DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on March 16, 2010, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the Claimant is not entitled to office visits for the left ankle/foot; CPT Code 99213 (x10) for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by PO, Ombudsman.
Carrier appeared and was represented by JC, Attorney.

BACKGROUND INFORMATION

On _____ Claimant twisted her left ankle while at work. She initially treated with Dr. B who performed a surgical lateral ankle reconstruction. Post operatively she was placed in a cast, received physical therapy, and returned to work in December 1999. She followed up with Dr. S who gave Claimant injections in her foot and ankle. On June 2, 2009 Dr. L diagnosed left plantar fasciitis, left ankle sprain/strain with associated sinus tarsi syndrome, left neuroma deformity 2nd and 3rd interspace, and tendonitis of the left posterior tibial tendon. Due to broken down inserts Dr. L ordered new orthotic devices. Dr. L treated Claimant on June 2, 2009, June 9, 2009 and June 16, 2009 with repeat splinting and injections. On June 16, 2009 Dr. L noted there was good prognosis following a plantar fascia injection. Dr. L requested 10 additional office visits that were denied and is the subject of this dispute.

Claimant, through Dr. L, appealed the denial of the 10 additional office visits and the dispute was forwarded to an Independent Review Organization (IRO) for decision. The IRO decision dated October 5, 2009 upheld the Carrier's denial of the requested 10 additional office visits. The IRO physician reviewer concluded that as the ODG notes, office visits need to be individualized and Claimant's records did not state why 10 additional visits are medically necessary for the treatment of her plantar fasciitis.

Texas Labor Code Section 408.021 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. Health care reasonably required is further defined in Texas Labor Code Section 401.011(22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with: evidence based medicine; or, if that evidence is not available, then generally accepted standards of medical practice

recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined, by Section 401.011(18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

The ODG states about office visits in treatment of the ankle and foot:

"Office visits

Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. *Note:* The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004)

Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy."

In evidence was a letter from Dr. L explaining that Claimant has not been fully treated for her various diagnoses and identified therapeutic goals. Even though continued treatment including office visits may be needed, Dr. L was not specific as to time allowances and activities for the proposed ten office visits. Nor did Dr. L state what modalities would take place in his office or referred out. Except for a different interpretation of the ODG guidelines for office visits, no evidence-based medical evidence was presented by Claimant. The Claimant failed to meet her burden of overcoming the decision of the IRO by a preponderance of the evidence-based medical evidence. Claimant is not entitled to the office visits for the left ankle/foot; CPT Code 99213 (x10) for the compensable injury of _____.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer).

   C. The IRO decision concluded that the office visits for the left ankle/foot; CPT Code 99213 (x10) is not medically reasonable and necessary for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. No specific schedule of treatment was proposed for the requested 10 office visits, as recommended in the ODG.

4. The evidence failed to establish that health care reasonably required for the compensable injury of _____ includes ten additional office visits as requested in the preauthorization request of June 16, 2009.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that office visits for the left ankle/foot; CPT Code 99213 (x10) is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to preauthorization of ten office visits for the left ankle/foot; CPT Code 99213 (x10) for the compensable injury of _____.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **CONTINENTAL CASUALTY COMPANY**, and the name and address of its registered agent for service of process is:

C T CORPORATION SYSTEM
350 NORTH ST. PAUL ST.
DALLAS, TEXAS 75201

Signed this 17th day of March, 2010.

Judy L. Ney
Hearing Officer