SOAH DOCKET NO. 453-03-3649.M5
TWCC MR NO. M5-03-0746-01

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

DECISION AND ORDER

Texas Mutual Insurance Company (Provider) requested a hearing to contest the May 1, 2003, Findings and Decision of the Texas Workers' Compensation Commission (Commission) authorizing reimbursement in the amount of $2,214.00, for patient focused office visits,[1] aquatic therapy,[2] therapeutic exercises,[3] and copies of medical records[4] from October 21, 2002, through November 7, 2002, (Disputed Services).[5] Carrier has the burden to show 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."[6]

This decision denies the relief sought by Carrier and grants reimbursement to Provider for the Disputed Services.

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[1] CPT Code 99211.

[2] CPT Code 97113.

[3] CPT Code 97110.

[4] CPT Code 99080.

[5] By Decision dated April 21, 2003, an independent review organization (IRO) determined that the Disputed Services were medically necessary.

[6] The last column setting out the reasons for denying the claims is not dispositive of that issue. The log does, however, list the correct dates, CPT codes, and description of services that are in dispute.

The hearing convened on February 2, 2005, before Administrative Law Judge (ALJ) Catherine C. Egan. 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 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 deposition and other items. 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 44-year-old female, sustained a work-related injury on ___, as she was getting off her chair. The chair slipped backwards from beneath her, and Claimant fell hard on her buttocks with the chair flipping over on top of her.[7] Claimant had undergone lower back surgery the previous month, on ___. Claimant went to Provider for treatment on February 22, 2001, but quit on March 8, 2001.[8]

On August 16, 2001, Claimant had a second surgery on her lumbar spine.[9] Claimant went to Provider for treatment sporadically between September 29, 2001, and December 7, 2001. On January 7, 2002, Claimant began to appear regularly for her therapy appointments with Provider. This continued through May 8, 2002, when treatment stopped until August 5, 2002. Treatment then continued on a regular basis through November 7, 2002. Ultimately, Gilbert Meadows, M.D., recommended the Claimant undergo a third surgery, which was performed on January 30, 2003.

In October 2002, after her second surgery, Claimant was five feet tall and weighed 162

[7] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 64.

[8] Carrier's Ex. 15, Tab 5 at 6.

[9] Joint Ex. 9, Tab 1 at 295.

pounds and reported to be in significant pain. She had been prescribed a significant amount of medication, some to address her back pain and some for her diabetes. Dr. Howell found she suffered with "failed back surgery."[10] Dr. Howell treated Claimant with aquatic therapy and therapeutic therapy.

II. LEGAL ISSUE

Except for the copies of the medical records,[11] Carrier denied payment to Provider for services provided from October 21, 2002, through November 7, 2002, under payment exception code "U" for "unnecessary treatment (without peer review)."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 "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 phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section."

Carrier's explanation for denying these services was set out in Carrier's rationale code "RG," described on the EOBs as "the treatment/service provided exceeds medically accepted utilization review criteria and/or reimbursement guidelines established for severity of injury, intensity of service and appropriateness of care."[12] Provider requested reconsideration and asked Carrier to clarify the protocol used to deny the claim. Carrier responded by reissuing the EOBs and adding payment exception code "O" for "denial after reconsideration" with a rationale code of "YO" for "reimbursement was reduced or denied after reconsideration of treatment/service billed."[13]

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[10] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol II at 70.

[11] Carrier denied payment for the special report under payment exception code "F" for "Fee guideline MAR reduction" with rationale code "TK." This code is defined by Carrier as "Rule 133.1 requires the submission of legible supporting documentation, therefore reimbursement is denied." Joint Ex. 9, Tab 1 at 13.

[12] Joint Ex. 9, Tab 1 at 13-21.

[13] Joint Ex. 9, Tab 1 at 24.

Dr. Howell testified that the explanation provided by Carrier for reference code "RG" did not inform him why Carrier was denying the claims as unnecessary treatment.[14] He was unaware of any healthcare provided to Claimant that exceeded any published medically accepted utilization review criteria.[15] Dr. Howell's testimony is consistent with his actions at the time Carrier denied reimbursement. In its request for reconsideration, Provider supplied additional information and asked Carrier to forward the written review protocols it used to deny these claims.[16] As noted above, Carrier provided no further explanation or details to Provider's request for additional information other than that set out in the original EOBs.

Carrier did not retain Dr. DeFoyd until December 2004. Obviously, he was not involved in Carrier's initial decision to deny this claim, nor does he know what Carrier's criteria and guidelines say that are referenced in the EOBs.[17] When asked if he knew the protocol Carrier used to deny a procedure based on the "U" payment denial code, Dr. DeFoyd stated he was not an employee of Carrier's and he did not know the process Carrier followed.[18]

Dr. Tsourmas, who serves as Carrier's medical director, testified that Carrier's guidelines track the medical guidelines. However, when Dr. Tsourmas was asked to explain Carrier's "RG" modifier, he could not do so.[19]

Even after Provider requested clarification, Carrier did not provide a sufficient explanation for denying Provider's claim. The Commission's rules required Carrier to provide on the EOB a sufficient explanation to allow Provider to understand the reason(s) for Carrier's denial. Carrier did not furnish Provider with the relevant portions of its criteria and guidelines in response to Provider's

[14] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 9.

[15] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell at Vol II, 11-12.

[16] Joint Ex. 9, Tab 1 at 54-60.

[17] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 52 and 557-564.

[18]

[19] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 57-58.

request for the same. Carrier did not provide a sufficient explanation of its denial for the disputed claims, and did not prove that its basis for denial at the time of the denial of the claims was correct.

Carrier cannot substitute at a much later date a reason or an explanation other than that provided by Carrier when it denied the claims. The physicians who testified at the hearing on behalf of Carrier were unable to testify regarding Carrier's criteria and guidelines referenced in the EOBs. Under the Commission's rules, Carrier's explanation was insufficient. The ALJ will not permit Carrier to now substitute an explanation that was not furnished in compliance with 28 TAC § 133.304(c). Therefore, where Carrier failed to timely submit a sufficient explanation of its denial, it is barred from denying the claim based on lack of medical necessity.

III. WERE THE DISPUTED MEDICAL SERVICES MEDICALLY UNNECESSARY?

A. IRO Decision and Medical Records

Because of the number of surgeries involved and intervening incidents, the following is a brief chronology of events:

10-18-00	First lumbar surgery
11-28-00	Claimant fell out of chair and sustained compensable injury
8-16-01	Second lumbar surgery
4-11-02	Claimant reached MMI
10-21 to 11-7-02	Dates of Disputed Services in this matter
2-3-03	Third lumbar surgery

On April 11, 2002, Howard Bernstein, M.D., conducted a comprehensive evaluation of Claimant's medical condition to determine whether she had reached Maximum Medical Improvement (MMI), and to determine her impairment rating. After completing a comprehensive evaluation, Dr. Bernstein reported a 10 percent impairment rating. According to Dr. Bernstein,

Claimant reach MMI on April 11, 2002.[20]

On April 21, 2003, the Independent Review Organization (IRO) issued its determination at the request of the Commission. The IRO found that Provider's records:

> ...clearly demonstrate a patient who is in need of care. The surgical interventions did nothing to relieve her pain syndrome and she is in need of some form of therapy. The records are convincing that the patient was at least making some progress in her efforts to return to a productive life. . . . The results, while probably minimal, are still significant enough to warrant a finding of medical necessity."[21]

In Provider's initial evaluation, Claimant reported that after her second spinal surgery she underwent four weeks of physical therapy with another doctor. During this time, Claimant's neck and back pain grew worse so the physical therapy was discontinued.[22] Claimant reported being on Darvocet and Vioxx, among other medications.[23] Dr. Howell's diagnoses for Claimant included: displacement of cervical intervertebral disc without myelopathy; displacement of lumbar intervertebral without myelopathy; thoracic or lumbosacral neuritis or radiculitis, disturbance of skin sensation, and facet syndrome.[24] In the November 8, 2002, interim assessment report, Dr. Howell noted that Claimant's back pain had improved slightly, and that she was slowly improving.[25]

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. Dr. Tsourmas has referred patients for aquatic therapy when they suffered with lower extremity issues, such as a broken bone, and need the buoyancy of the water. He agrees that while a patient has to be careful

[20] Joint Ex. 9, Tab 3 at 371.

[21] Joint Ex. 9, Tab 3 at 324.

[22] Joint Ex. 9, Tab 1 at 164.

[23] Joint Ex. 9, Tab 1 at 166.

[24] Joint Ex. 9, Tab 1 at 172.

[25] Joint Ex. 9, Tab 1 at 192-204.

with weight bearing exercises, aquatic therapy is useful, at least for the short term. However, he contends that 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."[26] Transitioning a patient from aquatic to land-based therapy may overlap, but not for more than a few weeks.[27]

After reviewing Claimant's medical records, Dr. Tsourmas opined that the disputed services were not medically necessary. While agreeing that Claimant needed to participate in active rehabilitation the rest of her life, Dr. Tsourmas maintained that it was not necessary to do "in-house" or one-on-one therapy because it was two years after Claimant's date of injury and Claimant had "experienced all the therapy a lumbar spine should have. She knows how to do this even before the date of injury, the work event."[28] Dr. Tsourmas contends Claimant should be doing physical therapy at home and that her diabetes did not justify the therapy being provided by Provider.

Dr. DeFoyd, Carrier's expert witness, practices at the Spine and Rehab Center and treats spinal injuries.[29] Dr. DeFoyd reviewed the Claimant's medical records, including those admitted into evidence, although he did not participate in Carrier's decision to deny these claims and was retained to review Claimant's medical records long after this claim arose. Under cross-examination, Dr. DeFoyd acknowledged that he had not reviewed Carrier's guidelines and criteria referenced in the rationale code "RG" in forming his opinions, and he did not know what they were.[30] Dr. DeFoyd also admitted that he did not know what Carrier meant by the term "and/or" in the definition of "RG."[31] Dr. DeFoyd testified that he had not prepared the EOBs and could not explain what the

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

[27] Ex. 16, Tab 3, Prefiled testimony of Dr. Tsourmas at 28.

[28] Ex. 16, Tab 3, Prefiled Testimony of Dr. Tsourmas at 92.

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

[30] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 556-558.

[31] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 563.

Carrier meant by its rationale code or what the guidelines provided.[32]

Dr. DeFoyd agreed with Dr. Tsourmas that by the time Claimant began the one-on-one aquatic therapy and therapeutic exercises that are in dispute Claimant had significant prior experience with doing these exercises so she should have been able to do them independently. In his opinion, no medical reason existed for providing therapy on a one-on-one basis. Dr. DeFoyd noted that on each date Provider billed for aquatic therapy, Provider also billed Carrier for an office visit. If the aquatic therapy and therapeutic exercises were not medically necessary, Dr. DeFoyd contends, then the office visits to evaluate her condition were not medically necessary.[33]

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

C. Provider's Position and Evidence

Dr. Howell, Provider's owner, has been a licensed chiropractor in Texas since October 1990. The 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, reception area, administrative offices, bathrooms with six showers, a return-to-work area, and a chronic pain management area.[34]

Dr. Howell testified that when Claimant came to see him in October 2002, she had numerous complaints, including: constant and severe inflammation in her neck; constant pain in her lower back; pain which radiated down her right leg; weakness, inflammation and a heavy sensation in her right hand; and pain that radiated down her back, hip and right leg. With the severity and complexity of Claimant's condition, Dr. Howell testified, he decided to put Claimant in a program

[32] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 563-564.

[33] Ex. 16, Tab 1, Prefiled Testimony of Dr. DeFoyd at 485.

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

with both aquatic and land-based exercises being done at the same time so that she could be transitioned to land-based therapy.[35]

Dr. Howell elaborated that, in general, doing aerobic exercises in the water promotes physical conditioning which in turn "creates positive health conditions."[36] In addition, Dr. Howell maintains, aquatic therapy improves a patient's psychological mood and reduces depression.[37] According to Dr. Howell, patients warm up in the deep end of the pool to encourage the secretion of synovial fluid-a fluid that helps lubricate the joint. After warming-up, the patient begins exercises that include running forward, backward, and sideways, to use all the major muscle groups in the body.

Claimant was a non-swimmer, a diabetic, in extreme pain, on heavy medications, and needed hands-on assistance in the water. All of these factors justified one-on-one therapy. Dr. Howell explained that because she could not swim and was afraid of the water, Provider had insufficient time to teach Claimant how to swim so that Claimant could feel safe enough to do the aquatic therapy in a group setting or independently. Hence, Provider moved Claimant into physical therapy as soon as possible.[38] Claimant's condition improved as indicated by her improved range of motion, the increase in the amount of therapy she could endure, and the reduction in her pain levels.

[35] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol II at 95.

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

[37] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol II at 19.

[38] Ex. 16, Tab 4, Prefiled Testimony of Dr. Howell, Vol II at 114.

D. ALJ's Analysis

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 at the time it issues the EOB. Carrier's explanation code "RG," and its definition, provided no explanation as it relied upon Carrier's confidential criteria and guidelines which Carrier chose not to disclose. Carrier's own expert, Dr. Tsourmas, was unable to explain what Carrier meant in its definition of "RG," and neither expert knew what Carrier's criteria and guidelines were. Despite Provider's request for clarification about what guidelines Carrier was referring to, Carrier failed to provide this information.

The ALJ notes, that neither of Carrier's experts could testify why Carrier denied Provider's claims at the time Carrier denied the claims, particularly since neither knew what Carrier's criteria and guidelines provided. Carrier chose not to offer any evidence explaining what its proprietary criteria and guidelines stated or to clarify the rationale for denying the claims, other than the global statement that they were not medically necessary. Consequently, the ALJ finds that Carrier failed to show by a preponderance of the evidence why it denied Provider's claims.

In addition, the ALJ finds Carrier failed to show by a preponderance of the evidence that the Disputed Services provided by Provider to Claimant from October 21, 2002, through November 7, 2002, were not medically necessary. The only service for which Carrier provided a sufficient explanation regarded the special report. However, Carrier offered scant evidence to support this position. As for the treatments provided, Claimant had already undergone two spinal surgeries and was being considered for a third. When she tried physical therapy in the past, without passive therapy and aquatic therapy, Claimant's pain grew worse. To improve Claimant's physical condition, while avoiding rein jury, Dr. Howell performed limited passive therapy, conducted office visits to assess Claimant's condition, and placed Claimant on both aquatic therapy and physical therapy concurrently. With this regimen, Claimant's pain levels and range of motion improved, albeit only a little. Therefore, the ALJ finds that Carrier failed to carry its burden of proof and Provider is entitled to recover the amount due for the Disputed Services.

IV. FINDINGS OF FACT

1. ___ (Claimant), a 44-year-old female, sustained a work-related injury to her lower back on ___, when a chair upon slipped out from underneath her and she stood up. Claimant fell to the floor with the chair landing on top of her, injuring her lower back.

2. The previous month, Claimant had spinal surgery to her lumbar region.

3. On August 16, 2001, Claimant underwent a second surgery to her lumbar spine as a result of the compensable injury.

4. Claimant was placed on physical therapy, but it caused her such pain it was discontinued.

5. Claimant presented to Robert S. Howell, D.C., at First Rio Valley Medical, P.A. (Provider), with complaints of constant pain in her neck and lower back.

6. Provider treated Claimant with one-on-one aquatic therapy and land-based exercises.

7. From October 21, 2002, through November 7, 2002, Carrier denied Provider's claims for copies of medical records, office visits, aquatic therapy, and therapeutic therapy (Disputed Services).

8. The October 21, 2002, claim for copies of medical records was denied by Carrier under payment exception code "F" for "Fee guideline MAR reduction" with a rationale code of "TK" for "Rule 133.1 requires the submission of legible supporting documentation, therefore reimbursement is denied."

9. This claim was for $18.00.

10. Carrier provided insufficient evidence to show why it denied this claim or that it was not medically necessary.

11. The Disputed Services, except the claim for copies of medical records provided October 2, 2002, through November 7, 2002, in the amount of $1,996.00, were denied by Carrier under the payment exception code "U," for "unnecessary treatment (without peer review)."

12. On the EOBs denying these Disputed Services, Carrier used the rationale code "RG,"and its definition for this code, as its explanation to Provider for denying the claims.

13. Carrier defined "RG" on the EOB as "the treatment/service provided exceeds accepted utilization review criteria and/or reimbursement guidelines for severity of injury, intensity of service and appropriateness care."

14. Carrier refused to disclose to Provider the relevant utilization review criteria and/or reimbursement guidelines asserting they were proprietary and confidential.

15. Carrier's failure to disclose to Provider the relevant utilization review criteria and reimbursement guidelines rendered Carrier's explanation insufficient for Provider to understand Carrier reason(s) for denying Provider's claims.

16. Provider filed a request for reconsideration of the Disputed Services with Carrier and asked Carrier to identify what guidelines it was using as a basis to deny the claims and to explain the rationale behind its denial of the Disputed Services.

17. Carrier denied the requests for reconsideration, and failed to provide any additional information regarding the rationale behind its denial of the disputed claims, including the contents of the criteria and guidelines it relied upon.

18. The Disputed Services for aquatic therapy and therapeutic exercises involved one-on-one therapy given in one hour sessions (four increments), and corresponding office visits from October 28, 2002, through November 7, 2002, (Disputed Services).

19. The condition of Claimant's lumbar spine after two surgeries rendered her disabled and in pain.

20. Claimant required one-on-one therapy so that Provider could show her how to do the exercises, make sure she did them properly, monitor her, and ensure she did not harm herself.

21. Claimant required the office visits in conjunction with the aquatic therapy and therapeutic exercises to assess Claimant's condition, progress, and to adjust her treatment.

22. On April 21, 2003, an independent review organization (IRO) concluded that the Disputed Services were medically necessary.

23. By Decision dated May 1, 2003, based on the IRO decision, the Texas Workers' Compensation Commission (Commission) Medical Review Division determined the Disputed Services were medically necessary and granted Provider reimbursement.

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

25. 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.

26. 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. The hearing adjourned and the record closed February 21, 2005.

27. For the dates of service in question, 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.§13.031.

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) §§ 102.7 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 §§ 148.21(h) and (i); 1 TAC § 155.41(b).

6. When a Carrier makes or denies payment on a medical bill, the carrier must include on the EOB the correct payment exception code and a sufficient explanation to allow the sender (Provider) to understand the reason for the Carrier's action. A general statement that simply states a conclusion is not sufficient. 28 TAC § 133.304(c).

7. Carrier's explanation for denying the claims from October 21, 2002, through November 7, 2002, was legally inadequate as it failed to deny reimbursement in compliance with the Commission's rules.

8. Because Carrier never denied reimbursement in compliance with the Commission's rules for the Disputed Services from October 21, 2002, through November 7, 2002, Carrier is required to provide reimbursement.

9. Based on the Findings of Fact, Carrier failed to demonstrate that the Disputed Services were not reasonable and medically necessary for the treatment of Claimant's compensable injury.

10. Based upon the Findings of Fact and Conclusions of Law, Provider is entitled to reimbursement for the Disputed Services as they were 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 October 21, 2002, through November 7, 2002, in the amount of $2,214.00, plus any and all applicable interest.

SIGNED April 19, 2005.

_____

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