SOAH DOCKET NO. 453-03-3680.M5
TWCC MR NO. M5-03-1553-01

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 May 12, 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 aquatic therapy,[1] focused established office visits,[2] therapeutic exercises[3] and massage therapy[4] provided from September 5, 2002, through October 24, 2002 (Disputed Services).[5] 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.

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.

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[1] CPT Code 97113.

[2] CPT Code 99211.

[3] CPT Code 97110.

[4] CPT Code 97124.

[5] By Decision dated May 6, 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.

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 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.[6] 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. On May 20, 2002, Claimant underwent an L5-S1 decompression, discectomy and fusion, and was released for physical therapy by his orthopedic surgeon, Gilbert Meadows, M.D., on August 16, 2002.[7] Claimant went to Provider for this rehabilitative physical therapy.

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)."[8] 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."[9] Provider requested reconsideration and asked Carrier to clarify the protocol used to deny the claim. 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."[10] Carrier did not disclose its criteria and guidelines to Provider.

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

[7] Joint Ex. 14, Tab 1 at 161.

[8] Joint Ex. 14, Tab 1 at 180-184.

[9] *Id*.

[10] Joint Ex. 14, Tab 1 at 189-194.

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.[11] He was unaware of any healthcare provided to Claimant that exceeded any published medically accepted utilization review criteria.[12] Provider filed its request for reconsideration seeking more information to explain why Carrier had denied these claims and asked Carrier several questions trying to elicit this information. Carrier did not respond with any clarifying information to explain the reason for denying these claims for lack of medical necessity.

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 "U" 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 national medical guidelines. However, when Dr. Tsourmas was asked to explain Carrier's "RG" modifier, he could not do so.[15]

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.[16]

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 other than that provided by Carrier when it denied the claims. For example, Carrier cannot wait until the hearing to explain its reason for denying the claim as unnecessary treatment. 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's rules will not permit Carrier now to substitute an explanation that was not furnished in compliance with 28 TAC § 133.304(c).[17] 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.

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

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

[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.

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

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

III. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO Opinion and the Medical Record

The IRO reviewed the documentation provided by the parties and recited a detailed clinical history prior to issuing a decision. In its May 6, 2003, decision, the IRO agreed with Provider and found that physical therapy was medically necessary three times a week from September 5, 2002, through October 24, 2002. In addition, the IRO found that the office visits were medically necessary "for proper referrals and re-exams."[18] The IRO explained that:

> The claimant was post-surgery for a L5-S1 disc decompression, diskectomy and fusion. The surgeon who performed this task prescribed 8 weeks of physical therapy and a strengthening program to continue the claimant's progress. It is in my opinion and that of current literature that postoperative rehabilitation is necessary for the continuation of care. Since the therapy that was performed at First Rio Valley Medical was within this guideline, it is medically necessary. Any therapy beyond the initial 8 weeks is not necessary and should have transitioned the claimant to a home-based exercise program. With the large amount of therapy this claimant has already had, there would be minimal need for showing him new exercises.[19]

Provider's August 19, 2002, interim assessment report indicates that on August 16, 2002, Claimant was released by Dr. Meadows to engage in eight weeks of rehabilitative physical therapy following his lumbar spine surgery. Provider's diagnoses for Claimant included "other postsurgical status; displacement of lumbar intervertebral disc without myelopathy; tear of medial cartilage or meniscus of knee, current; myalgia and myositis, unspecified."[20] After evaluating Claimant's physical condition, Provider stated that Claimant would be treated with physical medicine modalities and with rehabilitative measures to the lumbar spine and the affected extremities three times weekly for four weeks, including one-on-one aquatic therapy and therapeutic therapy (stretching exercises), and massage therapy.[21]

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

[18] Joint Ex. 14, Tab 3 at 406.

[19] Joint Ex. 14, Tab 3 at 406.

[20] Joint Ex. 14, Tab 1 at 40.

[21] Joint Ex. 14, Tab 1 at 40.

> 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.[22]

In the October 30, 2002, interim assessment report, Provider documented that Claimant was ready to undergo a return to work program. According to Provider, Claimant could return to light duty, but because of the type of work Claimant did as a diesel crane mechanic, he needed to be able to do heavy work.[23] Claimant experienced improvement in his Oswestry level of pain, in the extension range of motion, and in his strength and endurance as a result of Provider's care.

Carrier paid Provider for two units (15-minute increments) of one-on-one aquatic therapy provided on September 5, 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 Amore efficacious regarding producing results with range of motion and strength."[24] Transitioning a patient from aquatic to land-based therapy may overlap, but not for more than a few weeks.[25]

As for this Claimant, Dr. Tsourmas testifiedthat Claimant did not need any aquatic therapy, particularly one-on-one therapy after spinal surgery. Instead, Claimant should have been in a land-basedprogram at home.[26] According to Dr. Tsourmas, Carrier reimbursed Provider for some of the therapy for "reasonable reeducation, recoaching, retraining."[27] At that point, Dr. Tsourmas maintains, Claimant should have been on an at-home program only.

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[22] Joint Ex. 14, Tab 1 at 41.

[23] Joint Ex. 14, Tab 1 at 69.

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

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

[26] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 140.

[27] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 141.

Dr. DeFoyd, Carrier's expert witness, practices at the Spine and Rehab Center and treats spinal injuries.[28] Dr. DeFoyd reviewed Claimant's medical records including those admitted into evidence and opined that the aquatic therapy was not medically necessary three months after his spinal surgery.[29] Moreover, Provider did not show that Claimant could not tolerate land-based therapy, so Claimant should have been in a land-based program only. As for the massage therapy, Dr. DeFoyd testified that may be appropriate to do in the early stages of recovery, but not this long after surgery.[30]

It is Dr. DeFoyd's opinion 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.[31]

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.[32]

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."[33] Dr. Howell explained that Claimant spoke only Spanish and complained of constant pain to his lower back, right knee, and right and left ankles. Dr. Meadows prescribed eight weeks of rehabilitative physical therapy following the spinal surgery. By this time, Claimant had undergone surgeries on both his knees and had just had a lumbar spinal fusion. The treatment plan followed by Provider in treating Claimant was appropriate, in compliance with Dr. Meadow's prescription, and was medically necessary.

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

[29] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 398-399.

[30] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 399.

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

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

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

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's rationale code ARG@ provided no explanation to Provider as the explanations refer back to Carrier's confidential 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.

The ALJ further finds that Carrier failed to show why it denied Provider's claims as unnecessary treatment between September 5, 2002, and October 24, 2002, and failed to show by a preponderance of the evidence that the Disputed Services were not medically necessary. In the course of a year Claimant underwent two surgeries, one on each knee, and spinal surgery. The spinal surgery was performed by Dr. Meadows on May 20, 2002. On August 19, 2002, Dr. Meadows prescribed eight weeks of physical therapy as part of Claimant's post-surgical treatment. Provider assessed Claimant's condition and based on the totality of Claimant's condition provided one-on-one aquatic therapy and therapeutic exercises and massage therapy. The IRO reviewed Claimant's medical history and found that Provider's treatment was medically necessary.

While Dr. Tsourmas and Dr. DeFoyd maintain that Claimant should have directed Claimant to do a home-based program, they appear to ignore Dr. Meadows' prescription for the therapy or the effects three surgeries would have on the Claimant. Additionally, as a result of Provider's treatments, Claimant's Oswestry pain levels improved; his range of motion improved; his strength improved; and he improved enough to engage in a return to work program. Therefore, the ALJ finds that Carrier failed to prove by a preponderance of the evidence that the Disputed Services were not medically necessary.

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.

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. On May 20, 2002, Gilbert Meadows, M.D. performed an L5-S1 decompression, discectomy and fusion on Claimant's lumbar spine.

9. On August 16, 2002, Dr. Meadows released Claimant to participate in rehabilitation and prescribed eight weeks of physical therapy.

10. Claimant went to Provider for the rehabilitative physical therapy ordered by Dr. Meadows.

11. On August 19, 2002, Provider evaluated Claimant's condition and established a treatment protocol that included one-on-one aquatic therapy, therapeutic exercises, and massage therapy three times weekly.

12. From September 5, 2002, through October 24, 2002, Provider treated Claimant with one-on-one aquatic therapy, one-on-one therapeutic exercises, focused established office visits, and massage therapy (Disputed Services).

13. As a result of Provider's treatments, Claimant's Oswestry pain levels improved; his range of motion improved; his strength improved; and he improved enough for Provider to refer Claimant to a return to work program.

14. Provider requested reimbursement from Texas Mutual Insurance Company (Carrier) for the one-on-one aquatic therapy, one-on-one therapeutic exercises, focused established office and massage therapy provided to Claimant from September 5, 2002 through October 24, 2002.

15. Carrier paid Provider for two of the four units billed for the one-on-one aquatic therapy (billed in units of 15 minutes) provided on September 5, 2002.

16. Carrier denied reimbursement for the Disputed Services in the amount of $1,794.00.

17. 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).

18. Carrier used the rationale code "RG" on the EOB and its definition as its explanation to Provider for denying the Disputed Services.

19. Carrier defined rationale code "RG" 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."

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

21. 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.

22. 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.

23. 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.

24. By decision dated May 6, 2003, an independent review organization (IRO), determined the Disputed Services were medically necessary.

25. By decision dated May 12, 2003, the Medical Review Division of the Texas Workers' Compensation Commission (Commission) granted Provider reimbursement for the Disputed Services.

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

27. 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.

28. 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.

29. Carrier failed to provide Provider with a sufficient explanation for denying Provider's claims.

30. For the dates of service from September 5, 2002, through October 24, 2002, Carrier failed to show that the Disputed Services were not medically necessary to treat Claimant's compensable injury.

31. 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 Disputed Services from September 5, 2002, through October 24, 2002, was legally inadequate as it failed to deny reimbursement in compliance with the Commission's rules.

7. Because Carrier did not deny reimbursement in compliance with the Commission's rules for the disputed services from September 5, 2002, through October 24, 2002, Carrier is required to provide reimbursement.

8. Carrier failed to demonstrate that the Disputed Services from September 5, 2002, through October 24, 2002, were not reasonable and medically necessary for the treatment of Claimant's compensable injury.

9. Provider is entitled to reimbursement from Carrier for the Disputed Services provided by Provider to Claimant from September 5, 2002, through October 24, 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 September 5, 2002, through October 24, 2002, in the amount of $1,794.00, plus any and all applicable interest.

SIGNED April 22, 2005.

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