SOAH DOCKET NO. 453-05-2760.M5
TWCC MR NO. M5-04-3892-01

AMERICAN CASUALTY COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**
V.	§	
REAL HEALTH CARE, **Respondent**	§	

DECISION AND ORDER

I. INTRODUCTION

American Casualty Company (Carrier) disputes the decision of the Texas Workers' Compensation Commission (TWCC or Commission)/Medical Review Division (MRD)[1] directing Carrier to pay Real Health Care (Provider) for certain claims originally denied because Carrier found that the treatments were unrelated to the compensable injury (denial code "R"). The disputed services were provided to Claimant between August 4, 2003, and November 26, 2003, and included unattended electrical stimulation (CPT 97014), ultrasound (CPT 97035), manual therapy (CPT 97140), office visits (CPT 99212), and attended electrical stimulation (CPT 97032).[2] The decision of an independent review organization (IRO) issued on behalf of TWCC found that these disputed services were not medically necessary to treat Claimant's compensable injury.[3]

MRD adopted IRO's decision except for those claims Carrier denied for treatment of an unrelated injury, herniated lumbar discs. After Carrier had denied these claims, the Commission

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the newly created Division of worker's Compensation at the Texas Department of Insurance.

[2] The total in dispute is approximately $2,083.80.

[3] The IRO considered claims from July 2, 2003, to January 30, 2004, that included the disputed services.

found that Claimant's herniated lumbar discs were part of the compensable injury. Because Carrier had not denied the disputed claims on the explanation of benefits (EOB) for lack of medical necessity, MRD reviewed the claims and found that Carrier was obligated to pay Provider for some of these claims. As set out below, the Administrative Law Judge (ALJ) finds Carrier gave Provider sufficient notice that Carrier also denied the disputed services for lack of medical necessity. The ALJ further finds that the disputed services were not medical necessary.

II. BACKGROUND

On ___, Claimant sustained a compensable injury when she slipped and fell on a wet greasy floor while at work. Claimant went to Provider for treatment on October 11, 2001. After examining Claimant, Provider began treating Claimant with one-on-one physical therapy and chiropractic care. Claimant participated in approximately 49 weeks of physical therapy and chiropractic care. When Claimant's condition did not improve significantly, she underwent a bilateral laminectomy and diskectomy at L4-L5, and L5-S1 on March 28, 2003.

Claimant experienced postoperative infections and complications that required additional surgeries on April 26, and May 8, 2003. Claimant returned to Provider and began another course of one-on-one physical therapy and chiropractic care. Carrier denied payment for the services provided by Provider to Claimant from July 2, 2003, to January 30, 2004.

Provider appealed the matter to MRD asking to be reimbursed for the medical services provided to Claimant from July 2, 2003, to January 30, 2004. MRD referred all the claims to IRO for a determination of the medical necessity. On August 24, 2004, IRO found that the medical services provided by Provider to Claimant from July 2, 2003, to January 30, 2004, were not medically necessary and denied further reimbursement to Provider. MRD then reviewed the claims from August 4, 2003, to November 26, 2003, that Carrier denied for being unrelated to the compensable injury and ordered Carrier to pay Provider $2,083.80.

III. **LEGAL ISSUE**

Carrier raises a threshold issue of whether MRD had authority to consider the disputed services given the IRO's determination that these services were not medically necessary. Carrier contends that Provider knew medical necessity was in issue and argues Provider should not be reimbursed for services that were not medically necessary. Therefore, Carrier objects to the MRD's decision to review any of Provider's claims after the IRO found the medical services provided between July 2, 2003, through January 30, 2004, were not medically necessary.[4]

Provider argues that because Carrier denied the disputed services in the EOBs for being treatment of an unrelated injury, and not for a lack of medical necessity, the MRD properly considered the claims.

Pursuant to 28 TEX. ADMIN. CODE (TAC) 133.304(c), when a carrier denies payment, the carrier must send an EOB to the appropriate party with the proper exception code and "sufficient 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 phrase with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section.

The disputed services were initially denied because Carrier found that the medical treatments to Claimant's lumbar spine were unrelated to the compensable injury. Subsequently, the Commission held that Claimant's herniated lumbar spine was related to the compensable injury. At some point, Carrier advised Provider that these claims were also denied for lack of medical necessity because Provider then appealed all the disputed claims to MRD asserting that all the services were medically necessary. Provider prepared and submitted a Table of Disputed Services indicating that the reason Provider was requesting additional reimbursement was because the "Documentations (sic) supports medical necessity."

Essential to the integrity of the Texas Workers' Compensation Act is the requirement that

[4] Carrier's Brief.

medical services provided to a claimant for treatment of a compensable injury be reasonable and medically necessary.[5] Pursuant to 28 TAC § 133.304(c), Carrier had a duty to provide Provider with a sufficient explanation to allow Provider to understand the reason or reasons Carrier denied the claims. This requirement was satisfied once Provider understood why Carrier denied the claims. As indicated in Provider's Table of Disputed Services submitted in its Medical Dispute Resolution Request to MRD, Provider was on notice that medical necessity was the issue in dispute. Provider had the opportunity to provide documentation and explanations to show that the disputed services were medically necessary. Provider will not now be permitted to contend that medical necessity was not in issue simply because Carrier failed to technically comply with the requirements of 28 TAC §133.304(c).

Based on this evidence, the ALJ finds that Carrier timely notified Provider that the medical necessity of the disputed services was in dispute. Therefore, it was properly considered by the IRO and is properly within the scope of this case.

IV. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO Opinion and Medical Records

The IRO found that the disputed services, provided several months after surgery, were not medically necessary. Claimant underwent lumbar surgery on March 28, 2003. Due to complications, this surgery was followed by additional surgeries on April 26 and May 8, 2003. While Claimant was entitled to postoperative rehabilitative therapy, the IRO found that the one-on-one physical therapy provided by Provider was not medically necessary for the length and duration provided.

According to the IRO, "this patient could have been transitioned into a home exercise and rehabilitation program by July 2003. In fact, there is no evidence to support the need for monitored

[5] A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

therapy during the time frame in dispute." The IRO explained that Claimant had received enough one-on-one physical therapy to know how to do the exercises safely, without one-on-one supervision.[6] The IRO opined that if any improvements were obtained during the disputed time period these improvements could have been achieved by Claimant in a home exercise program.

The medical records admitted into evidence only went through July 30, 2003. Most of the records dealt with Claimant's pre-surgical condition and treatment and provided insufficient information to support the medical necessity of the disputed services.

B. Parties's Position

Carrier contends that Claimant should not have had spinal surgery because she had too many positive Waddell signs to support surgical intervention. However, once she had the surgery, Carrier maintains that months after the surgery Claimant did not need additional one-on-one physical therapy. Carrier argued that Claimant already had prolonged periods of one-on-one physical therapy and should have been able to participate safely in a home-based physical therapy program.

Provider argues that after the unsuccessful surgery, Claimant had significant problems. As a result, Claimant became extremely deconditioned and was in constant pain. In July, August and September 2003, Provider treated Claimant with physical therapy and chiropractic care. In October 2003, Claimant participated in a chronic pain program with another doctor. Claimant returned to Provider for physical therapy and chiropractic care in November and December 2003, and January 2004. According to Provider, Claimant needed to be actively prodded to get her to do what she needed to do to recover.

[6] Ex. 1 at Tab 1.

C. ALJ's Analysis

Carrier had the burden of proof in this matter. To meet this burden, Carrier relied on the IRO's findings and conclusion that the disputed services were not medically necessary because Claimant had already had sufficient one-on-one physical therapy by July 2, 2003, to be able to do the exercises safely in a home setting. The medical records admitted into evidence did not clarify why the disputed services were provided or if they were medically necessary. Nor did the record show that Claimant experienced any meaningful improvement because of the disputed services. Based on the evidence, primarily the IRO decision, Carrier showed that the disputed medical services provided to Claimant a couple of months after spinal surgery were not medically necessary. Therefore, the ALJ finds that the disputed services provided by Provider to Claimant were not medically necessary.

V. FINDINGS OF FACT

1. On ___, Claimant sustained a work-related injury when she slipped and fell as a result of her work activities (compensable injury).

2. At the time of Claimant's compensable injury, Claimant's employer's workers' compensation insurance carrier was American Casualty Company (Carrier).

3. On October 11, 2001, Claimant went to Real Health Care (Provider) for treatment of her compensable injury.

4. Provider treated Claimant with one-on-one physical therapy and chiropractic care until March 28, 2003, when Claimant underwent spinal surgery.

5. On March 28, 2003, Claimant had a bilateral laminectomy and diskectomy at L4-L5, and L5-S1.

6. Claimant experienced postoperative infections and complications, which required two additional surgeries on April 26 and May 8, 2003.

7. Subsequently, Provider resumed treating Claimant with one-on-one physical therapy and chiropractic care.

8. Carrier denied payment for the services provided by Provider to Claimant from July 2, 2003, to January 30, 2004, including the disputed services provided between August 4, 2003, and November 26, 2003.

9. Except for the services provided between August 4, 2003, and November 26, 2003, Carrier

denied payment asserting that the medical services were not medically necessary to treat Claimant's compensable injury.

10. Carrier denied payment for the services provided between August 4, 2003, and November 26, 2003, to treat Claimant's lumbar spine asserting that the condition was unrelated to her compensable injury.

11. On January 16, 2004, the Texas Workers' Compensation Commission (TWCC or Commission) found that Claimant's compensable injury extended to her herniated lumbar discs.

12. After the Commission's decision, Carrier did not pay these claims. Provider knew that Carrier also maintained that the disputed services were not medically necessary.

13. The disputed services that were provided to Claimant between August 4, 2003, and November 26, 2003, included unattended electrical stimulation (CPT 97014), ultrasound (CPT 97035), manual therapy (CPT 97140), office visits (CPT 99212), and attended electrical stimulation (CPT 97032).

14. On July 13, 2004, Provider filed a request for medical dispute resolution with the Texas Workers' Compensation Commission (TWCC) asking to be reimbursed for the claims Carrier denied between July 2, 2003, and January 30, 2004.

15. TWCC's Medical Review Division (MRD) referred all the claims to an independent review organization (IRO) to determine if the services were medically necessary.

16. Following the review of the appealed claims, the IRO found that the medical services provided from July 2, 2003, to January 2004, were not medically necessary.

17. Based on the IRO's findings, MRD denied further reimbursement to Provider except for the disputed services denied as not being related to the compensable injury.

18. MRD ordered Carrier to reimburse Provider $2,083.80 for the disputed services.

19. Provider did not appeal the claims denied by the MRD.

20. After the MRD order was issued, Carrier asked for a contested-case hearing by a State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ) to consider those claims the MRD ordered be paid by Carrier to Provider.

21. Prior July 13, 2004, the date Provider filed its Medical Dispute Resolution Request with the Commission, Provider knew that the reason Carrier did not pay for the dispute services was because Carrier maintained these services were not medically necessary.

22. After July 2, 2003, Claimant no longer required one-on-one physical therapy because she had undergone sufficient one-on-one therapy prior to that time to be able to do the exercises independently, which includes the disputed services provided from August 4, 2003, to November 26, 2003.

23. After July 2, 2003, it was not medically necessary to provide the disputed services to Claimant to treat her compensable injury.

24. Required notice of a contested-case hearing concerning the dispute was mailed to the parties.

25. On August 11, 2005, SOAH ALJ Catherine C. Egan held a contested-case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Attorney Shelley Gatlin appeared for Carrier. Provider's Collections Team Leader appeared on behalf of Provider. The hearing concluded and the record closed on that same day.

VI. 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. LABOR CODE ANN. (Labor Code) §§ 402.073(b) and 413.031(k) and TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

3. Carrier has the burden of proof in this case pursuant to 28 TEX. ADMIN.CODE (TAC) 148.14 and 1 TAC 155.41.

4. 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 that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. Labor Code § 408.021 (a).

5. Based on the above Findings of Fact and Conclusions of Law, the disputed services provided by Provider to Claimant from August 4, 2003, and November 26, 2003, were not medically necessary to treat Claimant's compensable injury.

ORDER

IT IS ORDERED THAT American Casualty Company is not required to reimburse Real Health Care for the disputed services provided to Claimant from August 4, 2003, to November 26, 2003.

Signed October 10, 2005.

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