SOAH DOCKET NO. 453-03-2745.M5
TWCC MR NO. M5-02-2245-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner** **V.** **FIRST RIO VALLEY MEDICAL, P.A.,** **Respondent**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) requested a hearing to contest the February 20, 2003, Findings and Decision of the Medical Review Division of the Texas Workers' Compensation Commission (Commission) authorizing reimbursement of $382.00 to First Rio Valley Medical P.A. (Provider) for aquatic therapy[1] and therapeutic exercises[2] provided on October 11 and 12, 2001 (Disputed Services). Carrier has the burden of showing by a preponderance of the evidence that the Disputed Services were not medically necessary.[3] This decision grants the relief sought by Carrier and denies reimbursement to Provider for the Disputed Services.

The hearing convened on February 2, 2005, before Administrative Law Judge (ALJ) Catherine C. Egan. Chris Trickey and Tom Hudson represented Carrier. Keith Gilbert represented Provider. William DeFoyd, D.C.; Nicholas Tsourmas, M.D.; and Alfred Ball testified for Carrier. Robert S. Howell, D.C., Provider's owner, testified for Provider. There were no contested issues of notice or jurisdiction.

[1] CPT Code 97113.

[2] CPT Code 97110.

[3] A copy of the claims log showing the dates and services in dispute is attached as Appendix AA.@

The hearing adjourned and, at the request of the parties, the record remained open for the filing of briefs regarding the admission of a deposition and other items with the ALJ. On February 16, 2005, Carrier filed a brief in support of the admission of the deposition of Sam Allen, D.C. Provider filed no response. On February 21, 2005, the deposition was admitted and the record closed.

I. BACKGROUND

On ___, ___ (Claimant), a __-year-old male, sustained a work-related injury. Claimant was working on a crane motor when he slipped, twisting his lower back, left knee and hitting his right knee against a wall. On June 21, 2001, he went to Provider for treatment because he was experiencing lower back pain that was radiating down his left leg in his knee.

Provider treated Claimant with electrical stimulation, ultrasound therapy, massage therapy, and whirlpool therapy through July 16, 2001. At that time, Provider added one-on-one aquatic therapy to Claimant's treatment protocol.[4] On August 24, 2001, Claimant underwent left knee arthroscopic surgery. He returned to Provider for rehabilitation on September 12, 2001. One-on-one therapeutic exercises and aquatic therapy were begun on September 14, 2001, and continued until the dates of the Disputed Services. On October 11 and 12, 2001, Provider treated Claimant with four units (an hour) of one-on-one aquatic therapy and two units (a half hour) of one-on-one therapeutic exercises. Carrier paid Provider for one unit of each. The remaining units are in dispute.

[4] Carrier=s Ex. 15, Tab 6 at 1-6.

II. LEGAL ISSUE

Pursuant to 28 TEX. ADMIN. CODE (TAC) 133.304(c), when a carrier denies payment, the carrier must send an Explanation of Benefits (EOB) to the appropriate party with the proper exception code and a "sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section."

Carrier denied payment to Provider under payment exception code "N" for "Not appropriately documented" with the rationale code "TH" which is described on the EOB as "Based on the TWCC treatment guideline's ground rule 2.A. I-VII, change in the patient's clinical condition and/or progression has not been documented to support 1:1 therapy. Patient's condition supports therapy in a group setting."[5]

The record offered in this matter is scant, consisting of only 20 pages. It is not clear whether Provider requested reconsideration, and if so, whether Carrier responded. However, it is clear from the explanation provided on the EOB why Carrier denied this claim, that the services needed to be provided in a group setting. Therefore, the ALJ finds that Carrier provided a sufficient explanation to allow Provider to understand why Carrier denied these claims in compliance with 28 TAC 133.304(c).

[5]Carrier=s Ex. 11, Tab 2 at 8-9.

III. WERE THE DISPUTE MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO opinion and the Medical Record

On February 7, 2003, the independent review organization (IRO) found that the Disputed Services were medically necessary. The IRO wrote:

> Sufficient documentation in the records reveal subjective symptoms and objection positive findings in this case. Given the patient's history of treatment and surgery, the therapeutic exercises and aquatic therapy were, in fact, usual, customary and medically necessary.[6]

On October 11, 2001, Provider's notes stated several reasons for prescribing one-on-one therapy rather than group. Provider's reasons for providing one-on-one therapeutic exercises included; (1) Claimant has not had formalized training academically or non-academically; (2) Claimant might have questions that only an informed health care provider could answer; (3) Claimant might experience cardiac arrest; and (4) Claimant's condition exposed him to possibly reinjuring himself.[7] The reasons for providing one-on-one aquatic therapy included that Claimant could not swim and needed supervision to ensure that he did the exercises properly and safely while obtaining the maximum benefit from the therapy.[8]

. Carrier's Position and Evidence

Dr. Tsourmas is an orthopedic surgeon and works for Carrier as the medical director. Dr. Tsourmas reviewed Provider's medical records to assess the medical necessity of the services in dispute. According to Dr. Tsourmas, he has referred patients to aquatic therapy when they suffered with lower extremity issues, such as a broken bone. He opined that during the time that a patient has to be careful with weight bearing exercises, short-term aquatic therapy is useful. However, he stated that the patient should progress to a land-based program as soon as it can be tolerated because it is "more efficacious regarding producing results with range of motion and strength."[9] According to Dr. Tsourmas, transitioning a patient from aquatic to land-based therapy may overlap, but not more

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[6] The IRO decision is part of the ALJ=s file of which she takes official notice.

[7] Carrier Ex. 11 at 13.

[8] Carrier Ex. 11 at 13.

[9] Ex.16, Tab 3, Prefiled testimony of Dr. Tsourmas at 19-20.

than a few weeks-"Certainly not months or - or longer."[10]

As for this Claimant, Dr. Tsourmas testified that Claimant did not need any aquatic therapy two months following his knee surgery. Instead, Claimant should have been working with land-based weights.[11] According to Dr. Tsourmas, Claimant had sufficient prior experience and training to know how to do these exercises so he no longer needed one-on-one supervision.[12]

Dr. DeFoyd, Carrier's expert witness, practices at the Spine and Rehab Center and treats spinal injuries.[13] Dr. DeFoyd reviewed the Claimant's medical records and Carrier's billing history. Dr. DeFoyd maintains that land-based therapy is preferable to aquatic therapy for several reasons. First, humans function on land, not in water. Second, it is easier to encourage a patient to do a home program if the exercises do not necessitate a pool. Finally, land-based exercise programs are generally less costly than aquatic programs. Aquatic therapy is used in cases where the patient cannot tolerate a land-based program because of weight bearing intolerance.[14]

Dr. DeFoyd agreed with Dr. Tsourmas that Claimant did not require aquatic therapy at this stage of his recovery.[15] Dr. DeFoyd further agreed that it was not medically necessary to do one-on-one therapy because Claimant already had received an adequate amount of one-on-one therapy to have learned the exercises so he could do them independently.[16]

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[10] Ex. 16, Tab 3, Prefiled testimony of Dr. Tsourmas at 28.

[11] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 131-132.

[12] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 132.

[13] Dr. DeFoyd has been a chiropractor for 18 years. Ex. 16, Tab 1, Prefiled Testimony at 9.

[14] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 21-24.

[15] Ex. 16, Tab 1, Prefiled testimony of Dr. DeFoyd at 106.

[16] Ex. 16, Tab 1, Prefiled testimony of Dr. DeFoyd at369.

Provider's Position and Evidence

Dr. Howell, Provider's owner, has been a licensed chiropractor in Texas since October 1990. Provider's clinic is a 12,300 square foot facility with a junior Olympic indoor pool (77,000 gallons), a 1,000 square foot gym with modern weight lifting equipment, massage therapy rooms, examination rooms, physical therapy rooms, an adjusting room, a reception area, administrative offices, bathrooms with six showers inside them, a return-to-work area, and a chronic pain management area.[17]

Dr. Howell testified that Claimant's diagnoses was "post-surgical status of the left knee, displacement of lumbar intervertebral disc, tear of medial cartilage or meniscus of knee and myalgia and myositis, unspecified."[18] Dr. Howell explained that Claimant spoke only Spanish, but provided little further explanation for why Claimant need one-on-one therapy on October 11 and 12, 2001.

. ALJ's Analysis

The Carrier was required to show by a preponderance of the evidence that when it denied Provider's claims for services provided to Claimant, the services were not medically necessary. In compliance with the Commission's rules, Carrier provided an explanation for why it determined Provider's medical services were not medically necessary, the services could be provided in a group setting. Carrier established that Claimant had participated in enough aquatic therapy and physical therapy prior to October 11 and 12, 2001, that Claimant should have been able to continue this therapy in a group setting. The medical records offered no convincing evidence to explain why a group setting was not appropriate, nor did Dr. Howell's testimony provide this information. Based on the evidence, Carrier properly paid for one unit of one-on-one aquatic therapy and one unit of therapeutic exercises on October 11 and 12, 2001, and properly denied the remaining units of one-on-one therapy on each of these dates of service.

IV. FINDINGS OF FACT

1. ___ (Claimant), a __-year-old male, sustained a work-related injury on ___, while working on a motor crane, when he slipped twisting his lower back, left knee and hitting his right knee against a wall.

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[17] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell Vol. I at 5-6.

[18] Ex. 16, Tab 4, Prefiled Testimony of Dr.Howell Vol III at 104.

2. On June 21, 2001, Claimant sought treatment from Dr. Howell, First Rio Valley Medical, P.A. (Provider), who initiated conservative chiropractic care that included electrical stimulation, ultrasound, massage therapy, and whirlpool therapy

3. On July 16, 2001, Provider placed Claimant on a one-on-one aquatic therapy program.

4. On August 21, 2001, Claimant underwent left knee arthroscopic surgery.

5. Claimant returned to Provider for rehabilitation on September 12, 2001.

6. On September 14, 2001, Provider placed Claimant on a one-on-one aquatic therapy program concurrently with a one-on-one therapeutic exercise program.

7. One October 11 and 12, 2001, Provider treated Claimant with four units (in 15-minute increments) of one-on-one aquatic therapy and two units of one-on-one therapeutic exercises.

8. Provider requested reimbursement from Texas Mutual Insurance Company (Carrier) for aquatic therapy and therapeutic exercises provided to Claimant on October 11 and 12, 2001.

9. Carrier paid Provider for one unit of aquatic therapy and one unit of therapeutic exercises for each date, but denied the remaining units.

10. Carrier denied reimbursement for the three units per day of one-on-one aquatic therapy for October 11 and 12, and for one unit per day of one-on-one therapeutic exercises, asserting that one-on-one therapy was not medically necessary as Claimant's condition warranted group therapy.

Provider received a sufficient explanation from Carrier to understand the reason Carrier denied part of Provider's claims for October 11 and 12, 2001, in the amount of $382.00.

12. The Disputed Services provided on October 11 and 12, 2001, should have been provided in a group setting.

It was not medically necessary to provide the Disputed Services on October 11 and 12, 2001, to Claimant in a one-on-one basis.

14. By decision dated February 7, 2003, an Independent Review Organization (IRO) determined the Disputed Services were medically necessary.

By decision dated February 30, 2003, the Medical Review Division of the Texas Workers' Compensation Commission (Commission) granted Provider reimbursement for the Disputed Services.

16. Carrier timely requested a hearing to contest the Commission's decision.

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

18. A hearing was convened by Administrative Law Judge Catherine C. Egan on February 2, 2005, in the hearing rooms of the State Office of Administrative Hearings. The hearing adjourned and the record closed on February 21, 2005.

V. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. ' 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Carrier timely requested a hearing in this matter pursuant to 28 TEX. ADMIN. CODE (TAC) '' 102.7 and 148.3.

3. Notice of the hearing was proper and complied with the requirements of TEX. GOV'T. CODE ANN. ch. 2001.

4. Carrier had the burden of proof in this matter, which was the preponderance of evidence standard. 28 TAC '' 148.21(h) and (i); 1 TAC ' 155.41(b).

5. When an insurance carrier makes or denies payment on a medical bill, the carrier must include on the EOB the correct payment exception code and a sufficient explanation to allow the sender (Provider) to understand the reason for the Carrier's action. A general statement that simply states a conclusion is not sufficient. 28 TAC § 133.304(c).
Carrier's explanation for denying the claims on October 11 and 12, 2001, was sufficient for Provider to understand the reason Carrier denied the claims in compliance with the Commission's rules.

7. Provider is not entitled to reimbursement for the Disputed Services provided on October 11 and 12, 2001, in the amount of $382.00.

ORDER

THEREFORE IT IS ORDERED that Texas Mutual Insurance Company is not required to reimburse First Rio Valley Medical, P.A., for the Disputed Services provided to Claimant from October 11 and 12, 2001, in the amount of $382.00.

SIGNED April 20, 2005.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS