SOAH DOCKET NO. 453-05-4246.M4
TWCC MR NO. M4-04-4246-01

AMERICAN HOME ASSURANCE CO.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
ACTIVE BEHAVIORAL HEALTH,	§	
L.L.C.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

American Home Assurance Company appealed a Texas Workers' Compensation Commission (Commission)[1] Medical Review Division's (MRD's) decision that ordered payment of $9,800 in reimbursement for 19 sessions of a chronic pain management (CPM) program provided from June 26, to July 30, 2003. This decision upholds MRD's determination.

The hearing convened as scheduled on January 18, 2006, and the record closed that day. The hearing was conducted at the State Office of Administrative Hearings, William P. Clements Building, 300 West 15th Street, Austin, Texas, before the undersigned Administrative Law Judge (ALJ). Attorney Steven Tipton represented the Carrier, and R. Todd Petersen, M.D., represented the Provider, Active Behavioral Health, L.L.C.

II. ANALYSIS

The Carrier's witness, Christa Jordan, Ph.D., testified about the deficits of the Provider's CPM program. Relying on generally accepted standards for such programs, Dr. Jordan said the

[1] Effective September 1, 2005, the functions of the Commission were transferred to the newly created Division of Workers' Compensation of the Texas Department of Insurance.

Provider's program:

- lacked objective measurements of the claimant's physical and psychological symptoms and abilities at the beginning and end of the program;
- lacked oversight by a psychologist and medical director;
- was not goal oriented;
- did not document times and types of specific physical therapy activities;
- had no individualized plan for the claimant;
- lacked a sufficient number of hours of mental health care;
- lacked documentation of vocational rehabilitation provided; and
- included no plan to diminish the claimant's use of pain medications.

The Provider recorded certain types of activities in which the claimant participated each hour of the program, but there was no documentation of the level of performance (for example, the number of times an exercise was repeated or the amount of time spent on a treadmill). Further, group psychotherapy was provided only four times, and individual psychotherapy was provided only twice.

Nevertheless, while the ALJ agrees with the Carrier that the program may have been deficient in the ways Dr. Jordan described, the record does not support the Carrier on two essential points. First, the Carrier preauthorized the program. In fact, on July 21, 2003, the Carrier denied payment as unnecessary based on a peer review when, on the same day, the Carrier also preauthorized continued service from July 21, 2003 through September 19, 2003. Pursuant to TEX. LAB. CODE ANN. 413.014(e)[2] and 28 TEX. ADMIN. CODE §133.301(a),[3] the Carrier's preauthorization of the CPM program precludes it from challenging medical necessity now that services have been provided

[2] The Labor Code section provides, "[i]f a specified health care treatment or service is preauthorized . . . that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service."

[3] The rule states, "[t]he insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Guidelines for Medical Services, Charges, and Payments)."

At the hearing, the Carrier argued that even when it is precluded from retrospectively challenging medical necessity, it may review the program to determine whether preauthorized services were actually provided. According to the Carrier, the CPM program did not meet the necessary standards, and thus, failed to provide the health care that the claimant needed.

The ALJ agrees with this reasoning with this exception. Section 408.027(e) of the Labor Code provides that if an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to MRD, the provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. The Carrier did not claim the program was inadequate on either the EOBs or in its response to the Provider's request for MRD action. MRD found that the Carrier's response to the Provider's request was untimely. At the hearing, the Provider argued that it provided a response; however, that response is not in the record.[4] Based on the exhibits admitted, it appears that the Carrier raised the issues of adequate treatment and sufficient documentation for the first time at the hearing.

For these two reasons, the prohibition against retrospective review of medical necessary and the Carrier's failure to state another reason for denial on the EOBs or in an MRD response, the ALJ finds the appeal should be denied.

III. FINDINGS OF FACT

1. On September 20, 2004, the Texas Workers' Compensation Commission's (Commission's) Medical Review Division (MRD) ordered payment of $9,800 to Active Behavioral Health, L.L.C., for payment of chronic pain management (CPM) services provided to a workers' compensation claimant from June 26, 2003, to July 30, 2003.

[4] Two exhibits were admitted into evidence. Exhibit 1, offered by the Carrier, contained 34 pages, and Exhibit 2, offered by the Provider, contained 178 pages.

2. On September 24, 2004, MRD issued an amended decision to include attachments to its previous decision.

3. In response to the MRD decision, the Carrier, American Home Assurance Company, timely requested a hearing before the State Office of Administrative Hearings (SOAH).

4. Notice of the hearing, dated February 25, 2005, was sent to both parties.

5. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

6. The hearing convened on January 18, 2006, and both parties were represented.

7. The claimant was injured on____, as he carried objects that weighed about 30 pounds.

8. The claimant received CPM services from the Provider on 19 dates of service between June 26, 2003, and July 30, 2003.

9. The Carrier preauthorized the CPM program.

10. The Provider's charges, reduced in accordance with the Medical Fee Guideline's maximum allowable reimbursement, totaled $9,800.

11. The Carrier denied payment for the services, stating they were unnecessary medical treatments or services per peer review.

12. The Carrier did not claim that the CPM program was inadequate or insufficiently documented on either an Explanation of Benefits (EOB) or in its response to the Provider's request for MRD action.

13. As reflected by the documentary evidence, the Carrier raised the issues of inadequate treatment and insufficient documentation for the first time at the hearing.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. ch. 401 *et seq.*

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

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

4. The Carrier had the burden of proof in this matter, pursuant to 28 TEX. ADMIN. CODE §148.14.

5. The Carrier's preauthorization of treatment precludes a challenge to payment based on medical necessity. TEX. LAB. CODE ANN. 413.014(e) and 28 TEX. ADMIN. CODE § 133.301(a).

6. If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier must send to MRD, the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. TEX. LAB. CODE ANN. 408.027(e).

7. When a carrier denies payment on a medical bill, the carrier must send an EOB to the provider that provides sufficient explanation to allow the provider to understand the reasons for the carrier's action. 28 TEX. ADMIN. CODE §133.304(c).

8. Based on the Findings of Fact and Conclusions of Law, the Carrier's appeal should be denied.

ORDER

IT IS, THEREFORE, ORDERED that the appeal from the Medical Review Division's decision is denied, and American Home Assurance Company shall pay the amount of $9,800, plus applicable interest, to Active Behavioral Health, L.L.C.

SIGNED March 17, 2006.

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SARAH G. RAMOS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS