SOAH DOCKET NO. 453-05-2111.M5
TWCC CASE NO. M5-04-2182-01

TEXAS MUTUAL INSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
PARKER CHIROPRACTIC CLINIC, P.C.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Co. ("Petitioner") has challenged the decision of an independent review organization ("IRO") on behalf of the Texas Workers' Compensation Commission ("Commission") in a dispute regarding the medical necessity of services related to a course of physical therapy. The IRO found that Petitioner improperly denied reimbursement for services that Parker Chiropractic Clinic, P.C., ("Respondent") provided between March 18 and May 23, 2003, to a claimant suffering from a back injury.

Petitioner challenged the decision on the basis that the treatment at issue was not, in fact, medically necessary, within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision disagrees, in part, with that of the IRO, finding that reimbursement of a portion of the disputed services should be denied.

I. JURISDICTION, NOTICE, AND VENUE

The Commission has jurisdiction over this matter pursuant to § 413.031 of the Act. The State Office of Administrative Hearings ("SOAH") has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction, notice, or venue.

II. STATEMENT OF THE CASE

The hearing in this docket was convened on August 1, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge ("ALJ") Mike Rogan presided. Petitioner was represented by Ryan Willett, Attorney. Respondent's representative – James W. Parker, D.C. – appeared by telephone. Both parties presented evidence and argument. The record closed on the same date.[1]

The record revealed that on ___, the claimant suffered a compensable injury to her lower back. She subsequently received treatment for the injury. However, in early 2003, her treating orthopedic surgeon referred her for a course of conservative therapeutic care with Respondent, which extended from February 18 through May 23, 2003.

Petitioner (the insurer for the claimant's employer) reimbursed Respondent for the initial month of the therapeutic program provided to the claimant, However, Petitioner denied reimbursement for services that were provided from March 18 through May 23, 2003, on grounds that these services were not medically necessary. (EOBs issued by Petitioner included the Payment Exception Code "U," indicating that the services had been determined to be unnecessary without performance of a peer review.)

Respondent sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute (MAXIMUS) issued a decision on June 3, 2004, concluding that Petitioner should have reimbursed Respondent for the disputed services. The IRO noted:

> The MAXIMUS chiropractor reviewer explained that a 6-8 week trial of conservative treatment is the standard of care for this type of injury. The MAXIMUS chiropractor reviewer also explained that if the patient does not respond to the trial of conservative care, the patient is routinely referred out for further treatment options, such as epidural steroid injections or possible surgical intervention. The MAXIMUS chiropractor reviewer further explained that interaction between all providers involved is medically necessary to ensure the patient is receiving proper treatment. Therefore, the MAXIMUS chiropractor consultant concluded that the hot/cold pack therapy, ultrasound, electrical stimulation, neuromuscular reeducation, level III office

[1] The staff of the Commission formally elected not to participate in this proceeding, although it filed a general "Statement of Matters Asserted" with the notice of the hearing.

visits, and physician team conference from 3/18/03 through 5/23/03 were medically necessary to treat this patient's condition.

The Commission's Medical Review Division ("MRD") reviewed the IRO's decision and, on October 8, 2004, issued its own decision confirming that the disputed services were medically necessary and should be reimbursed. Petitioner then made a timely request for review of the IRO and MRD decisions before SOAH.

III. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Petitioner

Petitioner argued that the medical services at issue (particularly the passive chiropractic modalities) were clearly inappropriate for a patient who had been injured more than two and a half years before the services were administered. Petitioner noted that the claimant exhibited no apparent benefit from her two months of therapy with Respondent – the level of pain she reported perceiving in her injured back was the same at the beginning and the end of the program.[2] Despite this lack of response by the patient, the notes recounting her visits to Respondent's clinic show almost no variation in her supervising therapist's assessment of the case or in the regimen of therapy administered.

Upon cross examination of Respondent's witness, Dr. Parker, Petitioner elicited confirmation that the claimant was not examined by any physician during her visits to Respondent's clinic for physical therapy (from February 18 through April 16, 2003), although Respondent's billing for several of those dates includes services under CPT Code 99213 – which identifies an office visit with a physician for the evaluation and management of an established patient, usually involving problems of "low to moderate severity."[3] Rather, the claimant's examinations and evaluations were performed during this period by a licensed physical therapist.

[2] Claimant reported subjective pain of 8, on an ascending scale of 1 through 10.

[3] TWCC *1996 Medical Fee Guideline,* p. 19.

B. Respondent

Dr. Parker testified for Respondent that the actual course of physical therapy sessions in this case (February 18 through April 16, 2003) was not very extended. In a letter to the Commission dated July 4, 2004, Dr. Parker also asserted that the disputed care was "consistent with nationally accepted treatment guidelines for disc protrusions or herniations with objectively described radiculopathy. Most criteria do allow for a (2) month trial of conservative care prior to performing injection therapy or surgical intervention."

Dr. Parker noted that the claimant was referred to Respondent by Martin Van Hal, M.D., an orthopedic surgeon. Clinical notes from Dr. Van Hal that were placed in evidence indicated that he first examined the claimant on June 25, 2002, and concluded that she was suffering a resurgence of pain from the small disc herniation at L5-S1. Dr. Van Hal also reported that the claimant had received "no therapy yet to date." After an eight-month interval, Dr. Van Hal examined the claimant again on February 11, 2003, apparently finding her back pain to have become more intense. He decided that she should be started in therapy, with reassessment in "5 to 6 weeks."

On April 22, 2003, Dr. Van Hal examined the claimant and found that she was experiencing "intractable pain," despite her recently concluded program of physical therapy. He concluded:

> [W]e are going to proceed with an ESI [epidural steroid injection]. We are also going to set her up for an EMS unit rental to see if that can help her control pain as she is asking for escalation of her narcotic medications. I am going to hold her at the Vicodin and would like to see it titrated down.

Respondent emphasized, in testimony and argument, that Petitioner relied wholly upon Payment Exception Code "U" in denying reimbursement in this case. Respondent thus appeared to suggest 1) that Petitioner's denial, since not based on peer review, lacks substantive support and 2) that any basis for denial asserted by Petitioner, other than lack of medical necessity, is inconsistent with the provision of the MRD's order barring the insurer from raising such new reasons for denial, in accordance with the Commission's rule at 28 TEX. ADMIN. CODE ("TAC") § 133.307(j)(2).

IV. ANALYSIS

Petitioner bears the burden of proving that the factual basis or analytical rationale for the IRO's decision in this case was invalid. In the ALJ's view, it has discharged that burden only with respect to the disputed services identified with CPT Code 99213.

With respect to those latter services, the record presented to the ALJ does not support a basic premise under which the review of this dispute apparently has proceeded up to this point – *i.e.*, it does not indicate that those disputed services recorded under CPT Code 99213 actually satisfied the definition for that category of services. As noted in TWCC's *1996 Medical Fee Guideline*, CPT Code 99213 includes only office visits conducted by a physician, whereas the visits in this case were conducted by a licensed physical therapist.

The ALJ does not believe that disallowance of services for the provider's failure to identify them properly is precluded by 28 TAC § 133.307(j)(2) or by SOAH's well-established principle (in Commission cases) that only those reasons for denial that are set out prior to a request for dispute resolution may be considered in subsequent review. On the contrary, in an administrative contest of this type, when a provider asserts that certain, specifically identified services were medically necessary, a later showing that the services actually delivered were of a significantly different nature must lead, normally, to a logical assumption that those different services were *not* medically necessary.

In addition, the failure to deliver the same services that a provider specifically bills is a deficiency that an insurer realistically may not be able to detect until a late stage in the dispute resolution process – if even then. In this case, Petitioner may not have had a firm basis for questioning whether Respondent actually provided CPT Code 99213 services until the cross examination of Dr. Parker at the hearing. Insurers certainly cannot be required to include, in their EOBs, the provider's inaccuracy of service identification as a speculative reason for denying reimbursement, on the mere chance that such inaccuracy might surface in the subsequent investigation of a dispute.

With respect to the other disputed services, Petitioner did not present a convincing or

adequately supported critique of the IRO's approval of reimbursement. No specific evidence countered the IRO's declaration that up to eight weeks of conservative care is appropriate, on a trial basis, in cases such as this one.

V. CONCLUSION

The ALJ finds that, under the record provided in this case, the disputed medical services reported under CPT Code 99213 have not been shown to be medically necessary. These services were reportedly provided on 12 separate dates, with $48.00 as the maximum allowable reimbursement ("MAR") under TWCC guidelines for such services on each date. Reimbursement for these services should be denied, counter to the previous determination by the IRO and MRD.

Petitioner did not show that the other disputed services were unnecessary. These included services in the following categories and amounts:

* CPT Code 97010, on 11 dates, with total MAR of $121.00.
* CPT Code 97032, on 11 dates, with total MAR of $242.00.
* CPT Code 97035, on 11 dates, with total MAR of $242.00.
* CPT Code 97112, on 12 dates, with total MAR of $2,065.00.
* CPT Code 99361, on five dates, with total MAR of $530.00.

Respondent should therefore be reimbursed for these services, in accordance with the IRO's previous determination in this matter.

VI. FINDINGS OF FACT

1. On ___, claimant suffered an injury to her lower back that was a compensable injury under the Texas Worker's Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. In the course of subsequent treatment for her compensable injury, the claimant presented to Martin Van Hal, M.D., an orthopedic surgeon, who later referred the claimant to Parker Chiropractic Clinic, P.C., ("respondent") for a program of conservative physical therapy.

3. Respondent described the program of physical therapy that was administered to claimant as including hot or cold packs (CPT Code 97010), electrical stimulation (CPT Code 97032),

ultrasound (CPT Code 97035), neuromuscular re-education (CPT Code 97112), office visits involving medical decision-making of low complexity (CPT Code 99213), and medical team conferences (CPT Code 99361).

4. Respondent sought reimbursement for services noted in Finding of Fact No. 3 B including care provided on dates of service from March 18 through May 23, 2003 B from Texas Mutual Insurance Co. ("Petitioner"), the insurer for claimant's employer.

5. Petitioner denied the requested reimbursement for those services associated with dates of service from March 18 through May 23, 2003.

6. Respondent 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 June 3, 2004, and concluded that the services in dispute had been medically necessary.

8. The Commission's Medical Review Division ("MRD") reviewed and concurred with the IRO's determination in a decision dated October 8, 2004, in dispute resolution docket No. M5-04-2182-01.

9. Petitioner requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the MRD decision regarding reimbursement.

10. The Commission mailed notice of the hearing's setting to the parties at their addresses on December 3, 2004.

11. A hearing in this matter was convened before SOAH on August 1, 2005. Petitioner and Respondent were represented. The record in the proceeding closed on the same date.

12. Among those services noted in Finding of Fact No. 3 that are in dispute, those billed by Respondent under CPT Code 99213 did not actually meet the definition for that category, since no physician took part in any of the claimant's office visits that were identified with that code.

13. The services noted in Finding of Fact No. 12 were provided on 12 separate dates of service, with a maximum allowable reimbursement ("MAR") under Commission rules of $48.00 for those services on each date, for a total MAR of $576.00.

14. With respect to those services noted in Finding of Fact No. 3 that were disputed and that were billed by Respondent under CPT Codes 97010, 97032, 97035, 97112, and 99361, Petitioner did not show that the IRO and MRD erred in finding such services to be medically necessary, as noted in Findings of Fact Nos. 7 and 8.

15. The services noted in Finding of Fact No. 14 were provided on 17 separate dates of service, with a total MAR of $3,200.00.

VII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ' 413.031.

2. 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 § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE ("TAC") § 133.305(g) and §§ 148.001-148.028.

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

5. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

6. Based upon the foregoing Findings of Fact, those disputed services for the claimant noted in Finding of Fact No. 12 do not represent elements of health care medically necessary under § 408.021of the Act.

7. Based upon the foregoing Findings of Fact, those disputed services for the claimant noted in Finding of Fact No. 14 represent elements of health care medically necessary under § 408.021of the Act.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions in this matter of the IRO, issued on June 3, 2004, and of the MRD, issued on October 8, 2004, were incorrect with respect to the services noted in Finding of Fact No. 12. Reimbursement of Respondent for such services, in the amount of $576.00, should be denied.

9. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decisions in this matter of the IRO, issued on June 3, 2004, and of the MRD, issued on October 8, 2004, were correct with respect to the services noted in Finding of Fact No. 14. Respondent should be reimbursed by Petitioner for such services, in the amount of $3,200.00.

ORDER

IT IS THEREFORE, ORDERED that the challenge by Texas Mutual Insurance Co., seeking reversal of the findings and decision of an independent review organization issued in this matter on June 3, 2004, be approved in part and denied in part; that Texas Mutual Insurance Co. shall not be required to reimburse Parker Chiropractic Clinic, P.C., for services provided from March 18 through May 23, 2003, that were identified with CPT Code 99213; but that Texas Mutual Insurance Co. shall be required to reimburse Parker Chiropractic Clinic, P.C., $3,200.00 for services provided during the same period that were identified with CPT Codes 97010, 97032, 97035, 97112, and 99361, consistent with the prior decision of the independent review organization.

SIGNED August 9, 2005.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS