SOAH DOCKET NO. 453-05-3185.M5

K. B. FAIRCLOTH, D.C.,	**§**	**BEFORE THE STATE OFFICE**
Petitioner	**§**	
	§	
VS	**§**	**OF**
	§	
US SPECIALTY INSURANCE,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

I. DECISION AND ORDER

K. B. Faircloth, D.C. ('Petitioner'), has challenged the Findings and Decision of the Texas Workers' Compensation Commission's Medical Review Division ('MRD') in a medical fee dispute. The MRD denied full reimbursement to the Petitioner for services provided between November 25, 2002, and February 17, 2003, to a claimant under the Texas workers' compensation laws.

The MRD concluded that Petitioner had failed to satisfy applicable rules upon the documentation and description of disputed services. This decision disagrees, in part, with the MRD decision.

II. JURISDICTION AND NOTICE

The Texas Workers'Compensation Commission ('Commission') has jurisdiction over this matter pursuant to § 413.031 of the Texas Workers' Compensation Act ('the Act'), TEX. LABOR CODE ANN. ch. 401 *et seq.* 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 or adequacy of notice.

III. STATEMENT OF THE CASE

The hearing in this docket was convened and concluded on June 6, 2005, at SOAH facilities in Austin, Texas. Administrative Law Judge ('ALJ') Mike Rogan presided over the hearing. Petitioner appeared by telephone and was represented by John Zachary, Attorney. Respondent did not appear and did not provide SOAH or the Commission any explanation for that failure to appear. After the hearing, the parties were allowed an opportunity to submit additional pleadings relating to the scope of SOAH jurisdiction in this case. The record closed on June 20, 2005.[1]

The record developed at the hearing revealed that the claimant suffered a compensable injury on __. As part of the claimant's subsequent treatment, Petitioner provided chiropractic and related services, encompassing dates of service from November 25, 2002, through February 17, 2003.[2]

US Specialty Insurance (Respondent) or an entity acting in its behalf was the insurance carrier for claimant's employer at the time of the injury. Respondent denied Petitioner's requested reimbursement for the services at issue in this case, prompting Petitioner to initiate an action for medical dispute resolution before the Commission.

On October 31, 2004, the MRD issued a decision in this matter, addressing five categories of disputed services. At the subsequent SOAH hearing, however, the Petitioner acknowledged agreement with the MRD's determination relating to two of those categories (*i.e.*, services under

[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.

[2] The record indicates that Petitioner originally sought dispute resolution with respect to not only those services addressed in this docket, but also with respect to related services that were provided to the same claimant, from November 25, 2002, through March 10, 2003, which were disputed for alleged lack of medical necessity. According to the MRD decision, the MRD initially assigned an Independent Review Organization ("RO") "to conduct a review of the disputed medical necessity issues between the requestor and the respondent." Subsequently, however, the MRD dismissed the medical necessity request due to nonpayment of the IRO fee by the health care provider and has determined that medical fees are the only issues to be resolved.

In a post-hearing submission, Petitioner urged that even though the MRD had failed to make a substantive ruling upon whether these additional services were reimbursable, SOAH should have jurisdiction over that issue, since the MRD's action in this case was tantamount to denying these services. Alternately, Petitioner urged that the ALJ should remand to the MRD the action with respect to the additional services. However, in part because Petitioner has not made even a *prima facie* presentation with respect to the MRD's stated reason for withholding consideration of the additional services (*i.e.*, the nonpayment of IRO fee), the ALJ concludes that Petitioner has not established sufficient basis for SOAH either to exercise jurisdiction over the question of reimbursement for the additional services or to remand this matter, in part, to MRD for further consideration of the additional services.

CPT Codes 97012 and 97024, which the MRD concluded should be reimbursed at the rate Petitioner actually billed for them, although less than the maximum allowable rate for such services under Commission guidelines). With respect to the other three categories of services in dispute, the MRD stated the following:

> [1] CPT Code 72100 for date of service 11/25/02. An EOB was not submitted by either party. Per Rule 133.307(e)(2)(A) the requestor has not submitted HCFA-1500s; therefore, MDR cannot determine the maximum allowable reimbursement as the CPT code does not have a modifier and it is unknown if the health care provider is billing for the whole person, technical component or professional component. Reimbursement is not recommended.
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> [2] CPT Code 98940 for dates of service 01/17/03, 01/23/03 through 02/17/03. EOBs were not submitted by either party; therefore, these dates of service will be reviewed according to the1996 Medical Fee Guideline. Per the . . . Guideline, Medicine Ground Rule (I)(B)(1) this CPT code is invalid for these dates of service; therefore, reimbursement is not recommended.
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> [3] CPT Code 99070 for date of service 02/10/03. An EOB was not submitted by either party; therefore, this date of service will be reviewed according to the1996 Medical Fee Guideline. Per the . . . Guideline, General Instructions (IV) the requestor did not include a description of the supplies. Reimbursement is not recommended.

The MRD accordingly ordered Respondent to reimburse Petitioner only for the disputed services under CPT Codes 97012 and 97024, plus all accrued interest due at the time of such reimbursement. Petitioner then properly sought review of the MRD's decision before SOAH.

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. PETITIONER

Evidence in the record indicates that Petitioner responded to the MRD decision in this matter with a letter dated November 24, 2004, which addressed the MRD's specific recommendations as follows:

> [1] Denial states that in response to CPT code 72100 for date of service 11/25/02, a HCFA 1500 nor an EOB was provided by either party and therefore, MDR cannot determine . . . . . However, we provide copies of all HCFAs on several occasions

to TWCC along with a copy of the EOB. As seen from the EOB, [Respondent's agent] incorrectly entered and processed 72100 as 92100. We ask that these services be reviewed.

[2] CPT code 98940 are being denied based on incorrect CPT using the 1996 Medical Fee Guidelines. We consulted the TWCC online guide which indicates that CPT codes could be obtained by AMA CPT coding. As 98940 is the current and has been the past CPT code for several years, we used this code as it was the service provided. We ask that these services be reviewed.

[3] CPT code 99070 for date of service 2/10/03 is being denied based on requestor did not include a description of supplies. However, on the original HCFA and as seen on the copy provided to your office, a written description was included next to the service (analgesic gel). We ask that this service be reviewed.

At the SOAH hearing, Petitioner reiterated these points through the testimony of Tracy Brown, the Petitioner's office manager. Ms. Brown also asserted, with respect to Item [1], that her examination of the CPT codes showed no modifiers applicable to an x-ray under this category.

B. RESPONDENT

Respondent did not appear at the hearing or submit any pleadings after the hearing.

V. ANALYSIS

The record presented in this case appears quite fragmentary and confusing, in part because it consists of submissions from only one party. Still, the ALJ finds the documentation offered by Petitioner sufficient, in the absence of controverting evidence and argument, to support most of the Petitioner's positions upon the disputed services.

In the ALJ's view, that documentation - particularly the response to Items [1] through [3] of the MRD's rationale for decision, along with clarifying testimony - is sufficient to negate the stated factual bases for the MRD's conclusions upon services under CPT Codes 72100, 98940, and 99070.

In any case, though, the ALJ perceives a more fundamental reason to invalidate the MRD's determinations upon these specific services. The record as a whole indicates with reasonable clarity

that the Respondent denied all of the disputed services on the grounds that they were medically unreasonable or unnecessary, based upon a peer review of the case.[3] Under principles well-established in past SOAH decisions, reasons for denial of reimbursement may not be considered or relied upon by the MRD unless those reasons were previously asserted by the carrier.[4] Nothing in the record suggests that the carrier in this case ever raised the reasons for denial cited by the MRD in its decision of October 31, 2004.

However, an exception to this principle regarding waiver of unasserted reasons for denial exists in circumstances where applying it would result in a clear violation of the Act or implementing rules. In this case, the services under CPT Code 72100 (radiologic examination) are subject to this consideration. According to the Commission's 1996 *Medical Fee Guideline* (*MFG*)[5], the maximum allowable reimbursement rate for a radiologic examination is $22 for the professional component and $34 for the technical component, a total of $56. Petitioner, in contrast, seeks reimbursement of $65. The ALJ concludes that reimbursement for this service must be limited to $56 to comport with Commission rules.

As to the other disputed services, Petitioner seeks reimbursement of $21 for services under CPT Code 99070 and $25 for each of 10 occasions upon which services under CPT Code 98940 were performed. Such reimbursements appear to be appropriate.

VI. CONCLUSION

The ALJ finds that the record in this case supports, in part, the Petitioner's challenge to the MRD's prior decision and order denying Petitioner's reimbursement for services provided to the

[3] While Respondent apparently failed to provide EOBs for most or all of the disputed services, other evidence indicates that the only basis asserted by Respondent for denial of the services was lack of medical necessity, as determined by peer review (Code V). This evidence includes a table of disputed services submitted during the TWCC dispute-resolution process, the conclusions of the peer review performed on Respondent's behalf (dated November 21, 2002), and correspondence among Petitioner, Respondent, and the Commission.

[4] See, *e.g.*, SOAH Docket No. 453-01-3456.M5 (May 7, 2003, ALJ Norman); SOAH Docket No. 453-02-2026.M5 (June 19, 2002, ALJ Kilgore); SOAH Docket No. 453-01-2758.M5 (January 25, 2002, ALJ Cloninger).

[5] 28 TEX. ADMINISTRATIVE CODE§ 134.201.

claimant under CPT Codes 72100, 98940, and 99070. Respondent should be required to reimburse Petitioner a total of $327 for these services.

VII. FINDINGS OF FACT

1. On __, a claimant whose employer was insured by US Specialty Insurance (Respondent) or an entity acting in its behalf suffered a compensable injury under the Texas Worker's Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. As part of the claimant's subsequent treatment, K. B. Faircloth, D.C. ('Petitioner') provided chiropractic and related services, encompassing dates of service from November 25, 2002, through February 17, 2003.

3. Petitioner requested from Respondent reimbursement for the services noted in Finding of Fact No. 2, among other services. The reimbursement sought included the following:

   a. For services under CPT Code 72100, one date of service: $65.

   b. For services under CPT Code 98940, ten dates of service: $250.

   c. For services under CPT Code 99070, one date of service: $21.

4. Respondent denied the request for reimbursement, on the basis that the services at issue were not reasonable or medically necessary for the treatment of the claimant.

5. Petitioner made a timely request to the Medical Review Division ('MRD') of the Texas Workers' Compensation Commission ('commission') for medical dispute resolution with respect to the disputed reimbursement.

6. In a decision dated October 31, 2004, in dispute-resolution docket No. M5-04-2048-01, the MRD ordered the denial of reimbursement sought by Petitioner for services under CPT Codes 72100, 98940, and 99070 of the Commission's 1996 *Medical Fee Guideline* (*MFG*), 28 TEX. ADMIN. ('TAC') § 134.201. The MRD's decision declared the following rationales for denial:

   a. CPT Code 72100: '. . . .An EOB was not submitted by either party. . . .[T]he requestor has not submitted HCFA-1500s; . . . MDR cannot determine the maximum allowable reimbursement as the CPT code does not have a modifier . . . .'

   b. CPT Code 98940: '.. . .EOBs were not submitted by either party; . . . Per the Medical Fee Guideline . . . this CPT code is invalid for these dates of service . . . .'

   c. CPT Code 99070: '. . . .An EOB was not submitted by either party; . . . Per the Medical Fee Guideline . . . the requestor did not include a description of the supplies

. . . .

7. The record indicates that factual bases for the MRD's rationales for denial of reimbursement, as noted in Finding of Fact No. 6, were incorrect, in that documents performing the function of EOBs were submitted in the case, requestor (Petitioner) submitted appropriate HCFA-1500s, a provider is only required to include a modifier with CPT Code 72100 when specifically seeking reimbursement for only one component of such services, and Petitioner did include a description of CPT Code 99070 supplies on a submitted HCFA-1500.

8. The MRD's rationales for denial of reimbursement, as noted in Finding of Fact No. 6, were not asserted or identified for consideration by Respondent prior to conduct of the dispute resolution proceeding that culminated in issuance of the MRD's decision.

9. According to the Commission's *MFG*, the maximum allowable reimbursement rate for service under CPT Code 72100 (radiologic examination) is $22 for the professional component and $34 for the technical component, a total of $56.

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

11. The Commission mailed notice of the hearing's setting to the parties at their addresses on January 19, 2005.

12. A hearing in this matter was convened on June 6, 2005, in Austin, Texas, before Mike Rogan, an Administrative Law Judge with SOAH. Petitioner was represented, but Respondent did not appear and provided no explanation for that failure to appear.

VIII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issues presented pursuant to § 413.031 of the Act.

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 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 Commission rule and past SOAH decisions, reasons for denial of reimbursement may not be considered or relied upon by the MRD unless those reasons were previously asserted by the carrier.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the MRD Findings and Decision issued in this matter on October 31, 2004, should be reversed to the extent that they deny Petitioner reimbursements for disputed services that are within the maximum allowable reimbursements permitted by Commission rules.

8. Based upon the foregoing, Respondent should reimburse Petitioner $327 for disputed services under CPT Codes 72100, 98940, and 99070.

ORDER

IT IS THEREFORE, ORDERED that Respondent, US Specialty Insurance, reimburse Petitioner, K. B. Faircloth, D.C., $327 (plus all accrued interest due at the time of payment) for services provided under CPT Codes 72100, 98940, and 99070 from November 25, 2002, through February 17, 2003, in the treatment of a claimant under the Texas workers' compensation laws. The previous mandate, in the Decision and Order of the Texas Workers' Compensation Commission's Medical Review Division issued on October 31, 2004, that Respondent reimburse Petitioner $269 for services under CPT Codes 97012 and 97024 (plus all accrued interest due at the time of payment) also remains in effect if not yet discharged by Respondent.

SIGNED June 22, 2005.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS