SOAH DOCKET NO. 453-03-3586.M5
TWCC MR NO. M5-03-0615-01

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 30, 2003, Findings and Decision of the Medical Review Division of the Texas Workers' Compensation Commission (Commission) authorizing reimbursement of $4,395.00 to First Rio Valley Medical, P.A., (Provider) for aquatic therapy,[1] focused established office visit,[2] supplies,[3] phonophoresis,[4] ultrasound,[5] and therapeutic exercises[6] provided from January 14, 2002, through May 13, 2002, (Disputed Services).[7] Carrier has the burden of showing by a preponderance of the evidence that the Disputed Services were not medically necessary. 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. 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 97113.

[2] CPT Code 99211.

[3] CPT Code 99070.

[4] CPT Code 97139-PH.

[5] CPT Code 97035.

[6] CPT Code 97110.

[7] By Decision dated April 29, 2003, an independent review organization (IRO) determined the Disputed Services were medically necessary. A copy of the claims log showing the dates and services in dispute is attached as Appendix A.

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 40-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 into 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.[8] 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. On March 1, 2002, Claimant underwent knee surgery on his right knee. Throughout this time, Claimant complained of pain in his lower back, knees, and ankles.

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 all the Disputed Services under payment exception code "U" for services that were "unnecessary treatment (without peer review)."[9] For the explanation, Carrier used the rationale code "U" on January 17, 2002, and "YU" on March 19, 2002, both of which are described on the EOB as "The service has been deemed unnecessary medical treatment based on a review of the claim file, billing records, and written review protocols established for appropriate health care treatment."[10] Thereafter, Carrier used the rationale codes "T2" and ARG" both of 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

[8] Carrier's Ex. 15, Tab 6 at 1-6.

[9] Joint Ex. 12, Tab 1 at 318-364.

[10] Joint Ex. 12, Tab 1 at 318.

appropriateness of care."[11]

Provider filed a request for reconsideration with Carrier on the denied claims and asked that Carrier explain the protocols, criteria, and guidelines it relied on to deny the claims. According to Dr. Howell, Carrier's rationale codes did not explain the reason Carrier found the services were medically unnecessary.[12] Carrier did not disclose to Provider the relevant protocols, criteria, and guidelines. Carrier did not retain Dr. Tsourmas or Dr. DeFoyd until late in 2004, well after this contested case proceeding began. Obviously, neither of them was involved in Carrier's decision to deny this claim nor could they testify as to the meaning of the criteria and guidelines Carrier relied upon in the EOBs.[13]

Mr. Ball currently serves as Carrier's dispute analyst, but began as a nurse on an audit team reviewing spinal surgery and hospital bills. Mr. Ball explained that Carrier's medically accepted utilization review criteria and its reimbursement guidelines established for severity, intensity, and appropriateness of care are "proprietary and confidential." Therefore, This information was not given to Provider.[14]

Even after Provider requested clarification, Carrier did not provide a sufficient explanation for denying Provider's claims other than to use the brief rationale codes listed above that failed to clarify what protocols, guidelines, and criteria Carrier relied upon in denying these claims. 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 may not substitute at a much later date a reason or an explanation for asserting that the service or treatment was unnecessary treatment other than that provided by Carrier when it denied the claims. For example, Carrier cannot explain for the first time its reasons for denial at the hearing. 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 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 now barred from denying the claim based on lack of medical necessity.

[11] Joint Ex. 7, Tab 1 at 272-351.

[12] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell Vol III at 108-111.

[13] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 52; Tab 3, Prefiled Testimony of Dr. Tsourmas at 57-58.

[14] Ex. 16, Tab 2, Prefiled Testimony of Mr. Ball at 25-26.

III. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO opinion and the Medical Record

On April 29, 2003, the IRO found that the Disputed Services were medically necessary. The IRO found that "one therapy per office visit is medically necessary to treat this patient's condition," and that the phonophoresis and phonophoresis supplies, office visits, aquatic therapy, conductive gel, and ultrasound provided to Claimant were medically necessary to treat Claimant's compensable injury.[15]

In Provider's December 26, 2001, interim assessment report, Provider documented that Claimant continued to experience pain in his lower back that radiated into his left leg, left knee, knee cap, and right knee. Provider diagnosed Claimant with "post surgical status, displacement of lumbar intervertebral disc without myelopathy; tear of medial cartilage or meniscus of knee, current; myalgia and myositis, unspecified.[16] The treatment included "rehabilitation measures to the lumbar spine and affected extremities weekly for 4 weeks."[17]

Provider's explanation for aquatic therapy included the following:

> 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.[18]

The interim assessment report dated February 5, 2002, documented that Claimant had complaints of lower back pain, pain and weakness in his left knee, and pain and numbness in his right knee. Claimant exhibited an "antalgic limping gait favoring the left ankle, foot, and knee."[19]

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[15] Joint Ex. 12, Tab 2 at 435.

[16] Joint Ex. 12, Tab 1 at 44.

[17] Joint Ex. 12, Tab 12 at 45.

[18] Joint Ex. 12, Tab 1 at 46.

[19] Joint Ex. 12, Tab 1 at 51.

Provider noted that Claimant was slowly improving and would be seeing Jorge Tijmes, M.D., for a right knee surgical consultation.

On March 1, 2002, Claimant had a lumbar discogram taken that showed a radial tear in his lumbar spine at L5-S1.[20] Claimant underwent right knee surgery on March 18, 2002, and was released to begin post-operative rehabilitation on April 1, 2002.[21] On April 4, 2002, Provider documented in Claimant's interim assessment report that Claimant still complained of lower back pain and pain in his right and left knee. The rehabilitation treatment included aquatic therapy, therapeutic exercise, and phonophoresis.

Carrier paid Provider for a portion of the phonophoresis charges for services delivered on April 15, 18, 25, 2002, and May 8, 2002; one unit (a 15-minute increment) of one-on-one aquatic therapy provided on April 25, 2002, and May 1, 6, and 8; and one unit of one-on-one therapeutic exercises provided on April 29, 2002.

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 for the 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."[22] Transitioning a patient from aquatic to land-based therapy may overlap, but not for more than a few weeks.[23]

As for this Claimant, Dr. Tsourmas testified that Claimant did not need any aquatic therapy, particularly one-on-one therapy four to five months after the surgery. By this time, Dr. Tsourmas maintained, Claimant should have been able to do land-based exercises on his own.[24] If Provider were concerned about Claimant's progress, Provider could have monitored Claimant's performance once a month. On March 18, 2002, Claimant underwent a right knee arthroscopy. According to Dr. Tsourmas, despite this surgery, Claimant did not require one-on-one therapy. Dr. Tsourmas testified that Claimant:

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[20] Joint Ex. 12, Tab 1 at 78.

[21] Joint Ex. 12, Tab 1 at 60-72.

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

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

[24] Ex. !6, Tab 3, Prefiled Testimony of Dr. Tsourmas at 131-132.

> . . . had an abundant amount of therapy . . . for knee and back problems; he had been exposed to those having undergone a very similar operative intervention on his left knee, some seven months prior, the rehabilitation is exactly the same. I don't believe the duration, intensity of those services, for two months, was medically necessary.[25]

Dr. Tsourmas further noted that nothing in the medical record indicated that Claimant had any mental health problems that required one-on-one therapy, such as problems with concentration, abstract thinking, or intelligence.

Dr. DeFoyd, Carrier's expert witness, practices at the Spine and Rehab Center and treats spinal injuries.[26] Dr. DeFoyd reviewed the Claimant's medical records including those admitted into evidence. 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 require a pool. Finally, land-based exercise programs are generally less costly than aquatic programs. In his opinion, aquatic therapy should be used in cases in which the patient cannot tolerate a land-based program because of weight-bearing intolerance.[27]

Dr. DeFoyd argued that Claimant did not require aquatic therapy and certainly not with one-on-one supervision. Instead, Claimant needed to progress to a land-based program. Dr. DeFoyd testified that it was not medically necessary for "a patient who is essentially doing the same exercise program that he has been shown to do many, many, many times previously" to continue to need one-on-one instruction.[28] According to Dr. DeFoyd, Claimant was strong enough to be in a land-based independent program. Likewise, he did not find any passive treatments, including the ultrasound and phonophoresis, to be medically necessary as it was too remote in time from the compensable injury or the surgeries.[29]

C. 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 1000-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.[30]

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[25] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 135.

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

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

[28] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 378.

[29] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 389-394.

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

Dr. Howell testified that Claimant's diagnoses were "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."[31] Dr. Howell explained that Claimant spoke only Spanish and complained of constant pain to his lower back, right knee, and right and left ankle. To address all these complaints, Dr. Howell testified he treated Claimant with aquatic therapy, therapeutic exercises, phonophoresis, and ultrasound. On March 1, 2002, Claimant had knee surgery on his right knee, which required further rehabilitation. According to Dr. Howell, between December 26, 2001, and April 4, 2002, Claimant's range of motion improved, and the strength to Claimant's lower extremity and lower back improved.[32] Dr. Howell argued that the Disputed Services he provided were medically necessary because "the patient had improvements, . . . subjectively and objectively;" his Oswestry pain levels improved; his range of motion improved; and Claimant's strength improved.[33]

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. Carrier rationale codes "U," "YU," "T2," and "RG" provided no explanation to Provider as the explanations refer back to Carrier's confidential protocols, criteria, and guidelines, which Carrier chose not to disclose to Provider.

The ALJ finds that neither of Carrier's experts could testify about why Carrier denied Provider's claims at the time Carrier denied the claims because neither knew what the explanation codes referred to, specifically the content of Carrier's criteria and guidelines. Carrier chose not to offer any evidence explaining what its "proprietary guidelines" stated or to timely clarify to Provider what its rationale was for denying the claims other than the global statement that they were not medically necessary. Consequently, the ALJ finds that Carrier failed to properly raise and preserve a medical necessity denial for the Disputed Services provided by Provider.

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

[32] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell Vol III at 104-108.

[33] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell Vol III at 117-118.

The ALJ further finds that Carrier failed to show why it denied Provider's claims as unnecessary treatment between January 14, 2002, and May 13, 2002, and failed to show by a preponderance of the evidence that Provider's services from January 14, 2002, through May 13, 2002, were not medically necessary. Carrier's experts argued that aquatic therapy was medically unnecessary, and further that Claimant had received a sufficient amount of one-on-one therapy to be able to do both aquatic therapy and therapeutic exercises on his own. However, Claimant underwent surgery on both knees and continued to experience lower back pain related to his compensable injury. A lumbar discogram showed a radial tear in his lumber spine at L5-S1. Provider was not treating one isolated problem, but three interrelated medical conditions that contributed to Claimant's pain and complicated the treatment process. Additionally, as a result of Provider's treatments, Claimant's Oswestry pain levels improved; his range of motion improved; and his strength improved.

IV. FINDINGS OF FACT

1. ___ (Claimant), a 40-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.

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. On March 1, 2002, Claimant underwent knee surgery on his right knee due to the compensable injury.

8. Between January 14, 2002, and May 13, 2002, Claimant experienced pain in his lower back, knees, and ankles related to his compensable injury.

9. From January 12, 2002, through May 13, 2002, Provider treated Claimant was one-on-one aquatic therapy, one-on-one therapeutic exercises, focused established office visits, supplies, phonophoresis, and ultrasound.

10. Provider requested reimbursement from Texas Mutual Insurance Company (Carrier) for the one-on-one aquatic therapy, one-on-one therapeutic exercises, focused established office visits, supplies, phonophoresis, and ultrasound (Disputed Services) provided to Claimant from January 12, 2002, through May 13, 2002.

1. Carrier paid Provider for a portion of the phonophoresis charges for services delivered on April 15, 18, 25, 2002, and May 8, 2002; one unit (a 15-minute increment) of one-on-one aquatic therapy provided on April 25, 2002, and May 1, 6, and 8, 2002; and one unit of one-on-one therapeutic exercises provided on April 29, 2002.

2. Carrier denied reimbursement for the Disputed Services in the amount of $4,395.00.

3. Texas Mutual Insurance Company (Carrier) denied reimbursement for the Disputed Services on the explanation of benefits (EOB) utilizing the denial code "U," which stands for unnecessary treatment (without peer review).

4. For the Disputed Services provided on January 17, 2002, Carrier used the rationale code "U," and for the Dispute Service provided on March 19, 2002, Carrier used the rationale code "YU" and the definition for both as its explanation to Provider for denying the claims.

5. Both rationale code "U" and "YU" are defined on Carrier's EOB as "the service has been deemed unnecessary medical treatment based on a review of the claims file, billing records, and written review protocols established for appropriate health care treatment."

6. For the remaining Disputed Services, Carrier used the rationale codes "T2" and "RG" on the EOB and the definition for both as its explanation to Provider for denying the claims.

7. Both rationale codes "T2" and "RG" are defined as "the treatment/ services provided exceeds medically accepted utilization review criteria and/or reimbursement guidelines for severity of injury, intensity of service, and appropriateness of care."

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

9. By failing to disclose to Provider the relevant protocols, utilization review criteria, and/or reimbursement guidelines, Carrier's explanation was insufficient for Provider to understand Carrier's reason(s) for the denial of these claims.

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

11. Carrier did not pay for the Disputed Services and failed to provide the contents of the protocols, criteria, and guidelines it relied upon in denying these claims to Provider.

12. By decision dated April 29, 2003, an independent review organization (IRO), determined the

Disputed Services were medically necessary.

13. By decision dated April 20, 2003, the Medical Review Division of the Texas Workers' Compensation Commission (Commission) granted Provider reimbursement for the Disputed Services.

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

15. 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.

16. 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.

17. Carrier failed to provide Dr. Howell with a sufficient explanation for denying Provider's claims.

18. For the dates of service from January 14, 2002, through May 13, 2002, Carrier failed to show that the Disputed Services were not medically necessary to treat Claimant's compensable injury.

19. The Disputed Services provided by Provider to Claimant were medically necessary.

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).

6. Carrier's explanation for denying the claims from January 14, 2002, though May 13, 2002, was legally inadequate as it failed to deny reimbursement in compliance with the Commission's rules.

7. Because Carrier never denied reimbursement in compliance with the Commission's rules for the disputed services from January 14, 2002, through May 13, 2002, Carrier is required to provide reimbursement.

8. Carrier failed to demonstrate that the Disputed Services from January 14, 2002, through May 13, 2002, were not reasonable and medically necessary for the treatment of Claimant's compensable injury.

9. Provider is entitled to reimbursement for the Disputed Services from January 14, 2002, through May 13, 2002, 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 January 14, 2002 through May 13, 2002, in the amount of $4,395.00, plus any and all applicable interest.

SIGNED April 21, 2005.

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