MEDICAL CONTESTED CASE HEARING NO. 08109

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

Contested case hearings were held on May 14 and June 3, 2008, to decide the following disputed issues:

In Docket No. 1:

1. Whether the health care provider is entitled to additional reimbursement in the amount of $166.58 for services rendered to Claimant on February 21, 2007, and March 1, 2007?

In Docket No. 2:

2. Whether the health care provider is entitled to additional reimbursement in the amount of $136.76 for services rendered to Claimant on January 22, 2007?

In Docket No. 3:

3. Whether the health care provider is entitled to additional reimbursement in the amount of $555.46 for services rendered to Claimant from February 8, 2007, through March 20, 2007?

In Docket No. 4:

4. Whether the health care provider is entitled to additional reimbursement in the amount of $661.81 for services rendered to Claimant from February 22, 2007, through March 1, 2007?

PARTIES PRESENT

Claimant appeared and was represented by JE, lay representative. Carrier appeared and was represented by TW, attorney.

BACKGROUND INFORMATION

Preauthorization Required for Psychological Testing Outside of Return-to-Work Program

In Docket No. 3, Petitioner, (the HCP), requested reimbursement for services in the amount of $555.46, which included fees for a psychological evaluation on March 20, 2007, under CPT Code 96101. In the above MDFR tracking number (for Docket No. 1)), the Medical Fee Dispute

Resolution Findings and Decision upheld Carrier's denial of reimbursement citing Rule 134.600 (p)(7) which rule states,

> [Preauthorization is required for] "all psychological testing . . . except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program."

The HCP incorrectly argues,

1. The service was rendered as a preliminary service in evaluating whether Claimant should be placed in a return-to-work program.

2. Nothing in Rule 134.600 (p)(7) requires the Claimant to be currently (at the time of service) enrolled in a return-to-work program.

3. The HCP is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); and by virtue of its CARF accreditation, the HCP is exempted from preauthorization.

The HCP is not entitled to reimbursement for the psychological testing on March 20, 2007, under CPT Code 96101 Psychological testing performed as part of a preauthorized or Division exempted return to work rehabilitation program such as work hardening or work conditioning does not require preauthorization. However, psychological testing performed prior to the preauthorized or Division exempted return to work program would require preauthorization. CARF accredited facilities prior to May 1, 2007, when the Division of Workers' Compensation adopted the Official Disability Guidelines (ODG) were exempt from preauthorization of the interdisciplinary return to work programs. Work hardening or conditioning could have been done without preauthorization. However, psychological testing done outside of these programs would have still required preauthorization.

Carrier Limitations on Length of Physical Therapy Sessions In Preauthorization Process

The remaining disputed issues herein arise from a health care provider's request for reimbursement of fees for physical therapy. When the Carrier's agent preauthorized the treatment, it imposed a limitation on the length of each of the sessions. The parties herein litigated the liability for the charges for sessions exceeding the length imposed in the preauthorization. The dates of service overlap among the sequences, but no individual date of service was addressed more than once in the four Medical Fee Dispute Resolution Findings and Decisions.

In each of the above docket numbers, the HCP submitted a request for physical therapy services to Carrier's preauthorization company which the HCP asserts was in accordance with Rule 134.600(f) in that the request included "specific health care, number of specific treatments, and the specific period of time requested to complete the treatment". The services were preauthorized by Carrier's preauthorization company with this qualification, "Per CMS [Centers for Medicare & Medicaid Services] Guidelines, no more than 60 minutes should be utilized per physical therapy session." The HCP points out that there was no agreement between the HCP and the Carrier to modify the request. Rule 134.600(n) provides:

> "The carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and carrier and is documented."

No request for reconsideration of the preauthorization was made by the HCP, and the HCP rendered the physical therapy services. Carrier then paid the HCP for the sessions as if they were all 60 minutes each, and the amounts in dispute in the above issues represents the charges for the physical therapy sessions in excess of 60 minutes each that fell within the periods listed in the issues. Carrier denied reimbursement for those excess portions of the treatment citing reason code,

> "152F-Payment adjusted because the payer deems the information submitted does not support this many services. *Documentation does not support the medical necessity for treatment exceeding 60 mins. Reference Trailblazer Physical Medicine Guidelines,"

and ANSI [American National Standards Institute] reason code,

> "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization."

The HCP asserts that there is no "four-unit standard" [60 minute standard] in the industry by arguing that CMS Guideline, Indications and Limitations of Coverage and/or Medical Necessity, page 93 makes no statement. On Page 93, the CMS Guideline states,

> "For all PM&R [Physical Medicine and Rehabilitation Modalities] modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Treatment times per session may vary based upon the patient's medical presentation. Treatment time, typically, should be a minimum of 45-60 minutes to provide full, optimal care to the Medicare beneficiary. Additional time may be required for the more complex and slow-to-respond patients. In these cases, documentation of these exceptional services must be maintained in the patient's medical record and available upon request."

The HCP also argues that Carrier's denial of reimbursement constitutes an improper retrospective review of preauthorized services and relies upon Texas Labor Code Sec. 413.014 (e) which states,

> "If a specified health care treatment or service is preauthorized as provided in this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service."

Carrier's brief correctly notes,

> "Despite the Provider's contention, the Self-Insured did not retrospectively deny the services in question. The 'denial' actually occurred prior to any services being performed and thus, by definition, could not have been denied retrospectively. It was during the preauthorization process that limitations were put in place which stated the provider could not perform more than the allowed 4 units of therapy per session. This limitation was put in place to avoid any retrospective denial."

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best qualified scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines.

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG.

The Preface to the ODG states,

> "Generally there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/ procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker."

In the preauthorizations herein, these are the "Reviewer Comments":

> "Preauthorization is based on medical necessity per DWC Rule 413.014 [actually Texas Labor Code Sec. 413.014]. . . . Per CMS Guidelines, no more than 60 minutes should be utilized per physical therapy session. Over the course of physical therapy treatment, CMS Guidelines that 75% of the modalities should be active. Treatment utilizing Physical and Occupational therapy to the same body part on the same date of service is considered a duplication of services. This medical necessity decision is based on the internal and national guidelines, review of evidence-based literature, medical training and experience of physician reviewer, narrative description of services and not on any CPT codes the provider may have included in the request.

Without anything more specific from the HCP, Carrier properly limited the time to 60 minutes. The HCP failed to seek a greater number of units based on medical necessity and failed to request a reconsideration of the preauthorization if it considered the limiting language to be

improper or unauthorized. The HCP proceeded to render services utilizing more units than authorized which it has done in treating other Claimants. This pattern of attempting to utilize more units with other injured workers is documented in Carrier's written brief and exhibits.

The HCP is required to be specific in what it is requesting; and Carrier is required to be specific in what it is denying. If the limit of the session length was an improper preauthorization, then the limiting preauthorization could be construed as a total denial of preauthorization. As a denial of preauthorization, the HCP would not be entitled to any reimbursement for any portion of the eighteen sessions. Finally, the HCP has the burden of proof herein to reverse the Medical Fee Dispute Resolution Findings and Decision. The HCP did not meet its burden of proof. Therefore, since the HCP delivered treatment under the limitations stated by the Carrier, the HCP is entitled only to reimbursement for 60 minutes or four-unit sessions. The HCP is not entitled to the additional reimbursement for the physical therapy services rendered on the subject dates.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Self Insured), when she sustained a compensable injury.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. In Docket No. 1, Carrier properly denied reimbursement of $166.58 for services rendered to Claimant on February 21, 2007, and March 1, 2007, in that the requested reimbursement was for services which were not preauthorized.

4. In Docket No. 2, Carrier properly denied reimbursement of $136.76 for services rendered to Claimant on January 22, 2007, in that the requested reimbursement was for services which were not preauthorized.

5. In Docket No. 3, Carrier properly denied reimbursement of $555.46 for services rendered to Claimant from February 8, 2007, through March 20, 2007, in that the requested reimbursement was for services which were not preauthorized.

6. In Docket No. 4, Carrier properly denied reimbursement of $661.81 for services rendered to Claimant from February 22, 2007, through March 1, 2007, in that the requested reimbursement was for services which were not preauthorized.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. In Docket No. 1, the health care provider is not entitled to additional reimbursement of $166.58 for services rendered to Claimant on February 21, 2007, and March 1, 2007.

4. In Docket No. 2, the health care provider is not entitled to additional reimbursement of $136.76 for services rendered to Claimant on January 22, 2007.

5. In Docket No. 3, the health care provider is not entitled to additional reimbursement of $555.46 for services rendered to Claimant from February 8, 2007, through March 20, 2007.

6. In Docket No. 4, the health care provider is not entitled to additional reimbursement of $661.81 for services rendered to Claimant from February 22, 2007, through March 1, 2007.

DECISION

In Docket No. 1, the health care provider is not entitled to additional reimbursement of $166.58 for services rendered to Claimant on February 21, 2007, and March 1, 2007. In Docket No. 2, the health care provider is not entitled to additional reimbursement of $136.76 for services rendered to Claimant on January 22, 2007. In Docket No. 3, the health care provider is not entitled to additional reimbursement of $555.46 for services rendered to Claimant from February 8, 2007, through March 20, 2007. In Docket No. 4, the health care provider is not entitled to additional reimbursement of $661.81 for services rendered to Claimant from February 22, 2007, through March 1, 2007.

ORDER

Self-Insured Carrier is not liable for the additional reimbursements sought herein by (the HCP). Claimant remains entitled to medical benefits for the compensable injury in accordance with Texas Labor Code Sec. 408.021.

The true corporate name of the insurance carrier is **(SELF INSURED)** and the name and address of its registered agent for service of process is

COUNTY CLERK
(ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 7th day of August, 2008.

Charles T. Cole
Hearing Officer