SOAH DOCKET NO. 454-08-3756.M4
DWC NO. ___

ERIC VANDERWERFF, D.C., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
AMERICAN HOME ASSURANCE COMPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Eric Vanderwerff, D.C., (Provider) seeks reversal of an order denying payment for $2,028 of chiropractic services for Claimant ___.The Administrative Law Judge (ALJ) finds that Provider properly billed for medically necessary services. American Home Assurance Company (Carrier) is ordered to reimburse Provider.

I. DISCUSSION

Claimant suffered a compensable back injury, a lumbar sprain/strain, on _____. Because Claimant had suffered a previous back injury, the parties entered an agreement on September 7, 2006, that Claimant's _____ injury does not include sciatica, subluxation of the sacrum, subluxation of the pelvis, muscle spasms, lumbar disc herniation, and radiculopathy.

From April 3 though December 5, 2006, Provider treated Claimant and billed Carrier for a number of services, most of which are not at issue. Only services billed under CPT code 97140-59 are in dispute. Dr. Vanderwerff testified that the use of the modifier "59" indicates a service (manual therapy) discrete from services billed under CPT codes 97110 (therapeutic procedure) and/or 97112 (neuromuscular reeducation). The latter codes, and others, were billed on the same day as CPT code 97140-59.

Carrier denied payment for this CPT code on the basis that "Payment is adjusted because this procedure/service is not paid separately." More specifically, Carrier argues that Provider

charged for services under CPT codes 97110 and/or CPT code 97112, and Provider cannot also bill for manual therapy under CPT code 97140 on the same date of service.[1]

Provider filed a request for medical dispute resolution with the DWC Medical Review Division (MDR). The MDR, on May 23, 2008, indicated that:

> CPT 97140 is considered per Rule 134.202(b) to be a component procedure of CPT codes 98941 and 97150, one of which was billed on the same date of service. A modifier is allowed in order to differentiate between the services billed. The Requestor billed with modifier "59 – Distinct Procedural Service." The 59 modifier is used to identify procedures/service that are not normally reported together.[2]

However, the MDR then denied the request because Provider used diagnosis codes that treated the sacrum and pelvis, areas that were not part of the compensable injury to a lumbar sprain/strain. The MDR also characterized the 722.10 diagnostic code used by Provider as "Displacement of lumbar intervertebral disc without myelopathy."[3] Carrier argues that the DWC had the authority to rule that the treatment failed to treat the compensable injury. Provider argues that the MDR misinterpreted the evidence and the law.

Provider testified that he treated Claimant and billed under diagnosis code 72210, which is the proper diagnostic code for a sprain/strain of the lumbar ligament fibers. According to Dr. Vanderwerff, a sprain of a lumbar disc involves tearing of ligament tissue, and a strain involves the tearing of muscle fibers. Claimant did not have a lumbar disc herniation but a sprain/strain to the fibers that form a band to connect bone to bone. Dr. Vanderwerff concluded that the diagnosis code of 722.10 was proper.

Carrier questioned Dr. Vanderwerff about the listing of diagnosis codes 839.42, 738.6, and 728.85 in addition to the 722.10 code on the claim form submitted to Carrier. However, Dr. Vanderwerff pointed out that he properly filled out the claim form by referencing only 722.10 under the column "Diagnosis Pointer," although he included other diagnoses that Claimant was suffering from at the time of treatment. Dr. Vanderwerff testified that he must list

[1] Carrier's Ex. 1 at 1.
[2] Provider's Ex. 1 at 6.
[3] *Id.*

all the problems Claimant had at the time of treatment even though he was providing services only to treat the lumbar sprain/strain.[4]

The undisputed evidence indicates that Dr. Vanderwerff was treating Claimant's ____ compensable injury under the proper diagnosis code. Although the MDR denied Provider's request because the billing did not appear to be for a lumbar sprain/strain, Dr. Vanderwerff testified that 722.10 is the proper diagnostic code for the compensable injury. Provider's position is supported by Carrier's own actions because Carrier paid Provider for all other services provided on the same dates, using the same diagnostic code 722.10 and the claim form that references 722.10 under the column "Diagnosis Pointer." There is no persuasive argument as to why the disputed services provided under CPT 97140-59 should be treated differently. The ALJ finds that Provider treated Claimant for the compensable injury and properly billed for such services under code 722.10.

Turning to the issue of whether Provider could bill for certain services on the same date of service, Dr. Vanderwerff testified that the 59-modifier indicates a myofacial therapy or joint mobilization, both of which can be performed on the same date of service as either therapeutic exercise or neuromuscular reeducation. The daily notes indicate that Provider treated the Claimant with both myofascial therapy and joint mobilization. [5] Dr. Vanderwerff's testimony was not controverted and was supported by the MDR's findings.[6]

Under 28 TEX. ADMIN. CODE § 148.14, Provider had the burden of proving the services were compensable and properly billed. The evidence was adequate to meet that burden of proof. Therefore, Carrier should reimburse Provider for services performed under CPT code 97140-59.

III. FINDINGS OF FACT

1. Claimant, ____, suffered a compensable back injury on ____, when pushing a pallet with bags of salt.

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[4] Provider Ex. 1 at 14-39, Health Insurance Claim Forms for the dates in question.

[5] Provider Ex. 1 at 111-133.

[6] Although MDR referenced different codes than that Carrier objected to, the ALJ interprets the decision as allowing Provider to bill for certain services on the same date of service using the 59 modifier.

2. Claimant complained of low back pain and muscle spasm. She was treated by Eric Vanderwerff, D.C. (Provider), initially via three visits a week.

3. On the date of the injury, American Home Assurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

4. Mark Doyne, M.D., conducted a peer review on February 27, 2006, finding that Claimant suffered from a lumbar strain superimposed on pre-existing multi-level degenerative disc disease, facet disease, and degenerative disc bulges.

5. Claimant had suffered a previous back injury on _____.

6. On September 7, 2006, the parties entered an agreement that Claimant's _____ injury does not include sciatica, subluxation of the sacrum, subluxation of the pelvis, muscle spasms, lumbar disc herniation, and radiculopathy.

7. From April 3 through December 5, 2006, Provider treated Claimant with chiropractic services. Carrier reimbursed Provider for services provided and billed under CPT codes 97110 and/or 97112.

8. From April 3 through December 5, 2006, Carrier denied payment for services billed under 97140-59, where Provider also billed for services under CPT codes 97110 and/or 97112 on the same dates of service. The amounts for the denied services totaled $2,028.00.

9. Provider requested medical dispute resolution for the services listed in the above finding of fact.

10. On May 23, 2008, a Texas Department of Insurance (TDI), Division of Workers' Compensation (DWC) determined that Provider could bill CPT code 97140 using the modifier 59. However, the DWC Decision and Order denied Provider's request for reimbursement because Provider billed under diagnosis codes 722.10, 839.42, 738.6, and 728.85 and did not bill for the compensable injury of lumbar sprain/strain.

11. Provider filed a timely request for a hearing before the State Office of Administrative Hearings (SOAH).

12. Notice of the SOAH hearing was sent to the parties July 11, 2008.

13. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

14. The SOAH hearing was held July 30, 2008, before Administrative Law Judge (ALJ) Charles Homer, III. Both parties appeared through representatives. After testimony and argument, the hearing was adjourned and the record closed the same day. Subsequent to the hearing, ALJ Homer left employment with SOAH. ALJ Lilo D. Pomerleau listened to a tape of the hearing and read the record.

15. Provider billed for the disputed services under diagnosis code 722.10.

16. Diagnosis code 722.10 is the proper diagnostic code for a sprain/strain of the lumbar ligament fibers.

17. Provider billed for the disputed services under CPT code 97140-59 to indicate myofascial therapy, which can be performed on the same date of service as therapeutic exercise and joint mobilization.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

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

3. Under 28 TEX. ADMIN. CODE (TAC) § 148.14(a), Provider had the burden of proving the disputed services were provided to treat the compensable injury and were properly billed.

4. The evidence was adequate to meet the burden of showing that the disputed services were provided to treat Claimant's lumbar sprain/strain.

5. The evidence was adequate to meet the burden of showing that the disputed services were properly billed.

6. Carrier should be required to reimburse Provider for the disputed services.

ORDER

It is, therefore, ordered that American Home Assurance shall reimburse Dr. Eric A. Vanderwerff $2,028.00 for the disputed services at issue in this proceeding.

SIGNED November 12, 2008.

LILO D. POMERLEAU
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS