SOAH DOCKET NO. 453-05-4351.M5
TWCC MR. NO. M5-04-3087-01

TEXAS HOSPITAL INSURANCE EXCHANGE,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
SCD BACK & JOINT CLINIC LTD.,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

Texas Hospital Insurance Exchange ("Carrier") has challenged decisions by an independent review organization ("IRO") and by the Medical Review Division ("MRD") of the Texas Workers' Compensation Commission ("Commission")[1] in a dispute primarily regarding medical necessity for chiropractic treatment. The IRO and MRD found that the Carrier improperly denied reimbursement for some of the services that SCD Back & Joint Clinic, Ltd., ("Provider") administered between May 6 and December 4, 2003, to a claimant suffering from a back injury.

The Carrier challenged the decisions on the basis that none of the treatment at issue was, 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.* The Provider also challenged the decisions, to the extent that they failed to find much of the disputed treatment necessary.

This decision generally agrees with the prior rulings of the IRO and MRD in the dispute.

I. JURISDICTION, NOTICE, AND VENUE

The Commission (or its successor agency) has jurisdiction over this matter pursuant to § 413.031 of the Act. The State Office of Administrative Hearings ("SOAH") has jurisdiction over

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

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, venue, or sufficiency of notice.

II. STATEMENT OF THE CASE

The hearing in this docket was convened on September 27, 2005, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge ("ALJ") Mike Rogan presided. Carrier was represented by Shelley D. Gatlin, Attorney. Provider was represented by David Bailey, D.C., who appeared by telephone. Both parties presented evidence and argument. The hearing was adjourned on the same date, but the record remained open until November 4, 2005, to allow the parties opportunity to submit closing arguments and briefing.[2]

The record revealed that on___, the claimant suffered a compensable injury to her back. She initially received treatment from Todd Maraist, M.D., who prescribed stretching exercises and pain medication. On April 3, 2003, the claimant changed her treating doctor to John Wyatt, D.C., who was then practicing with the Provider. From April 15 through June 11, 2003, Dr. Wyatt treated the claimant with physical therapy sessions on at least 18 separate dates.

Thereafter, financial and logistical issues caused about a three-month interruption in the claimant's treatment. She returned to Dr. Wyatt on August 25, 2003, and resumed physical therapy thereafter, undergoing another 21 therapy sessions through December 4, 2003.

When the Provider subsequently billed the Carrier (the insurer for the claimant's employer) for medical services in the case, the Carrier denied reimbursement for three dates of service before the interruption in treatment (May 6, 8, and 13, 2003) and for most of the dates of service after that interruption.

[2] The staff of the Commission (or its successor agency) formally elected not to participate in this proceeding, although it filed a general "Statement of Matters Asserted" with the notice of the hearing.

The Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred a portion of the dispute issued a decision on August 10, 2004, concluding that the following disputed services were medically necessary: electrical stimulator pads, special reports and/or record-copying charges, massages, and chiropractic manipulative therapies. On the other hand, the IRO found other disputed services to be unnecessary, with the following comments:

> . . . The medical necessity of the Bao Zhen Gao analgesic patches and the biofreeze gel was not adequately substantiated . . . . The full spine mechanical tractions were denied because the records did not indicate the medical necessity of traction to the cervical or thoracic spines. The minimal office visits were denied because this limited, brief level of E/M service is a component of CMT in terms of the "pre-service work." Therefore, performing a separate service is not supported. The [CPT Code] 99212-25 was denied because neither the diagnosis nor severity of injury required the performance of this level of E/M service on each patient encounter. The therapeutic exercise and group exercise were not indicated due to the length of time the patient had been receiving supervised care (April through October). The reviewer indicates that a home exercise program would have likely provided the same level of improvement. Moreover, the treating doctor failed to document the medical necessity of the muscle testing performed on 10-29-2003, or how the data obtained from this test would impact the patient's treatment plan. . . .

The Commission's MRD reviewed the IRO's decision and, on January 20, 2005, issued its own decision confirming the IRO's determinations as to medical necessity. Additionally, the MRD evaluated 13 categories of services in this case for which the Carrier allegedly denied reimbursement on some basis other than lack of medical necessity. While the Provider billed $1,131.74 for these services, which were provided between May 6 and December 4, 2003, the MRD recommended reimbursement of only $732.60.[3]

Both the Carrier and Provider then made timely requests for review of the IRO and MRD decisions before SOAH. Each challenged the portions of those decisions that were adverse to its own claims.

III. PARTIES' EVIDENCE AND ARGUMENTS

A. Carrier

[3] This figure takes into account an obvious $300.00 error in the MRD decision and order, which both parties acknowledged at the hearing. For CPT Code 99212-25 services provided on November 7, 2003, the MRD properly listed the MAR as $41.91, then erroneously recommended reimbursement of $341.91.

Carrier argued that almost all of the treatment at issue in this case was medically unnecessary, including those services that the MRD evaluated on some basis other than medical necessity. In the Carrier's view, the MRD erred by not referring all of those services to the IRO for a determination of

medical necessity – even though the record contains no direct documentation that the Carrier ever denied those services on the specific grounds that they were not medically necessary. The Carrier contends that its denial of those services for lack of medical necessity is a reasonable assumption or extrapolation, because it explicitly denied most of the other disputed services in this case on that basis. Moreover, the Provider acknowledged that medical necessity was at issue for all services in this case by submitting to the MRD a Table of Disputed Services that included (in the column stating the Provider's rationale for reimbursement) the notation that each listed service was "medically reasonable and necessary."

The Carrier also cited several SOAH decisions in which the ALJs relaxed the technical requirements for EOBs or other documentation showing that the issue of medical necessity had been raised at the outset of the medical dispute resolution process. The consistent theme of these cases on this subject was that, because medical necessity is the fundamental basis for reimbursement under the Act, it deserves consideration if a party raises at least a "credible question" about the issue.

The Carrier also presented the testimony of Cynthia Tays, D.C., who stated that the claimant showed no appreciable improvement from any of the disputed treatment. Dr. Tays noted that in December of 2003, at the end of the Provider's treatments, the claimant still reported about the same pain levels that she had been reporting for months.

Dr. Tays specifically took issue with the IRO's conclusion that some of the therapy administered after August of 2003 was medically necessary. The approved massage therapy, for instance, would only be appropriate in acute or subacute (exacerbated) stages of treatment, up to about two months following injury, she stated. Chiropractic manipulations, she added, were appropriate in this case through about November 21, 2003, but not thereafter. Dr. Tays explained that she based these judgments upon the "Mercy Guidelines"[4] for chiropractic care (a document, she acknowledged, that has not been adopted as defining standards of care for chiropracty in Texas).

[4] "Guidelines for Chiropractic Quality Assurance and Practice Parameters. Proceedings of the Mercy Center Consensus Conference."

B. Provider

Provider presented the testimony of Dr. Wyatt, who stated that the disputed treatment was consistent with Medicare Guidelines (which are applicable to services provided in TWCC cases after August 1, 2003). He disputed Dr. Tays' contention that the claimant failed to show improvement during the disputed treatment, noting particularly that the patient made significant gains in lifting capacity and lumbar strength from September to December of 2003. He also acknowledged, though, that the claimant apparently also registered significant improvements during the "gap" in her treatments by the Provider – the period from June to August of 2003 when she was unable to travel to the Provider's clinic.

IV. ANALYSIS

In the ALJ's view, neither party has persuasively shown that the IRO or the MRD decision in this case was inconsistent with Medicare guidelines or with other regulations or authorities definitively governing reimbursement for the disputed services. Under those circumstances, the ALJ is obliged to confirm those decisions, except for what is apparently a typographical or computational error in the MRD decision.

The ALJ cannot accept the Carrier's broad interpretation of the range of circumstances in which medical necessity can be raised before SOAH as an *implicit* issue in reimbursement disputes. In briefing on this subject, the Carrier mostly cited SOAH decisions dating from the period before the use of IROs in disputes over medical necessity. Even if all of these cases were correctly decided at the time, the initiation of the IRO system sharply increased the need to define, at an early stage in the process, which services raised issues of medical necessity (and were thus bound for IRO consideration) and which did not (and were thus left to the MRD's evaluation). Participants in the process must now be able to rely, to a heightened degree, on standardized indicators of the bases for denial (such as EOBs). Otherwise, the MRD will be called upon to repeatedly reconsider its IRO referrals, and SOAH will find itself frequently pre-empting the IROs as the body that initially considers questions of medical necessity.

Certainly, SOAH should continue to recognize the principle that medical necessity will be examined when a "credible question" is raised about its legitimate presentation in a case, but the principle must not be stretched to the point that it subverts the entire IRO system – which looks to the specialized expertise of practitioners for initial evaluations of medical necessity. In this case, the ALJ finds a "credible question" difficult to discern, with respect to those services for which the Carrier has failed to identify an EOB. The Carrier contends that because it explicitly denied many services in this case for lack of medical necessity, it may be presumed to have denied many more on the same basis. Such logic would be suspect in any context, but it is particularly so in the complex realm of medical treatment – both in general and in this case specifically, where a long hiatus in the disputed treatment suggests that earlier and later services might be objectionable for very different reasons.

The Carrier also asserts that the Provider must have known that the services considered by the MRD were denied for lack of medical necessity, since the Provider listed as its rationale for reimbursement of those services the contention that they were, in fact, "reasonable and necessary." In the ALJ's view, however, without more information, this circumstance merely indicates that the Provider filled in blanks on a standardized form with the most generic and fundamental justification for reimbursement possible – an action that would be consistent with uncertainty as to the Carrier's specific basis for denial.

As noted above, the parties agreed that the maximum reimbursement for CPT Code 99212-25 services provided on November 7, 2003, should be $41.91, (rather than $341.91, as erroneously stated in the MRD decision). In addition, Dr. Wyatt agreed that the Provider has already been properly reimbursed for services under CPT Code 95851, provided on September 30, 2003. (The MRD found that these services should be reimbursed at the MAR of $30.50.) Adjustments for these discrepancies reduce by $330.50 the total legitimate reimbursement for those services that were addressed only by the MRD decision. For those categories of services, therefore, the Carrier should reimburse Provider only $702.10, rather than the larger total set out in the MRD decision.

V. FINDINGS OF FACT

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

2. After initially receiving treatment from Todd Maraist, M.D., who prescribed stretching exercises and pain medication, the claimant on April 3, 2003, changed her treating doctor to John Wyatt, D.C., who was then practicing with SCD Back & Joint Clinic, Ltd. ("Provider").

3. Dr. Wyatt, through the Provider, administered to claimant a range of active and passive chiropractic modalities from about April 15 through June 11, 2003, and from about August 25 through December 4, 2003.

4. Provider sought reimbursement for services noted in Finding of Fact No. 3 from Texas Hospital Insurance Exchange ("Carrier") the insurer for claimant's employer.

5. Carrier denied the requested reimbursement for much of the service noted in Finding of Fact No. 3.

6. Provider 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 August 10, 2004, concluding that certain disputed services were medically necessary (*ie.*, electrical stimulator pads, special reports and/or record-copying charges, massages, and chiropractic manipulative therapies), but that all other disputed services were not medically necessary.

8. The Commission's Medical Review Division reviewed and concurred with the IRO's decision in a decision dated January 20, 2005, in dispute resolution docket No. M5-04-3087-01. Additionally, the MRD alone evaluated 13 categories of services for which Carrier

allegedly denied reimbursement on some basis other than lack of medical necessity. While the Provider billed $1,131.74 for these services, which were provided between May 6 and December 4,

2003, the MRD recommended reimbursement of only $732.60 (taking into account a $300.00 overstatement in the MRD decision with respect to the allowable reimbursement for CPT Code 99212-25 services provided on November 7, 2003).

9. In accordance with findings in the MRD decision noted in Finding of Fact No. 8, the Carrier has already reimbursed Provider $30.50 for services under CPT Code 95851, provided on September 30, 2003.

10. Both Carrier and Provider requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), each seeking review and reversal of adverse portions of the MRD decision regarding reimbursement. TWCC referred the case and SOAH accepted it for hearing prior to September 1, 2005.

11. The Commission mailed notice of the hearing's setting to the parties at their addresses on March 2, 2005.

12. A hearing in this matter was convened on September 27, 2005, in Austin, Texas, before an Administrative Law Judge with SOAH. Carrier and Provider were represented.

13. Neither Carrier nor Provider demonstrated that the IRO or the MRD decision in this case was inconsistent with Medicare guidelines or with other regulations or authorities definitively governing reimbursement for the disputed services.

14. No EOBs or other communications, nor any other circumstances indicate that those services initially considered only by the MRD, as noted in Finding of Fact No. 8, were actually denied by the Carrier on the basis of lack of medical necessity.

VI. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (or its successor agency, the Texas Department of Insurance) 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; TEX. GOV'T CODE ANN. ch. 2003; 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 TEX. ADMINISTRATIVE 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. Parties seeking relief bore the burden of proof with respect to all facts necessary to support such relief in this case, pursuant to 28 TAC §148.21(h).

6. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decision of the IRO issued on August 10, 2004, (as confirmed by the decision of the MRD, issued on January 20, 2005) were correct; the parties' respective requests for reimbursement contrary to the IRO decision accordingly should be denied.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decision of the MRD, issued on January 20, 2005, were correct with respect to those services for which Carrier allegedly denied reimbursement on some basis other than lack of medical necessity, as noted in Finding of Fact No. 8 B except that the MRD inadvertently overstated by $300.00 the allowable reimbursement for CPT Code 99212-25 services provided on November 7, 2003.

8. Based upon Findings of Fact Nos. 8 and 9 and Conclusion of Law No. 7, the Carrier should reimburse Provider $702.10 for those services for which Carrier allegedly denied reimbursement on some basis other than lack of medical necessity, as noted in Finding of Fact No. 8.

ORDER

IT IS THEREFORE, ORDERED that the requests by Texas Hospital Insurance Exchange and SCD Back & Joint Clinic, Ltd., for relief inconsistent with the findings and decision of the independent review organization issued in this matter on August 10, 2004, be denied, and that Texas Hospital Insurance Exchange also reimburse SCD Back & Joint Clinic, Ltd., $702.10 for those services initially addressed only in the findings and decision of the Commission's Medical Review Division issued in this matter on January 20, 2005.

SIGNED December 15, 2005.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS