SOAH DOCKET NO. 453-03-4642.M5
TWCC MRD NO. M5-03-0410-01

FIRST RIO VALLEY MEDICAL, P.A.,		**BEFORE THE STATE OFFICE**
Petitioner and Cross-Respondent	§	
	§	
V.	§	**OF**
	§	
INSURANCE COMPANY OF THE STATE	§	
OF PENNSYLVANIA,	§	
Respondent and Cross-Petitioner	§	**ADMINISTRATIVE HEARINGS**
	§	

DECISION AND ORDER

First Rio Valley Medical, P. A. (Provider), challenged the decision of the Medical Review Division of the Texas Workers' Compensation Commission (MRD/Commission) denying reimbursement to it for sessions of physical medicine that Provider administered to ___ (Claimant) from October 10, 2001, through June 14, 2002, and for the review of a medical report conducted on June 11, 2002. Insurance Company of the State of Pennsylvania (Carrier) appealed that portion of the MRD Decision ordering reimbursement to Provider for sessions of physical medicine conducted on May 27, 29, and 30, 2002 (the May dates).

The MRD ruled that most of the treatments were not medically necessary and also that Provider had failed to justify the amount claimed for the report review. In regard to services on the May dates, the MRD held that Provider was entitled to reimbursement for the billed amount because it demonstrated that the services billed were services compensable under the terms of the 1996 *Medical Fee Guideline* (MFG)[1] and Carrier had failed to inform Provider in the manner required by Commission rules of its reasons for denying reimbursement.[2]

The Administrative Law Judge (ALJ) finds no reimbursement is due for any of the disputed dates of service.

The hearing in this matter convened on January 20, 2005, in Austin, Texas, with ALJ Cassandra Church presiding. The record closed that day. Provider was represented by Robert Howell, D.C. Carrier was represented by Steve Tipton, attorney. The Commission did not participate in the hearing.

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[1] 28 TEX. ADMIN. CODE § 134.201.

[2] TEX. LABOR CODE ANN. § 408.027(d) and 28 TEX. ADMIN. CODE § 133.304(c). The Labor Code requires a carrier to notify a provider in a clearly understandable form of the substantive reasons it denied a claim for reimbursement. Carriers provide their reasons for denial in a document called the explanation of benefits (EOB). For each item billed, an EOB lists a shorthand description of the carrier's reason for denying reimbursement, usually by means of a letter code or a brief note.

Matters of jurisdiction and notice were not disputed, so are set forth in the Findings of Fact and Conclusions of Law without further discussion here.

I. DISCUSSION

A. Burden of Proof

As each party timely petitioned for hearing on that portion of the MRD decision adverse to it, each has the burden of proof in regard to those matters it disputes.[3]

B. Medical History

On ___, Claimant was injured in a fall. Claimant's injury was treated conservatively with physical medicine modalities, manipulations, and therapeutic procedures. Claimant's initial diagnosis was displacement of a cervical intervertebral disc, with some radiculitis.[4] Claimant was not a surgical candidate, although he was given trigger point injections.[5]

An MRI of Claimant's cervical spine taken in June 2000 showed degenerative changes in the vertebral bodies from C2 to C7 levels, as well as degeneration of the disc spaces in that spine area. However, there was no herniated disc lesions or compression of the nerve roots.[6]

Provider began treating Provider on July 30, 1999. Provider apparently treated Claimant, at least intermittently, from July 1999 though August 2001. Dr. Howell stated that his examination on August 21, 2001, indicated that Claimant had suffered an acute exacerbation of his cervical spine injury. The treatments at issue followed that examination.

C. Presentation of EOB's

Provider argued that because the MRD found that Carrier had failed to provide it with timely EOB's for the May dates, Carrier was not entitled to have the issue of medical necessity for these treatments considered at the SOAH hearing.[7] As it had no EOB before it, the MRD considered only the evidence submitted by Provider. In essence, the MRD concluded that Provider had made a *prima facie* case that it was entitled to reimbursement because it had billed for services that are compensable services.

The Carrier challenged the MRD's conclusion on lack of notice to Provider. Carrier surmised that Provider may have failed to file claims for the May dates, which, if true, might explain

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[3] TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41 (b), and 28 TEX. ADMIN. CODE § 148.21(h).

[4] Provider Exh. 2, p. 9.

[5] Carrier Exh. 1, p. 11.

[6] Provider Exh. 1, p. 41.

[7] TEX. LABOR CODE ANN. § 408.027(d) and 28 TEX. ADMIN. CODE § 133.304(c).

the absence of an EOB. Carrier pointed to the fact that there was no U.S. mail return receipt *i.e.*, green card for the May date claims, as was common for other of Provider's claim submissions.[8]

There is some evidence in the record that there was timely communication between the parties concerning the claim for the May dates. On June 17, 2002, and on July 23, 2002, Carrier denied reimbursement for the same types of services on the grounds that they were not medically necessary.[9] Between them, those two denials covered April 30, 2002; May 15, 16, 20, 22, and 23, 2002; and June 3, 10, and 12, 2002. On some unknown date after that, Provider submitted a request for reconsideration of all the above-listed dates as well as the May dates.[10] On August 26, 2002, Provider received an EOB on reconsideration denying payment for all treatments, including those on the May dates.[11] The EOB on reconsideration does not state the substantive reason for the denial.

The ALJ concluded that it is reasonable to infer from Provider's submission of a request for reconsideration of the May dates that either the original claim had been denied or that Provider elected to have it considered along with other arising from the same period, notwithstanding Carrier's failure to issue an EOB. In short, Provider either got an EOB or Provider waived his objection to Carrier's failure to file an initial EOB. Provider cannot assert that procedural defect as a basis for payment once it has waived it.

Further, the MRD's findings do not control the hearing before SOAH. Although commonly referred to as an appeal, the proceeding before SOAH is in fact a new hearing, or hearing *de novo*, on both medical necessity and fee dispute issues.[12] This means that the parties before SOAH can, and frequently do, introduce new evidence on the issues raised before the MRD. Carriers have been barred from raising any *issues* before SOAH that were not raised in the EOB's.[13] These decisions rest on the principles of notice and fairness. That is, a provider should not be surprised at hearing with issues new to it on which it has had no chance to prepare its case. Were this a case in which

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[8] Provider Exh. 1, pp. 339 and 366.

[9] Provider Exh. 1, pp. 324-347 and 354-366.

[10] Provider Exh. 1, pp. 368-409.

[11] Provider Exh. 1, pp. 358-359.

[12] 28 TEX. ADMIN. CODE § 133.307(p)(3) [regarding fee disputes]; 28 TEX. ADMIN. CODE § 133.308(u)(5) [medical necessity disputes]. The language of See. 133.308(u)(5) appears below:

> (5) Notwithstanding other provisions of this rule or any other rules, the acquiring, providing, assembling, filing and offering of documents at any *de novo* hearing (a new hearing based upon evidence admitted at the SOAH hearing) conducted by the State Office of Administrative Hearings on or after March 1, 2003, whether or not previously exchanged, is the responsibility of the requestor and respondent. Admission and use of such documents at the hearing are controlled by the procedural Rules of the State Office of Administrative Hearings. The commission will not file a copy of the record of the service review by the division with SOAH or any party for a hearing scheduled to be conducted by SOAH (or continued to a date) on or after March 1, 2003.

[13] *See, e.g.,* SOAH Docket No. 453-04-5337.M4 (September 2004), No. 453-02-0663.M4 (October 2002), and No. 453-01-1367.M4 (July 2001).

Carrier's conduct left Provider wondering about the reason for denial, the question of the adequacy of notice would arise, without or without issuance of an EOB.

However, lack of substantive notice did not arise in this case. The controversy in this case was straightforward. During that entire period, on dates both before and after the May dates, Carrier denied reimbursement on the basis of lack of medical necessity. Lack of medical necessity-with one exception-was the only issue Carrier raised regarding any of the many dates of service at issue. As noted above, Provider requested that the May dates be reconsidered along with nine other dates, all of which had been denied on the basis of lack of medical necessity.

Notice to Provider of the Carrier's concerns about Provider's services came in ample time to allow Provider to prepare its case. The EOB's on reconsideration were issued approximately nine months before the MRD took up the dispute in April 2003.[14] On September 8, 2003, Carrier filed with State Office of Administrative Hearings (SOAH) the documents it had presented to the Independent Review Organization (IRO) and which, presumably, it would offer into evidence in the contested case hearing. These included additional peer reports on the lack of medical necessity. Provider thus had over a year before the SOAH hearing to marshal its evidence on the medical specifics raised by the peer reviewers.

The ALJ concluded that the evidence as to whether Carrier committed a procedural defect under Commission rules for processing claims is inconclusive. Further, if a defect occurred, Provider waived it by its conduct in submitting the May dates for reconsideration.

The ALJ further concluded that Provider received sufficient substantive notice of the basis for Carrier's denial of the claims for the May dates to apprise it of the issue which would be aired at the SOAH hearing. The ALJ considered the evidence of medical necessity in regard to services rendered on the May dates along with that for all other dates of service at issue.

D. Medical Necessity

Provider supplied two clusters of services after August 2001. Each cluster comprised some combination of office visits, therapeutic procedures, physical therapy, aquatic therapy, massage, and the administration of a variety of physical modalities. These clusters occurred between October 10 and 15, 2001, and between April 30 and June 14, 2002. Provider treated Claimant on 12 dates during the latter period.[15] Dr. Howell asserted that all treatment was necessary and consistent with medical treatment guidelines in place for those dates.[16]

Provider's rationale for the first cluster of services was the conclusion that in August 2001 that Claimant had suffered an acute exacerbation of his initial compensable injury.[17] On August 21,

[14] Provider Exh. 1, pp. 410-441.

[15] Provider Exh. 2, pp. 345-348.

[16] 28 TEX. ADMIN. CODE § 134.1001, *Spine Treatment Guideline* (repealed eff. January 1, 2002, *See* 27 Tex. Reg. 1661 (2002)).

[17] Provider Exh. 2, pp. 6-14.

2001, Dr. Howell evaluated Claimant's pain levels, both objective and subjective, and also tested his strength and range of motion.[18] However, what is absent from the notes of that examination is any report of the incident, accident, or activity that exacerbated Claimant's original injury. Claimant apparently reported none. The only cause listed for Claimant's episodes of pain was performance of some of his activities of daily living (ADL's).[19]

Immediately before the therapy at issue, on October 2, 2001, Allen J. Sam, D.C., recommended continuing physical therapy to continue improving Claimant's range of motion and strength. No exacerbating event or activity beyond ADL's were noted and Claimant's pain episodes were noted as slight or mild in severity, although frequent.[20]

Although Provider asserted there had been an exacerbation of Claimant's injury in August 2001, Provider provided no credible reasons why the second cluster of services was initiated in April 2002. Again, no exacerbating event or activity was listed in the notes of Claimant's treatment.[21]

Carrier's peer reviewers differed on whether any continuing chiropractic care would be necessary to treat Claimant. However, they agreed that programs of rehabilitation therapy at the frequency administered in late 2001 and mid-2002 were basically to no purpose six years after Claimant's injury.

There is no dispute that Claimant was experiencing some pain in conducting his ADL's in late 2001 and in 2002. In July 2002, Carrier's chief peer reviewer, Farrukh Hamid, M.D., acknowledged that Claimant displayed signs of a chronic pain problem, although he saw no indication of radiculopathy (radiating pain).[22] Dr. Hamid also stated that one office visit when Claimant had new complaints with a follow-up visit every four to six weeks would be adequate to treat Claimant's condition. However, he also said that periodic symptomatic treatment with physical medicine modalities and aquatic therapy was neither reasonable nor medically necessary. In April 2002, Dr. Hamid stated specifically that treatments rendered on October 10, 12, and 15, 2001, were not medically necessary.[23]

In May 2000, Carrier also had the medical records in this case reviewed by a doctor of chiropractic, John W. Schweitzer, D. C.[24] Dr. Schweitzer's opinion differed from Dr. Hamid's somewhat in that he stated that no additional chiropractic care would be medically necessary so long after the accident. Dr. Schweitzer said such care would be only palliative in nature and would be outside the scope of treatment under the *Spine Treatment Guideline*.

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[18] Provider Exh. 2, pp. 30-46.

[19] Provider Exh. 2, p. 44.

[20] Provider Exh. 2, pp. 64-82.

[21] Provider Exh. 2, pp. 156-166.

[22] Carrier Exh. 1, pp. 7-8.

[23] Provider Exh. 1, p. 66. (Dr. Hamid's letter dated April 24, 2002, and apparently received by Provider on May 28, 2002).

[24] Carrier Exh. 1, pp. 9-14.

Considering the greater weight of credible evidence, the ALJ concluded therapy and physical modalities administered between in October 2001 and in late April, May, and June 2002 were not medically necessary to treat Claimant's compensable injury and that Provider is not entitled to further reimbursement.

E. Fee Issue

On June 11, 2002, Provider reviewed a medical testing report. There was no applicable maximum allowable amount (MAR) in the *Medical Fee Guideline* for this service. Therefore, in order to receive reimbursement, a provider must document the nature of, need for, and complexity of the service to justify the amount it asserts is due. Provider billed the Carrier for $500.00; the Carrier paid $100.00 and denied $400.00. The MRD held that Provider had failed to document that the amount claimed was fair and reasonable, so Provider had the burden of proof on this issue.

Provider offered no description of the service, the time spent performing it, the need for, or skills required to render this service, or any other information that explained why $500.00 would be a more fair and reasonable rate of reimbursement than $100.00. No further reimbursement is warranted.

III. FINDINGS OF FACT

1. On ___, ___ (Claimant) injured his cervical spine in a fall.

2. Insurance Company of the State of Pennsylvania (Carrier) was the responsible insurer.

3. Claimant's initial diagnosis was displacement of a cervical intervertebral disc, with some radiculitis.

4. Claimant was treated with physical medicine modalities, manipulations, and therapeutic procedures.

5. Claimant also received trigger point injections. Claimant was not a surgical candidate.

6. In June 2000, Claimant showed degenerative changes in the C2-C7 vertebral bodies, as well as degeneration of the disc spaces in that spine area. Claimant had no herniated disc lesions or compression of nerve roots in that area.

7. Claimant experienced some mild but frequent pain and difficulty in performing some activities of daily living (ADL's) in 2001 and 2002. Claimant was taking pain medication during this period.

8. First Rio Valley Medical, P.A. (Provider), began treating Claimant on July 30, 1999, and treated him intermittently between July 1999 and August 2001.

9. In August 2001, Dr. Robert Howell, D.C., concluded that Claimant had suffered an acute exacerbation of his compensable injury. Claimant's ongoing difficulty with some ADL's were the only events listed in Claimant's medical record as causing his symptoms.

10. On October 2, 2001, Allen J. Sam, D.C., recommended continuing physical therapy to continue improving Claimant's range of motion and strength. No exacerbating event or activity beyond performance of ADL's was documented.

11. On October 10, 12, and 15, 2001, Provider administered aquatic therapy and one-on-one physical therapy, and also conducted an office visit.

12. On 12 dates between April 30 and June 14, 2002, Claimant administered one-on-one physical therapy, massage, phonophoresis, spray and stretch pain relief treatment, and also conducted several office visits.

13. Claimant experienced no documented exacerbating event, accident, or activity before the treatments in May and June 2002.

14. Claimant had no documented medical need for additional rehabilitative treatments in late 2001 or mid-2002.

15. On June 11, 2002, Provider reviewed a medical testing report in connection with his treatment of Claimant.

16. Carrier reimbursed Provider $100.00 for reviewing a medical testing report on June 11, 2002. Provider had billed $500.00 for performing this service.

17. Provider did not establish that $500.00 was a fair and reasonable charge for the reported new service, based on the nature of or need for the service, or the skill level or time required to perform it.

18. Carrier denied payment for all treatments based on lack of medical necessity. Carrier denied payment for the report review on the basis that it was an unreasonable fee for a procedure requiring documentation.

19. Provider timely appealed the Carrier's determinations to the Medical Review Division (MRD) of the Texas Workers' Compensation Commission.

20. The MRD submitted the medical necessity issues to an Independent Review Organization (IRO), Texas Medical Foundation, on an unknown date before April 10, 2003.

21. On July 22, 2003, based on the review by the IRO, the MRD denied further reimbursement to Provider for treatments between October 10, 2001, and June 14, 2002, on the basis that they were not medically necessary six years after Claimant's injury.

22. On July 22, 2003, the MRD concluded Carrier had not submitted an explanation of benefits (EOB) to Provider for its denial of the claims submitted for services rendered on May 27, 29, and 30, 2002, then ordered reimbursement for services on the basis that Provider demonstrated that it had provided reimbursable medical services on those dates.

23. On an unknown date in 2002, Provider requested reconsideration of Carrier's denial of payment for May 27, 29, and 30, 2002, along with nine other dates of services in April, May, and June 2002.

24. Carrier informed Provider that it was denying payment for services rendered on May 27, 29, and 30, 2002,as well as services on nine other dates of service, through an EOB on reconsideration issued on August 26, 2002.

25. Provider was informed that Carrier disputed the medical necessity of services provided on all dates of service at issue.

26. On September 8, 2003, in the course of the contested case hearing, Carrier supplied Provider with additional peer reviews discussing the issue of the medical necessity for the services at issue.

27. On July 22, 2003, the MRD denied reimbursement to Provider for the additional $400.00 it had requested for reviewing a medical testing report on June 11, 2002, on the basis Provider failed to establish the amount billed was a fair and reasonable charge for the service.

28. On August 5, 2003, Provider requested a hearing on the July 22, 2003, MRD decision regarding its denial of additional reimbursement for certain dates.

29. On August 11, 2003, Carrier requested a hearing on the July 22, 2003, MRD decision regarding its award of additional reimbursement to Provider.

30. On September 2, 2003, the Commission issued a notice of hearing on both requests for hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted.

31. On January 20, 2005, Administrative Law Judge Cassandra Church conducted a hearing on the merits of both cases. The record closed that day.

III. 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 and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider and Carrier each timely requested a hearing, as specified in 28 TEX. ADMIN. CODE § 148.3.

3. Proper and timely notice of the hearing on both requests was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Provider has the burden of proof as to matters adverse to it and Carrier has the burden of proof as to matters adverse to it, pursuant to TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41 (b), and 28 TEX. ADMIN. CODE § 148.21(h).

5. Provider failed to meet its burden of proof to show that one-on-one physical therapy, massage, phonophoresis, aquatic therapy, and spray and stretch pain treatments administered on October 10, 12, and 15, 2001, and on dates between April 30 and June 14, 2002, or supplies and office visits related to those treatments, were medically necessary to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

6. Provider failed to meet its burden of proof to show that $500.00 was a fair and reasonable charge for its review of a medical testing report on June 11, 2002, within the meaning of TEX. LAB. CODE ANN. § 413.011(b) and 28 TEX. ADMIN. CODE § 134.201, *Medical Fee Guideline*BGeneral Instructions.

7. Carrier met its burden of proof to show that one-on-one physical therapy, phonophoresis, massage, spray and stretch pain treatments, any related supplies, and an office visit conducted on May 27, 29, and 30, 2002, were not medically necessary to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

ORDER

IT IS ORDERED that all claims by First Rio Valley Medical, P. A., for reimbursement for all treatments and procedures, related office visits and medical supplies, and medical report review administered to or conducted on behalf of Claimant ___ from November 10, 2001, through June 14, 2002, are hereby denied.

SIGNED March 10, 2005.

CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS