SOAH DOCKET NO. 453-05-3338.M5
MR NO. M5-05-0045-01

LAURENCE N. SMITH, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
LIBERTY MUTUAL FIRE INSURANCE,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

I. DECISION AND ORDER

Laurence N. Smith, D.C. (Provider), appealed the decision of the Texas Workers' Compensation Commission's Medical Review Division (MRD).[1] The MRD concluded that only the disputed services provided to an injured worker (Claimant) between September 29, 2003, and June 3, 2004, coded under 97110 and 98940 were medically necessary, found that documentation of many services was insufficient, and ordered reimbursement of $765.16 plus interest to Provider. This decision and order finds that the MRD decision should be upheld, and orders no additional reimbursement to Provider.

II. JURISDICTION AND NOTICE

The parties did not contest notice or jurisdiction; therefore, those issues are addressed in the Findings of Fact and Conclusions of Law below.

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the newly created Division of Workers' Compensation at the Texas Department of Insurance.

III. STATEMENT OF THE CASE

The hearing in this docket was originally set for July 21, 2005, but Provider did not appear. The case was continued after Carrier's counsel indicated that a recent conversation between him and Provider suggested that Provider intended to appear, and after the ALJ discovered that Provider had included a request to appear by telephone in his request for a hearing.[2] The hearing was rescheduled, and was convened and concluded on October 3, 2005, at SOAH facilities in Austin, Texas. Administrative Law Judge (ALJ) Charles Homer III presided over the hearing. Provider appeared by telephone. Liberty Mutual Fire Insurance Company (Carrier) appeared through Kevin Franta, its attorney. The record closed on October 3, 2005.

Claimant, whose work for Goodwill Industries of Dallas involved handling boxes that weighed up to 50 pounds each, suffered a compensable injury to his lower back and left leg on ___. From September 29, 2003, through June 3, 2004, Provider provided the following services and billed under the codes beside each:

manipulative therapies 1-2 spinal areas	(98940)
therapeutic exercises	(97110)
manipulative therapy 3-4 spinal areas	(98941)
manual therapy techniques	(97140-59)
neuromuscular reeducation	(97112)
attended electrical stimulation	(97032)
mechanical traction.	(97012)

Carrier denied Provider's requested reimbursement for most of these services and dates on medical necessity grounds. Despite its medical necessity dispute, Carrier, during the time between

[2] SOAH Rule 155.45 requires a "timely motion" and that other matters be stated in the motion. Whether or not strictly required by the rule, filing a separate motion that complies with Rule 155.45 is the best practice and helps all parties and SOAH to avoid similar incidents.

its initial denials and the MRD proceeding in September 2004, paid the maximum allowable reimbursement (MAR) for most claims, and then filed a second set of explanations of benefits (EOBs) asserting insufficient documentation and/or fee disputes for most of the services. Each of Carrier's first set of EOBs was apparently filed soon after the corresponding claim for reimbursement; the second set of EOBs was apparently filed after reimbursement checks for many services were issued on September 23, 2004, but before the MRD's September 28, 2004 cutoff date for additional documentation.

Provider initiated an action for medical dispute resolution before the Commission. An Independent Review Organization (IRO) was assigned by the MRD to consider the medical necessity disputes; it determined that the only medically necessary services were those coded 98940 and 97110 for all dates at issue.

In its decision dated November 10, 2004, the MRD adopted the IRO's findings as medical necessity. But in reviewing the case file, the MRD found that Provider submitted no requests for reconsideration (recon HCFAs) for most service dates, and denied reimbursement based on TWCC rule 133.307(a)(2), which requires the provider to submit claims (recon HCFA forms) for each date of service for which it requests reconsideration. Also, as to all services coded under CPT code 97110, the MRD found that Provider's documentation was inadequate to support billing for the one-on-one supervised therapeutic activities that are appropriately billed under 97110, and ordered no reimbursement for any 97110 services. Finally, the MRD determined that Carrier had not submitted EOBs for several dates of service, and ordered reimbursement up to the MAR for those services and dates.

Having so found, the MRD ordered Carrier to reimburse Provider $765.16 for those disputed services for which it found that Carrier failed to provide EOBs. Provider sought review of the MRD decision; Carrier did not. At the hearing, the burden of proof on the medical necessity and

documentation issues was assigned to Provider.[3]

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Provider

Provider offered a number of HCFA 1500s into evidence. The ALJ sustained Carrier's objection to their admission because no copies were provided to either Carrier or the ALJ before the hearing, as required by SOAH rule 155.25(a). Provider testified that, contrary to the MRD's finding that he had failed to comply TWCC rule 133.307(a)(2), he must have submitted recon HCFA forms in order to put the medical necessity issue before the MRD. Provider further testified that the disputed services were medically necessary because they relieved Claimant's pain, even if that relief was not of long duration, and cited case law in support of that position.[4]

B. Carrier

Carrier offered into evidence a benefit dispute agreement[5] and records pertaining to its

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[3] Carrier did not appeal. Had it done so with regard to those services for which the MRD awarded reimbursement, Carrier would have had the burden to show that it in fact had filed EOBs.

[4] *Travelers Insurance Co. v. Martin*, 2000 WL 1052965 (Tex. App. - Texarkana 2000). Provider also cited Tex. Labor Code Ann. § 408.021(a), which reads in pertinent part:

> 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. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or . . . .

Provider argues correctly that treatment is not required to promote recovery or enable the injured worker to return to work in order to be medically necessary; it may also simply relieve the effects naturally resulting from a compensable injury.

[5] Carrier Ex. A. The agreement, among other things, limits the compensable injuries to Claimant's lumbar spine and left leg.

denials of Provider's requests for reimbursement.[6] Carrier also requested that official notice be taken of several pages from the Medicare Correct Coding Guide.[7] Carrier offered no testimony other than by cross-examination of Provider.

V. ANALYSIS

Regarding the medical necessity issue, Provider's testimony was not sufficient to meet his burden of proving that more than the chiropractic manipulations (98940) and therapeutic exercises (97110) were medically necessary.[8] On the other hand, Carrier showed (and Provider did not contest) that it had issues were properly before the MRD, which ruled adversely to Provider on those issues. Carrier also showed that it had already paid the maximum allowable reimbursement for many of the disputed services. Therefore, no additional reimbursement is awarded.

A. Medical Necessity

Provider testified that Claimant's pain was relieved by the disputed services, but did not describe why the services were effective, why they were reasonably priced, nor that the alleged improvement lasted for a significant time, although he conceded that it was temporary. Treatment that relieves symptoms may be medically necessary, but it is not true, as Provider argues, that services that relieve pain are presumed to be medically necessary.[9]

Although Provider is correct that he is not required to show that his disputed services

[6] Carrier Ex. B.

[7] Medicare Correct Coding Guide, Ingenix Corp. (2005) The pages noticed concerned billing for mutually exclusive procedures and chiropractic manipulations.

[8] Carrier Ex. B, at p. B0009.

[9] Provider cited *Travelers Insurance Company v Wilson*, 28 S.W. 3d 42 (Tex. App. B Texarkana 2000, no writ). But that opinion only states that the Workers Compensation Act does not require healthcare that relieves pain to also cure claimant's injury before it can qualify as medically necessary. Nowhere in the opinion is a "presumption" in favor of the medical necessity of healthcare that relives pain discussed.

actually enabled Claimant to return to work, he is required to prove by a preponderance of the evidence that the disputed services were medically necessary, without benefit of a presumption that such was the case. The IRO decision in this proceeding noted that:

> In fact, the daily records submitted were absent any objective means to monitor patient response to care throughout the date range in dispute (e.g. specific range of motion measurements, reexamination findings, or even a pain scale rating). Therefore, there was no basis for continued application of these treatments, rendering their medical necessity unsupported.[10]

Provider's testimony did not link his treatments of Claimant with specific pain or other symptoms or conditions resulting from a compensable injury, did not describe how the extended course of treatment fitted Claimant's specific needs, and thus failed to demonstrate the medical necessity of the services for which he appeals.

B. Documentation and Fee Disputes

Carrier offered tables of disputed services collated with two sets of EOBs for each date of service attached. The first set denies the claims as not medically necessary ("U" or "V"); the second set denies Provider's claims as fee disputes (or insufficient documentation in the case of services coded 97140) and sets forth amounts it previously paid for each.[11]

Provider offered no evidence concerning the MRD's findings on the fee disputes, nor did he controvert Provider's evidence of payments made. Because Provider did not contest the amounts Carrier claimed it had paid, the ALJ accepts the amounts shown as "paid" in Exhibit B as correct.[12]

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[10] Carrier ex. B, at p. B0009.

[11] As discussed in Part III above, after filing its initial EOBs based upon medical necessity, Carrier submitted a second round of EOBs that denied reimbursement of billed amounts above the appropriate fee schedule as to all services except those billed under CPT 97140.

[12] Claims that Carrier asserts it has paid are marked "pd" on the table of disputed services. See tables of disputed services at Carrier Ex. B, at pp. B0026, B0050, B0090, B0112, and B0123, and the pages immediately following each. Payment is also reflected on the second set of EOBs in either the "PREV PAID" or the "CURR PAID" columns. Fro example, see *Id.* at p. B0040.

Regarding the MRD's determination that all services coded 97110 were insufficiently documented, Provider offered general testimony about the necessity of supervision for patients such as Claimant, but offered no documentation.

Although Carrier submitted documentation of payments for services whose medical necessity was not shown, Carrier did not request a refund either before the MRD or at SOAH. Therefore, no basis exists for changing the MRD's award of $751.16 reimbursement to Provider.

VI. CONCLUSION

This record supports only a finding that Provider did not prove that he is entitled to additional reimbursement beyond what the MRD ordered. The order of the MRD that Carrier reimburse Provider $765.16 plus interest accrued at the time of payment should be given effect.

VII. FINDINGS OF FACT

On ___, a claimant whose employer (___) was insured by Liberty Mutual fire Insurance Company (Carrier) 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, Laurence N. Smith, D.C. (Provider) provided chiropractic and related services from September 29, 2003, through June 4, 2004.

3. Provider requested from Carrier reimbursement for services referenced in Finding of Fact No. 2, including among others services coded 97110 and 98940.

3. Carrier initially denied Provider's claim for reimbursement for the disputed services on the basis of lack of medical necessity.

5. After denying the requests for reimbursement, Carrier paid many of the charges but denied the requests for reimbursement a second time, asserting insufficient documentation and billing in excess of the maximum allowable reimbursement (fee dispute).

6. On August 30, 2004, Provider requested the Medical Review Division (MRD) of the Texas

Workers' Compensation Commission (Commission) for medical dispute resolution with respect to the disputed reimbursement.

7. An Independent Review Organization (IRO) found that the services rendered by Provider for Claimant from September 29, 2003, through June 4, 2004, and billed under CPT Code 98940 and 97110 were medically necessary for him, and that all other disputed services were not medically necessary.

8. On November 12, 2004, the Texas Workers' Compensation Commission's Medical Review Division (MRD) issued its decision and ordered Carrier to reimburse Provider $756.16 for disputed services on dates for which Carrier did not provide an explanation of benefits (EOB).

9. On November 24, 2004, Provider requested a hearing with the State Office of Administrative Hearings (SOAH).

10. The Commission mailed notice of the hearing to the parties at their addresses on January 20, 2005.

11. This case was referred by the Commission and accepted by SOAH for hearing before September 1, 2005.

12. No services delivered to Claimant by Provider from September 29, 2003, through June 3, 2004, were medically necessary treatment for Claimant, except services billed under CPT codes 97110 and 98940, which were medically necessary.

13. Provider's documentation for services billed under CPT code 97110 did not clearly delineate exclusive one-on-one treatment nor did it identify a level of severity of the injury that is sufficient to warrant one-to-one therapy.

14. Payment of the $756.16 reimbursement ordered by the MRD plus interest accrued thereon at the time of payment will fully compensate Provider for services he delivered to Claimant and for which Carrier was found not to have submitted EOBs.

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 (SOAH) has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. (Labor Code) §§ 402.073(b) and 413.031(k) (West 2005), TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003 (West 2005), and Acts 2005, 79th Leg., ch. 265, § 8.013, eff. Sept. 1, 2005.

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

6. Provider did not prove that any services other than those for which the MRD previously ordered reimbursement were medically necessary for Claimant.

7. Provider did not prove that he is entitled to any additional reimbursement beyond the $765.16 previously ordered to be paid.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, Carrier should reimburse Provider for disputed services except for the $765.16 previously ordered to be paid (together with all interest accrued thereon at the time of payment).

ORDER

IT IS THEREFORE, ORDERED that Carrier, Liberty Mutual Fire Insurance Company, need not reimburse Provider, Laurence N. Smith, D.C., any additional amounts beyond the $765.16 plus accrued interest previously ordered to be paid in this proceeding.

SIGNED December 20, 2005.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS