SOAH DOCKET NO. 453-05-0972.M5
TWCC MR NO. M5-04-0552-01

JOHN RANDOLPH, D.C.	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE	§	
COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent		

DECISION AND ORDER

This case is a dispute over whether reimbursement is appropriate for treatment rendered to Claimant by John Randolph, D.C. (Provider), between October 21, 2002, and June 27, 2003. Provider initially sought reimbursement from Texas Mutual Insurance Company (Carrier) in the amount of $23,706 for the treatment rendered to Claimant, which was denied by Carrier as not medically necessary. The Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) declined to adopt the recommendation of the Independent Review Organization (IRO), which held Provider was entitled to partial reimbursement including charges for a lesser coded service. In this Order, the Administrative Law Judge (ALJ) concludes the MRD was correct by not adopting the IRO report and finds Provider is entitled to $3,791 reimbursement.

I. JURISDICTION, NOTICE AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those matters will be addressed in the findings of facts and conclusions of law without further discussion here.

A hearing convened on April 28, 2005, before the State Office of Administrative Hearings (SOAH) with Steven M. Rivas, ALJ, presiding. Sam Randolph, Provider's office manager, appeared on behalf of Provider. Carrier appeared and was represented by Tim Riley, attorney. The hearing adjourned the same day and the record remained open until May 20, 2005, to allow the parties an opportunity to file written closing arguments regarding the amount in dispute.

II. DISCUSSION

A. Background Facts

Claimant sustained a compensable back injury on___, and sought treatment with Provider for his back pain beginning October 21, 2002.[1] Provider treated Claimant with physical therapy through June 27, 2003. The treatment included manipulations, myofascial release, electric stimulation, hot and cold pack therapy, ultrasound, therapeutic exercises, and aquatic therapy. Provider billed Carrier for the treatment rendered, which Carrier denied as not medically necessary.

B. Applicable Law

The Texas Labor Code contains the Texas Workers' Compensation Act (the Act) and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims. In particular, the Act, as noted in ' 408.021, provides that 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. Under the same statute, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

C. Evidence

Provider's main argument was that the ALJ should abide by the findings made by the IRO, which found Provider was entitled to $6,145 reimbursement. This amount reflects Provider's calculations contained in his written closing argument. The IRO report did not stipulate an amount to be reimbursed, but rather found some services rendered to Claimant were medically necessary without listing an amount.

[1] The Commission's MRD received this dispute on October 22, 2003, more than one year after the disputed date of service for October 21, 2002. Under the Commission's rules at 28 TAC § 133.308(e), Provider waived his right to independent review for this date because it was received more than one year following the date of service.

The IRO report in this case was peculiar in two ways. First, it inexplicably failed to acknowledge several dates of service contained in Provider's original billing. At the hearing, however, Provider asserted he was not seeking any reimbursement for services not addressed by the IRO.

The other peculiarity in the IRO decision was its treatment of Provider's billing of CPT Code 99213-MP, an office visit with a manipulation. Provider billed for this code on at least 75 dates of service, and the IRO found Provider was entitled to reimbursement for the lesser service of 99212 rather than 99213-MP on several occasions. On other occasions where Provider billed for 99213-MP, the IRO found Provider was not entitled to any reimbursement under 99213-MP or 99212. The IRO found other services medically necessary, but never stipulated an amount owed to Provider for those services it found medically necessary including electric stimulation and hot and cold pack therapy. Based on his review of the IRO decision, Provider submitted a written closing argument that reflected an amount of $6,145 awarded by the IRO, which Carrier did not dispute in its written closing argument.

However, in this case, the MRD declined to adopt the findings of the IRO report that called for a "recoding" of Provider's original billing to a lesser reimbursable service. The MRD instead determined what the "allowable fees" were for each disputed service and found Provider was entitled to $3,064 for the disputed services addressed by the IRO. Additionally, the MRD report cited the IRO's rationale that the "office visits billed at the 99213 level were not supported as medically necessary as the chiropractic documentation submitted for review indicates a 99212 code would have been more characteristic of the documentation than was the 99213 code." The MRD report also found Provider was entitled to $727 as reimbursement for eight dates of service that were not addressed by the IRO.

Ultimately, the MRD found Provider was entitled to $3,791 reimbursement for the services rendered to Claimant. Carrier did not appeal this decision. Provider argued that it was entitled to reimbursement under the IRO report but presented only the medical records to support this position. Conversely, Carrier presented David Alvarado, D.C., who asserted the IRO was correct to the extent that the Provider's documentation did not warrant a 99213 level of service. Additionally,

Dr. Alvarado testified that Claimant experienced no improvement as part of his treatment with Provider based on his review of the record. Provider did not point to any improvement made by Claimant, but rather maintained his stance that the ALJ should adopt the IRO decision.

D. Analysis and Conclusion

In this case, the burden of proof is on the Provider to prove either the MRD was incorrect in not allowing the IRO to re-code the services as billed, or to prove the services as originally billed (including 99213-MP) were medically necessary.

At the hearing, and in its written closing arguments, Mr. Randolph argued the IRO decision should stand, and Provider should be reimbursed $6,145 because a proper re-coding of Provider's bills from 99213-MP to 99212 renders this amount. While Provider believes the IRO properly re-coded the services, he essentially concedes that the original billing for 99213-MP was not medically necessary, a point also addressed by the IRO.

The ALJ was more persuaded by Carrier's argument that SOAH has no jurisdiction to undertake such an endeavor. In support of this position, Carrier pointed out a prior SOAH decision where the ALJ found the provider was not entitled to receive payment for the lesser CPT Code of 99213 after initially billing the carrier for CPT Code 99214.[2] Carrier also cited out a recent Travis County case where the District Court Judge ruled SOAH was "without authority to recode work hardening as work conditioning when reimbursement was sought for work hardening."[3] Work hardening is a higher level of service than work conditioning, and the district court found SOAH had no authority to award a provider reimbursement for the lower level of service of work conditioning.

Therefore, the ALJ in this case concludes he has no authority to recode 99213-MP to 99212 because Provider initially sought reimbursement for 99213-MP on the disputed dates of service and 99212 is a lower level of service. If Provider initially billed services incorrectly, they cannot be subsequently recoded to a lower level of service, and as a result, reimbursed for a lower amount that

[2] SOAH Docket No. 453-03-3809.M5, ALJ Norman, March 1, 2004.

[3] Travis County District Court, Docket No. GN-301594, September 24, 2004.

correlates to the lower level of service. Hence, the ALJ is unable to adopt the findings of the IRO, which recoded 99213-MP to 99212.

Additionally, at the hearing, Provider presented insufficient evidence as to why he is entitled to full reimbursement for 99213-MP. Therefore, the ALJ will defer to the MRD decision, which found the services billed under 99213-MP were not medically necessary for all the dates of service in dispute. The MRD also found the following procedures were not medically necessary: CPT Code 97250 myofascial release procedures for 57 dates of service; CPT Code 97014 electric stimulation procedures for 34 dates of service; CPT Code 97010 hot and cold pack therapy for 19 dates of service; and CPT Code 97035 ultrasound therapy for 45 dates of service.

Conversely, the MRD found the following procedures were medically necessary: CPT Code 97250 myofascial release for 12 dates of service totaling $516; CPT Code 97014 electric stimulation therapy for 19 dates of service totaling $285; CPT Code 97010 hot and cold pack therapy for 19 dates of service totaling $209; CPT Code 97035 ultrasound therapy for 11 dates of service totaling $242; CPT Code 97110 therapeutic exercises for 7 dates of service totaling $980; and CPT Code 97113 aquatic therapy for 4 dates of service totaling $832. In addition to the aforementioned amounts, the MRD also found Provider was entitled to $727 for additional services that were not addressed by the IRO. These additional services were performed between 11/1/02 and 4/4/03 and involved two office visits with manipulation, ultrasound therapy, myofascial release, therapeutic exercises and aquatic therapy. Carrier did not dispute these findings, therefore, the ALJ concludes Carrier is obliged to reimburse Provider for the services the MRD found medically necessary.

For the above stated reasons, the ALJ finds Provider is entitled to $3,791 total reimbursement for the medically necessary services rendered to Claimant. The ALJ finds that Provider has not proven by a preponderance of the evidence that he is entitled to the amount awarded by the IRO.

III. FINDINGS OF FACT

1. Claimant suffered a compensable back injury on___.

2. Claimant sought treatment with John Randolph, D.C. (Provider), for his back pain.

3. Provider treated claimant from October 21, 2002, through June 27, 2003, with physical therapy that included office visits with manipulations, myofascial release, electric stimulation, hot and cold packs, ultrasound, therapeutic exercises, and aquatic therapy.

4. Provider requested reimbursement from Texas Mutual Insurance Company (Carrier), which was denied as not medically necessary.

5. Provider filed a Request for Medical Review Dispute Resolution with the Texas Workers' Compensation Commission (the Commission), seeking reimbursement for the treatment rendered to Claimant.

6. The dispute was referred to an Independent Review Organization (IRO), which found Provider was entitled to $6,145 based on its recoding of Provider's original billing.

7. On at least 75 different occasions, Provider billed Carrier for an office visit with manipulation under CPT Code 99213-MP.

8. The IRO found Provider should be reimbursed at the CPT Code 99212 level of payment instead of the CPT Code 99213-MP, which it originally billed.

9. CPT Code 99212 is a lower level of service than CPT Code 99213-MP.

10. The Commission's MRD declined to adopt the findings made by the IRO and found Provider was entitled to $3,791 reimbursement.

11. Provider timely appealed the decision and filed a request for hearing before the State Office of Administrative Hearings (SOAH).

12. Notice of the hearing was sent October 26, 2004.

13. 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.

14. The hearing convened on April 28, 2005, with Steven M. Rivas, Administrative Law Judge (ALJ) presiding. Sam Randolph, office manager for Provider, appeared on behalf of Provider. Carrier appeared and was represented by Tim Riley, attorney. The record remained open until May 20, 2005, to allow the parties an opportunity to file written closing arguments.

15. Claimant showed no improvement following the office visits and manipulations.

16. The documentation did not support Provider's billing for CPT Code 99213-MP on the disputed dates of service.

17. The IRO improperly recorded Provider's original billing from CPT Code 99213-MP to CPT Code 99212.

18. The following services were not medically necessary to treat Claimant's compensable injury: CPT Code 97250 myofascial release procedures for 57 dates of service; CPT Code 97014 electric stimulation procedures for 34 dates of service; CPT Code 97010 hot and cold pack therapy for 19 dates of service; and CPT Code 97035 ultrasound therapy for 45 dates of service.

19. The following services were medically necessary to treat Claimant's compensable injury: CPT Code 97250 myofascial release for 12 dates of service totaling $516; CPT Code 97014 electric stimulation therapy for 19 dates of service totaling $285; CPT Code 97010 hot and cold pack therapy for 19 dates of service totaling $209; CPT Code 97035 ultrasound therapy for 11 dates of service totaling $242; CPT Code 97110 therapeutic exercises for 7 dates of service totaling $980; and CPT Code 97113 aquatic therapy for 4 dates of service totaling $832. These medically necessary services totaled $3,064.

20. The additional services, which involved two office visits with manipulation, ultrasound therapy, myofascial release, therapeutic exercises and aquatic therapy, not mentioned in the IRO report, performed between November 1, 2002, and April 4, 2003, were medically necessary to treat Claimant's compensable injury. These additional services totaled $727.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. ch. 401 *et seq*.

2. SOAH has jurisdiction over 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.

3. Provider timely filed its request for hearing as specified by 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§2001.051, 2001.052 and 28 TEX. ADMIN. CODE § 148.4.

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

6. Under TEX. LAB. CODE ANN. § 408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

7. Provider has failed to show, by a preponderance of the evidence, that it was entitled to additional reimbursement than the MRD awarded.

8. Pursuant to the foregoing Findings of Fact and Conclusions of Law, Provider is entitled to the $3,791 reimbursement awarded by the MRD.

ORDER

IT IS, THEREFORE, ORDERED that Provider, John Randolph, D.C., is entitled to receive $3,791 reimbursement from Carrier, Texas Mutual Insurance Company, for the treatment it rendered to Claimant from October 22, 2002, through June 27, 2003.

SIGNED July 13, 2005.

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS