**SOAH DOCKET NO. 453-04-3712.M5**
**TWCC MR NO. M5-03-1914-01**

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| **ERIC A. VANDERWERFF, D. C.,** | **§** | **BEFORE THE STATE OFFICE** |
| **Petitioner** | **§** | |
| | **§** | |
| **V.** | **§** | **OF** |
| | **§** | |
| **FIREMAN'S FUND INSURANCE CO.,** | **§** | |
| **Respondent** | **§** | **ADMINISTRATIVE HEARINGS** |

## DECISION AND ORDER

Petitioner, Eric A. Vanderwerff, D.C., (Provider), requested a hearing from the Findings and Decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC) denying reimbursement from Fireman's Fund Insurance Co. (Carrier) for medical services provided to an injured worker (Claimant). The MRD ordered Carrier to pay for a portion of the services. Provider requested a hearing seeking full payment of its claims, in the amount of $1,260.00.[1] The Administrative Law Judge (ALJ) concludes Provider should be reimbursed for the services in dispute in the amount of $1,260.00.

## I. PROCEDURAL HISTORY

ALJ Penny Wilkov convened a hearing in this case on July 20, 2004, at the State Office of Administrative Hearings (SOAH), Austin, Texas. Provider appeared pro se at the hearing and by attorney, William Maxwell, for written closing arguments. Attorney Rebecca Strandwitz represented Carrier. The hearing record was left open until August 31, 2004, for submission of written closing arguments, and closed on that date. Subsequently, in an order dated October 22, 2004, the ALJ reopened the record and directed the parties to provide clarification and additional information. The additional clarification and information was submitted on November 15, 2004, closing the record. However, in an order dated December 2, 2004, the parties were directed to confer on a date for a telephonic post-hearing conference and on January 10, 2005, a telephonic post-hearing conference was convened and the parties stipulated to certain aspects of the dispute. The record closed again on January 10, 2005.

[1]At the telephonic post-hearing conference, the parties stipulated that the total amount in dispute is $1,260.00, disallowed by the IRO as not properly documented CPT Code 97110, one-on-one therapy.

The parties did not contest notice or jurisdiction, which are addressed in the Findings of Fact and Conclusions of Law.

## II. DISCUSSION

1. Introduction

During the hearing, Provider introduced only two documents: the Revised Report from Independent Review Incorporated dated January 19, 2004, and the MRD, Medical Dispute Resolution Findings and Decision dated January 21, 2004. The Carrier did not introduce any evidence. In response to a post-hearing order, a list of disputed services was provided by both Provider and Carrier.

Claimant injured her lumbar spine as a result of repetitive lifting and was diagnosed with lumbar sprain and anterolisthesis of L-5-S1.[2] Carrier denied payment for services rendered between March 19, 2002, and December 5, 2002**.** The services included office visits with manipulations, myofascial release, joint mobilization, therapeutic procedure, neuromuscular re-education, and electrical stimulation rendered on March 19, 2002, June 3, 2002, June 4, 2002 through July 24, 2002, July 31, 2002 through October 28, 2002, and October 31, 2002 through December 5, 2002.[3] The amount billed by Provider for these services totaled $9,661.00.

The majority of these services, totaling $7,311.90, were found by the MRD officer as reimbursable. For most of the services, Carrier had denied reimbursement using the explanation of benefits denial code of AE," contesting that the services were provided for a compensable injury. The MRD officer's rationale stated that a Contested Case Hearing Decision and Order dated December 11, 2002, had found the injury compensable. Therefore the MRD Officer recommended reimbursement of $7,311.90, which Carrier did not appeal.[4]

However, other services, totaling approximately $1,089.00, were found by the MRD officer as not reimbursable, since these services were in contravention of TWCC rules. These services, stipulated by the parties at the telephonic post-hearing conference as totaling approximately $1,089.00, included, among others, CPT 99080-53 rendered on March 19, 2002,[5] and CPT 97014

[2] Exh. 1, Report of Independent Review Incorporated (January 19, 2004).

[3] Exh. 2, Medical Review Division, Medical Dispute Resolution Findings and Decision (January 21, 2004).

[4] This amount also included, among others, that the MRD Officer found that the maximum reimbursement for H & F Reflex studies is six units, by rule. Therefore, the MRD Officer recommended reimbursement of $222.50 for H & F reflex studies, $122.50 for Somatosensory testing, and $1,164.80 for NCV studies.

[5] The MRD found that Form TWCC-53, Change of Treating Doctor was submitted but not reimbursable due to

rendered with other modalities on March 18, 2002 through July 25, 2002, and July 29, 2002 through October 29, 2002.[6]

Thus, at the telephonic post-hearing conference, the parties stipulated that the amount remaining in dispute totaled $1,260.00, billed under CPT Code 97110, and disallowed by the MRD Officer due to the failure of the daily notes to "clearly delineate the severity of the injury that would warrant one-to-one therapy."

**B. Applicable Law**

In order to seek reimbursement for medical services provided, health care providers must submit medical bills for payment on standard forms. 28 TEX. ADMIN. CODE § 134.800(a). The medical bills may be submitted by facsimile, electronic transmission, or by mail. 28 TEX. ADMIN. CODE § 134.800(e). The bills must, however, be submitted no later than the first day of the eleventh month after the date of service. 28 TEX. ADMIN. CODE § 134.801(c). Once the bills are properly submitted, Carrier must review the medical bills and either pay or deny the bill within 45 days of receipt. 28 TEX. ADMIN. CODE § 134.304(a).

In order to deny payment, Carrier must send an explanation of benefits to Provider which includes the payment exception codes with a sufficient explanation to allow Provider to understand the reason for the Carrier's action. A generic statement without a full description of the reason for reduction or denial of payment does not meet the requirements. 28 TEX. ADMIN. CODE § 134.304(3)(c). The payment exceptions codes are contained in the form and manner as prescribed by the Commission. 28 TEX. ADMIN. CODE § 134.304(3)(c). In order to deny payment for services on the basis of a peer review, Carrier must provide a copy of the report with the explanation of benefits. 28 TEX. ADMIN. CODE § 134.304(h).

Under the workers' compensation system, an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury. 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. LAB. CODE ANN. § 408.021. "Health care" includes "all reasonable and necessary medical . . . services." TEX. LAB. CODE ANN.§ 401.011(19).

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Commission Rule. The parties stipulated that this is not in dispute.

[6] The MRD found that the charge for physical medicine treatment shall not exceed any combination of four modalities as referenced in the rule. The parties stipulated that these services are not in dispute.

## C. Parties' Positions

### 1. Provider

Provider testified that he was denied due process of law because he was not provided with an Explanation of Benefits (EOB) Denial Code notice from Carrier, effectively foreclosing any opportunity to prepare documents or to obtain testimony to refute the reason for denial. He points to the Medical Dispute Resolution (MDR) Findings and Decision which states as a rationale for decision, "(n)either party submitted EOBs; therefore, this review will be per the Medical Fee Guidelines (MFG)." Using these guidelines, the MDR Officer declined to order payment for CPT 97110 because "the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment."[7] Provider argues that the MDR officer should not have made a negative finding as to medical necessity since there was no EOB Denial Code to define the reason for the dispute and further, by finding in favor of Carrier, the MDR has changed the burden of proof so that he had to defend his services against unknown reasons. Provider testified that he never received a "TWCC 62," a document prescribed by TWCC to notify the person of the reason for denial.

Provider did concede on cross-examination that in order to seek reimbursement the services must be performed regardless of EOB Denial notification and that TWCC had auditing authority to insure that the services were provided. However, in this case, he did not agree that MRD was acting in any other capacity other than an arbitrator.

### 2. Carrier

Carrier argues that the MRD in this case was acting in the capacity of an auditor by requiring that documentation be supplied that proved that the service was provided and the medical necessity of the procedure.

Carrier argues that Provider did not submit its SOAP[8] notes at the hearing to document the physical medicine, testing, and office visits that are the subject of this claim and that, therefore, Provider cannot prove it ever submitted a complete medical bill to Carrier. Carrier also argues that there are documentation requirements in order to request medical dispute resolution which had to include medical records, clinical notes, diagnostic test results, treatment plans and other documents

[7] Medical Review Division, Medical Dispute Resolution Findings and Decision (January 21, 2004).

[8] SOAP Notes encompass Subjective Findings, Objective Findings, Assessment, and Plan.

relevant to the dispute. However, since Petitioner did not submit the notes, plans, and records, the ALJ has nothing to review.

## III. ANALYSIS

Provider bears the burden of proof that the factual basis or rationale for the MRD's decision in this case was invalid. At the telephonic post-hearing conference, the parties stipulated that the total amount in dispute is $1,260.00, disallowed by the IRO as not properly documented CPT Code 97110, one-to-one therapy.

The services that were addressed in the IRO decision included office visits with manipulations, myofascial release, joint mobilization, therapeutic procedure, neuromuscular re-education, and electrical stimulation on the following dates of service: March 19, 2002, June 3, 2002, June 4, 2002 through July 24, 2002, July 31, 2002 though October 28, 2002, and October 2002 though December 5, 2002.[9] In the decision, the IRO notes that the rationale for treatment was well-documented. Although the IRO stated that the evidence of progress was lacking, Claimant's statements of diminished pain and improved functionality were compelling enough to allow the reviewing chiropractor sufficient justification to order compensation.

However, the MRD Officer, on review of the IRO decision, declined to recommend reimbursement for CPT Code 97110, because the daily notes did not indicate the severity of the injury would warrant one-to-one therapy. Although Provider has the burden of proof to show that a complete bill was submitted to the Carrier in a timely manner with the correct billing codes and with supporting documentation, here it is evident that the IRO reviewed a complete bill and documentation in order to support the decision made. When a complete bill is submitted, Carrier has the burden to take final action on the bill upon receipt by either reimbursing or deny the charges. Carrier also has the burden to supply an explanation of benefits with the proper exception codes with sufficient explanation to allow the sender to understand the reason for the Carrier's actions. Here, no explanation of benefits was properly submitted by Carrier. Therefore, these services, billed as CPT Code 97110, in the amount of $1, 260.00 should be reimbursed.

The ALJ finds that there is a long line of SOAH Decisions that have held that Carrier is limited to the payment exception codes used on the EOB in defending the denial of payment, citing

[9] The IRO ordered reimbursement of $7,311.90 for the majority of these services finding that the requestor was entitled to payment. These services were denied with an Explanation of Benefit Code Denial "E." The MRD stated that Carrier denied the claim as not compensable but noted that a Contested Case Hearing Decision and Order dated December 11, 2002 found that the claim was compensable. Therefore, all services challenged under Denial Code "E" were ordered to be reimbursed.

28 TEX. ADMIN. CODE § 134.304(3)(c) . The language which creates this responsibility is mandatory and clearly designed to provide fairness to the party defending against the denial. To require a party to bring forth evidence of all of the possible reasons for denial without a clear direction would be an overwhelming burden of proof.

In conclusion, Provider is entitled to reimbursement in the stipulated amount of $1, 260.00, billed as CPT Code 97110, for the medical services in dispute.

## IV. FINDINGS OF FACT

1. ___ (Claimant) injured her lumbar spine as a result of repetitive lifting and was diagnosed with lumbar sprain and anterolisthesis of L-5-S1.

2. Fireman's Fund Insurance Co. (Carrier), the insurer for Claimant's employer, denied payment to Eric A. Vanderwerff, D.C., (Provider) for services rendered between March 19, 2002, and December 5, 2002**.**

3. The services included office visits with manipulations, myofascial release, joint mobilization, therapeutic procedure, neuromuscular re-education, and electrical stimulation rendered on March 19, 2002, June 3, 2002, June 4, 2002 through July 24, 2002, July 31, 2002 through October 28, 2002, and October 31, 2002 through December 5, 2002. The amount billed by Provider for these services totaled $9,661.00.

4. Carrier denied payment for the treatments Provider administered to Claimant on the basis that Claimant was not entitled to the treatment as it did not relate to an injury that had been determined to be compensable, using the explanation of benefits (EOB) denial code "E."

5. In the EOB it issued denying payment, Carrier did not raise the grounds of lack of medical necessity for any of the services.

6. Provider made a timely request to the Texas Workers' Compensation Commission (Commission) for medical dispute resolution with respect to the requested reimbursement.

7. The independent review organization (IRO) to which the Commission referred the dispute issued a decision on January 19, 2004, concluding that the services were medically necessary.

8. The Commission's Medical Review Division (MRD) then examined the substantive portions of the dispute by applying the terms of the 1996 *Medical Fee Guideline* (MFG), 28 TEX. ADMIN. CODE § 134.201 (repealed effective January 1, 2002).

9. On January 21, 2004, the MRD Officer ordered Carrier to reimburse Provider in the amount of $7,311.90 of the total $9,661.00 billed.

10. On February 12, 2004, Provider requested a contested hearing on the MRD decision.

11. On March 18, 2004, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted.

12. ALJ Penny Wilkov convened a hearing in this case on July 20, 2004, at the State Office of Administrative Hearings (SOAH), Austin, Texas. Provider appeared pro se at the hearing and by attorney, William Maxwell, for written closing arguments. Attorney Rebecca Strandwitz represented Carrier. The hearing record was left open for submission of written closing arguments by August 31, 2004, and the record closed on that date. On October 22, 2004, the ALJ reopened the record and directed the parties to provide clarification and additional information which were received on November 15, 2004 and the record closed. On January 10, 2005, a telephonic post-hearing conference was convened and the parties stipulated to certain aspects of the dispute. The record closed on January 10, 2005.

13. The amount in dispute was $1,260.00, billed under CPT Code 97110, and disallowed by the IRO because Provider's daily notes did not indicate the severity of the injury would warrant one-to-one therapy.

14. Provider submitted a complete bill to the Carrier in a timely manner with the correct billing codes and with supporting documentation.

15. The IRO reviewed a complete bill and documentation in order to support the decision made.

16. Carrier did not supply an explanation of benefits with the proper exception codes with sufficient explanation to allow Provider to understand the reason for the Carrier's actions.

## V. 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 and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely requested a hearing, pursuant to 28 TEX. ADMIN CODE § 148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Provider, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41(b), and 28 TEX. ADMIN CODE § 148.21(h).

5. Carrier failed to timely raise the issues of entitlement and lack of medical necessity as required by TEX. LABOR CODE ANN. § 408.027(d) and 28 TEX. ADMIN. CODE § 133.304(c).

6. Carrier is barred from raising the issues of entitlement or medical necessity in this contested case hearing, pursuant to 28 TEX. ADMIN. CODE § 133.307(j)(2).

7. The services billed under the CPT Code 97110 in the amount of $1,260.00 should be reimbursed.

## ORDER

**IT IS ORDERED** that Fireman's Fund Insurance Co. reimburse Eric A. Vanderwerff, D.C., for all physical medicine treatments administered to Claimant ___ and billed under CPT Code 97110. Thus, Provider should be reimbursed for the services in dispute in the amount of $1,260.00.

**SIGNED January 14, 2005.**

**PENNY WILKOV**
**ADMINISTRATIVE LAW JUDGE**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**