MEDICAL CONTESTED CASE HEARING NO. 11130
M4-10-0093-01

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.

ISSUES

A contested case hearing was held on September 27, 2010 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the Medical Fee Dispute Resolution decision that Petitioner is not entitled to additional reimbursement in the amount of $1130.88 plus applicable accrued interest per Section 408.027(a)?

PARTIES PRESENT

Claimant did not appear. Petitioner appeared and was represented by AU, lay person. Carrier appeared and was represented by HW, adjustor.

BACKGROUND INFORMATION

The disputed issue herein arises from a health care provider's request for reimbursement of fees for physical therapy. The health care provider was approved preauthorization for twelve sessions for the dates of service for September 10, 2008 to October 17, 2008. There was no mention of any imposed limitations as to the length of each of the sessions. Carrier paid the HCP for the twelve sessions as if they were all 60 minutes each, and the remaining balance represents the charges for the physical therapy sessions in excess of 60 minutes each that fell within that portion of the period from September 10, 2008 to October 17, 2008. The parties herein litigated the liability for the charges for the portions of the sessions that were not reimbursed.

Petitioner, the HCP, requested reimbursement for services in the amount of $1988.19, which included a fee of $229.39 for a psychological evaluation for the date of service for April 15, 2009, which both parties agree is not at issue. Although discussed on the record, the fee for the psychological evaluation was not appealed. In the above MDFR tracking number M4-10-0093-01, the reviewer found that additional reimbursements were due to the Petitioner and thus ordered the Carrier to pay the HCP the amount of $568.70 plus interest. The remaining $1130.88 is the subject of the HCP's appeal and is for additional reimbursement for services rendered by the HCP from September 16, 2008 through April 15, 2009.

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". Carrier denied reimbursement for those excess portions of the treatment citing reason code, "150-Payment adjusted because the payer deems the information

submitted does not support this level of services. Need documentation to support additional timed therapy beyond 60 minutes." The HCP asserts by referencing the preface of the *Official Disability Guidelines* that even though sessions may typically take 50-60 minutes, there is no intended limit or cap on the number of units that are medically necessary for a particular patient in the industry.

Carrier argues that CMS Guideline, Indications and Limitations of Coverage and/or Medical Necessity, page 90 also governs this matter. Page 90, 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 initial therapy needs and progress to date toward established goals. Treatment time per session typically, will not exceed of [sic] 45-60 minutes. Additional time is sometimes required for the more complex and slow-to-respond patients. However, documentation of these exceptional circumstances must be maintained in the patient's medical record and available upon request." The Carrier asserts that it placed a limitation on the number of units per session based on the medical guidelines and industry standards.

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 Official Disability Guidelines (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 Official Disability Guidelines (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, for example, in unusual cases where co-morbidities involve completely

separate body domains, 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."

The HCP argues that the supporting documentation was provided in the request for preauthorization. And thus, the need for additional time was implicit in the request. The medical records reveal that time was spent on both passive and active modalities. The documentation shows that 45 to 60 minutes was spent on active therapy. The medical records do not support the need for additional time beyond the 60 minutes already reimbursed. Carrier properly limited the time to 60 minutes in accordance with the treatment guides. The HCP failed to seek a greater number of units based on medical necessity. The HCP proceeded to render services utilizing more time that was reasonably medically necessary in treating the Claimant.

The HCP has the burden of proof herein to reverse the Medical Fee Dispute Resolution Findings and Decision rendered under MFDR Tracking No. M4-10-0093-01. The HCP did not meet its burden of proof. Therefore the HCP is entitled only to reimbursement for 60 minutes or a four-unit session. The HCP is not entitled to the additional reimbursement of $1130.88.

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. Carrier properly denied reimbursement of $1130.88 for services rendered to Claimant from September 16, 2008 through April 15, 2009, in that the requested reimbursement was for services which were not medically reasonable and necessary.

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. The health care provider is not entitled to additional reimbursement in the amount of $1130.88 for services rendered to Claimant from September 16, 2008 through April 15, 2009.

DECISION

The health care provider is not entitled to additional reimbursement in the amount of $1130.88 for services rendered to Claimant from September 16, 2008 through April 15, 2009.

ORDER

Carrier is not liable for the additional reimbursement of $1130.88 sought herein by 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

SELF-INSURED
SECRETARY
(STREET ADDRESS)
(CITY), TX (ZIP CODE)

Signed this 21st day of April, 2011.

Alisha Darden
Hearing Officer