DOCKET NO. 453-05-9788.M5
MDR NO. M5-05-2290-01

ZURICH AMERICAN INSURANCE COMPANY, Carrier	§	**BEFORE THE STATE OFFICE**
vs.	§	**OF**
GEORGE KRISTOPHER WILSON, D.C., Provider	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

The issue involved is whether Zurich American Insurance Company (Carrier) correctly denied payment of claims filed by George Kristopher Wilson, D.C., Fort Worth Injury Rehabilitation Clinic (Provider) for chiropractic treatments provided to an injured worker (Claimant) between November 5, 2003, and January 16, 2004. Carrier challenged the medical necessity of the treatment, but Provider contended Claimant improved and returned to work, demonstrating the care was reasonable and necessary. The Administrative Law Judge (ALJ) finds that the chiropractic treatments at issue were not medically necessary, and Provider is not entitled to reimbursement.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

On November 3, 2005, ALJ Georgie B. Cunningham conducted the hearing on the merits at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Attorney Steven M. Tipton represented Carrier, and Provider was represented by Dr. Patrick R. E. Davis.[1] The parties did not contest jurisdiction or notice. Therefore, those issues are addressed in the findings of fact and conclusions of law without discussion.

After allowing time for the parties to file additional documentation, the ALJ closed the hearing on November 21, 2005. Upon realizing that the additional documentation was incomplete, the ALJ reopened the hearing to permit time for complete filing of the material and an opportunity

[1] Provider no longer employs Dr. Wilson. Instead, Dr. Davis represented Provider even though the request was docketed in Dr. Wilson's name.

for any objection. After receiving the additional documentation and no objection, the hearing again closed on January 25, 2006.

II. DISCUSSION

A. Background

Kevin Tomsic, D.C., testified on behalf of Carrier, and Dr. Davis testified on behalf of Provider. Additionally, the parties relied on documentary evidence and arguments. According to the documentary evidence, Claimant incurred a puncture wound to his lower right leg, ankle, and foot when a piece of metal machinery weighing approximately 100 pounds fell on him on___. He was examined at an emergency room and received follow-up care including physical therapy.

On September 29, 2003, Claimant was evaluated and deemed to be at Maximum Medical Improvement with no permanent impairment from the injury. After having on-going problems with his injured leg, however, Claimant changed treating doctors on October 22, 2003.

Provider's Dr. Wilson, the new treating doctor, evaluated Claimant's condition on October 27, 2003. Between November 5, 2003, and January 16, 2004, Provider treated Claimant with chiropractic manipulation, therapeutic exercises, manual therapy, neuromuscular re-education, gait training, and miscellaneous DME. Carrier denied Provider's claim for the treatment after determining it was not medically necessary.

Provider requested dispute resolution from the Texas Workers' Compensation Commission (Commission), and the case was reviewed by an Independent Review Organization (IRO) doctor. The IRO doctor found the treatments between November 5 and December 19, 2003, were medically necessary; however, the treatments thereafter were not medically necessary. On August 11, 2005, the Commission's Medical Review Division (MRD) staff issued its decision that Provider had prevailed in the medical necessity issues in CPT Codes 98943, 99070, 97140, 97110, 97112, 97116, and 99215 and HCPCS Code E1399 from November 5 through December 19 and was entitled to reimbursement of $2,841.47 on those claims.

The MRD staff further determined that medical necessity was not the only issue to be resolved. Therefore, the MRD staff addressed other issues and ordered Carrier to reimburse Provider a total of $6,373.05 plus accrued interest for its services. Because Carrier's request for a

hearing did not include the reimbursement for HCPCS Code E0745, that claim was not at issue in the hearing. Likewise, Provider did not request a hearing on any of the claims MRD denied. Therefore, those claims were not at issue either.

B. Medical Necessity Evidence

As might be expected, Dr. Tomsic testified that the treatment was not medically reasonable or necessary. Conversely, Dr. Davis testified that all of the care was medically necessary. From their testimony and the documentary evidence, the ALJ has concluded the points discussed herein and set out in the Findings of Fact.

The IRO doctor was certified in chiropractic medicine and was currently on the Commission's approved doctor list. The records the IRO doctor considered included the following:

(1) TWCC 60,
(2) Table of Disputed Services,
(3) EOB's (Explanation of Benefits)
(4) Office Notes 11/21/03 - 01/16/04,
(5) Physical Therapy Notes 10/27/03 - 01/18/04,
(6) Pain Management Specialist Office Notes and Procedure Reports, and
(7) Orthopedic Surgeon Office Notes and Nerve Conduction Study.

In the rationale, the IRO doctor wrote:

> There is sufficient clinical documentation as well as justification for this patient to receive all services rendered from 11/05/03 through 12/19/03. Services performed after 12/19/03 through 01/16/04 were not usual, reasonable, customary, or medically necessary for the treatment of this patient's on-the-job injury.

When Provider first examined Claimant, he wrote that Claimant complained that his right lower leg, ankle, and foot were constantly painful and that the pain was worsened by weight bearing on the right lower extremity. Claimant also complained about a painful popping and grinding sensation in his right ankle and foot with weight bearing.

By October 27, 2003, Claimant had developed an abscess of the puncture wound for which he was taking antibiotics. Provider diagnosed Claimant's problem as right ankle and foot crush injury with resulting internal derangement. His secondary diagnosis was post right lower leg puncture wound with subsequent abscess, weakness, effusion, and pain. Provider indicated he

planned to treat Claimant with physical medicine rehabilitation using active and passive treatment to ensure Claimant's safe and successful return to work.

According to Dr. Tomsic, Provider's treatment documentation was subjective as Provider used no range-of-motion measurements, no accepted standards for muscle-strength testing, no pain diagrams, and no other objective pain reporting. Furthermore, Claimant's examinations, bone scan, and MRI failed to show significant acute abnormality. Based on his review of the records and his knowledge of chiropractic, Dr. Tomsic testified about the following points: (1) a four-week course of chiropractic care immediately following Claimant's injury would have been appropriate; (2) the continued use of passive modalities so long after an injury might foster chronic behavior; (3) Claimant's compression injury could cause pain and swelling for up to six months whether or not he received active care; (4) Provider's records did not contain evidence that continued physical therapy would improve Claimant's pain level; and (5) Claimant's infection could better be treated by a physician licensed to prescribe pharmaceutical antibiotics.

Carrier also asked Michael Earle, M.D., to provide a medical addendum to the peer review performed by an individual licensed in chiropractic. According to Dr. Earle's written opinion, Claimant could have managed with home exercises and the use of his compression stocking. He noted that the treatment was inordinately excessive for the injury. The pain and swelling should have resolved within six months even without treatment.

Provider contended Claimant needed the treatment because his job required him to stand all day and handle heavy equipment. Provider pointed to specific pages in the record and asserted that measurable objectives were used. For example, he pointed to the records indicating Claimant had muscle grade weakness of four. Additionally, he referenced the statutory requirement about providing treatment to injured workers and argued that all treatment that relieved pain and helped injured workers return to work must be provided.[2]

C. Analysis of Medical Necessity Issue

[2] TEX. LAB. CODE ANN. § 408.021.

Although Provider asserted that measurable objectives were used, the ALJ finds the evidence thereof lacking. Instead, the patient record consists largely of narrative reports that vary little from visit to visit. Many of the reports quote Claimant as praising Provider rather than addressing his own condition. After Carrier challenged the validity of even the limited patient assessments in the records, Provider failed to explain the method of assessment or the significance of these assessments.

Although Provider's treatment plan refers to ensuring Claimant's safe and successful return to work, Claimant was working when he first consulted Provider. Neither the patient records nor the testimony explains why Claimant had to stop working. According to Dr. Tomsic, Claimant needed care from a medical doctor to treat the wound, and the injury would have been resolved with or without the chiropractic care at issue. Dr. Earle also concluded the injury would have resolved within six months even without the treatment.

Evidence is lacking that the health care was reasonably required by the nature of the injury. The ALJ concludes that Carrier prevailed on the issue that the treatment provided was not medically necessary.

D. The Other Denial Codes Addressed in the Decision

1. November 5 - December 19, 2003

The MRD decision specified that Provider had prevailed in the medical necessity issue in reimbursement of $2,841.47 from November 5 through December 19. The decision further stated that Carrier denied some of the claims using denial codes, "E - Entitlement to Benefits" or "F - Not Timely Submitted."

The MRD decision concluded Provider was entitled to an additional $2,353.00 for multiple dates of service for the listed codes. Specifically, the decision found that Carrier should pay $382.33 for 13 dates of service (DOS) under CPT Code 98943; $80.00 for 5 DOS under HCPCS Code E1399; $195.00 for 13 DOS under CPT Code 99070; $781.20 for 24 units under CPT Code 97140; $363.84 for 12 DOS under CPT Code 97116; $317.34 for 9 DOS under CPT Code 97112; and $143.78 under CPT Code 99215.

According to Carrier, it denied all the claims using the following codes: (1) "U- Unnecessary treatment without peer review" or (2) "V- Unnecessary treatment with peer review." The ALJ found no evidence that suggests the Carrier challenged reimbursement of the claims on any point other than a lack of medical necessity. Carrier's EOBs through December 19, 2003, consistently show that the claims were denied using the "U" code.

The *Table of Disputed Services*, which the IRO doctor reviewed, indicated Provider's rationale for requesting reimbursement was "documentation supports medical necessity." The IRO doctor gave the opinion based on medical necessity without excepting any part of the billing records. Provider did not present any records, testimony, or objection regarding Carrier's contention that it challenged the bills as being medically unnecessary.

Without evidence thereof, the ALJ is at a loss how the MRD reviewer found that Carrier denied reimbursement using a code other than "U." Therefore, the ALJ concludes Carrier does not have to reimburse Provider for claims filed between November 5 and December 19, purportedly denied using codes other than a lack of medical necessity.

2. Codes After December 19, 2003

a. The MRD Decision

Additionally, the MRD decision found that Provider was entitled to reimbursement for certain treatment provided after December 19, 2003, and purportedly denied for reasons other than a lack of medical necessity. Specifically, the decision found Provider was due $150.00 for supplies billed as CPT Code 99070 on December 22, 29, 30, and 31 and January 5, 7, 9, 12, 14, and 16, calculated as $15.00 X 10 DOS. According to the decision, Provider had furnished documentation to support delivery of services even though Carrier denied using the code "N- not appropriately documented."

The MRD decision also determined that Provider was entitled to reimbursement of $48.00 for HCPCS Code E1399, miscellaneous DME, on January 5 (2 units) and 14 (1 unit), calculated as $16.00 X 3 units, because Carrier gave no exception code.

According to the MRD decision, Provider was entitled to reimbursement of $554.35 for CPT Code 97140, myofascial release, on December 29 (2 units), 30 (2 units), and 31 (1 unit), and January 5 (2 units), 7 (1 unit), 9 (1 unit), 12 (2 units), 14 (1 unit), and 16 (2 units), calculated as $32.55 X 7 DOS in December 2003 plus $32.65 X 10 DOS in January, because Carrier denied reimbursement using an "F" code and quoted a recommended allowance, but failed to reimburse Provider.

Additionally, the MRD decision further indicated that Provider was entitled to reimbursement of $317.34 for CPT Code 97112, neuromuscular reeducation, on December 29, 30, and 31 and January 5, 7, 9, 12, 14, and 16, calculated as $35.26 X 9 DOS, because Carrier denied using an "F" code and quoted a recommended allowance, but failed to reimburse Provider.

b. The Parties' Positions

Carrier contended reimbursement had been denied based on a lack of medical necessity. Carrier further argued that the IRO doctor had agreed with Carrier's decision after reviewing the *Table of Disputed Services* and the EOBs. In the alternative, however, Carrier presented evidence to address both medical necessity and the use of the alternative codes.

Provider did not submit any documentary evidence or testimony addressing the issue of which codes were used. Neither did Provider object to any of the evidence offered. Instead, Dr. Wilson's testimony focused on the issue of medical necessity.

c. Analysis

The MRD decision is confusing to read and difficult to understand. It appears to have been rushed and contains numerous errors on its face. For example, units and dates of service are used interchangeably when multiple units were used on some dates of service for Code 97140. Some of the numbers of units were incorrect. Even more troubling is the source of the codes the decision discusses.

The evidence supports Carrier's contention that all of the claims were denied using the "U" and "V" codes to designate its finding of a lack of medical necessity. The IRO doctor reviewed the

record including the EOBs and the *Table of Disputed Services* and concluded the treatment after December 19 was not medically necessary. The opinion did not address any exceptions. The evidence admitted at the hearing supports a finding that none of the treatment was medically necessary, and the documentary evidence that was submitted at the hearing supports a conclusion that Carrier consistently used this reason for denial.

Furthermore, Provider did not request a hearing on the MRD decision that some of the treatment after December 19 was not medically necessary and did not object to the evidence Carrier offered. It is also noteworthy that Provider prepared the original table of disputed services referencing only the issue of medical necessity. Furthermore, Provider's testimony addressed only this issue.

Accordingly, the ALJ finds no basis for ordering Carrier to reimburse Provider for its claims after December 19. Because the treatment was not medically necessary, it is not necessary to address the alternative codes purportedly used.[3] The lack of medical necessity resolves the issue.

E. Conclusion

Based on the evidence summarized above and set forth in the Findings of Fact, the ALJ concludes that Carrier showed by a preponderance of the evidence that the treatment Provider furnished Claimant from November 5, 2003, through January 16, 2004, was not medically necessary. A preponderance of the evidence showed that Carrier denied the claims using "U" or "V" codes to indicate a lack of medical necessity as the reason for denying most of the claims. Therefore, Carrier is not liable for those claims put into issue in this hearing.

III. FINDINGS OF FACT

1. Between November 5, 2003, and January 16, 2004, George Kristopher Wilson, D.C., of the Fort Worth Injury Rehabilitation Clinic (Provider) treated Claimant for a work-related injury.

[3] The ALJ considered all of the evidence admitted, however.

2. Zurich American Insurance Company (Carrier), which provided workers' compensation coverage for Claimant's employer, denied payment for the chiropractic treatment provided between November 5, 2003, and January 16, 2004.

3. Provider requested medical dispute resolution by the Texas Workers' Compensation Commission (Commission) based on Carrier's denial.

4. On August 5, 2005, an Independent Review Organization (IRO) doctor determined that the treatment from November 5 through December 19, 2003, was medically necessary, but the treatment after December 19, 2003, through January 16, 2004, was not medically necessary.

5. The Commission's Medical Review Division (MRD) decision determined that medical necessity was not the only issue to be resolved.

6. On August 11, 2005, the MRD decision ordered Carrier to reimburse Provider $6,376.05 plus accrued interest for the chiropractic care of Claimant between November 5, 2003, and January 16, 2004.

7. On August 31, 2005, Carrier requested a hearing before the State Office of Administrative Hearings on the MRD order that it pay reasonable and necessary costs for CPT Codes 98943, 99079, 97140, 17112, 97116, and 99215 and for HCPCS Code E1399.

8. On October 21, 2005, the Division of Workers' Compensation, Texas Department of Insurance, sent a hearing notice advising the parties of the matters to be determined; the right to appear at the hearing; the date, time, and place of the hearing; and the statues and rules involved.

9. Representatives for Provider and Carrier appeared at the hearing at the State Office of Administrative Hearings.

Issues

10. The MRD decision specified that Provider had prevailed in the medical necessity issue through December 19, 2003, and was due reimbursement of $2,841.47.

11. The MRD decision stated that Carrier denied some of the treatment CPT Codes 98943, 99070, 97140, 97112, 97116, and 99215 and HCPCS Code E1399 from November 5 through December 19, 2003, using denial codes, "E - Entitlement to Benefits" or "F - Not Timely Submitted."

12. The MRD decision determined that Claimant's injury was compensable based on a benefit review conference between the parties.

13. The MRD decision determined that Provider had submitted documentation to support its claims.

14. Based on Findings of Fact Nos. 11 - 13, the MRD decision concluded Provider was entitled to an additional $2,353 for multiple dates of service for the listed codes between November 5 and December 19, 2003.

15. The MRD decision determined that Provider was entitled to reimbursement of $150.00 for CPT Code 99070 on December 22, 29, 30, and 31, 2003, and January 5, 7, 9, 12, 14, and 16, 2004, calculated as $15.00 X 10 DOS, because Provider furnished documentation to support delivery of services even though Carrier denied using the code "N- not appropriately documented."

16. The MRD decision determined that Provider was entitled to reimbursement of $48.00 for HCPCS Code E1399 on January 5 and 14, 2004, calculated as $16.00 X 3units, because Carrier gave no exception code.

17. The MRD decision determined that Provider was entitled to reimbursement of $554.35 for CPT Code 97140 on December 29 (2 units), 30 (2 units), and 31 (1 unit), 2003, and January 5 (2 units), 7 (1 unit), 9 (1 unit), 12 (2 units), 14 (1 unit), and 16 (2 units), 2004, calculated as $32.55 X 7 DOS in December 2003, plus $32.65 X 10 DOS in January 2004, because Carrier denied reimbursement using an "F" code and quoted a recommended allowance, but failed to reimburse Provider.

18. The MRD decision determined that Provider was entitled to reimbursement of $317.34 for CPT Code 97112 on December 29, 30, and 31, 2003, and January 5, 7, 9, 12, 14, and 16, 2004, calculated as $35.26 X 9 DOS, because Carrier denied using an "F" code and quoted a recommended allowance, but failed to reimburse Provider.

Evidence

19. On___, Claimant was injured at work when a large piece of metal machinery weighing approximately 100 pounds fell on him causing a puncture wound to the right lower leg and pain and swelling in the right lower leg, ankle, and foot.

20. Claimant was examined at an emergency room and released with a pain medication prescription.

21. Following his injury, Claimant received treatment including prescription medication and physical therapy.

22. On September 29, 2003, Claimant was evaluated and deemed to be at Maximum Medical Improvement with no permanent impairment from the injury.

23. Claimant requested a change in treating doctors after he continued having problems arising from his injury.

24. Claimant's request to change treating doctors was approved on October 22, 2003.

25. Provider's George Kristopher Wilson, D.C., became Claimant's new treating doctor.

26. Carrier denied reimbursement for Provider's treatment of Claimant asserting it was not medically necessary.

27. The IRO review was performed by a physician who was certified in chiropractic medicine and who was currently on the Commission's approved doctor list.

28. The IRO reviewer considered Provider's *Table of Disputed Services*; Carrier's Explanation of Benefits (EOBs); Provider's office notes from November 21, 2003 through January 16, 2004; physical therapy notes from October 27, 2003, through November 16, 2004, and reports prepared by specialists after the service period at issue.

29. The IRO reviewer determined that the treatment and services were not medically necessary after December 19, 2003, through January 16, 2004.

30. Carrier denied Provider's request for reimbursement using the denial codes "U - unnecessary treatment without peer review" or "V-treatment not reasonable or necessary per peer review attached.

31. Claimant complained that his right lower leg, ankle, and foot were constantly painful and that the pain was worsened by weight bearing on the right lower extremity. Claimant also complained about a painful popping and grinding sensation in his right ankle and foot with weight bearing.

32. Provider diagnosed Claimant's problem as right ankle and foot-crush injury with resulting internal derangement. His secondary diagnosis was post right lower leg puncture wound with subsequent abscess, weakness, effusion, and pain.

33. By October 27, 2003, Claimant had developed an abscess of the puncture wound for which he was prescribed antibiotics.

34. Provider planned to treat Claimant with physical medicine rehabilitation using active and passive treatment.

35. Although Provider's treatment plan refers to ensuring Claimant's safe and successful return to work, Claimant was working when he first consulted Provider and continued working after consulting Provider.

36. Provider's treatment documentation was subjective and contained no range-of-motion measurements, no accepted standards for muscle strength testing, no pain diagrams, and no other pain reporting measurements.

37. Claimant's examinations, bone scan, and MRI failed to show significant acute abnormality.

38. A four-week course of chiropractic care immediately following Claimant's injury would have been appropriate.

39. The continued use of passive modalities so long after an injury may foster chronic behavior.

40. Provider's records did not contain evidence that continued physical therapy would improve Claimant's pain level.

41. Claimant's compression injury could cause pain and swelling for up to six months whether or not he received active care.

42. Provider's records did not contain evidence to support furnishing chiropractic manipulation for Claimant's contusion or puncture wound.

43. Claimant's infection could have been more appropriately treated by a physician licensed to prescribe pharmaceutical antibiotics.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission had jurisdiction to decide the issue presented pursuant to the Texas Workers' Compensation Act, TEX. LAB. 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 TEX. LAB. CODE ANN. §§ 402.073 and 413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

3. Carrier timely requested a hearing on the order to reimburse the Provider.

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

5. A preponderance of the evidence showed that Carrier denied Provider's claims for reimbursement for treating Claimant from November 5, 2003, through January 16, 2004, based on Carrier's determination that the treatment was not medically necessary.

6. Based on the findings of fact and conclusions of law, the disputed services were not medically necessary, as specified in TEX. LAB. CODE ANN. § 408.021.

ORDER

IT IS, THEREFORE, ORDERED that Fort Worth Injury Rehabilitation Clinic is not entitled to reimbursement from Zurich American Insurance Company for the disputed services from November 5, 2003, through January 16, 2004.

SIGNED this 27th day of March 2006.

GEORGIE B. CUNNINGHAM
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS