**DOCKET NO. 453-05-4410.M5**
**TWCC MR NO. M5-05-0538-01**

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| **FIDELITY & GUARANTY INSU RANCE CO. (ST. PAUL)** | § | **BEFORE THE STATE OFFICE** |
| **v.** | § | **OF** |
| **INTEGRA SPECIALTY GROUP, P.A.** | § | **ADMINISTRATIVE HEARINGS** |

## DECISION AND ORDER

Fidelity & Guaranty Insurance Company (Carrier) and Integra Specialty Group (Integra) both requested a hearing to contest a determination by the Texas Workers' Compensation Commission (Commission) Medical Review Division (MRD)[1] that the Carrier should pay for some, but not all, of the services Integra provided to an injured worker from November 4, 2003, until July 12, 2004. With the exception of one type of service, the Administrative Law Judge (ALJ) agrees with the MRD decision and orders that the Carrier pay for some of the services.

## I. PROCEDURAL HISTORY

A hearing convened on November 7, 2005, before the undersigned ALJ at the State Office of Administrative Hearings (SOAH), Austin, Texas. The Carrier appeared and was represented by its counsel, Gregory D. Solcher. Integra appeared and was represented by Spencer Sloane, D.C. Because there were no notice or jurisdiction issues, those matters are addressed in the findings of fact and conclusions of law without further discussion here. On November 9, 2005, the Carrier submitted certain CPT code[2] guidelines it had referred to at the hearing, and the hearing closed on that date.

[1] Effective September 1, 2005, the Commission's duties were transferred to the Texas Department of Insurance, Division of Workers Compensation (Division).

[2] CPT codes means current procedural terminology codes established by the American Medical Association.

## II. DISCUSSION

### A. Background

The Claimant suffered a work-related leg and low-back injury in___, while lifting a heavy box over her head. After seeing various providers, she presented to Integra in October 2003.

Integra filed a claim for certain services it provided from November 4, 2003, through July 12, 2004, under CPT codes 99080-73, 95833, 96004, 97012, 97110, 97140, 99213, 97032, 97124, and 97010. The Carrier denied the claim and Integra requested medical dispute resolution (MDR).

Because Integra failed to pay the independent-review-organization fee, MRD dismissed Integra's MDR request for services the Carrier had denied on the basis of medical necessity. At the hearing, Dr. Sloane said Integra did not dispute that decision. Therefore, the MRD decision stands and the Carrier will not be ordered to pay for those services. This includes almost all services provided from November 4, 2003, through December 22, 2003; January 4, 2004; from January 12, 2004, through February 2, 2004; March 3, 2004; and from April 4, 2004, through May 3, 2004.

At the hearing, Dr. Sloane said Integra did not intend to contest the portion of the MRD decision relating to services under CPT code 97010 performed on March 17 and 22, 2003. Therefore, the MRD decision stands and the Carrier will not be ordered to pay for those services.

Employees have a right to necessary health care under TEX. LABOR CODE ANN. (the Act) §§408.021 and 401.011. Section 408.021(a) provides, "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 (3) enhances the ability of the employee to return to or retain employment." Section 401.011(19) of the Labor Code provides that health care includes "all reasonable and necessary medical . . . services."

Each party has the burden of proof on the services for which it has requested a hearing.[3]

## B. Discussion

### 1. Carrier's Failure to Provide Reasons for Denying Claims

MRD ordered the Carrier to pay for most of the services at issue that the Carrier did not deny on the basis of medical necessity based on its findings that Integra proved it provided the services and the Carrier did not provide explanations of benefits (EOBs) as required by 28 TEX. ADMIN. CODE (TAC) §133.307(e)(3)(B). Rule 133.307(e)(3)(B) requires that upon receipt of an MDR request, a respondent shall provide any required missing information, including absent EOBs, that was not provided by the requestor.

Integra contended the Carrier is precluded from asserting any ground for denying a claim that it did not assert before Integra requested MDR. It cited §408.027(d) of the Act, which requires an insurer to send to the provider, the injured employee, and the Commission a report that sufficiently explains its reasons for denying a claim; SOAH decisions holding that an insurer is precluded from asserting at MDR or at a SOAH hearing a reason for denying a claim that had not previously been asserted; and 28 TAC § 133.307(j)(2), which says, in responding to an MDR request, that an insurer may address only those reasons for denial that it asserted prior to the request and that MRD may not consider any reasons for denying the claim that were not asserted before the request.

The Carrier responded with several assertions in this regard. First, it maintained that it had, in fact, sent some of the allegedly unprovided EOBs (missing EOBs) to Integra. It did not dispute that it failed to produce these missing EOBs for consideration at MDR, but said, in searching its files, it discovered some of these missing EOBs.[4] It asserted that the existence of these missing EOBs constitutes circumstantial evidence that they were sent to and received by Integra. It argued that this assertion is supported by evidence that it sent and that Integra received other EOBs for services to the Claimant, in which claims were denied for lack of medical necessity.[5]

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[3] 1 TAC § 155.41(b); 28 TAC § 148.14(a).

[4] These EOBs are contained in Exhibit 1 at 1-6.

[5] The Carrier said it was not making this assertion with regard to EOBs that have not been discovered.

Dr. Sloane testified that Integra did not receive any of the missing EOBs.

The ALJ concludes that the Carrier did not prove it sent the missing EOBs to Integra. The mere existence of the missing EOBs and that the fact that other EOBs were sent for other services to the Claimant are less persuasive than Dr. Sloane's testimony that Integra did not receive the EOBs. The Carrier's evidence is weakened further by its failure to find the missing EOBs in time for consideration at MDR-the inability to find the missing EOBs before MDR is consistent with an explanation that they were also lost before being sent to Integra. Even if the Carrier's sending of other EOBs to Integra relating to other similar services to the Claimant is considered evidence of a routine practice of sending EOBs to Integra, it is insufficient to prove they were sent in this case because, when the sender of a document relies on office routine or custom to support an inference that a document was mailed, the inference is merely a presumption that vanishes when evidence is introduced that rebuts it.[6]

The Carrier argued that the issue of medical necessity cannot be "waived," even if other grounds for denying a claim can be waived by a failure to assert them. This position is against the majority of SOAH decisions, however, which do not distinguish medical necessity from other grounds for denying a claim.[7] Again, §408.027(d) of the Act states if an insurer disputes the amount of payment or the health care provider's entitlement to payment, it must send a report that "sufficiently explains the reasons for the reduction or denial of payment. . . ."

The Commission fleshed out §408.027 at 28 TAC §133.304, which expressly requires, when an insurer denies payment, it must send an EOB containing a correct payment exception code and a statement that sufficiently explains its reasons for denying the claim. The Commission has also enacted Rule 133.308, providing an elaborate procedure for processing disputed medical necessity claims. Lack of medical necessity is a primary ground for claim denials. A ruling that an insurer may wait until a hearing to raise that issue would largely undermine §408.027 and Rules 133.304 and 133.308. On these bases, the ALJ concludes that lack of medical necessity is not an available ground

[6] *Cliff v. Huggins*, 724 S.W. 2d 778, 780 (Tex. 1987); *State Mutual Fire Insurance Company v. Williams*, 924 S.W. 2d 746, 749 (Tex. App.B1996, no writ).

[7] *See* SOAH Docket No. 453-03-3579.M4 (ALJ Norman); SOAH Docket No. 453-01-0309.M5 (ALJ Doherty); SOAH Docket No. 453-00-1570.M5 (ALJ Smith); SOAH Docket No. 453-99-3399 (ALJ Pacey); SOAH Docket No. 453-99-2021.M5 (ALJ Rusch); and SOAH Docket No. 453-97-1189.M2 (ALJ Hunn). These cases were based primarily on § 408.027(d) of the Act..

for denying a claim at a SOAH hearing unless the insurer informed the provider of that reason when it denied the claim, or at least before an MDR request is filed.

The Carrier also contended Integra was on notice that the claims were denied on the basis of a lack of medical necessity because it had denied other services Integra provided to the Claimant on that ground and had attached peer reviews clearly explaining its reasons for the denial. This contention was likewise unpersuasive. The fact that a provider knows the reasons an insurer denied some claims is not, by itself, persuasive evidence that it knew or should have known an insurer's reasons for denying similar claims.[8]

The Carrier's arguments at the hearing included other reasons for denying services under some of the CPT codes at issue. It contended that an order requiring payment of these services would be contrary to applicable fee guidelines and, therefore, in violation of §413.016 of the Act and 28 TAC §180.2.[9] The Carrier maintained it would be impermissible to order a payment in violation of those standards under any circumstance, even in the unusual case of an insurer failing to appear at a hearing.[10] In this connection, the Carrier argued that MRD's fee analysis relating to services under a number of CPT codes was erroneous and, as a result, MRD incorrectly ordered payment. These include

- CPT code 99080-73, concerning work-status reports, which the Carrier argued are not automatically required on a periodic basis as concluded by MRD, but are required under certain circumstances only, as described in 28 TAC §129.5(d);

- CPT code 95833, concerning a total body evaluation for muscle and range of motion testing, which "arguably," according to the Carrier, should have been coded as a 95831, a trunk evaluation;

[8] This ruling does not preclude a conclusion in other cases that the evidence demonstrates that a provider had actual knowledge or was on reasonable notice of an insurer's reasons for denying a claim.

[9] Section 413.016 of the Act says, among other matters, that the Division shall order a refund of charges paid to a provider in excess of those allowed by the medical policies or fee guidelines and if it determines that an insurer has paid medical charges inconsistent with medical policies or adopted fee guidelines, it shall refer the insurer to the agency's division of compliance and practice. Rule 180.2 says that any person may make a referral to the agency's monitoring and enforcement department for violations of statutes or rules by a systems participant.

[10] This position seems to imply that it would be the ALJ's duty in such a case to search applicable policies and fee guidelines to make sure any order he or she issued was consistent with those standards.

- $ CPT code 96004, a physician review and interpretation of a comprehensive computer-based-motion analysis, which needs to be done in a dedicated facility or laboratory in order to qualify; and

- $ CPT code 99213, concerning office visits that occurred at the same time as therapy sessions, which are payable only if a provider documents the need for an independent evaluation unrelated to the therapy, as required by CMS Medicare-Medicaid guidelines.

The Carrier's argument was unpersuasive. Its position, if accepted, would eviscerate both the Division's rules at §133.307(j)(2), requiring that defenses not asserted before an MDR request will not be considered, and SOAH decisions reaching the same conclusion. As indicated above, it would also undermine the intent of the legislature expressed in §408.027(d) of the Act and of the Division as expressed in Rule 133.304(c) that insurers provide their reasons at the time claims are denied.[11]

A production of evidence is required to justify denying services cited by the Carrier, *i.e.*, proof that the work status reports under CPT code 99080-73 were not generated for one of the reasons described in 28 TAC §129.5(d); that a total body evaluation might not be medically necessary in some circumstances when an injury is to the back only; that the physician review and interpretation of a comprehensive computer-based motion analysis under CPT code 95833 was not done in a properly dedicated facility; and that office visits under CPT code 99213 did not involve an independent evaluation that was unrelated to the therapy being performed.

The ALJ concludes that an insurer is precluded from asserting a reason for denying a claim on the ground that the claim violates applicable guidelines unless the violation is clearly established as a matter of law on the face of the claim or in the provider's request for MDR.[12] [13] [14] In this case, the

[11] It is noteworthy that the legal provisions the Carrier cited apply not only to the fee guidelines but also broadly to "medical policies" (§ 413.016 of the Act), "reasonable and necessary medical care" (§180.2 of the Division's rules) and "other . . . Statute[s] or Rules . . . ." (§180.2).

[12] This exception would not include a circumstance where reasonable minds could differ over which version of competing factual explanations should be accepted.

[13] This ruling does not necessarily prevent an insurer from raising a defense based on fraud that was discovered after an MRD request. (A fraud defense was not raised in this case.)

[14] This ruling does not prevent MRD from reviewing a claim pursuant to its authority under §413.016 of the Act, as it did for services under CPT code 97110 (discussed below), and ordering that the claim not be paid.

Carrier did not prove that the alleged invalidity of Integra's claim for the services under CPT codes 99080-73, 95833, 95831, 96004, and 99213 was established in either fashion. It was necessary, instead, for the Carrier to develop evidence to prove the invalidity.

The foregoing position is in line with case-law treatment of other issues that are analogous in legal principle, *i.e.*, where there are strong policy reasons for not disturbing the finality of an circumstance or position taken. For example, a defense of illegality in a civil lawsuit is an affirmative defense that must be plead and proved unless the defect appears on the face of the plaintiff's petition and is established as a matter of law. A defense of illegality that is not clearly established in the pleadings is waived if not plead.[15] In another example, a final judgment may not be collaterally attacked if voidable only - it must be void on its face.[16]

On the basis of the foregoing discussion, the Carrier will be ordered to pay for all of the services provided under CPT codes 95833, 96004, 97012, 97140, 99213, 97032, and 97124 for which it failed to state a reason for its denial before Integra requested MDR.

The ALJ agrees with the Carrier that work status reports under CPT code 99080-73 are payable only under certain circumstances as provided in Rule 129.5.[17] Therefore, because Integra failed to pay the IRO fee, the Carrier will not be ordered to pay for work status reports that were denied on the basis of medical necessity, including reports on November 4, 2003, December 4, 2003, January 4, 2004, and April 4, 2004. It will, however, be ordered to pay for the work status reports provided on February 4, 2004, March 4, 2004, and May 4, 2004, because it did not state its reasons for denying those claims before MDR.

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[15] *Phillips v. Phillips*, 820 S.W. 2d 785, 789-790 (Tex. 1991); 2 Roy W. McDonald & Elaine A. Grafton Carlson, TEXAS CIVIL PRACTICE §§9:45 and 9:54 (2d ed. 2003).

[16] *Brown v. Placke*, 698 S.W.2d 362, 363 (Tex. 1985); *Bridgman v. Moore*, 183 S.W. 2d 705,708 (Tex. 1944).

[17] Rule 129.5(d) requires a report in the following instances: after the initial examination of the employee, regardless of the employee's work status; when the employee experiences a change in work status or a substantial change in activity restrictions; and on the schedule requested by the insurance carrier or agent or the employer requesting a report through its carrier. Subsection (f) requires a report from the provider upon receipt of functional job descriptions from the employer listing available modified duty positions available to the injured worker; and when the injured worker can return to work with or without restrictions.

The Carrier will be ordered to pay for specific dates of service for the various CPT codes rather than amounts calculated by MRD because some of the calculated amounts do not accurately reflect the number of services multiplied by the charge for each service. This includes CPT code 97012, where five dates of service (DOS) times $18.90 plus eleven DOS times $19.21 does not equal $611.62; and CPT code 99213, where five DOS times $66.19 plus twelve DOS times $68.24 does not equal $2,299.66. MRD's calculation for other services appears to be accurate.

**2. MRD's Determination that CPT Code 97110 Services are not Payable**

MRD declined to order payment for certain services Integra provided under CPT code 97110, involving individually supervised (one-on-one) therapeutic exercises, even though the Carrier failed to provide EOBs for the services. At the first of its decision, MRD said providers have been deficient in documenting both the medical necessity of one-on-one therapy and that the services were actually performed. Consistent with its obligations under §413.016 of the Act, it said it reviewed services under CPT code 97110 in light of documentation requirements and declined to order payment because Integra's SOAP notes did not clearly delineate exclusive one-on-one treatment and because Integra did not state how the severity of the injury required exclusive one-on-one therapy.

The ALJ concludes that the Carrier should not be ordered to pay for these services. As indicated above, the Division has an affirmative duty under §413.016 of the Act to order a refund of charges paid to a health care provider in excess of those allowed by medical policies or fee guidelines. MRD was fulfilling this responsibility in advance of payment because of particular difficulties with

services under CPT code 97110. Integra failed to carry its burden of presenting evidence to rebut MRD's conclusions.[18]

[18] The Carrier did not cite authority to support a conclusion that an insurer may compel MRD to perform its §413.016 duties in advance for every type of service.

## III. FINDINGS OF FACT

1. Fidelity & Guaranty Insurance Company (Carrier) and Integra Specialty Group (Integra) both requested a hearing to contest a determination by the Texas Workers' Compensation Commission (Commission) Medical Review Division (MRD) that the Carrier should pay for some, but not all, of the services Integra provided to an injured worker from November 4, 2003, until July 12, 2004.

2. The disputed care included services provided under CPT codes 99080-73, 95833, 96004, 97012, 97110, 97140, 99213, 97032, 97124, and 97010.

3. Integra did not intend to appeal the portion of the MRD decision applicable to services under CPT code 97010 that were performed on March 17, 2003, and March 22, 2003.

4. Except for certain work status reports provided under CPT code 99080-73, MRD dismissed Integra's claim for services provided from November 4, 2003, through December 22, 2003; January 4, 2004; from January 12, 2004, through February 2, 2004; March 3, 2004; and from April 4, 2004, through May 3, 2004, that the Carrier denied on the basis of a lack of medically necessity because Integra failed to pay the independent-review-organization (IRO) fee.

5. Integra did not dispute the MRD decision described in Finding of Fact No. 4.

6. MRD ordered payment for work status reports provided under CPT code 99083-73 based on its conclusion that the report is required and not subject to an IRO review.

7. The Carrier denied Integra's claims for work status reports provided under CPT code 99083-73 on November 4, 2003, December 4, 2003, January 4, 2004, and April 4, 2004, based on its determination that the services were not medically necessary.

8. The Carrier did not provide an explanation of benefits (EOB) or other reason for denying Integra's claim for work status reports provided under CPT code 99083-73 on February 4, 2004, March 4, 2004, and May 4, 2004, before Integra requested medical dispute resolution.

9. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on December 29, 2003; under CPT code 95833before Integra requested medical dispute resolution.

10. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on December 29, 2003, under CPT code 96004 before Integra requested medical dispute resolution.

11. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on December 29, 2003, December 30, 2003, January 5, 2004, January 6, 2004,

January 7, 2004, February 17, 2004, March 9, 2004, March 17, 2004, March 22, 2004, March 31, 2004, May 17, 2004, June 7, 2004, June 11, 2004, June 14, 2004, June 30, 2004, and July 12, 2004, under CPT code 97012 before Integra requested medical dispute resolution.

12. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on December 29, 2003, December 30, 2003, January 5, 2004, January 6, 2004, January 7, 2004, February 9, 2004, February 17, 2004, March 9, 2004, March 17, 2004, March 22, 2004, March 31, 2004, May 17, 2004, June 7, 2004, June 11, 2004, June 14, 2004, June 30, 2004, and July 12, 2004, under CPT code 97140 before Integra requested medical dispute resolution.

13. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on December 29, 2003, December 30, 2003, January 5, 2004, January 6, 2004, January 7, 2004, February 9, 2004, February 17, 2004, March 9, 2004, March 17, 2004, March 22, 2004, March 31, 2004, May 17, 2004, June 7, 2004, June 11, 2004, June 14, 2004, June 30, 2004, and July 12, 2004, under CPT code 99213 before Integra requested medical dispute resolution.

14. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on January 5, 2004, January 6, 2004, January 7, 2004, February 9, 2004, March 17, 2004, and March 22, 2004, under CPT code 97032 before Integra requested medical dispute resolution.

15. The Carrier did not provide an EOB or other reason for denying Integra's claim for services provided on January 5, 2004, provided under CPT code 97124 before Integra requested medical dispute resolution.

16. The Carrier contended it is impermissible to order payment for Integra's claim for services provided under CPT codes 99080-73, 95833, 95831, 96004, and 99213 because payment would be contrary to applicable fee guidelines.

17. In none of the services described in Finding of Fact No. 16, for which the Carrier failed to state a reason for denying the claim before Integra requested medical dispute resolution, was any alleged invalidity of the claim shown, as a matter of law, to be on the face of the claim or in Integra's request for medical dispute resolution.

18. In order to establish the alleged invalidity of the services described in Finding of Fact No. 16, for which the Carrier failed to state a reason for denying the claim before Integra requested medical dispute resolution, it would be necessary to produce evidence on matters other than on the face of the claim or in Integra's request for medical dispute resolution.

19. MRD declined to order payment for certain services Integra provided under CPT code 97110, on December 29, 2003, December 30, 2003, January 5, 2004, January 6, 2004, January 7,

2004, February 9, 2004, February 17, 2004, March 9, 2004, March 17, 2004, March 22, 2004, March 31, 2004, May 17, 2004, June 7, 2004, June 11, 2004, June 14, 2004, June 30, 2004, and July 12, 2004, involving individually supervised (one-on-one) therapeutic exercises, even though the Carrier failed to provide EOBs for the services.

20. Integra's SOAP notes for the services described in Finding of Fact No. 19 do not clearly delineate exclusive one-on-one treatment, and Integra did not state how the severity of the injury required exclusive one-on-one therapy.

21. All parties received adequate notice of not less than 10 days of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

22. All parties had an opportunity to respond and to present evidence and argument on each issue involved in the case.

## IV. CONCLUSIONS OF LAW

1. 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. TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T. CODE ANN. ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.052.

3. Each party had the burden of proof on the services for which it requested a hearing. 1 TEX. ADMIN. CODE (TAC) §155.41(b); 28 TAC § 148.14(a).

4. The Carrier is not required to pay for the services Integra provided under CPT code 97010 as described in Finding of Fact No. 3.

5. The Carrier is not required to pay Integra's claim for the services described in Finding of Fact No. 4 that MRD dismissed.

6. The Carrier is required to pay only for work status reports provided in accordance with 28 TAC §129.5.

7. The Carrier is not required to pay for the services described in Finding of Fact No. 7.

8. The Carrier is precluded from asserting a reason for denying Integra's claim for the services described in Findings of Fact Nos. 8 through 15. TEX. LAB. CODE ANN. §408.027(d); 28 TAC §§133.304(c), 133.307, and 133.308.

9. The Carrier should pay for the services described in Findings of Fact Nos. 8 through 15.

10. MRD is authorized to order a refund of amounts paid to a health care provider in excess of those allowed by medical policies or fee guidelines. TEX. LAB. CODE ANN. §413.016.

11. MRD was authorized to order that Integra's claim for the services described in Finding of Fact No. 19 be denied. TEX. LAB. CODE ANN. § 413.016.

12. The Carrier should not be ordered to pay for the services described in Finding of Fact No. 19.

## ORDER

**IT IS THEREFORE ORDERED** that Fidelity & Guaranty Insurance Company (St. Paul) pay Integra Specialty Group, P.A. for the services described in Findings of Fact Nos. 8 through 15, plus applicable interest.

**IT IS ORDERED FURTHER** that Integra Spcialty Group, P.A.'s claim for all other services reviewed by MRD, for which payment is not required by this order, be, and the same is hereby, denied.

**SIGNED January 6, 2006.**

**JAMES W. NORMAN**
**ADMINISTRATIVE LAW JUDGE**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**