**SOAH DOCKET NO. 453-04-6343.M5**
**TWCC MRD NO. M5-04-0729-01**

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| **FLORISTS MUTUAL INSURANCE COMPANY,** | § | **BEFORE THE STATE OFFICE** |
| **Petitioner** | § | |
| | § | **OF** |
| **V.** | § | |
| | § | |
| **HEALTHTRUST, LLC,** | § | |
| **Respondent** | § | **ADMINISTRATIVE HEARINGS** |

## DECISION AND ORDER

Florists Mutual Insurance Company (Carrier) challenged the decision of the Medical Review Division of the Texas Workers' Compensation Commission (MRD/Commission) ordering it to reimburse Healthtrust, LLC (Provider), for a pain management program that Provider administered to ___ (Claimant) from December 2, 2002, through February 19, 2003. Carrier also appealed the MRD's denial, in fact or implied, of a refund request for monies Carrier had already paid to Provider. In the alternative, Carrier appealed the MRD's refusal to rule on Carrier's refund claim.

The Administrative Law Judge (ALJ) finds that Provider is not entitled to reimbursement for any of the unpaid dates of service and further finds that Carrier is entitled to a refund of all reimbursement paid to Provider, with interest accrued from September 23, 2003, as provided by TEX. LAB. CODE ANN. § 413.019(b) and 28 TEX. ADMIN. CODE § 133.304(r).

The hearing in this matter convened on November 10, 2004, in Austin, Texas, with ALJ Cassandra Church presiding. The record closed on December 21, 2004, to permit the parties to file briefs. Provider was represented by Daniel Horne, attorney. Carrier was represented by Steve Tipton, attorney. The Commission did not participate in the hearing.

Adequacy of notice was not disputed so is set forth in the Findings of Fact and Conclusions of Law without further discussion here. The ALJ found that the State Office of Administrative Hearings (SOAH) has jurisdiction over all matters raised by Carrier in its request for hearing, as discussed below.

## I. DISCUSSION

### A. Medical History

On ___, Claimant injured his back when he caught a heavy falling object. He suffered a sprain/strain of his lumbosacral area. Claimant was treated with conservative measures and also received epidural steroid injections.[1] However, he continued to experience pain in his lower back which interfered with his activities of daily living (ADL's) including his sleep. Claimant was not a surgical candidate and had degenerative changes in his lumbar spine.

In late 2002, Carrier agreed that a chronic pain management program was medically necessary to treat Claimant's compensable injury. On November 12, 2002, Carrier preauthorized Provider to administer 30 sessions of pain management treatment to be conducted five times a week for six weeks.

The program was actually administered over a 12-week period between December 2, 2002, and February 19, 2003. Provider asserted that it provided the service that Carrier had preauthorized, albeit not on the scheduled timetable. Carrier conducted a retrospective audit which it asserted showed that Provider failed to document that it had provided the service that Carrier had preauthorized. Carrier also asserted that Provider had failed to get concurrent review for an extension of the service period.

### B. Characterization of MRD Decision and SOAH Jurisdiction

On February 19 and September 23, 2003, Carrier requested a refund from Provider for sessions of the chronic pain management program for which it had reimbursed Provider.[2] Carrier had reimbursed Provider for 19 dates of services, for a total of $19,737. Provider did not respond to those requests. In its September 23, 2003, letter, Carrier stated that the services Provider was performing were outside the scope of the preauthorization, were inadequately documented, and were not medically necessary. Carrier also stated that Provider had failed to undergo concurrent review before performing services outside the preauthorized period of service. The letter on February 19, 2003, had mentioned only lack of medical necessity for the treatment sessions Provider was conducting. On December 1, 2003, Carrier requested the MRD adjudicate its request for a refund.

[1] Provider Exh. 1, p. 287.

[2] Carrier Exh. 2, pp. 9-11.

Carrier denied Provider's request for payment for the final 11 dates of service. Provider sought additional reimbursement in the amount of $11,520. On November 6, 2003, Provider requested an MRD hearing on Carrier's denial of reimbursement. Carrier had issued multiple EOB's for the unpaid dates, listing the follow denial codes in some combination: "F" for fee reduction, "V" for medical necessity with a peer review, "U" for medical necessity, and "N" for documentation concerns. Carrier raised lack of documentation in regard to all unpaid dates of service.[3]

At the SOAH hearing, Carrier argued that it was not denying the medical necessity of the service it had preauthorized, but the medical necessity of the service actually provided-something other than a pain management program. Carrier draws a subtle but not inconsiderable distinction between those two interpretations. However, in the context of the dialog via forms that comprises the initial salvos of a medical fee dispute, this distinction is too fine. The ALJ concludes that Provider could not have comprehended from Carrier's use of the "V" and "U" codes that Carrier believed Provider was not providing, or not demonstrating the provision of, the services preauthorized.[4] This case will go forward on the fee grounds raised in the EOB's and in Carrier's September 23, 2003, refund request, i.e., lack of documentation, fee reduction, and lack of concurrent review.

A carrier is entitled to medical dispute resolution if it has made a request for refund and the health care provider failed to pay the refund request within 60 days of the request.[5] If found to be due, such a refund accrues interest beginning on the 60th day after the provider received notice of the alleged overpayment.[6] In this case, Provider received substantive notice of the alleged overpayment on September 23, 2003.

On May 3, 2004, the MRD ordered Carrier to pay Provider $11,520 for all unpaid dates on which Provider rendered service. However, the MRD decision was silent on the refund, either as to whether Carrier had properly raised the issue or as to the substance of its refund claim. Notwithstanding the silence of the MRD on the refund issue, the ALJ concluded it is a reasonable inference that the MRD denied any requested relief which it did not grant; therefore, it made an

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[3] Carrier Exh. 4.

[4] Carrier Exh. 1, pp. 6-9, and Exh. 4.

[5] 28 TEX. ADMIN. CODE § 133.304(p).

[6] TEX. LAB. CODE ANN. § 413.019(b).

implicit determination denying Carrier's refund claim. The ALJ concludes both the refund issue and the appeal from the order for reimbursement are properly before SOAH.

Carrier has the burden of proof in regard to both elements of its appeal.

**C. Admission of Carrier Exhibit 8**

Carrier offered Carrier Exhibit 8, copies of prescriptions for pain medications filled by Claimant in November and December of 2002 and in January, February, March, and April of 2003. Carrier offered them to compare levels of medication prescribed before, during, and after the pain management program.[7] Provider argued that the prescriptions are not relevant and that their naked offer does not show for what purpose the medications were prescribed.[8] A ruling on admission was taken under consideration at hearing.

Carrier's Exhibit 8 is admitted. This information is relevant to the issue of what elements of a chronic pain management program Provider documented. In addition, these medications were prescribed by Dr. Joel Joselevitz. Dr. Joselevitz had been treating Claimant since at least June 2002 and had prescribed these medications for Claimant's low back pain.[9] Dr. Joselevitz was a participant in the pain management program.[10]

**D. Adequacy of Documentation**

Carrier agreed it was foreclosed from challenging the medical necessity of a chronic pain management program.[11] However, Carrier also argued that preauthorization of the treatment did not reduce its authority to retrospectively audit Provider's bill in order to determine whether the service provided was the same program that was preauthorized, had been appropriately documented, and had been provided in a manner consistent with Commission rules.[12]

Provider did not argue that Carrier did not have the right to conduct a retrospective bill review, but rather argued that the Carrier's conclusions based on that review were flawed and that it

[7] Carrier's Response, December 8, 2004.

[8] Respondent's Objection, December 14, 2004.

[9] Carrier Exh. 6, pp. 5-9 (Designated doctor report, Thomas M. Raymond, M.D.); Provider Exh. 1, p. 245.

[10] Carrier Exh. 7, p. 30.

[11] 28 TEX. ADMIN. CODE § 133.301(a).

[12] 28 TEX. ADMIN. CODE § 133.301(a).

had met the documentation requirements of the Commission rules.[13] The ALJ concludes that Carrier did have authority to conduct a retrospective review on any grounds provided by the Labor Code or Commission rules and did so properly in this case.

Carrier's root contention is that Provider's documentation failed to show that it was providing chronic pain management as that service is defined by applicable Commission rules. Provider argued that it had provided the appropriate service and had properly documented it.

The MRD and the parties applied the 1996 *Medical Fee Guideline* (MFG) to this case.[14] Provider argued from 1994 guidelines for pain management set by the Commission of Accreditation of Rehabilitation Facilities (CARF), but noted they had been adopted in the 1996 MFG.[15]

Under the 1996 MFG, a provider of a chronic pain management program was required to maintain specific documentation because that course of treatment was one for which the Commission did not set a maximum allowable reimbursement (MAR) level. Procedures without a MAR were deemed too unusual or too variable to have a MAR applicable to all treatments. The supporting documentation of such a procedure (DOP) must include the following elements:

1. Exact description of procedure or service provided.
2. Nature, extent, and need (diagnosis and rationale) for the service or procedure.
3. Time required to perform the service or procedure.
4. Skill level necessary for performance of service or procedure.
5. Equipment used, if applicable.[16]

To meet the requirements in the 1996 MFG for documenting an interdisciplinary chronic pain management program, a provider must maintain daily notes on the treatment and the patient's response to the treatment, reviews of the daily treatments to show continued progress, an initial evaluation of the worker's readiness for the program, and a written individualized treatment plan by the supervising doctor, supplemented as needed by plan changes.[17]

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[13] Provider Exh. 1, pp. 131-134.

[14] 28 TEX. ADMIN. CODE § 134.201.

[15] Provider's Closing Response, December 27, 2004, pp. 2-4.

[16] MFGBGeneral Instructions, Sec. III, pp. 1-2.

[17] MFGBMedicine Ground Rules, Sec. II (G), pp. 40-41.

Under the 1996 MFG, a chronic pain management program must comprise a coordinated, goal-oriented, interdisciplinary team service to reduce pain, improve functioning, and decrease the worker's dependence on the health care system.[18] A physician trained in treating chronic pain must provide direct on-site supervision of the daily program activities, participate in the patient's initial and final evaluation, write the patient's treatment plan and any needed modifications, and direct the interdisciplinary team.

Provider's documentation showed deficiencies at the intake, treatment, and measurement stages of the program.

Claimant's specific deficits were not fully documented when intake occurred nor was it clear how the initial program was tailored to meet Claimant's needs. It is questionable whether the program plan was individualized for Claimant's needs, as some documentation referred to a female patient and some contained references to exercises for neck and shoulder injuries.[19] Only Claimant's back was injured.

Testifying for Carrier, Francisco Perez, Ph. D., a specialist in pain management, stated that Claimant's intake evaluation did not include evaluation of Claimant's motivation for undertaking the program, which is one of the most essential elements in an occupational medicine program. Dr. Perez also noted that the program did not show any treatment for depression, although that element had been mentioned in Claimant's initial evaluation. Dr. Perez stated that depression is normally treated through one-on-one sessions, not group sessions. Provider's documentation listed only group sessions and Dr. Perez said none of the documentation of the program showed any sessions tailored for Claimant. Dr. Perez also noted that the mental health intake evaluation appeared rote and very similar in language to other evaluations he had reviewed.

Claimant was deposed in this matter. He recalled that all participants were involved in the same group activities, such as watching films on relaxation or pain control, counseling, nutrition, or social activities.[20]

Testifying for Carrier, Charles R. Crane, M.D., noted a lack of justification in Claimant's intake records for why regular socialization activities were needed as Claimant did not show deficits

[18] 1996 MFGBMedicine Ground Rules, Sec. II, Single and Multi-disciplinary Programs, pp. 36-41.

[19] Carrier Exh. 6, pp. 22-23.

[20] Carrier Exh. 7.

in the social skills area. Participants regularly engaged in playing dominoes, cards, and chess and assembling puzzles.[21] Similarly, extensive nutrition counseling was provided to Claimant, although no nutritional deficits were noted in his initial evaluation.

Similar problems were noted concerning administration of the program. There is no record of interdisciplinary team meetings or of a treatment plan developed by the supervising physician.[22] There is a paucity of records that clearly show Claimant's response to each session's treatment or any changes made to address those responses.[23]

Claimant reported that the sessions were not progressive and that he got the basic premise of the program-not letting pain dominate your life and thinking-early in the program.[24] Claimant stated that he did not intend to return to work but that the treatment program included training and activities to lead to a return to work.[25] Dr. Perez also noted that the Provider's records did not show a progression in treatment and did not show that any of the units on relaxation or changing focus from pain were tailored to Claimant's particular pain control issues.

Dr. Crane stated that the documentation of physical conditioning and therapeutic activities, which were close to half of the program, were simply general descriptions that did not document Claimant's progress toward specific targets or goals. Dr. Crane stated that he saw little if any indication in Provider's records that individualized goals or measurable steps toward those goals had been set for Claimant. Most comments on progress were simply feelings or impressions recorded by the attending staff members. Claimant's range of motion (ROM) was not comprehensively measured in the course of the chronic pain management program or at the end. There is some suggestion in the records that the limited gains that Claimant experienced in his ROM apparently occurred well before the program that Provider administered began.[26]

Provider's records did not provide clear documentation of the outcomes of the chronic pain management program. Claimant's pain medication prescriptions remained much the same before,

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[21] Provider Exh. 1, pp. 138-202.

[22] Carrier Exh. 5, p. 22.

[23] Provider Exh. 1, pp. 138-202.

[24] Carrier Exh. 7, pp. 57-58.

[25] Provider Exh. 1, p. 73.

[26] Provider Exh. 1, pp. 275-289.

during and after the administration of the pain management programs.[27] Dr. Crane stated that in late 2002 Claimant's history did not demonstrate a medication-use problem that needed to be addressed through an interdisciplinary program. Whether Claimant's actual use of the prescribed medications changed was not clear. Similarly, there was no documentation of pain reduction by the end of the program. Although a goal is to reduce pain, Claimant's pain levels varied little from the beginning to the end of the program. Claimant reported pain levels between five and six on a scale of one to 10 in October 2002.[28] By January 14, 2003, Claimant reported pain levels of between five to seven on a scale of one to 10.[29]

Provider did not offer any medical evidence, apart from the treatment notes and evaluations in Claimant's file, regarding its practices or its documentation of its practices.

In sum, Provider's documentation failed to demonstrate that Provider provided a chronic pain management program meeting the Commission's standards. The records do not demonstrate that the program it administered was coordinated, goal-oriented, interdisciplinary team service to reduce pain, improve functioning, and decrease the worker's dependence on the health care system within the meaning of the 1996 MFG. Lacking that documentation, there is no credible basis to conclude Carrier has any liability to reimburse Provider for a chronic pain management program.

The ALJ, therefore, concludes that Carrier met its burden of proof to show that Provider failed to document that it provided the type of service that Carrier preauthorized so Provider is not entitled any further reimbursement for administration of a chronic pain management program. Further, on the same ground, Carrier met its burden of proof to show that it was entitled to a refund for reimbursement that it had already paid Provider.

As the documentation grounds is sufficient to resolve this case, this Decision does not reach the question of whether Provider's failure to respond to Carrier's request for a refund would constitute a separate grounds for recovery by Carrier of the money it had paid.

**E. Concurrent Review**

[27] Carrier Exh. 6, pp. 5-9, and Exh. 8.

[28] Provider Exh. 1, pp. 288 and 302.

[29] Provider Exh. 1, p. 264.

Carrier alleged that Provider did not seek concurrent review for variations in service outside the terms of its preauthorization. Provider said the variances in the program were warranted under the circumstances and that there had been leniency in the past in enforcing preauthorization timetables.[30]

Concurrent review is a review of on-going health care for an extension of treatment beyond previously-approved health care.[31] Chronic pain management treatment is a rehabilitation service that requires preauthorization and concurrent review.[32] In preauthorizing a course of treatment, a carrier must specifically identify the health care approved, and the number of health care treatments and/or the specific period of time approved.[33]

The preauthorization by Carrier required that the service be provided five times a week for a period of six weeks. The preauthorization specifically references the need for concurrent review for deviations from the approved program. Provider began the program sessions on December 2, 2002. The six-week period would have expired on January 10, 2003. However, Provider extended the program for approximately six weeks beyond the authorized termination date, to February 19, 2003. In addition, it did not offer five sessions per week in any of the weeks in which service was provided. In five of the weeks only three sessions were provided; in two of the weeks, only two sessions were provided; and, in three of the weeks, only one session per week was provided.[34]

Provider did not seek concurrent review for either the extension of the duration of the program or for varying the number of sessions per week. Although Provider asserted that he as a provider, or providers in general, had been granted leniency in complying with authorized service periods, Provider did not support that proposition with any evidence.

Provider also asserted that the holiday season interrupted the program and had elevated Claimant's anxieties and depression. However, the documentation of the immediate post-holiday

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[30] Provider Exh. 1, p. 133.

[31] 28 TEX. ADMIN. CODE § 134.600(a)(2), Preauthorization, Concurrent Review, and Voluntary Certification of Health Care. (Eff. date January 1, 2002). This rule covers requests for preauthorization submitted between January 1, 2002, through March 14, 2004. References in this Decision and Order shall mean the version of Rule 134.600 in effect for preauthorization requests made in 2002 unless otherwise noted.

[32] 28 TEX. ADMIN. CODE § 134.600(h) and (i).

[33] 28 TEX. ADMIN. CODE § 134.600(f)(5).

[34] Carrier Exh. 5.

sessions did not reflect Claimant's reports of those mental states or state that extension of the program was the appropriate response to address them.[35] In considering the reasonableness of Provider's extension, the ALJ took into consideration that the Christmas-New Year holiday season fell in the middle of this period. Even allowing for some disruption of the program by the demands of the holiday season, an additional six weeks is not reasonable and is well outside the authorized period of service.

Services provided for dates outside the preauthorized six-week period for which it failed to seek concurrent review were not provided in accord with the applicable Commission rules. A carrier is not liable for payment unless services requiring concurrent review were approved.[36] The ALJ concludes that Provider is not entitled to reimbursement for services provided from January 13, 2003, through February 19, 2003, because they were not approved through the concurrent review process.

Carrier paid for four sessions on dates outside the approved period of service, specifically January 14, 16, 17, and 20, 2003. As those services were not provided in accordance with applicable Commission rules, Carrier is entitled to a refund of reimbursement it has paid for those dates.

**E. Fee Reduction Issue**

Carrier denied payment for services on January 13, 27, 29, and 30, and on February 5, 7, 10, and 12, 2003, on the additional grounds that the amounts billed were not fair and reasonable amounts for the services rendered.[37]

Provider billed $180.00 per hour for the service. The only evidence in the record on the reasonableness of fees is testimony from Dr. Crane that CARF-accredited facilities charge between $100.00 to $135.00 for chronic pain management programs and that a non-CARF accredited facility would be expected to charge approximately 80 per cent of that amount, or between $80.00 and $108.00. Provider did not offer any evidence regarding the basis of the fee it billed.

The ALJ concludes that as the ruling in this case is against any reimbursement, this Decision need not reach the issue of the proper amount due for the services rendered.

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[35] Provider Exh. 1, pp. 63-73.

[36] 28 TEX. ADMIN. CODE § 134.600(b)(1).

[37] Carrier Exh. 4.

**F. Summary**

All dates, both paid and unpaid, on which Provider provided service to Claimant were at issue in this case. Carrier met its burden of proof to show that Provider failed to document that it provided a chronic pain management program as that service is defined in the 1996 MFG. Carrier also met its burden of proof to show that Provider provided services beyond the approved end date for the services and at a different frequency than preauthorized without seeking concurrent review either for that extension or frequency variation. The ALJ concludes that Provider is not entitled to any additional reimbursement and also that Carrier is entitled to a refund from Provider in the amount of $19,737, with interest as provided for in TEX. LAB. CODE ANN. § 413.019(b) and 28 TEX. ADMIN. CODE § 133.304(r).

## III. FINDINGS OF FACT

1. On ___, ___ (Claimant) injured his back when he caught a heavy falling object.

2. Florists Mutual Insurance Company (Carrier) was the responsible insurer.

3. Between April and December 2002, Claimant was treated conservatively but continued to have significant pain in his low back. Claimant received epidural steroid injections for his back.

4. Claimant was not a surgical candidate and had degenerative changes in his lumbar spine.

5. In late 2002, a chronic pain management program was medically necessary to treat Claimant's compensable injury.

6. On November 11, 2002, Carrier preauthorized Provider to conduct a 30-session, six-week pain management program to treat Claimant. Sessions were to be conducted five days per week.

7. The sessions provided by Provider were not conducted within a six-week period, but over a 12-week period between December 2, 2002, and February 19, 2003.

8. Provider did not provide five days of treatment in any week of service. In five of the service weeks only three sessions were provided; in two service weeks only two sessions per week were provided; and, in three service weeks, only one session was provided.

9. Provider did not seek concurrent review for extension of the service period or for modification of the chronic pain management program from a six-week to a twelve-week program or for varying the number of sessions conducted per week.

10. Claimant was prescribed pain medications of the same type and in the same amounts before, during, and after the pain management, and no medication overuse by Claimant prior to the program was documented.

11. Provider did not prepare an individualized treatment program tailored to Claimant's needs.

12. Claimant's treatment plan listed exercises for body parts that Claimant did not injure and did not document nutritional or socialization deficits.

13. Claimant participated in the same group activities as other participants in regard to relaxation and pain control, nutrition, and healthy mental attitudes.

14. At intake, Provider indicated Claimant had depression but did not document treatment specific for Claimant's depression.

15. The program administered to Claimant included extensive socialization activities such as dominoes, cards, chess, and puzzle assembling, and also nutrition counseling.

16. In December 2002 and in January and February 2003, Claimant did not intend to return to work. Provider's treatment program included return-to-work activities and training.

17. Provider did not document a change in Claimant's perceived pain levels. Claimant reported pains levels between five and six on a 10-point scale in October 2002, and reported levels between five and seven on a 10-point scale in January 2003.

18. Provider did not document that Claimant's treatment included regular interdisciplinary meetings supervised by a physician.

19. Provider did not document how the course of therapeutic activities that comprised approximately half of the chronic pain management program improved Claimant's physical functioning or how Claimant was making measurable progress toward any individual goals.

20. Carrier reimbursed Provider for services provided from December 2, 2002, through January 20, 2003, with the exception of service provided on January 13, 2003.

21. Between February and September 2003, Carrier conducted a retrospective review of Provider's services.

22. Carrier denied payment for services provided on January 13, 2003, and from January 21, 2003, through February 19, 2003. Carrier denied payment for the services provided on the basis that Provider failed to document that it had provided the service that Carrier had preauthorized, within the meaning of the *Medical Fee Guideline* (MFG), 28 TEX. ADMIN. CODE § 134.201, and that the services which it did document were not medically necessary.

23. Carrier denied payment for services provided on January 13, 27, 29, and 30, and on February 5, 7, 10, and 12, 2003, on the additional basis that the amounts billed were not fair and reasonable reimbursement amounts for the services rendered.

24. On February 19, 2003, and September 23, 2003, Carrier requested that Provider refund to it all reimbursement already paid to Provider for chronic pain management program sessions.

25. The September 23, 2003, letter outlined the alleged deficiencies in record keeping and alleged failure to seek concurrent review as the basis for its refund request. The letter constituted notice to Provider of the Carrier's allegations of an overpayment.

26. Provider did not pay Carrier a refund in whole or in part and did not respond to Carrier's request for a refund.

27. On December 10, 2003, Carrier referred its unanswered refund request to the Medical Review Division (MRD) of the Texas Workers' Compensation Commission. Carrier alleged that Provider had not provided the chronic pain management program that Carrier had preauthorized, had not gotten concurrent review for extension of the period of service, and had not responded to its refund requests of February 19 and September 23, 2003.

28. On November 6, 2003, Claimant referred its denied request for reimbursement to the MRD.

29. On March 11, 2004, the MRD determined the disputed claim was limited to fee matters and requested additional documentation from Provider.

30. On May 3, 2004, the MRD ordered Carrier to reimburse Provider for all unpaid dates of service between December 2, 2002, and February 19, 2003.

31. The May 3, 2004, decision by the MRD did not expressly rule on Carrier's December 10, 2003, request for refund. The MRD overruled Carrier's claim for refund by implication.

32. On May 12, 2004, Carrier requested a hearing on the May 3, 2004, MRD decision and also requested hearing on the denial, actual or implied, of Carrier's claim for refund and/or on the MRD's failure to rule on its claim.

33. On June 18, 2004, the Commission issued a notice of hearing on the request for hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted.

34. On November 10, 2004, Administrative Law Judge Cassandra Church conducted a hearing on the merits. The record closed December 21, 2004, to permit the parties to file briefs.

## III. CONCLUSIONS OF LAW

1. 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 and TEX. GOV'T CODE ANN. ch. 2003.

2. Carrier timely requested a hearing, as specified in 28 TEX. ADMIN CODE § 148.3.

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

4. Carrier has the burden of proof, pursuant to TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41(b), and 28 TEX. ADMIN CODE § 148.21(h).

5. In December and January 2002, a chronic pain management program was medically necessary to treat Claimant's back injury, within the meaning of TEX. LAB. CODE ANN. § § 401.011(19) and 408.021.

6. Carrier met its burden of proof to show that Provider failed to document that the health care service provided was the service authorized, *i.e.*, a chronic pain management program, as

required by the terms of the 1996 *Medical Fee Guideline* (MFG), 28 TEX. ADMIN. CODE § 134.201.

7. Carrier met its burden of proof to show that Provider administered health care on dates outside a preauthorized period of service, from January 11, 2003, through February 19, 2003, without obtaining concurrent review as required by TEX. LAB. CODE ANN. § 413.014 and 28 TEX. ADMIN. CODE § 134.600(b)(1).

8. Carrier met its burden of proof to show Provider is not entitled to further reimbursement and that Carrier is entitled to a refund from Provider for any reimbursement Provider received for a chronic pain management program as that service was not provided in accordance with applicable Commission rules pursuant to TEX. LAB. CODE ANN. §§ 413.014, 413.016, and the MFG, 28 TEX. ADMIN. CODE § 134.201.

9. Carrier met is burden of proof to show it is entitled to interest from 60 days after September 23, 2003, on all refund amounts due, pursuant to TEX. LAB. CODE ANN. § 413.019(b) and 28 TEX. ADMIN. CODE § 133.304(r).

## ORDER

**IT IS ORDERED** that all claims by Healthtrust, LLC, for reimbursement for all chronic pain management sessions administered to Claimant ___ between December 2, 2002, and February 19, 2003, are hereby denied, and it is further ordered that Healthtrust, LLC, shall refund to Florists Mutual Insurance Company the amount of $19,737, which is all reimbursement paid to Healthtrust, LLC, for chronic pain management program sessions conducted between December 2, 2002, and February 19, 2003, such payment to include interest that has accrued from 60 days after September 23, 2003, on all refund amounts due.

**SIGNED February 16, 2005.**

**CASSANDRA J. CHURCH**
**ADMINISTRATIVE LAW JUDGE**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**