SOAH DOCKET NO. 453-01-3366.M4
TWCC MR NO. M4-01-1263-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
FIRST RIO VALLEY MEDICAL, P.A., **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) requested a hearing to contest the May 15, 2001 Findings and Decision of the Medical Review Division of the Texas Workers' Compensation Commission (Commission) authorizing reimbursement in the amount of $624.00 to First Rio Valley Medical, P.A. (Provider) for aquatic therapy[1] provided to Claimant from November 30, 2000, through December 6, 2000 (Disputed Services).[2] Carrier has the burden of showing by a preponderance of the evidence that the Disputed Services were not medically necessary A copy of the claims log showing the dates and services in dispute is attached as Appendix "A"

This decision denies the relief sought by Carrier and grants reimbursement to Provider as set forth below.

The hearing convened on February 2, 2005, before Administrative Law Judge (ALJ) Catherine C. Egan at the State Office of Administrative Hearings, Austin, Texas. Attorneys Chris Trickey and Tom Hudson represented Carrier. Attorney Keith Gilbert represented Provider.

William DeFoyd, D.C., Nicholas Tsourmas, M.D., and Alfred Ball testified for Carrier. Robert S. Howell, D.C., Provider's owner, testified for Provider. There were no contested issues of

[1] CPT Code 97113.

[2] This Decision predates the use of independent review organizations.

notice or jurisdiction.

The hearing adjourned and, at the request of the parties, the record remained open for the filing of briefs regarding the admission of a deposition and other items with the ALJ. On February 16, 2005, Carrier filed a brief in support of the admission of the deposition of Sam Allen, D.C. Provider filed no response, and, on February 21, 2005, the deposition was admitted and the record closed.

I. BACKGROUND

___ (Claimant), a 54-year old male, sustained a work-related injury on ___, when he slipped and fell into a ditch while carrying plywood. Claimant experienced lower back pain that radiated into his left leg. He was treated with passive physical therapy through May 11, 2000. On May 9, 2000, Claimant underwent a lumbar MRI that showed "a small left subligamentous L4-5 disc herniation and also borderline spinal stenosis . . . chronic degenerative disc changes at the L2 level, but without a disc herniation or stenosis at L2."[3] On May 26, 2000, Claimant went to Provider for treatment. Provider treated Claimant in May, June, July and August 2000, but Claimant's condition continued to deteriorate.

On September 11, 2000, Claimant underwent lumbar spinal fusion surgery. Claimant returned to Provider for rehabilitative therapy following this surgery. On November 30, 2000, and December 1, 4, and 6, 2000, Provider treated Claimant with four units of one-on-one aquatic therapy. The units are in 15-minute increments. Carrier paid for one unit of aquatic therapy on each date, but denied the other three.

II. LEGAL ISSUE

Pursuant to 28 TEX. ADMIN. CODE (TAC) §133.304(c) when a carrier denies payment, the carrier must send an explanation of benefit (EOB) to the appropriate party with the proper exception code and "ufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or

[3] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 201.

denial of payment does not satisfy the requirements of this section."

Carrier denied payment to Provider for treatment rendered on November 30, 2000 and December 1, 4, and 6, 2000, under payment exception codes "U" and "F."[4] Carrier denied the aquatic therapy provided on December 1 and 6, 2002, under "U," which Carrier defined on the EOB as "Documentation does not support the need for fact-to-face therapy where therapist attention is directed to only one patient. Clinical condition of patient supports therapy rendered in a group setting."

For the one-on-one aquatic therapy provided on November 30, 2000, and December 4, 2000, Carrier denied three of the four units billed each day under payment exception code "F." Carrier defined "F" on the EOBs as "the documentation does not support the service billed. Carrier may not reimburse the service at another billing level."[5]

Provider filed a request for reconsideration with Carrier on the denied claims and asked detailed questions trying to determine why the claims were denied. Carrier did not answer these questions.

The reasons set forth in Carrier's EOB provided a sufficient explanation to Provider to allow Provider to understand why Carrier denied these claims: two were medically unnecessary because services could have been provided in a group setting, and two for lack of documentation. However, Carrier cannot now substitute an explanation other than that provided by Carrier when it denied the claims as provided by 28 TAC § 133.304. Because Carrier did not deny the services provided on November 30, 2000, and December 4, 2000, for unnecessary treatment, but instead on lack of documentation, the ALJ will consider the issue of medical necessity only for the aquatic therapy provided on December 1 and 6, 2000.

The MRD considered Carrier's argument that Provider failed to have supporting documentation for an hour of one-on-one aquatic therapy on two of the four claims, and found it was without merit. According to the MRD, Provider's documents supported that the services were rendered on November 30, and December 4, 2000, and recommended reimbursement of $312.00. Neither of Carrier's experts testified that Provider failed to document the service, although both

[4] Joint Ex. 1, Tab 1 at 50-53.

[5] Joint Ex. 1, Tab 1 at 50-53.

expressed frustration with theredundancy and length of Provider's records. The ALJ finds that Provider sufficiently documented the services billed, and therefore Provider is entitled to reimbursement in the amount of $312.00.

III. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. MRD's Decision and the Medical Record

MRD concluded that an hour of one-on-one aquatic therapy provided by Provider to Claimant on December 1 and 6, 2000, was medically necessary. The MRD found the "outpatient medical rehabilitation is considered a treatment intervention and medically necessary during the tertiary phase of care."[6]

On October 26, 2000, Provider documented in its interim assessment report that Claimant was a month-and-a-half post-surgical following the lumbar fusion. His surgeon recommended a waiting period of three months to allow the fusion to heal before initiating rehabilitation.[7] On November 22, 2000, Claimant's surgeon released him to participate in physical therapy three times a week for four weeks. On November 30, 2000, Provider documented that Claimant had complaints of pain in his lower back that radiated into his front hip and thigh. Provider placed Claimant in aquatic therapy. In general, the aquatic therapy included running forward, backward, and sideways in the pool, and doing resistance exercises.

Provider's explanation for aquatic therapy included the following:

> The medical necessity of aquatic therapy is simple. It is a commonly accepted fact in the medical community that healing tissues should never be overstressed. If Claimant were subjected to active therapy (resistive/progressive) exercise too quickly, the consequences may be detrimental. Re-injury, increased pain, and decreased range of motion are the most common side effects. This will of course increase the amount of time it takes to heal the soft tissues. The longer the time it takes to heal the more costly it is. This is not the goal of the TWCC or the guidelines it uses. By placing Claimant in water, his bodyweight or the affected area weight is reduced and stress is minimized significantly. By minimizing the stress on the injured area, range of motion will usually increase because the gravity factor is

[6] Joint Ex. 1, Tab 3 at 117 to 120.

[7] Joint Ex. 1, Tab 3 at 163.

lowered therefore allowing for the naturally occurring sticking points of conventional progressive weights to be overcome with much more ease.[8]

As a result of the therapy, Claimant's pain level decreased and his range of motion improved slightly.

B. Carrier's Position and Evidence

Dr. Tsourmas, an orthopedic surgeon who works for Carrier as a medical director, reviewed Provider's medical records to assess the medical necessity of the services in dispute. According to Dr. Tsourmas, he has referred patients to aquatic therapy when they suffered with lower extremity issues, such as a broken bone. He opined that during the time that a patient has to be careful with weight bearing exercises, short-term aquatic therapy is useful. However the patient should progress to a land-based program as soon as it can be tolerated because it is "more efficacious regarding producing results with range of motion and strength."[9] Transitioning a patient from aquatic to land-based therapy may overlap, but not more than a few weeks-"Certainly not months or - or longer."[10]

As for this Claimant, Dr. Tsourmas testified that before the lumbar fusion, Claimant had three months of back rehabilitation that included aquatic therapy. The aquatic therapy provided by Provider to Claimant after the surgery was essentially the same as before the surgery. Claimant had no special needs to justify intensive one-on-one therapy. Consequently, Dr. Tsourmas opined, brief coaching to remind Claimant how to perform the aquatic exercises was all that might be necessary. However, four units of one-on-one aquatic therapy was excessive and medically unnecessary.[11]

Dr. DeFoyd, Carrier's expert witness, practices at the Spine and Rehab Center and treats spinal injuries.[12] Dr.DeFoyd opined that land-based therapy is preferable to aquatic therapy for several reasons. First, humans function on land, not in water. Second, it is easier to encourage a patient to do a home program if the exercises do not require a pool. Finally, land-based exercise

[8] Joint Ex. 1, Tab 1 at 180. The ALJ removed Claimant' name in the quotation and inserted the word "laimant."

[9] Ex.16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 19-20.

[10] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 28.

[11] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 223-228.

[12] Dr. DeFoyd has been a chiropractor for 18 years. Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 9.

programs are generally less costly than aquatic programs. Aquatic therapy is used in cases where the patient cannot tolerate a land-based program because of weight bearing intolerance.[13]

Dr. DeFoyd agreed with Dr. Tsourmas that none of the aquatic therapy required one-on-one supervision because Claimant had significant training in this program from Provider before the surgery, with over 45 visits for aquatic therapy. Likewise, Dr. DeFoyd did not find Claimant had any special needs to justify one-on-one supervision.[14] Although Carrier reimbursed Provider for one unit of aquatic therapy on the dates of service, Dr. DeFoyd opined that Claimant did not require one-on-one aquatic therapy

Mr. Ball currently serves as Carrier's dispute analyst, but began as a nurse on an audit team reviewing spinal surgery and hospital bills. Mr. Ball affirmed that each time Carrier received a bill from Provider, it issued an EOB. He did not testify that Carrier ever provided an explanation for denying the claims other than that described above.

C. Provider's Position and Evidence

Dr. Howell has been a licensed chiropractor in Texas since October 1990. Provider's clinic is a 12,300-square-foot facility with a junior Olympic indoor pool (77,000 gallons), a 1,000-square-foot gym with modern weight lifting equipment, massage therapy rooms, examination rooms, physical therapy rooms, an adjusting room, a reception area, administrative offices, bathrooms with six showers, a return-to-work area, and a chronic pain management area.[15]

Dr. Howell testified that Claimant could only speak Spanish, was a diabetic, and could not swim. Claimant returned to Provider following major spinal surgery. Dr. Howell's diagnoses included other post-surgical status, lumbosacral sprain, myalgia and myositis, thoracic or lumbosacral neuritis or radiculitis and displacement of lumbar intervertebral disc without

[13] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 21-24.

[14] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 210-224.

[15] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol. I at 5-6.

myelopathy.[16]

Dr. Howell explained that he used one-on-one aquatic therapy because Claimant was an older post-surgical patient with persistent complaints of pain. Claimant's condition justified the need to reduce the amount of weight-bearing and joint compressing exercises he engaged in to avoid reinjuring his spine.[17] The warmer water in Provider's pool afforded a "palliative thermo effect making Claimant's muscles relax." In addition, Claimant spoke Spanish and only a little English; consequently, Provider and Claimant had a language barrier that required direct supervision to individualize the actual therapy needed and to make sure Claimant understood what he was to do.[18] Claimant had 15 minutes of warm up to allow the synovial fluid to flow into his joints; 15 minutes of cardiovascular aquatic therapy; 15 minutes ofresistance training; and 15 minutes to cool down. According to Provider, the healthcare provider technician in the water with Claimant could stretch Claimant's muscles further than if Claimant were trying to do the therapy alone.[19]

D. ALJ's Analysis

The Carrier was required to show by a preponderance of the evidence that when it denied Provider's claims for services provided to Claimant, the services were not medically necessary.

Under the Commission's rules, Carrier is required to provide an explanation for why it determined Provider's medical services were not medically necessary. In December 2000, Carrier's denial code contained sufficient explanation for Provider to understand that Carrier did not believe one-on-one therapy was medically necessary and that the aquatic therapy could be provided in a group setting.

Carrier paid for one unit of one-on-one aquatic therapy on December 1 and 6, 2000, but contended that one unit was enough to retrain Claimant to be able to do the rest of the therapy in a

[16] Joint Ex. 1, Tab 1 at 180.

[17] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol III at 44.

[18] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol III at 45-50.

[19] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol III at 51-53.

group setting. The ALJ disagrees. Claimant had just undergone major spinal surgery and was still in pain, pain that radiated into his hip and thigh. The evidence presented by Carrier did not persuade the ALJ that the additional three units of one-on-one aquatic therapy were not medically necessary.

In conclusion, the ALJ finds that Carrier failed to show by a preponderance of the evidence that the Disputed Services provided November 30, 2000, through December 6, 2000, in the amount of $624.00 were not medically necessary or were not properly documented.

IV. FINDINGS OF FACT

1. Claimant, a 54-year-old male, sustained a work-related injury on ___, when he slipped and fell into a ditch while carrying plywood (compensable injury).

2. On May 26, 2000, Claimant sought treatment from Robert S. Howell, D.C., First Rio Valley Medical, P.A. (Provider).

3. Provider treated Claimant in May, June and July 2000, with aquatic therapy.

4. On September 11, 2000, Claimant underwent spinal surgery, a fusion of his lumbar spine.

5. Claimant was not released by his surgeon to participate in rehabilitative physical therapy until November 22, 2000.

6. On November 30, 2000, and December 1, 4, and 6, 2000, Provider provided Claimant with an hour of aquatic therapy, four 15-minutes units, on each date.

7. Provider requested reimbursement for the aquatic therapy provided from November 30, 2000, through December 6, 2000 (Disputed Services).

8. Texas Mutual Insurance Company (Carrier) issued an explanation of benefits (EOB) paying for one unit of the four units billed each day for aquatic therapy.

9. Carrier denied reimbursement for three units per day of one-on-one aquatic therapy for December 1 and 6, 2000, asserting that one-on-one aquatic therapy was not medically necessary, as Claimant's condition warranted group therapy.

10. Carrier denied reimbursement for three units per day of one-on-one aquatic therapy for November 30 and December 4, 2000, asserting that Provider's documentation did not support the service billed.

11. Provider filed requests for reconsideration of the Disputed Services and asked Carrier to clarify why it denied the Disputed Services.

12. Provider received a sufficient explanation from Carrier to understand the reason Carrier denied part of Provider's claims for November 30, 2000, and December 1, 4, and 6, 2000, in the amount of $624.00.

13. The Disputed Services provided on November 30, 2000, and December 4, 2000, were properly supported by Provider's documentation of the aquatic therapy.

14. The Disputed Services provided on December 1 and 6, 2000, were reasonable and medically necessary.

15. By decision dated May 15, 2001, the Medical Review Division of the Texas Workers' Compensation Commission (Commission) granted Respondent reimbursement for the Disputed Services.

16. Carrier timely requested a hearing to contest the Commission's decision.

17. All parties received not less than 10 days notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of matters asserted.

18. A hearing was convened by Administrative Law Judge Catherine C. Egan on February 2, 2005, in the hearing rooms of the State Office of Administrative Hearings, Austin, Texas. The hearing adjourned and the record closed on February 21, 2005.

19. For the dates of service from November 30, 2000, through December 6, 2000, Carrier failed to show that the Disputed Services were not medically necessary to treat Claimant's compensable injury.

V. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issue presented pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. §413.031.

2. 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(k) and TEX. GOV'T. CODE ANN. ch. 2003.

3. Carrier timely requested a hearing in this matter pursuant to 28 TEX. ADMIN. CODE (TAC) §§02.7 and 148.3.

4. Notice of the hearing was proper and complied with the requirements of TEX. GOV'T. CODE ANN. ch. 2001.

5. Carrier had the burden of proof in this matter, which was the preponderance of evidence standard. 28 TAC §§48.21(h) and (i); 1 TAC §155.41(b).

6. Carrier failed to demonstrate that the Disputed Services from November 30, 2000, through December 6, 2000, were not reasonable and medically necessary for the treatment of Claimant's compensable injury.

7. Carrier failed to show that the Disputed Services provided on November 30, 2000, and December 4, 2000, were not supported by Provider's documentation.

8. Provider is entitled to reimbursement for the Disputed Services from November 30, 2000, through December 6, 2000, as they were documented, reasonable, and medically necessary.

ORDER

THEREFORE IT IS ORDERED that Texas Mutual Insurance Company reimburse First Rio Valley Medical, P.A., for the Disputed Services provided to Claimant from November 30, 2000, through December 6, 2000, in the amount of $624.00, plus any and all applicable interest.

SIGNED April 19, 2005.

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CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS