SOAH DOCKET NO. 453-04-5337.M4
TWCC MRD NO. M4-03-4522-01

AMERICAN HOME INSURANCE COMPANY, Petitioner	:	BEFORE THE STATE OFFICE
V.	:	OF
DR. WILLIAM KOWALSKI, D.C., **Respondent**	:	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

American Home Assurance Company (Carrier) challenged the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) ordering reimbursement to Dr. William Kowalski, D. C. (Provider), for medical treatments that Provider administered to ____(Claimant) from April 9, 2002, through June 19, 2002. On March 12, 2004, the MRD required Carrier to pay for sessions of aquatic therapy, neuromuscular reeducation, gait training, and massage, as well as for office visits related to those treatments. Carrier asserted that the treatments given were beyond the scope of services for which Claimant was referred and also were provided to treat injuries whose compensability had not been established. Carrier also argued that none of the treatment Provider administered during the two-month-long period was medically necessary to treat the injury that Claimant sustained in September 2000. Provider asserted that Carrier had failed to timely raise the issues both of medical necessity and entitlement to treatment (compensability) so was barred from raising those issues in the contested case.[1] Provider also

[1] This contested case is a medical fee dispute; medical fee disputes exclude the issue of medical necessity. 28 TEX. ADMIN. CODE ''133.305 (a) and 133.308 (a). Under the Commission's current procedural rules, a dispute on medical necessity would be directed to an Independent Review Organization (IRO) for resolution. Had the ruling in this case been that medical necessity had been timely raised, the appropriate relief would appear to have been remand of that portion of the dispute to the Commission for resolution under Rule 133.308.

asserted that the treatment was within the scope of services requested by the treating doctor and was also medically necessary.

Based on the evidence submitted, the Administrative Law Judge (ALJ) concluded that Carrier failed to timely raise the issues of entitlement and medical necessity so is barred from raising either issue in the contested case hearing. The ALJ also concluded that Carrier failed to meet its burden of proof to show that the services provided were outside the scope of the referral made by Claimant's treating doctor. The services were rendered in accordance with agency guidelines so the Carrier should compensate Provider for all services it rendered to Claimant.

The hearing in this matter convened on September 2, 2004, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra Church presiding. The record closed September 8, 2004, to allow supplementation of the record.[2] Provider was represented by Carlos Cerrato, attorney. Carrier was represented by Peter L. Macaulay, attorney. The Commission did not participate in the hearing.

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

I. DISCUSSION

This case was primarily a dispute concerning proper procedure. Carrier acknowledged that it had failed to raise the issue of the lack of medical necessity as a basis for denial in the explanation of benefits (EOB) it issued to Provider on July 1, 2002. However, Carrier argued it had made its

[2] On September 7, 2004, Petitioner submitted a statement from counsel that it had not found a copy of the October 9, 2000, TWCC-21 form which had been file-stamped as being received by the Commission. The filing of a TWCC-21 form with the Commission initiates a compensability dispute. This letter is admitted to the record as Carrier Exh. 3.

objections to the medical treatment known by sending Provider a copy of the June 12, 2002, report on the required medical examination (RME). The RME doctor had concluded additional treatment was unneeded.[3] Carrier argued that sending the letter was sufficient notice to Provider to put medical necessity in issue.

Provider argued that, as Carrier had not formally raised its medical necessity objections by the time Provider requested medical dispute resolution at the agency, Carrier was foreclosed from raising them in the SOAH hearing. Rule 133.307(j)(2) limits the Carrier to grounds for reimbursement raised before the request for an MRD dispute resolution is filed.[4] Rule 133.307(j)(2) states:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or
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> defenses after the filing of a request. Any new denial reasons or defenses shall not be considered in the review.

In this case, Provider requested dispute resolution by the MRD on April 10, 2003.[5] Carrier issued amended EOBs on April 14 and 15, 2003, in which it raised for the first time medical

[3] Carrier Exh. 1, pp. 49-53. The RME doctor, Martin R. Steiner, M.D., concluded that Claimant's injury was minor and should have cleared up in a few weeks without additional treatment.

[4] 28 TEX. ADMIN. CODE ' 133.307 applies to this medical fee dispute resolution as the party requesting resolution did so after January 1, 2003. (Eff. date January 2, 2002, amended to be effective January 1, 2003, 27 Tex. Reg. 12282).

[5] Provider Exh. 1, p. 254.

necessity as a reason for denying payment for the disputed treatments.[6] This case presents a straightforward application of Rule 133.307(j)(2). Notwithstanding Carrier's argument urging recognition of alternate means of notice, the Commission's rules make no provision for alternate means of notice. Rather, the rules require carriers to give health care providers detailed reasons via an EOB for denying a claim at the time they deny that claim. TEX. LAB. CODE ANN. ' 408.027(d) and 28 TEX. ADMIN. CODE ' 133.304(c).[7] Carrier is foreclosed from challenging the medical necessity of these services in this contested case because it did not raise medical necessity timely before the MRD.

Carrier also argued that it properly denied the claim on entitlement grounds. The entitlement grounds for denying a claim for payment of services is used when a carrier is disputing the compensability of the injury and the matter has not been finally adjudicated.[8] Notwithstanding the existence in Carrier's records of a completed TWCC-21 form dated October 9, 2000, diligent search failed to turn up a file-stamped copy showing receipt by the Commission.[9] Thus, there was no verification that Carrier had filed a compensability challenge on this injury. The ALJ concluded that Carrier had not filed a compensability challenge at the time it denied Provider's claim so was ineligible to deny this claim for reimbursement on entitlement grounds.

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[6] Provider Exh. 1, pp. 126-163.

[7] In contested case hearings at SOAH, carriers have been limited to pursuing the grounds for denial which they raised in the EOB and aired before the MRD. *See* SOAH Dkt. Nos. 453-02-0663.M4 (October 4, 2002) and 453-01-1367.M4 (July 23, 2001).

[8] Exception code AE@ is used when a carrier is disputing liability for the claims or compensability of the injury and the issue has not been adjudicated. (TWCC-62 form, List of payment exception codes Revised July 2000).

[9] Carrier Exh. 3.

The additional ground Carrier raised was that the treatment at issue was provided by someone other than the treating doctor or had not been approved by the treating doctor.[10] Grant Pector, M.D., was Claimant's treating doctor between April and June 2002. On April 10, 2002, Dr. Pector referred Claimant to Provider for aquatic therapy. Dr. Pector renewed his instruction on May 10, 2002, when he authorized the additional weeks requested by Provider to wrap up the treatment sequence. In the May 20, 2002, directive Dr. Pector listed all of the services Provider administered and requested them for treatment of RSD of Claimant's left foot.[11] Provider also received a referral from Anthony J. LaMarra, D.P.M., Claimant's podiatrist.[12] Carrier did not dispute that these doctors referred Claimant to Provider for treatment. The ALJ concluded the treatments were authorized by Claimant's treating doctor.

In the alternative, Carrier argued for a broader reading of this denial code, contending that while the treating doctor did authorize treatment to Claimant's foot and ankle, any treatment involving Claimant's leg was outside the scope of the referral authority.[13] Provider acknowledged that some therapy was administered to the entire leg, but said the Claimant's foot and ankle problems necessarily affected the entire leg. Dr. Kowalski stated that appropriate treatment of any gait problem resulting from a foot or ankle injury included treating the entire leg. Although not entirely persuaded that Carrier's broad reading of this denial reason is valid, the ALJ evaluated the evidence in light of this argument. Based on that evidence, the ALJ concludes that there was no credible

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[10] The MRD hearing officer noted that he had evaluated the substantive issues regarding the disputed services under the terms of the 1996 *Medical Fee Guideline* (MFG), 28 TEX. ADMIN. CODE ' 134.201 (repealed effective January 1, 2002). Neither party objected to consideration of the issues using the provisions of the 1996 MFG.

[11] Provider Exh. 1, pp. 22-25.

[12] Carrier Exh. 1, p. 59.

[13] Exception code AL@is used when a carrier is denying payments because a referred health care provider performed treatments or services without the treating doctor's approval. The explanatory language for this denial code does not expressly address the scope of the referral. (TWCC-62 form).

evidence in the record to suggest that the treatment Provider administered exceeded the services which the treating doctor requested or inappropriately focused on an uninjured body part.

In sum, Carrier failed to properly or timely raise two of the three grounds for denial of reimbursement. In addition, Carrier failed to carry its burden of proof to show that the treatments Provider administered had not been authorized by Claimant's treating doctor. Therefore, the ALJ concluded that the medical treatment in this case was provided in accordance with Commission rules and Carrier should compensate Provider for all treatments and office visits at issue.

II. FINDINGS OF FACT

1. On ____, ____(Claimant) injured her left foot and ankle on the job.

2. American Home Assurance Company (Carrier) was the responsible insurer.

3. Claimant's left foot and ankle were treated with passive therapy and nerve blocks. She had arthroscopic surgery to her left ankle in February 2002 and she was using crutches to walk in April 2002.

4. In April 2002, Claimant was unable to bear weight on her left foot, had pain, and extreme sensitivity to heat and touch in her left foot and ankle. In April 2002, Claimant's treating doctor, Grant Pector, M.D., diagnosed Claimant as having reflex sympathetic disorder (RSD) of the left foot.

5. On April 4, 2004, Dr. Pector referred Claimant to William Kowalski, D.C. (Provider), for treatment of RSD of her left foot through aquatic therapy. Dr. Kowalski operates and oversees treatment at Northshore Aqua-Therapy Clinic.

6. On May 10, 2002, Dr. Pector renewed his prescription, instructing Provider to administer aqua-massage, gait training, and neuromuscular reeducation, as well as aquatic therapy to Claimant.

7. On May 14, 2004, Anthony J. LaMarra, D.P.M., Claimant's podiatrist, requested Provider continue administering aquatic therapy to Claimant.

8. In sessions conducted between April 9, 2002, and June 19, 2002, Provider administered aquatic therapy, neuromuscular reeducation, gait training, and aqua-massage treatments. Provider also saw Claimant in office visits on April 9, 2002, and at intervals through June 19, 2002.

9. The treatments were directed toward relieving the RSD and restoring mobility to the left foot and ankle. Some treatment involved the entire left leg since gait problems caused by Claimant's foot and ankle injury affected the entire left leg.

10. On July 1, 2002, Carrier denied payment for all treatments Provider administered to Claimant from April 9, 2002, through June 19, 2002, on the basis Provider was not the treating doctor and that Claimant was not entitled to the treatment as it did not relate to an injury that had been determined to be compensable. In the explanation of benefits (EOB) it issued denying payment, Carrier did not raise the grounds of lack of medical necessity for the services.

11. Carrier had not initiated a compensability dispute for the injury to Claimant's left ankle and foot on July 1, 2002, the date on which it denied payment to Provider for services administered between April and June 2002.

12. On April 10, 2003, Provider appealed the Carrier's determination to the Medical Review Division (MRD) of the Texas Workers' Compensation Commission.

13. On April 14 and 15, 2003, Carrier amended its EOBs to deny Provider's claim for payment on the additional basis that the treatment was not medically necessary.

14. The MRD examined the substantive portions of the dispute by applying the terms of the 1996 *Medical Fee Guideline* (MFG), 28 TEX. ADMIN. CODE ' 134.201 (repealed effective January 1, 2002). The parties did not object to reviewing the disputed issues under the terms of the 1996 MFG.

15. On March 12, 2004, the MRD ordered Carrier to reimburse Provider for all services provided from April 9, 2002, through June 19, 2002.

16. On April 2, 2004, Carrier requested a contested hearing on the MRD decision.

17. On May 4, 2004, the Commission issued a notice of 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.

18. Administrative Law Judge Cassandra Church conducted a hearing on the merits of this case on September 2, 2004, and the record closed on September 8, 2004.

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. Carrier timely requested a hearing, pursuant to 28 TEX. ADMIN CODE ' 148.3.

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

4. Carrier, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. ' 413.031, 1 TEX ADMIN. CODE ' 155.41(b), and 28 TEX. ADMIN CODE ' 148.21(h).

5. Carrier failed to timely raise the issues of entitlement and lack of medical necessity as required by TEX. LABOR CODE ANN. ' 408.027(d) and 28 TEX. ADMIN. CODE ' 133.304(c).

6. Carrier is barred from raising the issues of entitlement or medical necessity in this contested case hearing, pursuant to 28 TEX. ADMIN. CODE ' 133.307(j)(2).

7. Carrier failed to meet its burden of proof to show that Claimant's treating doctor had not authorized the services provided, as the requirements for authorization of services performed by referred doctors were set forth in the 1996 *Medical Fee Guideline*, 28 TEX. ADMIN. CODE ' 134.201 (repealed effective January 1, 2002), as applied by the parties in this case.

ORDER

IT IS ORDERED that American Home Assurance Company reimburse William Kowalski, D.C., for all office visits and physical medicine treatments administered to Claimant___. from April 9, 2002, through June 19, 2002.

SIGNED September 30, 2004.

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