STATE OF MONTANA
DEPARTMENT OF LABOR AND INDUSTRY
HEARINGS BUREAU

IN THE MATTER OF	)	**Case No. 2120-2003**
MICHAEL H. PARDIS, D.C,	)	
Petitioner,	)	**CONFIDENTIALITY ORDER AND**
vs.	)	**FINAL AGENCY DECISION**
MONTANA STATE FUND,	)	
Respondent.	)	

I. INTRODUCTION

Helena chiropractor Michael H. Pardis sought a declaratory ruling regarding the adjustment practices of the Montana State Fund. He contended that the Fund could not limit the number of treatments he provided to workers' compensation claimants on the Fund's accepted liability industrial injury claims. The Fund contended that it could limit the number of authorized treatments by Dr. Pardis based upon its chiropractic consultant's recommendations. The Fund claimed that once it had authorized a limited number of treatments, it had no further liability for Dr. Pardis' treatment unless it subsequently authorized additional treatments. Dr. Pardis also sought an order requiring payment for the treatments already delivered to particular claimants and unpaid by the Fund and declaratory rulings that the Fund could not use referral either to managed care or to a different treating physician as cost control measures.

The hearing convened on September 24, 2003, in Helena, Montana. Dr. Pardis appeared for himself. The Fund appeared through legal counsel, Thomas Martello, and its designated representative, Linda Nelson. Pardis, Stan Wells, chiropractor Gary Phillip Blom, Lucinda Dixon and Nelson testified under an oath. The hearing examiner admitted Exhibits 1-7. After filing of the transcript, the parties filed their respective post-hearing arguments and submitted the case for decision.

II. Confidentiality Order

The hearing examiner provisionally sealed the entire record and hearings file, pending receipt of patient consents to limited disclosure of their medical information with the seal maintained on information that might identify them. Having received the patient consents and the post-hearing filings, the hearing examiner now issues the following confidentiality order:

1. The patient records submitted as exhibits ("patient exhibits") are not part of the public record. These original exhibits are part of the evidentiary record, but sealed and subject to this confidentiality order.

2. The transcript of the hearing identifies each patient only as "patient number 1" through "patient number 6," assigning the numbers according to the exhibit number of that patient's

patient exhibit. All references to the patient by personal identifying information have been replaced with the patient numbers only.

3. The sealed and confidential original patient exhibits are in the file, but not in the public record, so that any reviewing court, if necessary, can look at the sealed exhibits in the course of appellate review. The transcript, the unsealed exhibit (exhibit 7) and this decision are unsealed and constitute the public record in this matter.

4. The entirety of the rest of the contested case file, including but not limited to the sealed patient exhibits are sealed and private and shall not be disclosed by the parties or the department to any person or entity other than the parties and department personnel involved in the case. This order applies to parties, the department, the witnesses (all of whom were present when the oral order issued at the commencement of the hearing) and the court reporter who transcribed the hearing record. This order remains in full force and effect until further order of the hearing examiner or any administrative or judicial tribunal exercising jurisdiction over this case or the confidentiality of the sealed portions of the file and record.

5. This broad sealing is the least restrictive sealing possible to protect the privacy of the patients, while providing public access to the hearing process. The public may read the transcript of the hearing, the decision, and exhibit 7, thereby having access to all of the pertinent information involved in the decision and hearing, except information as to which the patients have privacy demands that clearly outweigh the public's right to know.

III. Findings of Fact

1. Dr. Michael H. Pardis is a chiropractor licensed to practice in the State of Montana. He treats patients who have suffered compensable industrial injuries (claimants), submitting his bills for treatment to the workers' compensation insurance provider for each such claimant's employer.

2. The Montana State Fund is the insurer for some of Dr. Pardis' claimants. The Fund is the insurer for the industrial injury claims of Patient 1 through Patient 6, inclusive. The Fund and Dr. Pardis are in dispute over payment for some of the treatments for some of these claimants. Dr. Pardis also seeks rulings on the Fund's use of recommendations by its chiropractic consultant with regard to (a) authorization of treatment by Dr. Pardis of industrial injuries for which the Fund is the responsible insurer, (b) payment by the Fund of Dr. Pardis' bills for such treatment and (c) the Fund's adjustment practices regarding referrals to managed care and other treating physicians.

3. The Fund routinely reviews chiropractic treatment plans from chiropractors (including Dr. Pardis) who treat patients claiming industrial injuries in the employ of the Fund's insured. The Fund approves or rejects those treatment plans for a specific number of treatments over 30 days or longer.

4. The Fund's authorizations are on a form that states that the authorization is "based on the peer review of information submitted." The form further states:

> Requests for additional/subsequent treatment must be submitted to Montana State Fund for review. Payment is not guaranteed if information is not submitted for peer review prior to the date of service. Payment is also not guaranteed if treatment is not provided within the treatment duration period specified above. If you disagree with the peer review opinion, you may request an alternative peer review of the number of approved treatments by submitting a request to Montana State Fund.

5. Treating chiropractors (including Dr. Pardis) typically submit additional evaluations and updated treatment plans each 30 days.[(1)] Unless and until the chiropractor submits a new reevaluation and supplemental treatment plan at the end of the approval period, no further treatment is accepted by the Fund. Frequently the Fund does not timely respond to reevaluations and supplemental treatment plans. As a result, more often than not any subsequent authorization of further chiropractic treatment is only an after the fact acceptance of some but not all of the additional treatments already delivered to the claimant.

6. The Fund's "peer review" consists of review by a single Helena chiropractor, Dr. Gary Phillip Blom. Dr. Blom is licensed to practice in the state of Montana. The Fund's adjusters submit inquiries to Dr. Blom regarding what treatment is medically necessary and appropriate. The Fund apparently has internal guidelines regarding when to consult with Dr. Blom. Nevertheless, the adjusters have discretion regarding both when to seek Dr. Blom's advice and whether to follow that advice.

7. Dr. Blom reviews the records submitted to him by Fund adjusters regarding particular claims. Those records typically include:

- the accident report and claim
- the "Attending Chiropractor's First Report" (a standardized form)
- the "Health Insurance Claim Form," HCFA-1500 (the bills, formatted on another standardized form)
- any "Chiropractor's Supplemental Report" (another standardized form, used when treatment continues)
- the treating chiropractors' handwritten or typed notes and
- (within the foregoing documents) the chiropractors' procedural terminology codes for diagnosis and treatments.

8. Dr. Blom reports to the adjuster whether he considers the treatments appropriate and reasonable and whether the treatments appear to be related to the industrial injury. He also reports his opinion of the number of treatments appropriate for the condition or conditions related to the industrial injury.

9. Dr. Blom has reviewed a number of cases with Dr. Pardis as the treating chiropractor, including but not limited to the six cases involved in this proceeding. Based upon his reviews of Dr. Pardis' treatment records, Dr. Blom believes that Dr. Pardis routinely treats more frequently than the average practitioner does for most common conditions resulting from industrial injury. Dr. Blom applies his own experience, training and opinions to decide how many chiropractic

treatments would ordinarily be appropriate for a particular diagnostic code in the records he is reviewing. He advises the Fund of his conclusion that a particular number of treatments is appropriate for the particular claimant. This is frequently fewer treatments than Dr. Pardis proposes for his claimants. The adjusters will authorize more treatments than Dr. Blom suggests, when they believe the claimant is on a course of recovery that will soon resolve the need for further treatments.

10. Mont. Code Ann. (1999) § 39-71-1101(3)(b), empowers the Fund to refer an injured worker to managed care if the injury did or will result in:

- total loss of wages for any time
- permanent impairment
- referral for specialized treatment or specialized diagnostic tests.

11. When a new patient with a worker's compensation claim arrives in Dr. Pardis' office seeking treatment related to the claim, the office follows a standard procedure. Stan Wells, Dr. Pardis' billing and insurance clerk, first sends an e-mail inquiry to the department's Employment Relations Division (ERD), to identify the insurer for that claimant's employer as of the date of injury. This is necessary because the claimant usually does not know who the worker's compensation insurer is. Identifying the proper insurer usually takes from three to five days from the date of the claimant's initial visit, after which Dr. Pardis sends the initial paperwork to the insurer, unless ERD has not assigned a claim number and the Fund is the insurer. All other insurers covering industrial injuries in Montana accept the paperwork without a claim number, but the Fund sends paperwork back unless it includes the claim number. Thus, for claims insured by the Fund, there can be a delay in submission of paperwork, or a delay when the Fund sends back the paperwork.

12. The initial paperwork includes the chiropractor's first report, the actual bills and copies of Dr. Pardis' office notes. The office notes report the subjective complaints of the claimant, objective signs of injuries and abnormalities, the chiropractic assessment of the claimant and the initial treatment plan. The first report includes clinical diagnoses, with their standardized codes. The bills include standardized codes of the treatments the claimant received during the billed visits.

13. Dr. Pardis bills compensation insurers weekly for his services. After the initial paperwork, Wells submits the new bills and copies of unpaid prior billings and copies of office notes of visits since the last prior billing. Once a month Wells submits a supplemental chiropractic report with the other documents. This procedure continues for as long as the claimant receives treatment. The pattern and practice of the Fund regarding the authorization and acceptance of Dr. Pardis' chiropractic treatments are illustrated by the experiences of the six claimants whose treatments are at issue in this case.

Patient 1

14. The Fund received Dr. Pardis' initial paperwork regarding Patient 1 on November 20, 2002.[(2)] The chiropractor's first report, described an industrial accident on October 18, 2002, for

which Dr. Pardis first provided treatment for the claimant's industrial injury on October 22, 2002.[(3)] The first report also indicated that the claimant would not be off work more than six days due to the injury. The paperwork included eight pages of typed office notes, covering office visits on October 23, 24, 25, 28, 29, 30 and 31, and November 1, 4, 5, 6, 7, 8, 11 and 13, 2002, and the bills for visits through November 13 (including the initial visit of October 22, for which no office notes appear in the initial paperwork). The bills indicated the coded procedures for each visit and itemized the charges, which totaled $1,385.00. On November 21, 2002, the Fund sent the paperwork back for lack of both a claim number and any record of a claim.

15. On November 25, 2002, the Fund received additional paperwork from Dr. Pardis, documenting further treatments and providing a supplemental chiropractic report and a release to light duty work as of October 22, 2002. The Fund sent that paperwork back the same day, this time indicating that it was not the insurance carrier for the employer. The apparent trigger for this erroneous assertion was the lack of a claim number.

16. On November 26, 2002, after receiving an Employers' First Report of the October 18 industrial injury, the Fund sent Patient 1 a letter advising of the injured worker's obligation to file a first report of injury.

17. On December 2, 2002, the Fund received additional paperwork from Dr. Pardis documenting further treatments of Patient 1. By this time, Dr. Pardis had seen and treated Patient 1 for 24 office visits.

18. On December 4, 2002, the adjuster asked Dr. Blom to review the case. On December 6, 2002, Dr. Blom submitted his advice to the Fund, "approving" 12 chiropractic treatments. On December 9, 2002, the adjuster wrote to Dr. Pardis, authorizing 12 treatments over 60 days. By this time, Dr. Pardis had provided 26 treatments to Patient 1.

19. On January 3, 2003, Dr. Pardis' office wrote to the Fund's adjuster on Patient 1's industrial injury, requesting that the Fund approve all 26 treatments to date and base further review upon a supplemental report that Dr. Pardis would issue on January 7, 2003.

20. On January 6, 2003, the Fund referred Patient 1 to a managed care organization, with evaluation and treatment by Dr. Allen Weinert, M.D. The Fund had no statutory authority for such a referral [***cf.*** Finding No. 10].[(4)]

21. On January 7, 2003, the Fund wrote to Dr. Pardis authorizing "dates of services through December 10, 2002" and denying responsibility to pay for any subsequent services rendered through the end of December. The Fund thus accepted liability for the first 26 treatments. The letter stated that if Dr. Pardis disagreed with the decision, he could provide a "written demand" with "sufficient explanation and documentary evidence to allow us to thoroughly evaluate your request." The letter also stated that the Fund would respond to such a written demand "within 15 days" and that if Dr. Pardis still disagreed he could ask for "a non-binding mediation process." Mediation could take two months.[(5)] Since it was "non-binding," the dispute could remain unresolved after its completion. Mediation is not a prerequisite to a request for department review of a decision denying medical benefits.

22. In February 2003, Patient 1 requested mediation. The mediation conference was set for March 13, 2003. The Fund took the position, in correspondence with Dr. Pardis, that the January 7 letter was a denial of all chiropractic services for dates after December 10, 2003, rather than merely those for December 11 through December 31. However, the Fund agreed to pay all existing bills from Dr. Pardis, and the mediation was cancelled. After the contested case hearing in this matter, the Fund paid the remaining amount agreed upon during the mediation, $300.00, in October 2003. The Fund had ultimately authorized and paid for more than the number of treatments recommended by Dr. Blom.

Patient 2

23. On May 21, 2003, Patient 2 reported an industrial accident ("neck and shoulder cracked and are out now") to the employer, stating that the accident occurred on May 20, 2003. The Fund received the first report on May 27, 2003, as well as initial documentation from Dr. Pardis. The Fund received Dr. Pardis' billing on June 2, 2003, for six treatments of Patient 2, on May 21, 22, 23, 24, 27 and 28, 2003. The bill indicated the coded procedures for the six visits and itemized the charges, which totaled $535.00. Dr. Pardis requested authorization for 32 treatments.

24. On June 5, 2003, the adjuster asked Dr. Blom to review the case. On June 10, 2003, Dr. Blom approved 18 total visits over a period of 90 days (which would cover May 21, 2003, through August 19, 2003). The adjuster wrote to Dr. Pardis on June 11, 2003, approving 18 visits within 90 days. By June 11, Dr. Pardis had treated Patient 2 a total of 25 times, for charges of $1,095.00. Dr. Pardis asked for authorization for another 12 treatments.

25. Patient 2 continued to receive treatment from Dr. Pardis. By his June 19, 2003, report, Dr. Pardis had treated Patient 2 an additional 15 times (total treatments to date, 40), for additional charges of $995.00.

26. On July 7, 2003, the adjuster requested another peer review from Dr. Blom, who provided it on July 8. Dr. Blom approved another 8 treatments (total approved treatments, 26) within the 90 days ending in August. Accordingly, the adjuster sent an authorization letter to Dr. Pardis on July 14. By that date, Dr. Pardis had treated Patient 2 a total of 44 times for charges of $2,410.00.

27. On August 29, 2003, Dr. Pardis provided answers to specific questions from the adjuster about Patient 2. By that date, he had treated Patient 2 a total of 63 times for charges of $3,840.00. Dr. Pardis proposed to treat Patient 2 once a week for four additional weeks, then evaluate the need for further treatment. He still reported that Patient 2 had not reached maximum medical improvement, would not have a permanent physical impairment and did not have any lifting restrictions.

28. On September 22, 2003, the Fund arranged an independent medical evaluation of Patient 2 by Dr. Allen Weinert, M.D.[(6)] By the date of the IME referral, Dr. Pardis had treated Patient 2 a total of 65 times for charges of $4,000.00. Dr. Pardis agreed, after hearing, that there was at that point no dispute about payments due for medically necessary treatment of Patient 2's industrial

injury. The Fund had ultimately paid for more than the number of treatments recommended by Dr. Blom.

Patient 3

29. On November 18, 2002, Patient 3 first received treatment from Dr. Pardis for problems resulting from an industrial injury that occurred either on October 25 or November 11, 2002.[(7)] Dr. Pardis completed a chiropractic first report, with accompanying bills, on November 29, 2002. By that date he had treated Patient 3 a total of 7 times, for charges of $545.00.

30. On November 29, 2002, the adjuster requested peer review from Dr. Blom, who approved 14 of the 24 visits Dr. Pardis had requested, over 60 days, and recommended denial of payment of some of the services, based upon the treatment codes and time involved according to Dr. Pardis' bills. The adjuster followed Dr. Blom's recommendations, notifying Dr. Pardis of the authorization and limitations on December 4, 2002. By that date, Dr. Pardis had treated Patient 3 a total of 9 times, for charges of $665.00.

31. On December 4, 2002, the Fund notified Patient 3 that it accepted liability for the injury (identified by date of October 25, 2002).

32. On December 18, 2002, Dr. Pardis submitted a supplemental chiropractic report, indicating that missed treatments in early December had slowed recovery, and that the claimant needed treatment for more than 30 additional days to return to preinjury condition. The report indicated the last treatment date as December 12, although Dr. Pardis treated Patient 3 through December 18, for a total of 15 treatments, charging $1,085.00.

33. On December 31, 2002, Dr. Blom responded to another peer review request from the adjuster, authorizing 8 of 18 additional treatments requested by Pardis, for a total of 22 authorized treatments.

34. On January 4, 2003, the adjuster gave Dr. Pardis the limited authorization recommended by Dr. Blom. On January 15, 2003, Dr. Pardis submitted another supplemental chiropractic report, requesting authority to continue treating for another 4-6 weeks (3 times weekly) to return Patient 3 to preinjury status. Included were bills for 6 additional treatments, bringing the total treatments to 21, with total charges of $1,440.00.

35. On February 10, 2003, the adjuster wrote to Patient 3, stating that the Fund had authorized 22 visits and denied responsibility to pay for any additional treatments. The adjuster included the same explanatory paragraph written to Dr. Pardis about Patient 1's treatments [***cf.*** Finding No. 18], requesting a "written demand" if Patient 3 disagreed, with "sufficient explanation and documentary evidence" supporting it, to which the Fund promised to respond within 15 days. That paragraph also stated that if Patient 3 was not satisfied with the Fund's response, the claimant could request a "non-binding mediation process." By February 12, 2003 (when Patient 3 had probably received the letter), Dr. Pardis had treated Patient 3 12 more times, bringing the total treatments to 33, with charges of $2,380.00. Dr. Pardis treated Patient 3 twice more in February 2003, making the final total 35 treatments, with charges of $2,495.00.

36. On February 26, 2003, Patient 3 filed a mediation request. The Fund then agreed to pay Dr. Pardis' outstanding bills (which would otherwise be Patient 3's responsibility), and the mediation was dismissed. After the dismissal, the Fund paid all but $180.00 of Dr. Pardis' charges, which it still owes. The Fund ultimately authorized and paid for more treatments than Dr. Blom had recommended.

Patient 4

37. On January 17, 2003, Dr. Pardis began treating Patient 4, for a work injury on December 23, 2002.[(8)] Dr. Pardis submitted his initial billing on or about February 11, 2003, for treatments on Jan. 17, 18, 20, 21, 22, 23, 24, 25, 27, 28 and 29, Feb. 3, 5, 7 and 10, 2003. On February 19, 2003, the adjuster approved 20 visits, based on Dr. Blom's review. Patient 4 had already seen Dr. Pardis 20 times by February 19. The adjuster denied authorization and Fund liability for treatments after February 28, 2003, based apparently on Dr. Blom's review. Through February 28, 2003, Dr. Pardis had already treated Patient 4 a total of 24 times.

38. Dr. Pardis challenged the denial of additional treatment on April 9. He had submitted an updated treatment plan on April 1, 2003, and followed up with another undated treatment plan on April 18, 2003. Receiving no responses, he repeated his challenge to the denial for additional treatment on May 9, 2003. The Fund responded on May 28, 2003, stating that changes to the treatment plan must be noted and a copy of any amended treatment plan promptly furnished to the insurer. The Fund's response necessarily concluded that changes in the treatment plan were subject to prior approval. The Fund's response also noted that Dr. Pardis had by now submitted billings for 50 treatments, with an authorization for 20 treatments. The Fund authorized an additional 18 treatments for payment and refused to authorize additional treatments for payment without a "current" treatment plan and request for authorization.

39. On June 3, 2003, Dr. Pardis replied, providing copies of the previous treatment plan update of April 1 and April 18, and challenging the limited authorizations and the power of the Fund to require preauthorizations.

40. The Fund accepted liability for the treatments three days before the first telephone scheduling conference in this contested case (June 2003). The Fund did not complete payment of the bills until October 2003, after the actual contested case hearing. The Fund ultimately paid for more treatments than Dr. Blom had recommended.

Patient 5

41. On May 19, 2003, Dr. Pardis began treating Patient 5, for a work injury on May 16, 2003. Dr. Pardis submitted his initial billing on or about May 22, 2003, for treatments on May 19, 20 and 21, 2003. The initial treatment plan was for 18 visits over five weeks.

42. On May 27, 2003, the adjuster approved 16 visits over 60 days, based on Dr. Blom's review. By that date, Patient 5 had already seen Dr. Pardis 7 times. By a letter dated May 23, 2003[(9)], Dr. Pardis challenged the authorization for 2 fewer treatments over a longer period of time. The Fund did not respond. Dr. Pardis continued to treat Patient 5 for 19 total visits by June

20, 2003, when he submitted a supplementary report proposing treatment for 12 visits over the next 4 weeks. The Fund did not respond.

43. Dr. Pardis treated Patient 5 for 15 more visits from June 20 through July 22, 2003, when he submitted another supplemental report proposing 8 more visits over 4 weeks. The Fund began denying payment requests (for visits on or after June 9, 2003) on July 15, 2003, apparently based on the original 16 visit authorization. On July 18, 2003, Dr. Pardis met with the Fund regarding nonpayment of bills for treatment of Patient 5 as well as Patients 3, 4 and 6. Nothing was resolved.

44. Dr. Pardis treated Patient 5 for 6 more visits from July 22 through August 12, 2003, when he submitted another supplemental report proposing 4 more visits over the next 4 weeks. Dr. Pardis' office notes reflect visits and treatments on August 14, 18 and 21, 2003. There are no billing forms for those visits. There are later billing forms for visits to another chiropractor by Patient 5 on August 29 and September 3, 2003. On September 10, 2003, the Fund sent a letter to Patient 5, notifying him that "current" chiropractic treatments were for maintenance and were not the responsibility of the Fund.

45. The Fund took no action to investigate or evaluate the need of Patient 5 for further treatment after the initial 16 authorized treatments. It effectively relied upon the initial recommendation of Dr. Blom, and sought no further information to verify or dispute the treating physician's later reports that further treatment was medically necessary. The Fund produced no evidence to contradict the testimony of Dr. Pardis that his additional treatment of Patient 5 was medically necessary and reasonable for conditions resulting from the industrial injury. The Fund owes Dr. Pardis $2,285.00 for that additional treatment.

Patient 6

46. On March 3, 2003, Dr. Pardis began treating Patient 6, for a work injury on January 29, 2003. Dr. Pardis submitted an initial treatment plan by fax on March 4, 2003, at the written request of the Fund. The plan was in the office notes for the initial visit, and no chiropractor's first report or subsequent report appears of record.

47. The initial plan was for 11 daily treatments followed by 12 more treatments over 4 weeks. The Fund authorized 18 visits rather than 23, over 90 days, based upon Dr. Blom's recommendation.[(10)] Patient 6 received treatment on 52 visits to Dr. Pardis, through May 14, 2003.

48. Dr. Pardis never submitted a supplemental treatment plan that detailed the reasons for the prolonged treatment of Patient 6. Instead, he recited his evolving treatment plan (with additional treatments proposed) in the office notes he submitted to the Fund, in accord with his usual practice.

49. According to Stan Wells' letter addressed to Thomas Martello (dated July 18, 2003, found in Patient Exhibit 5), the Fund referred Patient 6 to managed care, and denied bills for treatment

on dates after April 7, 2003. Patient Exhibit 6 does not indicate that Patient 6 ever met the criteria for such referral.

50. Although Dr. Pardis did not provide supplemental treatment plans labeled as such, he did provide detailed information regarding the ongoing treatment. The Fund took no action to investigate or evaluate the need of Patient 6 for further treatment after the initial 18 authorized treatments. It effectively relied upon the initial recommendation of Dr. Blom, and sought no further information to verify or dispute the treating physician's later office notes that further treatment was medically necessary. The Fund produced no evidence to contradict the testimony of Dr. Pardis that additional treatment of Patient 6 was medically necessary and reasonable for conditions resulting from the industrial injury. The Fund owes Dr. Pardis $1,075.00 for medically necessary treatment of Patient 6.[(11)]

IV. Opinion

Montana law requires that a worker's compensation insurer "shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires." Mont. Code Ann. (2001) § 39-71-704(1)(a). "Primary medical services" are defined by statute as "treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability." Mont. Code Ann. (1999) § 39-71-116(26). At the times pertinent to the disputes regarding each of these six claimants, they had each selected Dr. Pardis as their treating physician.[(12)]

This conflict arises because chiropractic treatments generally move faster than virtually all other primary medical services. Physical therapy can involve multiple treatments per week for a month or more, but is not typically provided by treating physicians. ***See***, Admin. Code Mont. 24.29.1513(4). The Fund struggles to maintain cost control over chiropractic services more than other primary medical services because of the rapid pace of delivery chiropractic services. For any compensation insurer, if one doctor regularly costs more money over more time for the same result, the more expensive doctor is less cost effective.

Added fuel for this controversy comes from the Fund's perception, encouraged by its chiropractic consultant, that Dr. Pardis treats injured workers more often for longer periods of time than the average chiropractor. This perception may be accurate. However, each claimant is unique in some respects and averages will always be potentially misleading. Nonetheless, some health care practitioners will deliver more extensive standard treatments than others with the same credentials. What one chiropractor (or one surgeon, for that matter) considers necessary to achieve medical stability for a condition resulting from an industrial injury will be more than what another practitioner considers necessary for the same condition. Sometimes claimants' conditions differ. Sometimes the experience and philosophy of the practitioners differ.

Cost containment alone cannot justify insurer action to limit medically necessary treatment.[(13)] Thus, the primary issues presented in this case are whether the Fund can limit the number of authorized treatments by the treating physician (Dr. Pardis) based upon (1) a chiropractic consultant's recommendations after file review and (2) the Fund's practice of

authorizing treatments for only 30 days or a longer specific time within the scope of Dr. Pardis' most recent evaluation and treatment plan.

There are two additional issues. Dr. Pardis sought payment by the Fund for additional treatments of the six claimants involved in this proceeding, which he testified were medically necessary. He also challenged the Fund's referrals of claimants to managed care and to other treating physicians.

Each of these four issues will be addressed separately.

1. Refusal to Authorize Additional Treatment Based on Dr. Blom's Reviews

Dr. Pardis is not entitled to a declaratory ruling that the Fund must authorize his treatment plans in their entirety even when it has contrary medical information from Dr. Blom. However, he is entitled to a declaratory ruling that after the Fund relies upon Dr. Blom's advice in an authorization for treatment, the Fund cannot thereafter give rubber stamp refusals to further treatment requests without investigating and addressing additional medical information Dr. Pardis provides after the "peer review."

When an injured worker selects Dr. Pardis, the Fund applies the same methods it applies to other workers with other chiropractors. Specifically, the Fund relies upon peer review by Dr. Blom to limit authorized treatments. There is no factual question regarding this practice. Clearly, the Fund obtained advice from Dr. Blom regarding the usual number of treatments expected for the diagnoses Dr. Pardis provided for each claimant. The Fund relied upon Dr. Blom's peer reviews for guidance about how many treatments to accept, as the workers' compensation insurer liable for treatment of injured workers treated by Dr. Pardis.

The clearest statement of this declaratory relief issue is whether, when Dr. Pardis is properly the treating physician, the Fund can authorize fewer treatments than Dr. Pardis recommends based upon Dr. Blom's advice. This is a question about the Fund's practices in adjusting claims. The declaratory relief Dr. Pardis seeks is proper only if the Fund unreasonably relies upon Dr. Blom, who has not seen the claimants. Thus, the crux of the question is whether the consulting chiropractor's disagreement with the treating chiropractor is a sufficient basis for limiting authorized treatment.

What the Fund may do in making adjusting decisions to limit treatment authorization does not ultimately depend upon it being right, but rather depends upon it being reasonable. Under the existing case law, a worker's compensation insurer who has conflicting medical reports may reasonably refuse further liability, even though the courts may ultimately disagree and impose liability. *Satterlee v. Lumberman's Mut. Cas. Co.* (1996), 280 Mont. 85, 929 P.2d 212, 217 (termination of benefits reasonable based upon letter from physician who saw the claimant once, even though benefits were reinstated by the Supreme Court); ***compare***, *Plooster v. State Fund* (1993), 256 Mont. 287, 846 P.2d 976, 977-78 and 981 (insurer denying liability for prescriptions written by treating physician, with no contradictory medical information, acted unreasonably).

The treating physician's opinion is normally due deference from the deciding tribunal. "[T]estimony of a treating physician is entitled to greater evidentiary weight than that of other doctors. *Snyder v. San Fran. Feed & Grain* (1987), 230 Mont. 16, 27, 748 P.2d 924, 931; ***and*** *Pepion v. Blackfeet Tribal Ind.* (1993), 257 Mont. 485, 489, 850 P.2d 299, 302." *Nielson v. State Fund*, ¶39, 2003 MT 95, 315 Mont. 194, 69 P.3d 1136.[(14)] However, this evidentiary deference does not mandate automatic acceptance of Dr. Pardis' treatment plans. In making its adjustment decisions, the Fund reasonably authorized less than the entire treatment plan of Dr. Pardis, when it had contemporaneous conflicting medical information regarding the appropriate amount of treatment.

The professional disagreements between Dr. Pardis and Dr. Blom regarding the number of treatments appropriate for each claimant involve their differing views about the treatment necessary to achieve medical stability.[(15)] If Dr. Blom's views provide a sufficient basis for an insurer reasonably to refuse to authorize additional treatments, then the Fund is within its rights to do so.

As a general rule, a compensation insurer's denial of benefits without investigation is unreasonable. *S.L.H. v. State Fund*, ¶ 50, 2000 MT 362, 303 Mont. 364, 15 P.3d 948:

> We have repeatedly held that insurers have an affirmative duty to investigate workers' compensation claims and that absent such an investigation, the denial of a claim for benefits is unreasonable. *Marcott v. Louisiana Pacific Corp.* (1996), 275 Mont. 197, 210, 911 P.2d 1129, 1137; *Stevens v. State Comp. Mut. Ins. Fund* (1994), 268 Mont. 460, 467, 886 P.2d 962, 966 (***overruled on other grounds by*** *Kloepfer v. Lumbermens Mut. Cas. Co.* (1995), 272 Mont. 78, 899 P.2d 1081); *Lovell v. State Comp. Mut. Ins. Fund* (1993), 260 Mont. 279, 288, 860 P.2d 95, 101.

These are penalty cases, but penalty cases are the most specifically on point. The issue is precisely whether the Fund is acting contrary to the law in denying authorization for additional treatments, based upon Dr. Blom's recommendations. This is an issue of reasonableness. The issue of ultimate liability is discussed in Section 3 of this opinion.

The evidence reflects that the Fund sometimes simply relied upon the advice from Dr. Blom, and refused to authorize any additional treatment (Patient 5 and Patient 6). In these instances, the Fund's silence in the face of the continuing stream of new information from Dr. Pardis is tantamount to a failure to investigate. There is no credible evidence that the Fund considered the new information, or even reconsulted Dr. Blom. The Fund effectively cut off treatment, and waited to see if Patient 5 and Patient 6 (or Dr. Pardis) started a proceeding to challenge that decision. For the other claimants, the adjusters exercised their discretion, based upon the entire claims files, to consider authorizing additional treatments. Thus, the Fund did not have a consistent pattern and practice of total reliance upon Dr. Blom.

There is no specific statute or regulation that authorizes the Fund to ignore new medical information from the treating chiropractor and rely entirely upon Dr. Blom's prior advice. Thus, for at least two of the claimants, the Fund acted illegally in cutting off treatment in complete

reliance upon the advice of Dr. Blom, without further inquiry to address the further information that Dr. Pardis provided as he continued to treat Patient 5 and Patient 6.

Mont. Code Ann. (2001) § 39-71-704(1)(a) (the applicable medical benefits statute), read in light of the penalty case law (cited above), permits the Fund to limit or deny authorization for treatment when it has conflicting medical reports about the reasonableness of the primary medical care that Dr. Pardis proposes to provide. Whether or not that limitation, applied flexibly in light of all the information in the file, is upheld on any subsequent administrative or judicial review is a separate issue entirely. Thus, for four of the six particular patients, the Fund acted reasonably in its authorizations.

While it is at most a secondary aspect of the current case, the form authorization the Fund utilizes can continue to cite "peer review" as the basis for the authorization. The Fund can continue to warn chiropractors that "payment is not guaranteed" unless information is submitted prior to the date of service and treatment is provided within the specified treatment duration period. The Fund is not entitled to deny treatment purely on the basis of failure to meet these requirements, but the form does not assert any such absolute right. The Fund can also continue to suggest that an aggrieved practitioner may request an alternative peer review of the number of approved treatments. There is no requirement that an aggrieved practitioner do so, but the Fund can offer such an informal alternative.

2. Limiting Authorizations to Specific Numbers of Treatments and/or Days

Dr. Pardis is entitled to a declaratory ruling that the Fund cannot fail and refuse to investigate and address new medical information denying further liability for medical treatment in reliance upon prior advice from Dr. Blom.

Dr. Pardis also asserts that the Fund illegally requires preapproval of his treatment plans. Admin. R. Mont. 24.29.1573 generally governs prior authorization of chiropractic treatment. It provides, in its most pertinent part:

> Evaluations and reevaluations may not be billed more than once every 30 days without prior authorization. For the first visit and for each 30-day evaluation, the chiropractor may charge for an office call in addition to treatment codes. For all other visits, the provider may charge only treatment codes without prior authorization.
>
> Admin. R. Mont. 24.29.1573(1).

Dr. Pardis contends that only the specific chiropractic treatment codes identified in 1573 (subparts 2 and following) require any preauthorization, and that the Fund cannot authorize only parts of his treatment plans.

Dr. Pardis, the treating physician, must initially provide a treatment plan for a new claimant, update it whenever it changes, and provide office notes, the bill and a statement of improvement (related to the treatment plan) every 30 days. Admin. R. Mont. 24.29.1513.[(16)] Implicit in the

statutes and these rules is the right of the insurer, when it has conflicting medical information or any other legitimate question about liability, to deny or to limit authorization under a proposed original or updated treatment plan until the question is resolved. The insurer does not have to be correct in its denial or limitation-only reasonable.

Dr. Pardis has not established that the Fund's limited authorizations are in violation of the law. The Fund's method of adjusting the claims by relying upon its claim information (including Dr. Blom's consulting advice) is reasonable. Dr. Pardis is not entitled to a declaratory ruling that the Fund can never authorize less than the entire treatment plan, even if the Fund has a contemporaneous "peer review" recommendation suggesting fewer treatments. The Fund behaves unreasonably only when it stops adjusting and sits silent and unresponsive, relying upon prior advice from Dr. Blom despite new medical information from Dr. Pardis. It did that in two of the six cases.

3. Additional Liability for Treatments of the Individual Claimants in this Case

Dr. Pardis' testimony about additional medically necessary treatments he delivered for which the Fund has not paid proves his entitlement to the additional payments.[(17)] Dr. Pardis asserts that the Fund owed additional money for unpaid treatments it authorized, accepted after the fact or continued to reject.[(18)] As noted, *Nielson*, ***supra*, *and cases cited therein*** (see p. 15, above), the treating physician's testimony is entitled to deference in this proceeding. Dr. Pardis did not enhance his credibility by citing and relying upon a chiropractic procedure manual that emphasized geriatric considerations (Exhibit 7). Nonetheless, he was both the treating physician and the only physician to testify who had actually evaluated the claimants rather than merely their files. His testimony that his treatments of the claimants were reasonably necessary primary medical care is entitled to deference.

4. Other Claims by Dr. Pardis Regarding Referrals

Dr. Pardis is entitled to a declaratory ruling that the Fund cannot refer to managed care or a replacement treating physician unless the injured worker's condition conforms to the statutory prerequisites for the referral.

This case originated with a request for hearing by Dr. Pardis, involving unpaid bills for treatment of one of the six claimants now involved in this case. As the case has evolved, Dr. Pardis has also asserted other claims against the Fund, beyond those addressed in sections 1-3 of this opinion. Those claims were that the Fund improperly referred claimants to managed care or to other treating physicians.

This record establishes a dysfunctional pattern of interaction between Dr. Pardis and the Fund. Dr. Pardis, through his office staff, regularly generates the documentation he believes the regulations require. The Fund regularly seeks Dr. Blom's input while regularly responding slowly enough that Dr. Pardis has often already delivered more treatments than the Fund subsequently authorizes. There is considerable evidence, much of it in the demeanor of witnesses, to suggest that the Fund and Dr. Pardis are in an adversary relationship that extends far beyond the six claimants involved in this case. This adversarial relationship appears to affect

medical care for the injured workers. The Fund's delays in payment (and in other responses to Dr. Pardis) are disturbing, to say the least.

Dr. Pardis proved, for at least two of the six individual claimants involved in this case, that the Fund improperly referred to managed care. His evidence certainly suggests that the Fund engaged in a wrongful pattern or practice, evading review, of using referral to managed care or to another treating physician to remove claimants from Dr. Pardis' care. There is sufficient proof of a pervasive practice contrary to the statute, mandating an order to the Fund to follow the law.

V. Conclusions of Law

1. The department has jurisdiction to decide the Fund's liability to pay for treatment of the claimants and Pardis' petition for declaratory ruling. ***See***, Mont. Code Ann. (1991) §§ 39-71-2401(2) ***and*** (2001)39-71-704(6); ***see also*** Admin. R. Mont. 24.29.1404 ***and*** 24.1.101(2)(e)(i); ***see also (for declaratory rulings)*** Admin. R. Mont. 24.2.101(1) ***and*** 1.3.226 ***through*** 1.3.229.

2. The Fund is liable to Dr. Pardis for $180.00 for reasonably necessary primary medical treatment that he provided as the treating physician to Patient 3. Mont. Code Ann. (2001) § 39-71-704(1)(a).

3. The Fund is liable to Dr. Pardis for $2,285.00 for reasonably necessary primary medical treatment that he provided as the treating physician to Patient 5. Mont. Code Ann. (2001) § 39-71-704(1)(a).

4. The Fund is liable to Dr. Pardis for $1,075.00 for reasonably necessary primary medical treatment that he provided as the treating physician to Patient 6. Mont. Code Ann. (2001) § 39-71-704(1)(a).

5. The Fund acted beyond its legal authority as the responsible workers' compensation insurer on the claims of Patients 5 and 6 when it continued to deny liability for further primary medical treatment based upon previous medical advice from its medical consultant, without responding specifically to new medical information and treatment plan proposals from Dr. Pardis. Mont. Code Ann. (2001) § 39-71-704(1)(a).

6. The Fund acted beyond its authority as the workers' compensation insurer on the claims of Patients 1 and 6 when it referred to managed care or another treating physician without the claimants meeting the criteria for the referrals. Mont. Code Ann. (1999) § 39-71-1101(3)(a) through (d).

VI. Order

1. The Montana State Fund is liable to Dr. Michael H. Pardis, D.C., for chiropractic treatment provided to Patients 3, 5 and 6 in the total amount of $3,540.00.

2. The Montana State Fund cannot refer a claimant whose treating physician is Dr. Pardis unless the claimant's condition satisfies the requirements of Mont. Code Ann. (1999) § 39-71-1101(3)(a) through (d).

3. The Montana State Fund cannot deny authorization to Dr. Pardis to treat a claimant for whom he is the treating physician either:

a. Relying solely on any peer review by the Fund's chiropractic consultant done before Dr. Pardis' applicable treatment proposals; or

b. Without inquiry and investigation to determine whether Dr. Pardis' applicable treatment proposals are for primary medical care necessary as a result of the industrial injury.

DATED: May 6, 2004.

Terry Spear, Hearing Examiner
Montana Department of Labor and Industry

NOTICE OF APPEAL RIGHTS

This Order is signed by the Hearing Officer of the Department of Labor and Industry under authority delegated by the Commissioner. Any party in interest may appeal this Order to the Workers' Compensation Court pursuant to Mont. Code Ann. § 39-71-2401(3), within thirty (30) days after the date of mailing of this Order pursuant to Admin. R. Mont. 24.29.215(3). The Court's address is:

Workers Compensation Court
P.O. Box 537
Helena, MT 59624-0537
(406) 444-7794

CERTIFICATE OF MAILING

The undersigned hereby certifies that true and correct copies of the foregoing documents were, this day served upon the following parties or such parties' attorneys of record by depositing the same in the U.S. Mail, postage prepaid, and addressed as follows:

Pardis Chiropractic & Professional Center
Michael Pardis
950 North Montana Ave
Helena, MT 59601

The undersigned hereby certifies that true and correct copies of the foregoing documents were, this day, served upon the following parties or such parties' attorneys of record by means of the State of Montana's Interdepartmental mail service.

Montana State Fund
Thomas Martello, Legal Dept
PO Box 4759
Helena, MT 59604-4759 Signed this 6th day of May , 2004.

Administrative Assistant
Department of Labor and Industry

1. [1] Treating chiropractors' evaluations at the insurer's expense cannot be more frequent than every 30 days without prior authorization. Admin. R. Mont. 24.29.1573(1).

2. [2] The pertinent pages of sealed Exhibit 1 either bear a Fund's date stamp of 11/20/02, (the first report and office notes) or the date 11/14/02 (first nine pages of the HCFA-1500's.

3. [3] Sealed Exhibit 1 seems to show that Dr. Pardis had treated Patient 1 before the 10/18/02 industrial accident, but that fact does not appear relevant to this case.

4. [4] Although the claimant, who had not reached maximum healing, had some physical limitations which might ultimately have resulted in permanent impairments, the statute refers to claimants who "will" have permanent impairments as proper for managed care referrals, not those who might. Mont. Code Ann. (1999) § 39-71-1101(3)(b).

5. [5] A mediation request triggers a conference within 45 days and a decision within 2 weeks (10 business days) thereafter. ***Cf.*** Admin. R. Mont. 24.28.101 ***et seq*** . If the Fund first received the "written demand" it requested, and responded within 15 days, the potential time during which Patient 1 would have no authorized treatment could be closer to 3 months.

6. [6] Unlike its limited authority regarding referrals, an insurer may request an independent medical examination of any claimant who has a current entitlement to compensation benefits. Mont. Code Ann. (1999) § 39-71-1101(3)(b).

7. [7] The evidence does not clearly explain why there are two injury dates, but that is not relevant to the issues in this proceeding, nor is compensability of the injury within the Department's jurisdiction.

8. [8] Dr. James Burkholder, Boulder, Montana, previously treated Patient 4.

9. [9] The record does not explain how Dr. Pardis knew of the authorization before the date on which the Fund sent it to him.

10. [10] Dr. Blom's advice to the Fund is not in the file, but the authorization is on the standard form, citing "peer review" as its basis.

11. [11] The Fund contends the bill is $995.00, the amount in Wells' July 18, 2003, letter to Martello. However, the letter goes on to note an additional bill for treatment which the Fund had denied as duplicative, but which actually had been submitted with a date error. A copy of that bill was enclosed with the original letter, bringing the total unpaid bills for medically necessary treatment to $1,075.00.

12. [12] " 'Treating physician' means a person who is primarily responsible for the treatment of a worker's compensable injury and is: . . . (b) a chiropractor licensed by the state of Montana under Title 37, chapter 12 . . . ." Mont. Code Ann. (1999) § 39-71-116(36).

13. [13] ***Cf.*** , *Heisler v. Hines Motor Co.* (1997), 282 Mont. 270, 937 P.2d 45. The point of *Heisler*, for this case, is that cost containment alone cannot justify insurer denial of benefits, without statutory or regulatory authority for the denial. In *Heisler* the statutory authority for insurer action was invalid. Here, Pardis asserts there is no statutory authority.

14. [14] This evidentiary deference supports Dr. Pardis' claims for additional payments on the six individual claimants involved in this case, as discussed in section 3 of the opinion.

15. [15] They may also disagree whether claimants reached medical stability or needed more treatment to continue current employment. Mont. Code Ann. (2001) § 39-71-704(1)(f)(iii). This case did not present this question. ***Cf.***, ***e.g.*** , *Synek v. State Fund* (1995), 272 Mont. 246, 900 P.2d 884, for an example of a full record on this particular issue.

16. [16] (1) When a treating physician . . . sees the claimant for the first time (related to the claim), the provider must furnish to the insurer the initial report and treatment bill within 7 business days of the visit. . . . .

(2) As soon as possible, upon completion of the initial diagnostic process, the provider must prepare a treatment plan and promptly furnish a copy to the insurer. Changes in the overall treatment plan must be noted and a copy of the amended treatment plan must be promptly furnished to the insurer.

(3) To be eligible for payment for subsequent visits, the provider must furnish to the insurer:

(a) documentation;

(b) improvement status with respect to the treatment plan; and

(c) office notes with the bill every 30 days.

17. [17] In post-hearing filings, Dr. Pardis admitted that for some of the claimants no additional payments were now due.

18. [18] In the course of this hearing, the Fund implied that Dr. Pardis fraudulently billed for treatments not delivered. The Fund failed to prove any claim of fraudulent billing.