SOAH DOCKET NO. 453-03-3244.M5
TWCC MR NO. M5-03-1367-01

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

DECISION AND ORDER

First Rio Valley Medical, P.A. (Provider) requested a hearing to contest the April 22, 2003, Findings and Decision of the Medical Review Division of the Texas Workers' Compensation Commission (Commission) authorizing reimbursement to First Rio Valley Medical, P.A. (Provider) for office visits,[1] aquatic therapy,[2] sterile whirlpool,[3] electrical stimulation,[4] massage therapy[5] and therapeutic exercises[6] provided to Claimant from July 31, 2002, through October 17, 2002 (Disputed Services). Carrier has the burden of showing by a preponderance of the evidence that the Disputed Services were not medically necessary. A copy of the claims log showing the dates and services in dispute is attached as Appendix A.

This decision denies the relief sought by Carrier and grants reimbursement to Provider for the Disputed Services.

The hearing convened on February 2, 2005, before Administrative Law Judge (ALJ) Catherine C. Egan at the State Office of Administrative Hearings, Austin, Texas. Attorneys Chris Trickey and Tom Hudson represented Carrier. Attorney 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.

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[1] CPT Code 99211.

[2] CPT Code 97113.

[3] CPT Code 97022-22.

[4] CPT Code 97032.

[5] CPT Code 97124.

[6] CPT Code 97110.

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. 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 54-year old male, sustained a work-related injury on ___, when he slipped and fell into a ditch while carrying plywood. Claimant experienced lower back pain that radiated into his left leg. He was treated with passive physical therapy through May 11, 2000. On May 9, 2000, Claimant underwent a lumbar MRI that showed "a small left subligamentous L4-5 disc herniation and also borderline spinal stenosis . . . chronic degenerative disc changes at the L2 level, but without a disc herniation or stenosis at L2."[7] On May 26, 2000, Claimant went to Provider for treatment. Provider treated Claimant in May, June, July and August 2000, but Claimant's condition continued to deteriorate.

On September 11, 2000, Claimant underwent lumbar spinal fusion surgery. Claimant returned to Provider for rehabilitative therapy following this surgery, which continued through April 2001. Claimant continued to experience a great deal of lower back pain that radiated into his leg. On August 1, 2001, Provider again treated Claimant with passive modalities and aquatic therapy. This treatment continued through January 28, 2002. During this time, Claimant underwent a second spinal surgery on August 23, 2001, to insert a trial spinal cord stimulator on his spine. On October 4, 2001, a permanent spinal cord stimulator was inserted.[8] The battery of the stimulator had to be replaced the following year which necessitated another surgery. On June 18, 2002, Claimant underwent surgery to replace this battery.[9]

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 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."

[7] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 201.

[8] Ex, 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 231-235.

[9] Joint Ex. 2, Tab 3 at 450.

Carrier denied payment to Provider for treatment rendered from July 31, 2002, through October 17, 2002, under payment exception code "U" for "unnecessary treatment (without peer review)."[10] Carrier's explanation for denying these services was set out in Carrier's rationale code "RG," described on the EOB 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."[11] Provider requested reconsideration and asked Carrier to clarify the protocol used to deny the claims. Carrier responded by reissuing the EOBs, and adding payment exception code "O" for "denial after reconsideration" with a rationale code of "YO" for "reimbursement was reduced or denied after reconsideration of treatment/service billed."[12] Carrier did not disclose its criteria and guidelines to Provider.

Dr. Howell testified that the explanation provided by Carrier for rationale code "RG" did not tell him why Carrier found the services to be unnecessary treatment. He was unaware of any healthcare provided to Claimant that exceeded any published medically accepted utilization review criteria. Provider filed its request for reconsideration seeking more information to explain why Carrier had denied these claims, but received none.

Carrier did not retain Dr. DeFoyd until December 2004. Dr. DeFoyd was not involved in Carrier's initial decision to deny this claim, nor does he know what Carrier's criteria and guidelines say that are referenced in the EOBs.[13] When asked if he knew the protocol Carrier used to deny a procedure based on the AU" payment denial code, Dr. DeFoyd stated he was not an employee of Carrier's and he did not know the process Carrier followed.[14] Dr. Tsourmas, Carrier's expert and medical director, testified that he believed Carrier's guidelines track the medical fee guidelines. However, when Dr. Tsourmas was asked to explain Carrier's "RG" modifier, he could not do so.[15]

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 not furnish Provider with the relevant portions of its criteria and guidelines in response to Provider's request for the same.

Carrier may not substitute at a much later date a reason or an explanation other than that

[10] Joint Ex. 2, Tab 1 at 227-269.

[11] Joint Ex. 2, Tab 1 at 226.

[12] Joint Ex.2, Tab 1 at 252.

[13] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 52 and 557-564.

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

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

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 Commission rules do not permit Carrier now to substitute an explanation that was not furnished in compliance with 28 TAC ' 133.304(c).[16] Therefore, where Carrier failed to timely submit a sufficient explanation of its denial, it may not now create one to deny the claim based on lack of medical necessity.

III. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO's Decision and the Medical Record

On April 11, 2003, the independent review organization (IRO) determined that some of the claims in controversy at that time were medically necessary. The IRO noted that it was important to "remember that a person is attached to this dispute and consider what is best for the patient. The patient apparently had a procedure in the lumbar spine for the implantation of a spinal stimulator, which does carry a certain amount of trauma."[17] The IRO opined that two units of aquatic therapy and therapeutic therapy would benefit the patient, and generally found the other passive modalities and other treatments to be medically necessary.[18] Claimant was assessed to have reached Maximum Medical Improvement on March 28, 2002, and received a 25 percent whole body impairment rating.[19]

On July 30, 2002, Provider documented in the interim assessment report that Claimant underwent the replacement of a spinal cord stimulator synergy battery on June 18, 2002, and that Claimant continued to experience depression and anxiety because of his injury and the long term pain and discomfort it had caused. Provider noted that Claimant "exhibits manifestations of chronic disc injury to the lumbar spine."[20] The diagnoses for Claimant included the following: "failed back syndrome; other postsurgical status; thoracic or lumbosacral neuritis or radiculitis, unspecified; displacement of lumbar intervertebral disc without myelopathy; neuropathy."[21] According to this report, Claimant's pain management specialist prescribed continued physical therapy with Dr. Howell.

On October 4, 2002, Provider documented in another interim assessment report that Claimant

[16] *See also* 28 TAC § 133.307(j)(2).

[17] Joint Ex. 2, Tab 3 at 329.

[18] Id.

[19] Joint Ex. 2, Tab 3 at 343.

[20] Joint Ex. 2, Tab 1 at 40-50.

[21] Joint Ex. 2, Tab 1 at 49.

complained of moderate and frequent pain in his lower back, the back of his hip and his left buttocks. Claimant also experienced slight radiating pain down his left leg.[22] Provider noted that Claimant had shown significant improvement with the treatment as shown by a reduction in his Oswestry pain level, increased strength, and improved range of motion.[23]

Provider's records provide the following explanation for medical necessity of aquatic therapy:

> The medical necessity of aquatic therapy is simple. It is a commonly accepted fact in the medical community that healing tissues should never be overstressed. If Claimant were subjected to active therapy (resistive/progressive) exercise too quickly, the consequences may be detrimental. Re-injury, increased pain, and decreased range of motion are the most common side effects. This will of course increase the amount of time it takes to heal the soft tissues. The longer the time it takes to heal the more costly it is. This is not the goal of the TWCC or the guidelines it uses. By placing Claimant in water, his body weight or the affected area weight is reduced and stress is minimized significantly. By minimizing the stress on the injured area, range of motion will usually increase because the gravity factor is lowered therefore allowing for the naturally occurring sticking points of conventional progressive weights to be overcome with much more ease.[24]

B. Carrier's Position and Evidence

Dr. Tsourmas, an orthopedic surgeon who works for Carrier as a medical director, 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, 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."[25] Transitioning a patient from aquatic to land-based therapy may overlap, but not more than a few weeks- "Certainly not months or - or longer."[26]

As for this Claimant, Dr. Tsourmas testified that before the dates of the Disputed Services, Claimant underwent a small surgical procedure on June 18, 2002, to replace the batteries in his

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[22] Joint Ex. 2, Tab 1 at 52.

[23] Joint Ex. 2, Tab 1 at 60.

[24] Joint Ex. 2, Tab 1 at 49. The ALJ removed Claimant's name in the quotation and inserted the word "Claimant."

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

[26] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 28.

implant. Dr. Tsourmas opined that none of the aquatic therapy provided in July 2002, was medically necessary because the surgery was so minor.[27] Likewise, no one-on-one aquatic therapy and land-based therapy was necessary in August, September, and October 2002.[28] Despite the lack of medical necessity of this treatment, Dr. Tsourmas noted that Carrier paid for one to two units of therapy. According to Dr. Tsourmas, Provider should have directed Claimant to do land-based activities at home or in a gym.[29] While Claimant spoke predominately Spanish, the language barrier did not, in his opinion, justify the length of treatment provided by Provider to Claimant.[30] According to Dr. Tsourmas, Provider was more than adequately paid for the services provided.[31]

Dr. DeFoyd practices at the Spine and Rehab Center and treats spinal injuries.[32] Dr.DeFoyd opined 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 require 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.[33]

Dr. DeFoyd agreed with Dr. Tsourmas that replacing the battery on Claimant's spinal implant was outpatient day surgery and not complicated. Aquatic therapy is not necessary following a battery replacement.[34] Dr. DeFoyd testified that the Disputed Services were not medically necessary because Claimant "had had an excessive amount of essentially the same treatment previously without significant benefit and there was no reason to reinitiate this based on just a battery replacement, and there was also no reasonable expectation that this was going to result in a significantly better outcome than had been previously attained."[35] None of the aquatic therapy required one-on-one supervision because Claimant already had significant training and was fit enough to do the exercises on his own.

C. Provider's Position and Evidence

Dr. Howell has been a licensed chiropractor in Texas since October 1990. Provider's clinic is

[27] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 243.

[28] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 244.

[29] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 251.

[30] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 282.

[31] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 266.

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

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

[34] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 251-253.

[35] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 255.

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, a return-to-work area, and a chronic pain management area.[36]

Dr. Howell testified that Claimant could only speak Spanish, was a diabetic, and could not swim. Claimant had degenerative spur formation at L2/L3 and L3/4, a laminectomy at L4/5, and degeneration at L5.[37] As a result of Provider's treatment, Claimant's range of motion improved, his pain decreased, he improved in his ability to engage in activities of daily living, and his strength improved.[38]

D. ALJ's Analysis

Carrier was required to show by a preponderance of the evidence that it properly denied Provider's claims for services provided to Claimant due to a lack of medical necessity. 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 its definition provided no explanation as it relied upon Carrier's confidential criteria and guidelines which Carrier chose not to disclose. Carrier's own expert, Dr. Tsourmas, was unable to explain what Carrier meant in its definition of "RG," and neither expert knew what Carrier's criteria and guidelines were. 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, particularly since neither knew what Carrier's criteria and guidelines provided. Carrier chose not to offer any evidence explaining what its proprietary criteria and 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 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 from July 31, 2002, through October 17, 2002, were not medically necessary. Carrier's experts argued that Carrier was more than generous in paying for one or two units of the four units billed for one-on-one aquatic therapy and therapeutic exercises. The

reasoning behind Carrier's partial payments was never adequately explained. Despite the opinions voiced by Carrier's experts, Carrier's conduct in paying for part of the claims strongly indicates that Carrier found these services to be medically necessary, just not for an hour. However, Carrier offered insufficient proof to show that Claimant needed only 15 to 30 minutes of one-on-one therapy to

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

[37] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell Vol. III at 78.

[38] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell Vol. III at 79-81.

address Claimant's complaints and disabling condition.

Claimant had undergone several spinal surgeries, both major and minor. Provider's treatment helped Claimant's physical condition given that he continued to experience pain and was undergoing another trauma to his spine with the replacement of the battery. With Provider's treatment, Claimant's pain levels and range of motion improved. 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 54-year-old male, sustained a work-related injury on ___, when he slipped and fell into a ditch while carrying plywood (compensable injury).

2. On May 26, 2000, Claimant sought treatment from Robert S. Howell, D. C., First Rio Valley Medical, P.A. (Provider).

3. On September 11, 2000, Claimant underwent lumbar spinal fusion surgery.

4. Claimant continued to experience a great deal of lower back pain that radiated into his leg.

5. On August 23, 2001, Claimant underwent spinal surgery to insert a trial spinal cord stimulator.

6. On October 4, 2001, Claimant underwent spinal surgery to insert a permanent spinal cord stimulator.

7. On June 18, 2002, Claimant underwent spinal surgery to replace the battery on the spinal cord stimulator.

8. Provider diagnosed Claimant as failed back syndrome, thoracic or lumbosacral neuritis or radiculitis, displacement of lumbar intervertebral disc without myelopathy, and neuropathy.

9. Provider treated Claimant's compensable injury from July 20, 2002, through October 17, 2002, and requested reimbursement from Carrier for the office visits, one-on-one aquatic therapy and therapeutic exercises, electrical stimulation, massage therapy, and for the sterile whirlpool treatments (Disputed Services).

10. Texas Mutual Insurance Company (Carrier) issued an explanation of benefits (EOB) paying for one unit or two units of the four units billed each day for aquatic therapy and therapeutic exercises, but denying all other reimbursement.

11. Carrier denied reimbursement for the Disputed Services under the payment exception code

"U," for "unnecessary treatment (without peer review)."

12. On the EOBs denying these Disputed Services, Carrier used the rationale code "RG,"and its definition for this code, as its explanation to Provider for denying the claims.

13. Carrier defined "RG" 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."

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

15. Carrier's failure to disclose to Provider the relevant utilization review criteria and reimbursement guidelines rendered Carrier's explanation insufficient for Provider to understand Carrier reason(s) for denying Provider's claims.

16. Provider filed a request for reconsideration of the Disputed Services with Carrier and asked Carrier to identify what guidelines it was using as a basis to deny the claims and to explain the rationale behind its denial of the Disputed Services.

17. 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 criteria and guidelines it relied upon.

18. The condition of Claimant's lumbar spine after multiple spine surgeries rendered him disabled.

19. As a result of Provides treatment from July 31, 2002, through October 17, 2002, Claimant's range of motion improved, his pain decreased, his ability to engage in regular activities of daily living improved and his strength improved.

20. The Disputed Services provided by Provider to Claimant was medically necessary to treat his compensable injury.

21. On April 11, 2003, an independent review organization (IRO) concluded that the Disputed Services were medically necessary to treat the compensable injury.

22. By Decision dated April 22, 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.

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

24. 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.

25. 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 February 21, 2005.

26. 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 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).

7. Carrier's explanation for denying the claims from July 31, 2002, through October 17, 2002, was legally inadequate as it failed to deny reimbursement in compliance with the Commission's rules.

8. Carrier is barred from asserting grounds not stated in the Explanation of Benefits.

9. Based on the Findings of Fact, 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 as they were reasonable and medically necessary.

ORDER

THEREFORE IT IS ORDERED that Texas Mutual Insurance Company reimburse First Rio Valley Medical, P.A., for the Disputed Services provided to Claimant from July 31, 2002, through October 17, 2002, in the amount of $3,315.00, plus any and all applicable interest.

SIGNED April 20, 2005.

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