SOAH DOCKET NO. 453-05-2806.M5
MDR Tracking No. M5-04-4064-01

EAST TEXAS CHIROPRACTIC,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
DEEP EAST TEXAS SELF INSURANCE FUND,	§	
	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. SUMMARY DECISION

East Texas Chiropractic, Petitioner, requested a hearing following the issuance on October 22, 2004, of the Findings and Decision of the Medical Review Division (MRD) Texas Workers'Compensation Commission (Commission). The Commission's Findings and Decision relied upon a decision of an Independent Review Organization (IRO) that Petitioner's treatments rendered to Claimant were not medically necessary. After considering the evidence and the written arguments of the parties, the judge concludes that the disputed treatments were not medically necessary. However, in the instances in which a peer review was not provided in accordance with Explanation Of Benefits (EOB) payment exception code requirements, the Petitioner is entitled to reimbursement.

II. PROCEDURAL HISTORY

The parties pre-filed all exhibits. On November 16, 2005, presiding Administrative Law Judge (ALJ) Georgie Cunningham convened the hearing on the merits. The hearing was continued to permit Deep East Texas Self Insurance, Respondent, an opportunity to designate a licensed attorney or licensed insurance adjuster as its representative. The hearing on the merits was reconvened on March 21, 2006, before ALJ Paul Keeper. Counsel appearing at the hearing were William Maxwell for Petitioner and Beverly L. Vaughn for Respondent.

Each party announced that it would call no witnesses and agreed to rely solely upon their written evidence. Counsel then rested their cases subject to their right to submit written closing arguments and Petitioner's right to assert objections to specific documents among Respondent's

written exhibits. Counsel agreed that Petitioner would submit its closing arguments, including objections to Respondent's exhibits, by April 17, 2006, Respondent would submit its closing arguments by May 8, 2006, and Petitioner would submit its reply to Petitioner's closing arguments by May 22, 2006. The record closed on May 22, 2006.

III. RULING ON PETITIONER'S OBJECTIONS TO RESPONDENT'S EXHIBITS

In its closing argument, Petitioner presented multiple objections to all or part of Respondent's exhibits. These objections may be classified into three categories. The ALJ overrules all three categories of objections.

First, Petitioner objects to the admission of all documents on the basis that the order continuing the hearing did not extend the deadline for filing of exhibits. The ALJ has already addressed this issue in Order No. 6, in which all exhibits were admitted subject to Petitioner's other objections. The first category of objections is overruled.

Second, Petitioner objects to the admission of pages 7-18 of Respondent's exhibits on the basis that the documents are hearsay and/or conclusory. The contents of pages 7-18 are two peer review reports completed by Charles Crane, M.D., and Roger Canard, D.C. The reports evaluate medical treatment rendered to Claimant and state the reviewers' opinions on medical necessity of the treatment rendered. These reports became part of Claimant's file as maintained by Respondent and were submitted with a business records affidavit. Accordingly, these documents qualify under the hearsay exception outlined in TEX. R. EVID. 803(6) and 902(10). Additionally, these peer review reports are substantiated with sufficient medical testimony based on the writers' experience and training for the ALJ to find that neither are merely conclusory. Petitioner's second category of objections is overruled.

Third, Petitioner objects to admission of Respondent's EOB reports based on the allegation that the EOB payment exception codes were incorrect and/or inaccurate. Although the incorrect and/or inaccurate use of these codes may have some substantive relation to the case, the alleged incorrect or inaccurate *use* of the codes does not relate to the documents' admissibility as exhibits. Accordingly, Petitioner's third objection is overruled.

IV. ANALYSIS

Claimant sustained a work-related injury on ___and sought treatment from Ronald Corley, M.D., on ___. Dr. Corley diagnosed Claimant's injury as a possible reinjury of a disk herniation. Dr. Corley recommended an MRI, and a study was performed a few days later. The MRI revealed that Claimant had a protruding disk at L5-S1, and on May 21, 2003, Dr. Corley referred Claimant to Stig Peitersen, M.D., a neurosurgeon. During this period, Claimant was in considerable pain and was receiving pain control medication from Dr. Corley.

However, instead of obtaining a recommendation for treatment from Dr. Peitersen, Claimant changed treating doctors. On July 8, 2003, Claimant first saw Michael Fleck, D.C., and then Keith Calda, D.C., Dr. Fleck's associate, each of whom were practicing through Petitioner's office. Claimant's treatment with Petitioner began on July 18, 2003, and continued through August 5, 2004, including four weeks of work hardening. At the end of that period, Dr. Calda referred Claimant to Rajesh K. Bindal, M.D., a neurosurgeon, for a surgical consultation for his lumbar injury.

On October 6, 2004, Dr. Bindal examined Claimant and reviewed the MRI study from May 2003. Dr. Bindal's diagnosis was the same as that of Dr. Corley's diagnosis. Claimant underwent surgery for decompression of the S1 nerve root and experienced significant relief from the pain since his injury.

Petitioner's history of treatment of Claimant is summarized as follows:

Dates of Service	Number of Days of Therapy	Type of Therapy
07-19-03 to 07-24-03	5	Chiropractic care
07-28-03 to 10-24-03	33	Aquatic therapy
10-27-03 to 04-22-04	58	Exercise program
07-06-04 to 08-05-04	9	Work hardening

In addition to these types and episodes of therapy, Petitioner billed for Claimant's office visits, nerve conduction studies, epiduragrams, epidural steriod injections, and educational sessions.

In addition, on April 5, 2004, Dr. Calda noted that Claimant needed a surgical consultation. Despite this recommendation, Petitioner continued to render exercise programs and a work hardening program to Claimant for another four months.

Dr. Fleck's written testimony in support of this course of treatment follows:

> Ultimately we were able to prevent spinal surgery which was the original recommendations [sic] prior to seeing us. If the patient would have underwent the spinal surgery and not received care through our office, this would have cost the carrier 50 to 70,000 dollars, plus all the extensive rehab he would have needed after the surgery. Of course spinal surgery would not have been a guarantee that his condition would have improved anyway. More than 50% of spinal surgeries require a second surgery after the first. This adds to the overall expensive [sic] in this case if the patient would have chose [sic] surgery over conservative care. In the end, the carrier would have had expenses would range well into 300,000 to 700,000 dollars. This Dispute is over approximately 24,000 dollars. I believe our treatment was cost effective because we prevented surgery to a disc which was originally displacing the nerve root and causing altered neurological changes in the lower extremity.[1]

Respondent's evidence included the written report of Roger Canard, D.C. Dr. Canard evaluated Claimant through a medical record review on September 26, 2003. Among his criticisms of Petitioner's decision to continue treatment was that "[t]his patient should have been immediately referred to a neurosurgeon for evaluation with attempted blocks and/or possible diskectomy."[2]

Respondent's evidence also included the written report of Dr. Crane, a board certified physician in physical medicine and rehabilitation. Dr. Crane's report concluded that nothing in the medical record supported the medical necessity of the services provided by Petitioner, that the treatments rendered by Petitioner resulted in no improvement in Claimant's condition, and that Petitioner's treatments merely delayed the appropriate treatment of the care that Claimant should have received.[3]

In keeping with these same conclusions, the IRO found that Claimant Aobtained no significant relief [and that] promotion of recovery was not accomplished.@[4] In addition, the IRO

---

[1] Petitioner Ex. 1 at P6.

[2] Respondent Ex. 1 at 17.

[3] Respondent Ex. 1 at 14-15.

[4] Respondent Ex. 1 at 5.

found that Petitioner's treatment program involved Aan unchanging treatment plan and performance of activities that [could have been] performed as a home exercise program.@[5] None of the services rendered by Petitioner were determined by the IRO to have been medically necessary.

The overwhelming weight of the evidence supports the position of Respondent. Few, if any, of the 809 pages of Petitioner's evidence explain the need for the year of therapy that was rendered. The alleged cost savings realized by Petitioner's treatment of Claimant were not proved.

However, Petitioner additionally argues that Respondent did not comply with the EOB payment exception code requirements. The payment exception codes were mandated by the Commission for use by an insurance carrier in identifying the general rationale for reducing or denying payment for a properly completed medical bill.[6] On one EOB, Respondent listed payment exception code "V" as its reason for denial of reimbursement for services.[7] Code "V" is listed as "Unnecessary Treatment With Peer Review."[8] Rule 133.304(h) provides "when an insurance carrier reduces or denies payment for treatment(s) and/or service(s) on the recommendation of a peer review . . . the insurance carrier shall provide a copy of the peer reviewer's report to the sender of the bill."[9] However, in violation of this rule, Respondent failed to include a peer review with its usage of code "V."[10] Accordingly, reimbursement cannot be denied in this instance because Carrier's denial of reimbursement is legally inadequate. This determination is consistent with past SOAH decisions.[11] Therefore, for this $2,615.71 portion of the claim, the ALJ concludes that: (1) Respondent never properly denied reimbursement for this portion of the claim, (2) Respondent's medical necessity issues may not be reached, and (3) Petitioner is entitled to reimbursement.

---

[5] *Id.*

[6] Petitioner Ex. 1 at P492.

[7] Petitioner Ex. 1 at P489.

[8] Petitioner Ex. 1 at P492.

[9] 28 TEX. ADMIN. CODE §§ 133.1(12) and 133.304(h) (repealed).

[10] Petitioner Ex. 1 at P489.

[11] *See* SOAH Docket Nos. 453-02-0991.M5, Decision and Order (April 12, 2002) (ALJ Ingraham); 453-03-2310.M5, Decision and Order (Sept. 3, 2002) (ALJ Wood) 453-03-3682.M5, Decision and Order (Oct. 17, 2003)(ALJ Bennett).

Having reviewed the evidence and the argument of counsel, the ALJ grants Petitioner's request for compensation for $2,615.71 in services improperly denied by the carrier's use of denial code "V" and failure to provide a copy of the peer reviewer's report. For all other services, the ALJ denies Petitioner's request for compensation on the basis that none of the services rendered were medically necessary.

V. FINDINGS OF FACT

1. On___, Claimant sustained a work-related injury.

2. On April 30, 2003, Claimant sought treatment from Ronald Corley, M.D.

3. Dr. Corley diagnosed Claimant's injury as a possible reinjury of a disk herniation and recommended an MRI.

4. The MRI revealed that Claimant had a protruding disk at L5-S1.

5. Claimant was in considerable pain and was receiving pain control medication from Dr. Corley.

6. On July 8, 2003, Claimant began his treatment with Petitioner through Michael Fleck, D.C., and later through Keith Calda, D.C.

7. On July 18, 2003, East Texas Chiropractic, Petitioner, began treating Claimant and continued to treat Claimant through August 5, 2004.

8. Petitioner's treatment for claimant's disk herniation included: chiropractic care (5 episodes of treatment during 07-19-03 to 07-24-03), aquatic therapy (33 episodes of treatment during 07-28-03 to 10-24-03), exercise program (58 episodes of treatment during 10-27-03 to 04-22-04), and work hardening (9 episodes of treatment during 07-06-04 to 08-05-04), plus office visits, nerve conduction studies, epiduragrams, epidural steriod injections, and educational sessions.

9. At the end of Petitioner's course of treatment of Claimant, Petitioner referred Claimant to Rajesh K. Bindal, M.D., a neurosurgeon, for a surgical consultation for his lumbar injury.

10. On October 6, 2004, Dr. Bindal examined Claimant and rendered the same diagnosis of Claimant's medical problems as made by Dr. Corley in May 2003.

11. On May 12, 2005, Claimant underwent surgery for decompression of the S1 nerve root and experienced significant relief from the pain that he had suffered since his injury.

12. The treatments rendered by Petitioner resulted in no significant improvement in Claimant's condition.

13. Petitioner's treatments merely delayed the appropriate treatment of the care that Claimant should have received.

14. Deep East Texas Self Insurance Fund, Respondent, used a denial code "V," "Unnecessary Treatment with Peer Review," in denying $2,615.71 in Petitioner's claims.

15. Respondent did not provide a copy of the peer reviewer's report to Petitioner.

16. On November 16, 2005, the hearing on the merits was convened pursuant to notice and was continued to permit Respondent to obtain counsel.

17. On March 21, 2006, the hearing on the merits was reconvened pursuant to notice.

18. Counsel for Petitioner was William Maxwell, and counsel for Respondent was Beverly Vaughn.

19. On May 22, 2006, the record closed following counsel's submission of closing arguments and briefs.

VI. 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 parties' requests for a hearing were 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. The party requesting the contested case hearing has the burden of proof.

6. Respondent failed to include a peer review report in its denial of reimbursement for the services in violation of 28 TEX. ADMIN. CODE 133.304(h)(repealed). Petitioner is entitled to compensation of $2,615.71 for these services.

7. The preponderance of the evidence demonstrated that the balance of the disputed services rendered by Petitioner were neither reasonable nor medically necessary.

Therefore, Respondent is ORDERED to pay Petitioner the sum of $2,615.71. All other relief not expressly granted herein is denied.

SIGNED July 5, 2006.

PAUL D. KEEPER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS