SOAH DOCKET NO. 453-05-9154.M5
MRD No. M5-05-2498-01

HORIZON HEALTH,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
CITY OF HOUSTON,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

An Independent Review Organization (IRO) determined that various chiropractic services rendered by Horizon Health (Provider) to Claimant for her compensable injury were not medically necessary. The Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission)[1] ordered that the City of Houston (Carrier) need not reimburse Provider for the disputed services. Provider requested a hearing. This decision finds that Carrier's failure to furnish peer review reports to Provider and to the MRD waives its defense that the services were not medically necessary, and orders reimbursement to Provider for all services actually rendered to Claimant. No reimbursement is ordered, however, for services billed that Provider admits were not actually rendered.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened July 5, 2006, at the State Office of Administrative Hearings (SOAH), 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Charles Homer III presiding. Attorney Annie Basu appeared for Provider, and Carrier was represented by counsel Robert F. Josey. The record was held open until July 25, 2006, for receipt of briefing and response on the issue of whether Carrier's alleged procedural failures should deprive it of the opportunity to raise medical necessity as a defense in this proceeding. In addition, the ALJ

[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.

requested the parties to agree upon and submit additional evidence concerning hours of service rendered versus hours billed under CPT code 97110. The record closed July 25, 2006.

II. DISCUSSION

A. Claimant's Injury and Treatment History

On___, Claimant__, a 46-year-old female working as a dispatcher for the City of Houston, slipped and fell down three steps on a wet stairway. She fell to her left, onto her left shoulder, and began suffering pain in her left shoulder, knee, and ankle.[2]

X-rays of Claimant's left shoulder, knee, and ankle were all negative. Ben Tiongson, M.D., who initially evaluated Claimant, recommended four to six weeks of "physiotherapy." On June 18,2003, Lubor Jarolimek, M.D., performed an orthopedic examination and noted that Claimant had improved with physiotherapy and recommended continuance of that treatment. Claimant continued to have shoulder pain, and on September 8, 2003, Dr. Jarolimek performed arthroscopic surgery (debridement of a partial-thickness rotator cuff tear and subachromial decompression) on Claimant's left shoulder.

Claimant returned to work on February 28, 2004, and was seen by Carrie R. Schwartz, D.C., for an impairment rating. In April 2004, Robert E. Whitsell, M.D., an orthopedic surgeon, examined Claimant and noted significant limitation in the range of motion (ROM) of Claimant's left shoulder, but he recommended only that she follow up with Dr. Jarolimek for that problem.[3]

Dr. Schwarz began the treatments at issue on April 12, 2004,[4] and continued them until December 22, 2004, with an interruption from September 3 to October 14, 2004, for an October 5 manipulation under anesthesia on Claimant's left shoulder by Dr. Jarolimek.

B. Payment Exception Codes and Alleged Failure to Timely Provide Peer Review Report

Provider admits that Carrier filed timely EOBs in which Carrier coded its reason for denial as "V," but it argues that Carrier has waived its medical necessity denial by failing to timely provide

[2] Provider Ex. 1, p. 44-45.

[3] Carrier Ex. 2, p. 7.

[4] Dr. Schwartz also provided treatments to Claimant in 2003, one item of which was disputed before the MRD. Carrier did not appeal the MRD decision awarding reimbursement to Provider for service provided on June 7, 2003, under Code 99213.

the peer review report[s] that support the denial. Provider cites SOAH decisions[5] for the proposition that Carrier's failure to follow 28 Tex. Admin. Code (TAC) § 134.304(h)[6] prohibits Carrier from asserting the peer review as its reason for denial at SOAH.

Carrier argues that it gave Provider adequate notice of the reason for denial by denying payment with Code "V."[7] Carrier's basis for its contention is that it did furnish Provider with Carrier's report from Robert E. Whitsell, M.D., in which Dr. Whitsell recommended no more therapy for Claimant's left ankle and recommended only a follow-up with Dr. Jarolimek for her limited range of motion in her left shoulder.[8]

Finally, Provider argues that in challenging whether all services billed under 97110 were actually performed, Carrier is attempting to raise adequacy of documentation issues. Provider asserts that those issues should not be heard in this proceeding because Carrier failed to raise adequacy of documentation before the MRD and, therefore, cannot attack the sufficiency of the documentation of services at SOAH, citing the decision in SOAH Docket No. 453-04-5337.M4.

C. Analysis

Payment Exception Code "V" and the Requirement for a Peer Review Report

The report that Carrier offers as a peer review report in this proceeding is Dr. Whitsell's medical evaluation of Claimant that was prepared on April 8, 2004, before the disputed services were provided. Therefore, the report is not a peer *review* of Provider's services made after the services were rendered. Providing a negative report made prior to the rendition of services does not comply with 28 Tex. Admin. Code (TAC) §134.304(h). That rule requires the peer review report to be given to Provider with the explanations of benefits denying reimbursement. It obviously contemplates that the services being denied were denied after a peer review of the services actually provided, and not a prospective opinion.

[5] SOAH Docket Nos. 453-03-3613.M5 (2003); 453-03-2355.M5; and 453-03-3682.M5.

[6] 28 TAC § 134.304(h) was repealed effective February 20, 2006, but was in effect at the time of the failures Provider complains of. 31 Tex. Reg. 796 (2006).

[7] Carrier Ex. 1, pp. 185-206.

[8] Carrier Ex. 2.

Furthermore, Dr. Whitsell, a medical doctor and orthopedic surgeon, does not qualify as a peer reviewer of Dr. Schwartz under 28 (TAC) § 134.304(g),[9] which required a peer reviewer to be "of the same or similar specialty as the prescribing or performing health care provider." Adopting the reasoning of the SOAH decisions Provider cites, the ALJ concludes that, because of Carrier's failure to provide a peer review when it denied services with exception code "V," reimbursement for all services provided should be ordered without reaching the issue of whether those services were medically necessary.

On the other hand, Provider submitted to the IRO and MRD a "Statement of Position" that addressed Carrier's failure to provide a peer review report and the peer reviewer's name and specialty information.[10,11] The IRO determination[12] and the MRD decision[13] failed to address the issue thus raised, but Carrier is in no position to claim surprise or that Provider is attempting to raise an issue before SOAH that it did not raise at the MRD.

2. Services Billed But Not Rendered

At the hearing, Provider's witness Dr. Schwarz admitted that in several instances time was charged to Carrier for services that were not rendered. Specifically, some SOAP notes reflect, for example, 33 minutes (three units) of one-on-one supervised therapeutic activity, but the corresponding charge to Carrier is for six units.[14]

Dr. Schwarz made these admissions while being cross-examined from Provider's own records, but Provider asserts that no deduction should be taken from Provider's charges because Carrier did not deny payment under Code "N," the appropriate payment exception code for insufficient documentation. Carrier responds that this is not a case of insufficient documentation,

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[9] 28 TAC § 134.304(g) was repealed effective February 20, 2006, but was in effect at the time of the failures Provider complains of. 31 Tex. Reg. 796 (2006).

[10] Provider Ex. 1, p.7.

[11] The statement of position is listed in the IRO's determination among the documents submitted to the IRO. Carrier Ex. 1, p. 175.

[12] *Id*., pp. 174-179.

[13] *Id.*, pp. 172-173.

[14] ALJ Ex. 1, p. 5 (entry for November 16, 2004). A unit is fifteen minutes, rounded up, and the charge for each unit is $37.04.

but rather incorrect documentation, and that there is no clearly appropriate denial code. As requested, after the hearing Carrier submitted a reconciliation of hour billed and hours reflected in the SOAP notes.[15] Provider did not dispute those figures

The ALJ finds that the principle that no order should violate a clear provision of the Workers' Compensation Act (Act) (Tex. Labor Code ANN. §§401 *et seq*.) applies to this situation. As Provider argues, Carrier's assertion that the 97110 charges reflect more services than were actually rendered is not a medical necessity dispute: for some units billed, there are no services about which to dispute their medical necessity. Nevertheless, although Carrier did not raise a fraud or fee dispute before the MRD, it should not be ordered to reimburse Provider for services that Provider admits were not provided to Claimant. To do so would nullify the express limitation on reimbursement in the Act, which follows:

> Texas Labor Code § 413.015. PAYMENT BY INSURANCE CARRIERS; AUDIT AND REVIEW. (a) Insurance carriers shall make appropriate payment of charges *for medical services provided* under this subtitle. . . . (b) The commissioner shall provide by rule for the review and audit of the payment by insurance carriers *of charges for medical services provided* under this subtitle to ensure compliance of health care providers and insurance carriers with the medical policies and fee guidelines adopted by the commissioner. (Emphasis added.)

3. Decision Limited to Facts of This Case

This decision is limited to these facts, and does not address a situation in which Provider does not, as it did here, admit that the total time charged exceeded the units of treatment reflected in the SOAP notes. Under the circumstances of this case, to order Carrier to pay for services that undisputedly were not rendered would violate Act § 413.015, by requiring Carrier to pay for something other than "medical services provided." Thus, this Decision and Order requires reimbursement only for services that Provider actually rendered from April 12 through December 22, 2004.

D. Summary and Conclusion

Because Carrier did not provide a peer review report concerning services that it denied under Code "V," it must reimburse Provider for all billed services except those that Provider admits were not provided to Claimant.

[15] The compilation was admitted into evidence as ALJ Exhibit 1.

III. FINDINGS OF FACT

1. On___, ___(Claimant), who worked for self-insured employer City of Houston (Carrier), injured her left shoulder when she slipped and fell while working at her job for the City of Houston.

2. Horizon Health (Provider) provided chiropractic and related services to Claimant for her compensable injury on ___, and from April 12, 2004, through December 22, 2004.

3. Provider requested reimbursement for all services referenced in Finding of Fact No. 2, and also inadvertently requested reimbursement for units of service that it did not render (together referred to as "disputed services").

4. Carrier denied Provider's claim for reimbursement for the disputed services based upon under denial code "V," "Unnecessary Treatment with Peer Review."

5. Carrier did not raise any reason for denying reimbursement to Provider before the MRD other than medical necessity.

6. When it submitted explanations of benefits denying reimbursement to Provider, Carrier did not furnish to Provider reports of peer reviews explaining the reason for its denial of reimbursement.

7. Carrier did not furnish to Provider reports of a peer of Provider's treating doctor, Carrie Schwartz, D.C., explaining the reason for its denial of reimbursement when it submitted explanations of benefits denying reimbursement to Provider.

8. Provider requested medical dispute resolution regarding the disputed reimbursement at the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

9. An Independent Review Organization (IRO) found the disputed services were not medically necessary, except for the service rendered on ___, and billed under code 99213.

10. On July 19, 2005, the MRD issued its decision that all services rendered by Provider to Claimant were not medically necessary except for those rendered on ___, and it ordered Carrier to reimburse Provider $67.25 for the disputed services.

10. On August 3, 2005, Provider requested a hearing with the State Office of Administrative Hearings (SOAH).

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

12. The Commission mailed notice of the hearing to the parties at their addresses of record on November 2, 2005.

14. Provider charged Carrier for 182 units of service billed under payment exception code 97110 that it did not provide to Claimant.

13. The 182 units of services not provided were billed under code 97110 at $37.04 per unit.

14. The amount Provider billed for the 182 units of services not provided was $6,741.28.

IV. CONCLUSIONS OF LAW

1. At the time this case was referred to the State Office of Administrative Hearings (SOAH), the Texas Workers' Compensation Commission (Commission) had jurisdiction to decide the issues presented by this proceeding pursuant to § 413.031 of the Texas Workers' Compensation Act (Act), TEX. LABOR CODE ANN. §§ 401.001 *et seq*.

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

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

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

5. Carrier failed to include a peer review report with its denial of reimbursement for Provider's services, thus violating 28 TAC § 133.304(h).

6. Carrier's violation of 28 TAC §133.304(h) precludes it from asserting lack of medical necessity in this SOAH proceeding.

7. Carrier should not be ordered to pay for services that were not provided. Act §413.015.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, Carrier should be ordered to reimburse Provider for all disputed services that were actually delivered.

ORDER

IT IS THEREFORE, ORDERED that Carrier, the City of Houston, reimburse Provider, Horizon Health, for all services charged by Provider for Claimant __from April 12 through December 22, 2004, less $6,741.28.

Carrier is **further ORDERED** to reimburse Provider for the office visit coded 99213 provided to Claimant on ___, if it has not already done so.

SIGNED October 12, 2006.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS