SOAH DOCKET NO. 454-09-5469.M4
MR NO.M4-08-6118-01

INJURY ONE TREATMENT CENTER,	**§**	**BEFORE THE STATE OFFICE**
Petitioner,	**§**	
	§	
VS.	**§**	**OF**
	§	
FIDELITY & GUARANTY INSURANCE,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Petitioner, Injury One Treatment Center (Injury One) seeks reimbursement for health care services it provided the Claimant, ____. The Administrative Law Judge (ALJ) finds the Respondent, Fidelity & Guaranty Insurance (Fidelity) should be required to reimburse Injury One an additional $2,216.17, for the reasons described below.

I. HISTORY, JURISDICTION, AND NOTICE

The Claimant sustained a compensable ___ on _____. Fidelity is the workers' compensation carrier responsible for paying the Claimant's reasonable and necessary workers' compensation benefits. Fidelity and the Claimant disputed the extent of her compensable injury. In a Decision and Order issued _____, the Texas Department of Insurance's Division of Workers' Compensation (DWC) determined that the compensable injury was limited to a lumbar strain/sprain and did not include disc bulges at the L4/5 and L5/S1 levels.

After the Carrier had raised the extent-of-injury issue, but before it was decided, Injury One requested preauthorization for the following treatments for the Claimant: individual psychotherapy one time per week for six weeks (CPT Code 90806), physical therapy three times per week for three weeks (CPT Codes 97110 and 97140), and physical therapy two times per week for two weeks (CPT Codes 97110, 97530, and 97140). For each request it cited the diagnosis code as 847.2, which is

lumbar strain/sprain. Each of those requests was granted with the notation that the services were determined to be medically necessary.[1]

Injury One provided the preauthorized services and other medical services that did not require preauthorization to the Claimant from June 25, 2007, through September 10, 2007. The other services included hypnotherapy (CPT Code 90880), electrical stimulation (CPT Code G0283), one-on-one therapy (CPT Code 97530), physical therapy-reevaluation (CPT Code 97002), and health and behavioral assessment (CPT Code 96151).

Fidelity declined to pay for any of those services on the grounds that the lumbar strain had resolved well before the treatments were provided and, therefore, the treatments were outside the extent of the compensable injury. Fidelity contended Injury One had tailored its diagnoses to reflect a lumbar strain/sprain after it realized that the extent of the injury was being contested. Injury One subsequently filed a request for medical dispute resolution, seeking reimbursement in the amount of $2,982.56.

The Medical Review Division (MRD) generally agreed with Fidelity, although it ordered reimbursement of $88.56 for CPT Code 97002.[2] In addition to the grounds raised by Fidelity, the MRD disallowed some of the services for other reasons:[3] It disallowed some physical therapy services because they were performed by a licensed physical therapy assistant, but submitted by her supervisor, a licensed physical therapist. As explained by the MRD in the Findings and Decision:

> In accordance with Division Rule at 28 TAC Section 133.20(d)(2) states that the health care provider that provided the health care shall submit its own bill, unless the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill. The bills submitted for physical therapy were submitted by

[1] Petitioner's Ex. 3.

[2] Fidelity did not seek a hearing at the State Office of Administrative Hearings (SOAH) regarding that portion of the MRD Order.

[3] The MRD cited 28 TEX. ADMIN. CODE (TAC) § 133.307(e)(2), which states, "The Division may raise issues in the MDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and Division rules."

> Arlene Henderson, PT Lic. #1014587; however, the physical therapy was provided by Leslie Lindsay, LPTA Lic. #2-0097-0. Although CMS does not allow physical therapy assistants, licensed or unlicensed, to bill for services rendered, per Division Rule at 28 TAC Section 134.202(a)(4), specific provisions contained in the Texas Workers' Compensation Act, or Texas Workers' Compensation Commission Rules, including this rule, shall take precedence over any conflicting provision adopted by or utilized by CMS in administering the Medicare program.

In other words, although Medicare procedures prohibited the licensed physical therapist assistant from submitting the bill, DWC rules required her, rather than her supervisor, to do so.

The MRD also disallowed some services because, although the CMS 1500 forms used to request payment cited CPT Code 847.2, the medical notes in some cases originally set out CPT Code 847.0 (neck strain/sprain). The MRD also disallowed the hypnotherapy (CPT Code 90880) and electrical stimulation (CPT Code G0283) as not being preauthorized.

Injury One filed a timely request for a hearing before SOAH. After timely and adequate notice, the hearing was held November 11, 2009, with both parties participating, before the undersigned ALJ. The hearing was adjourned and the record closed the same day. Fidelity has paid for some of the disputed dates of service, in the amount of $428.75. At the end of the hearing, Injury One conceded it had failed to meet its burden of proof regarding the electrical stimulation ($117.36) and the one-on-one therapy ($133.72). Subtraction of those amounts and the $86.56 of reimbursement ordered by the MRD from the original amount in controversy leaves $2,216.17 still in dispute.

II. DISCUSSION

Preauthorization/Coding

The parties and the DWC agree that the Claimant suffered a compensable lumbar strain/sprain. Injury One requested, and received, preauthorization for several forms of treatment for that lumbar strain/sprain. The ALJ agrees with Injury One that Fidelity, having preauthorized

treatments for the specific injury, cannot now claim that the treatments are beyond the scope of that compensable injury.

The ALJ also agrees with Injury One that the coding discrepancies in the medical notes should not preclude reimbursement. The coding used on some of the notes referred to neck strain/sprain, not to lumbar/sacral disc bulges, which were the conditions in controversy in the extent-of-injury dispute. The treatments did not pertain to the Claimant's neck—it seems far more likely that the replacement of CPT Code 847.0 with 847.2 was the rectification of an error rather than part of a scheme to conceal the treatment of a non-compensable injury.

Billing

Under TEX. LAB. CODE ANN. § 401.011(22), "health care provider" is defined as "a health care facility or health care practitioner." A review of the bills shows that they were provided by Injury One, although the physical therapy bills were signed by Ms. Henderson. Injury One is a health care facility as defined by TEX. LAB. CODE ANN. § 401.011(20); therefore, the bills were submitted by the health care provider as required by the DWC rules.

Hypnotherapy

Phil Bohart, a licensed counselor employed by Injury One, testified preauthorization was not available for the hypnotherapy and that it was medically necessary to treat anxiety and depression related to the Claimant's compensable injury. There was no contradictory testimony on that issue; therefore, the ALJ finds those services were medically necessary.

Summary

The ALJ concludes Fidelity should reimburse Injury One an additional $2,216.17 for the services at issue provided the Claimant.

III. FINDINGS OF FACT

1. The Claimant, ___., sustained a compensable __ on ___.

2. Fidelity & Guaranty Insurance (Fidelity) is the workers' compensation carrier responsible for paying the Claimant's reasonable and necessary workers' compensation benefits.

3. Fidelity and the Claimant disputed the extent of her compensable injury. In a Decision and Order issued ___, the Texas Department of Insurance's Division of Workers' Compensation (DWC) determined that the compensable injury was limited to a lumbar strain/sprain and did not include disc bulges at the L4/5 and L5/S1 levels.

4. After the Carrier had raised the extent-of-injury issue, but before it was decided, Injury One Treatment Center (Injury One) requested preauthorization for the following treatments for the Claimant: individual psychotherapy one time per week for six weeks (CPT Code 90806), physical therapy three times per week for three weeks (CPT Codes 97110 and 97140), and physical therapy two times per week for two weeks (CPT Codes 97110, 97530, and 97140).

5. For each request, Injury One cited the diagnosis code as 847.2, which is lumbar strain/sprain.

6. Each of the preauthorization requests was granted with the notation that the services were determined to be medically necessary.

7. Injury One provided the preauthorized services and other medical services that did not require preauthorization to the Claimant from June 25, 2007, through September 10, 2007. The other services included hypnotherapy (CPT Code 90880), electrical stimulation (CPT Code G0283), one-on-one therapy (CPT Code 97530), physical therapy-reevaluation (CPT Code 97002), and health and behavioral assessment (CPT Code 96151).

8. Fidelity declined to pay for any of the services provided on the grounds that the lumbar strain had resolved well before the treatments were provided and, therefore, the treatments were outside the extent of the compensable injury. Fidelity contended Injury One had tailored its diagnoses to reflect a lumbar strain/sprain after it realized that the extent of the injury was being contested.

9. Injury One subsequently filed a request for medical dispute resolution, seeking reimbursement in the amount of $2,982.56.

10. The Medical Review Division (MRD) of the Texas Department of Insurance, Division of Workers' Compensation (DWC) generally agreed with Fidelity, although it ordered reimbursement of $88.56 for CPT Code 97002.

11. The MRD disallowed some physical therapy services because they were performed by a licensed physical therapy assistant, but submitted by her supervisor, a licensed physical

therapist. The MRD determined that although Medicare procedures prohibited the licensed physical therapist assistant from submitting the bill, DWC rules required her, rather than her supervisor, to do so.

12. The MRD also disallowed some services because, although the CMS 1500 forms used to request payment cited CPT Code 847.2, the medical notes in some cases originally set out CPT Code 847.0 (neck strain/sprain).

13. The MRD also disallowed the hypnotherapy (CPT Code 90880) and electrical stimulation (CPT Code G0283) as not being preauthorized.

14. Injury One filed a timely request for a hearing before SOAH.

15. Notice of the hearing was sent to the parties on July 22, 2009.

16. 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.

17. The hearing was held on November 11, 2009, with both parties participating, before ALJ Henry D. Card. The hearing was adjourned and the record closed that same day.

18. Fidelity has paid for some of the disputed dates of service, in the amount of $428.75.

19. At the end of the hearing, Injury One conceded it had failed to meet its burden of proof regarding the electrical stimulation ($117.36) and the one-on-one therapy ($133.72).

20. Subtraction of the amounts set out in the preceding Findings of Fact and the $86.56 of reimbursement ordered by the MRD from the original amount in controversy leaves $2,216.17 still in dispute.

21. The treatments that were preauthorized to treat a lumbar strain/sprain were within the scope of that compensable injury.

22. Considering the codes in question, the replacement of CPT Code 847.0 with 847.2 in medical notes was more likely the rectification of an error rather than part of a scheme to conceal the treatment of a non-compensable injury.

23. The coding discrepancies in the medical notes should not preclude reimbursement.

24. The bills were submitted by Injury One, although the physical therapy bills were signed by Ms. Henderson.

25. Preauthorization was not available for the hypnotherapy, which was medically necessary to treat anxiety and depression related to the Claimant's compensable injury.

IV. CONCLUSIONS OF LAW

1. 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.

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

3. Under 28 TEX. ADMIN. CODE (TAC) § 148.14(a), the Petitioner has the burden of proof in hearings, such as this one, conducted pursuant to TEX. LAB. CODE ANN. § 413.031.

4. Injury One is a health care facility as defined by TEX. LAB. CODE ANN. § 401.011(20) and therefore is a health care provider as defined by TEX. LAB. CODE ANN. § 401.011(22).

5. The bills in question were submitted by the health care provider as required by 28 TEX. ADMIN. CODE §133.20(d).

6. Fidelity should reimburse Injury One an additional $2,216.17 for the services at issue provided the Claimant.

ORDER

It is, therefore, ordered that Fidelity & Guaranty Insurance Company shall reimburse Injury One Treatment Center the additional amount of $2,216.17, plus interest as appropriate, for the services at issue in this case.

SIGNED January 15, 2010.

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS