SOAH DOCKET NO. 453-03-3230.M5
TWCC MR NO. M5-03-0746-01

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

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) requested a hearing to contest the April 3, 2003, Findings and Decision of the Texas Workers' Compensation Commission (Commission) authorizing reimbursement to First Rio Valley Medical, P.A. (Provider) for patient focused office visits,[1] expanded problem office visits,[2] one-on-one aquatic therapy,[3] spray and stretch,[4] attended electrical stimulation, [5]and massage therapy[6] from January 28, 2002, through August 8, 2002, (Disputed Services) in the amount of $2,845.00.[7] A copy of the claim log showing the dates and services in dispute is attached as Appendix "A."[8]

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[1] CPT Code 99211.

[2] CPT Code 99213.

[3] CPT Code 97113.

[4] CPT Code 97139-SS.

[5] CPT Code 97032.

[6] CPT Code 97124.

[7] By Decision dated March 27, 2003, an Independent Review Organization (IRO) determined the Disputed Services were medically necessary.

[8] The last column of the claims log is in dispute and is not dispositive of any issue in this matter

This decision denies the relief sought by Carrier and grants reimbursement by 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., testified for Provider. There were no contested issues of notice or jurisdiction.

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, and on February 21, 2005, the deposition was admitted and the record closed.

I. BACKGROUND

Claimant, a 44-year-old female, was injured on ___, while at work. She was picking up packages of clothing and heaving them into a six-foot cart when she felt a pop in her right shoulder and pulled a muscle in her neck. Despite the pain, Claimant continued to work until February 15, 2000. Claimant began treatment with Provider on February 11, 2000. According to Provider, Claimant had cervicobrachial syndrome (diffuse); sprain of shoulder and upper arm; myalgia; and myosotis.[9] Provider treated Claimant with one-on-one aquatic therapy from February 24, 2000, through March 10, 2000, and then began land-based therapeutic exercises. MRI scans taken on March 17, 2000, indicated that Claimant had a "partial tear of her supraspinatus, which is a muscle in the rotator cuff that goes into the right shoulder. She was also reported to have mild midline disc protrusions at C3-4 and C4-5."[10]

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[9] Joint Ex. 6, Tab 1, at 0008.

[10] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 31; and Joint Ex 6, Tab 1 at 199-200.

On January 3, 2001, Claimant underwent surgery to correct her right shoulder. Following the surgery, Claimant returned to Provider on February 7, 2001, for post-surgical treatment. On April 7, 2001, Provider began treating Claimant with one-on-one aquatic therapy for a month.

On January 17, 2002, Claimant underwent an epidural steroid injection (ESI) into her spinal canal.[11] Following the ESIs, on January 28, 2002, Provider began treating Claimant with one-on-one aquatic therapy for a month concurrently with physical therapy. Dr. Howell diagnosed Claimant with post-surgical stiffness of right shoulder, parenthesis, impingement of shoulder region and rotator cuff tear.[12] Provider also treated Claimant with massage therapy and electrical stimulation.

II. LEGAL ISSUES

Carrier denied payment to Provider from January 28, 2002, through August 8, 2002, under payment exception code "U" for "unnecessary treatment (without peer review)." Pursuant to 28 TEX. ADMIN CODE (TAC) §133.304(c) when a carrier denies payment, the carrier must send an explanation of benefit (EOB) to the appropriate party with the proper exception code and "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's explanation was included in the reference codes "T2" and "RG" which are described on the EOBs as "the treatment/service provided exceeds medically accepted utilization review criteria and/or reimbursement guidelines established for severity of injury, intensity of service and appropriateness of care."[13] Later, Carrier began adding a rationale code of "YO" for "reimbursement

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[11] This was one of a series; the other dates ESIs were performed include September 27, 2002, and November 15, 2002, which were after the dispute dates.

[12] Joint Ex. 6, Tab 1 at 0020.

[13] Joint Ex. 6, Tab 1 at 0229-0259.

was reduced or denied after reconsideration of treatment/service billed."[14]

Dr. Howell testified that the explanation provided by Carrier for reference codes AT2" and "RG" did not tell him anything.[15] He was unaware of any healthcare provided to Claimant that exceeded any published medically accepted utilization review criteria.[16] Dr. Howell's testimony is consistent with his actions at the time Carrier denied reimbursement. In its request for reconsideration, Provider provided additional information and asked Carrier several questions to determine the basis for the denial of these claims.[17] Carrier provided no further explanation to Provider's request for additional information other than to deny the claims.

Carrier did not retain Dr. DeFoyd until December 2004. Obviously, he was not involved in Carrier's initial decision to deny this claim, nor did he clarify the guidelines to which Carrier was referring in the EOB.[18] When asked if he knew the protocol Carrier used to deny a procedure based on the "U" code, Dr. DeFoyd stated he was not an employee of Carrier's and he did not know the process Carrier followed.[19] Dr. Tsourmas, who serves as Carrier's medical director, testified that Carrier's guidelines track the medical guidelines. However, when Dr. Tsourmas was asked to explain Carrier's "RG" modifier, he could not do so.[20]

Even after Provider requested clarification, Carrier did not provide a sufficient explanation for denying Provider's claim. The Commission's rules required Carrier to provide on the EOB a sufficient explanation to allow Provider to understand the reason(s) for Carrier's denial. Carrier did

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[14] Joint Ex. 6, Tab 1 at 0256.

[15] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 9.

[16] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 11-12.

[17] Joint Ex. 6, Tab 1 at 0328.

[18] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 52.

[19] Ex 16 Tab 1, Prefiled Testimony of Dr. DeFoyd at 178.

[20] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 57-58.

not furnish Provider with the relevant portions of its criteria and guidelines in response to Provider's request for the same. Carrier did not provide a sufficient explanation of its denial and did not prove that its basis for denial at the time of the denial of the claims was correct. Carrier cannot substitute at a much later date a reason or an explanation other than that provided by Carrier when it denied the claims. The physicians who testified at the hearing on behalf of Carrier were unable to testify regarding Carrier's criteria and guidelines referenced in the EOBs. Under the Commission's rules, Carrier's explanation was insufficient. The ALJ will not permit Carrier to now substitute an explanation that was not furnished in compliance with 28 TAC § 133.304 (c). Therefore, where Carrier failed to timely submit a sufficient explanation of its denial, it is barred from denying the claim based on medical necessity.

III. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO Decision and Medical Records

On March 27, 2003, the Independent Review Organization (IRO) issued its determination at the request of the Commission. The IRO found that Claimant had showed steady improvement and had been released from care when she experienced an exacerbation of her injury in August 2002, (the ESI) which justified further chiropractic care. According to the IRO, Provider failed to document the medical necessity of one-on-one therapeutic exercise and noted that Claimant's condition had not changed requiring this special treatment. The IRO concluded that "the one-on-one therapeutic exercises from 1/28/02 through 8/21/02 were not medically necessary to treat this patient's condition."[21] However, the IRO found that the remaining chiropractic treatment, including the one-on-one aquatic therapy, was medically necessary.

[21] Joint Ex. 6, Tab 3 at 435-436.

The aquatic therapy included running forward, backward, and sideways in the pool, using a ball to turn from side to side, raising her arms from under the water to the surface from various positions, and lowering her arms from the surface to underwater at times using a float. Most of Provider's reports include the following language, "[t]he patient will progress to weight bearing exercises once they have (sic) demonstrated that they (sic) can handle the increased demands of land-based exercises."[22] However, Claimant also underwent one-on-one therapeutic exercises during this time including the treadmill, cardiovascular equipment, and other weight-bearing exercises.

B. Carrier's Position and Evidence

Dr. Tsourmas, an orthopedic surgeon, works for Carrier as the medical director and reviewed Provider's medical records to assess the medical necessity of the services in dispute. Dr. Tsourmas has referred patients for aquatic therapy when they suffered with lower extremity issues, such as a broken bone, and the patient needs the buoyancy of the water. He agrees that while a patient has to be careful with weight bearing exercises, aquatic therapy is useful, at least for the short term. However, he contends 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."[23] Transitioning a patient from aquatic to land-based therapy may overlap, but not more than a few weeks.[24]

William D. DeFoyd, D.C., Carrier's expert witness, practices at the Spine and Rehab Center and treats spinal injuries.[25] Dr. DeFoyd reviewed the Claimant's medical records, including those admitted into evidence, although he did not participate in Carrier's decision to deny these claims and was retained to review Claimant's medical records long after this claim arose.

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[22] Joint Ex, 6, Tab 1 at 0075.

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

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

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

Dr. DeFoyd maintains that land-based therapy is preferable to aquatic therapy for several reasons; first, because 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. In his opinion, aquatic therapy is used in cases where the patient cannot tolerate a land-based program because of weight bearing intolerance.[26]

Dr. DeFoyd noted that on each date Provider billed for aquatic therapy, Provider also billed Carrier for an office visit. Dr. DeFoyd testified that these office visits were medically unnecessary, but failed to explain why.[27] On April 16, 2002, Provider billed Carrier for an intermediate established patient evaluation. According to Dr. DeFoyd this office visit was unnecessary because there was no reason to reevaluate Claimant's condition. Dr. DeFoyd reviewed the medical records for August 7 and 8, 2002, and opined that the office visits, the spray and stretch, and the electrical stimulations were medically unnecessary because this passive treatment was not likely to be of any benefit two years after the injury and there was no apparent medical reason for the office visit.[28]

Mr. Ball currently serves as a dispute analyst, but began with Carrier as a nurse on an audit team reviewing spinal surgery and hospital bills. Mr. Ball affirmed that for each time Carrier received a bill from Provider, it issued an EOB, but he did not testify that Carrier ever provided an explanation for denying the claims other than that described above.

C. Provider's Position and Evidence

Dr. Howell, Provider's owner, has been a licensed chiropractor in Texas since October 1990. The 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

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

[27] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 41.

[28] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 45.

rooms, physical therapy rooms, an adjusting room, reception area, administrative offices, bathrooms with six showers inside them, a return-to-work area, and a chronic pain management area.[29]

Dr. Howell explained that Claimant was obese and could not speak English. The ESI done on January 17, 2002, exacerbated her pain. All the services, including the one-on-one aquatic therapy were medically necessary to treat Claimant following the ESI. The one-on-one aquatic therapy was medically necessary because of the reduction of weight-bearing and joint bearing compression and because the "palliative thermal effect" of the water reduces pain levels.

Dr. Howell elaborated that doing aerobic exercises in the water promotes physical conditioning which in turn "creates positive health conditions."[30] In addition, Dr. Howell maintains, aquatic therapy improves a patient's psychological mood and reduces depression.[31] According to Dr. Howell, patients prewarm-up in the deep end of the pool to encourage the secretion of synovial fluidBa fluid that helps lubricate the joint. After warm-up, the patient begins exercises that include running forward, backward, and sideways, to use all the major muscle groups in the body.

Claimant was reported to be a non-swimmer. Between January 28, 2002, and August 21, 2002, Claimant underwent one-on-one land-based physical therapy and one-on-one aquatic therapy. According to Dr. Howell, this was medically necessary because Claimant underwent an ESI on January 17, 2002, and without aggressive therapy Claimant would not have had long-term benefits.

According to Dr. Howell, Claimant was receiving both land-based and aquatic therapy because she was transitioning from water to land-based therapy.[32] Under cross-examination, Dr. Howell explained that while Claimant could engage in land-based physical exercise, she was unable

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

[30] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 17.

[31] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 19.

[32] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 27.

to do so at the intensity level at which he wanted her to perform. Therefore, he augmented the land-based therapy with water therapy to achieve the intensity level he believed was medically necessary for her to improve. Claimant underwent aquatic therapy for approximately a month. Prior to that, Dr. Howell explained, Claimant had approximately a month of aquatic therapy in 2000 and another month in 2001. In view of the facts that she was not experienced in doing aquatic therapy, could not swim, did not speak English, and had just undergone an ESI, Dr. Howell opined that one-on-one aquatic therapy was medically necessary. In conclusion, Dr. Howell testified that Claimant did improve with therapy and that she went from a 62 percent on her Oswestry neck pain scale to a 50 percent.

D. ALJ's Analysis

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. Under the Commission's rules, Carrier is required to provide an explanation for why it determined Provider's medical services were not medically necessary at the time it issues the EOB. Carrier's explanation codes "RG" and "T2," and their definition, provided no explanation. Carrier's own expert, Dr. Tsourmas, was unable to explain what Carrier meant in its definition of "RG." Despite Provider's request for clarification about what guidelines Carrier was referring to, Carrier failed to provide this information.

The ALJ notes that neither of Carrier's experts could testify about why Carrier denied Provider's claims at the time Carrier denied the claims. Carrier chose not to offer any evidence explaining what its "proprietary guidelines" stated or to clarify the rationale for denying the claims other than the global statement that they were not medically necessary. Consequently, the ALJ finds that Carrier failed to show by a preponderance of the evidence why it denied Provider's claims.

In addition, the ALJ finds Carrier failed to show by a preponderance of the evidence that the Disputed Services provided by Provider to Claimant from January 28, 2002, through August 8, 2002, were not medically necessary. Claimant had just undergone the first of a series of ESIs to her spinal canal. To improve Claimant's physical condition while avoiding re-injury, Dr. Howell performed limited passive therapy, conducted office visits to assess Claimant's condition, and placed Claimant on both aquatic therapy and physical therapy concurrently for a month. This permitted Claimant to increase the intensity of her workout while reducing the risk of harming herself.

Although Dr. Tsourmas did not agree that the ESI amounted to an operation, he did testify that transitioning between aquatic therapy and physical therapy was not unreasonable post-operatively for several weeks. Furthermore, he acknowledged that one-on-one aquatic therapy would be appropriate for someone who could not speak English.[33] This appears consistent with Dr. Howell§s treatment regime for this patient. While it is clear Dr. Tsourmas, Dr. DeFoyd, Provider, and the IRO have a difference of opinion about how to treat this patient, this does not prove that the treatment was not medically necessary. Therefore, the ALJ finds that Carrier failed to carry its burden of proof and Provider is entitled to recover the amount due for the Disputed Services.

IV. FINDINGS OF FACT

1. Claimant, a 44-year-old female, sustained a work-related injury to her right shoulder and cervical spine on ___, while she was heaving large packages of clothing into a cart.

2. Claimant presented to Robert S. Howell, D.C., at First Rio Valley Medical, P.A. (Provider) with complaints of pain in her right shoulder and neck.

3. Claimant underwent surgery to her right shoulder on January 3, 2001.

4. On January 17, 2002, Claimant underwent an epidural steroid injection (ESI).

5. Following the ESI, Provider diagnosed Claimant without post-surgical stiffness of right shoulder, parenthesis, impingement of shoulder region and rotator cuff tear.

6. Following the ESI, Provider conducted office visits, treated Claimant with passive therapy,

[33] EX 16, Tab 3, Prefiled testimony of Dr. Tsourmas at 258.

and one month of aquatic therapy (January 28, 2002 through February 27, 2002) concurrently with physical therapy to increase the intensity of Claimant§s exercises to improve her physical condition.

7. At the time of treatment, Claimant could not speak English, could not swim, and was obese.

8. Following the ESI, Claimant was prescribed muscle relaxants and anti-inflammatory medications.

9. The disputed services involve one-on-one aquatic therapy given in one hour session (four increments), office visits, spray and stretch, attended electrical stimulation, and massage therapy from January 28, 2002, through August 8, 2002, (Disputed Services) in the amount of $2,845.00.

10. Claimant required the office visits following the ESI and the subsequent treatments to assess her condition and adjust her treatment.

11. Claimant required one-on-one aquatic therapy so that Provider could show her how to do the exercises, make sure she did them properly, monitor her, and ensure she did not harm herself.

1. Texas Mutual Insurance Company (Carrier) denied reimbursement for the Disputed Services on the Explanation of Benefits (EOB) using the Commission code “U” "unnecessary treatment (without peer review)."

2. On the EOBs, Carrier used the reference codes "T2" and "RG" and the definition for these codes, as its explanation to Provider for denying the claims.

3. Both “T2" and “RG” were defined by Carrier on the EOB as “the treatment/service provided exceeds accepted utilization review criteria and/or reimbursement guidelines for severity of injury, intensity of service and appropriateness care."

4. Carrier refused to disclose to Provider the relevant utilization review criteria and/or reimbursement guidelines asserting they were proprietary and confidential.

5. Carrier's explanation was insufficient for Provider to understand Carrier's reason(s) for the denial of these claims.

6. Provider filed a request for reconsideration with Carrier and asked Carrier to identify what guidelines it was using as a basis to deny the claim and to explain the rationale behind its denial of the disputed services.

7. Carrier denied the requests for reconsideration, and failed to provide any additional information regarding the rationale behind its denial of the disputed claims, including the contents of the guidelines it relied upon.

8. On March 27, 2003, an independent review organization (IRO) concluded that the Disputed Services were medically necessary.

9. By Decision dated April 3, 2003, based on the IRO decision the Texas Workers' Compensation Commission (Commission) Medical Review Division determined the Disputed Services were medically necessary and granted Provider reimbursement.

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

11. 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.

12. 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 remained open for briefing and to file certain items. The record closed February 21, 2005.

13. For the dates of service in question, Carrier failed to show that the Disputed Services were not medically necessary to treat Claimant's compensable injury.

V. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has 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. § 413.031(k) and TEX. GOV'T. CODE ANN. ch. 2003.

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

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

5. 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).

6. When a 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 in not sufficient. 28 TAC § 133.304.

7. Carrier's explanation for denying the claims was legally inadequate as it failed to deny reimbursement in compliance with the Commission's rules.

8. Because Carrier never denied reimbursement in compliance with the Commission's rules for the disputed services from January 28, 2002 through August 8, 2002, Carrier is requested to provide items reimbursed.

9. Carrier failed to demonstrate that the Disputed Services were not reasonable and medically necessary for the treatment of Claimant's compensable injury.

10. Based upon the Findings of Fact and Conclusions of Law, Provider is entitled to reimbursement for the Disputed Services.

ORDER

THEREFORE IT IS ORDERED that Carrier Texas Mutual Insurance Company pay Provider First Rio Valley Medical, P.A., for the Disputed Services provided to Claimant from January 28, 2002, through August 8, 2002, in the amount of $2,845.00, plus any and all applicable interest.

SIGNED April 15, 2005.

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