conclusion that the disputed services exceeded the maximum time allowed for a physical medicine session as stated in the Commission-adopted 1996 Medical Fee Guideline (MFG).

8. It is undisputed that Back & Joint requested a hearing not later than the twentieth day after receiving notice of the IRO decision.

9. All parties received not less than ten 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.

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

11. A portion of the MFG provides:

> A physical medicine session is defined as any combination of four modalities (97010-97039), procedures (97110-97150) and/or physical medicine activities and training (97220-97541). The maximum amount of time allowed per session is two hours. If additional time is required to complete the treatment rendered in a session, a maximum of one additional hour may be allowed. DOP [documentation of

procedure] is required for time exceeding the two hour maximum. Two sessions are allowed per day for the first week of the acute phase of the injury. Thereafter, only one session per day is allowed.

12. Portions of the MFG show that services under some CPT codes are timed, but others are not.

13. The services in dispute in this case are un-timed.

14. At the hearing, American Home asserted additional reasons for denying Back & Joint's claim, including the following:

    1. because soft tissue manipulation, myofacial release, and joint mobilization are the same procedure and American Home paid for manipulation on the dates of the disputed services, the disputed myofascial release and joint mobilization services were medically unnecessary; and

    2. because the Claimant's pain level on March 27, 2002, was only a two out of ten (with ten the highest) and in a short time decreased to one out of ten and because most soft tissue injuries resolve by themselves over time, the services were not medically necessary.

15. The reasons American Home asserted in Finding of Fact No. 14 that the disputed services were not medically necessary were not provided to Back & Joint before it requested medical dispute resolution.

III. 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. LAB. CODE ANN. ' 413.031(k) and TEX. GOV'T. CODE ANN. ch. 2003.

2. Back & Joint timely requested a hearing in this matter pursuant to 28 TEX. ADMIN. CODE (TAC) '' 102.7 and 148.3.

3. Notice of the hearing was proper and complied with the requirements of TEX. GOV'T. CODE ANN. '' 2001.051 and 052.

4. The two-hour-per session time limitation in the MFG for services under certain CPT codes does not apply to the services described in Finding of Fact No. 3. 28 TEX. ADMIN. CODE (TAC) ' 134.201.

5. American Home is precluded from raising the matters described in Finding of Fact No. 14 as a basis for denying the claim based on a lack of medical necessity. 28 TAC '' 133.304(c) and 133.307(j)(2).

6. American Home should pay the claim described in Finding of Fact No. 3.

ORDER

IT IS THEREFORE ORDERED that American Home Assurance Company pay SCD Back & Joint Clinic $950.00 plus applicable interest for the services described in Finding of Fact No. 3.
SIGNED August 3, 2004.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS