DOCKET NO. 453-05-7677.M2
TWCC MR NO. M2-05-1579-01

ZURICH AMERICAN INSURANCE COMPANY	**§**	**BEFORE THE STATE OFFICE**
V.	**§**	**OF**
SYZYGY ASSOCIATES, L.P.	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Zurich American Insurance Company (Carrier) requested a hearing on a decision by an Independent Review Organization (IRO) granting preauthorization to Syzygy Associates, L.P. (Provider) for six sessions each of individual psychotherapy and biofeedback for injured worker __(Claimant). This decision concludes that Carrier has shown that the psychological therapy sessions were not medically necessary, and that the biofeedback treatments are not medically necessary for Claimant. This order orders that Carrier not be required to reimburse Provider for the psychotherapy sessions and orders no preauthorization for biofeedback.

I. BACKGROUND

On___, Claimant suffered a compensable injury to her back while working as an ___, a job in which she had to lift patients. While lifting a patient, she felt a pain in her lumbar back. Although her MRI and EMG were both negative, Claimant continued to have pain related to her lumbar spine. Claimant was referred for psychological work-up with Provider, who in September 2004 requested preauthorization for six sessions of individual psychotherapy and six sessions of biofeedback. Carrier, as the workers' compensation insurer for Claimant's employer, denied the request for the individual psychotherapy and biofeedback, contending it was not medically necessary. Provider did not appeal that decision to the Medical Review Division of the Texas Worker's Compensation Commission (MRD).[1]

In March 2005 Provider submitted two separate requests to Carrier for preauthorization of the same services, both of which Carrier denied based upon medical necessity. In April 2005, Provider appealed the denial to the MRD. An IRO designated by the MRD to hear Provider's

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

appeal decided in favor of Provider, i.e., that the services were medically necessary and should be preauthorized. The IRO decision is dated May 26, 2005. On the following June 7, Provider began a series of six psychological counseling sessions with Claimant. On June 13, 2005, Carrier timely filed its request for a hearing before the State Office of Administrative Hearings (SOAH).

The hearing convened on September 28, 2005, with ALJ Charles Homer III presiding. Carrier appeared through its attorney, Steven M. Tipton. Provider appeared by telephone through its representative, Linda Kinney. The hearing concluded and the record closed that same day. No parties objected to notice or jurisdiction, and those matters are discussed only in the Findings of Fact and Conclusions of Law, except to the extent jurisdiction is referred to in consideration of Carrier's motions to dismiss the proceeding in Part II. below.

II. CARRIER'S MOTIONS TO DISMISS

At the hearing, Carrier moved to dismiss this proceeding on two grounds: (1) that the proceeding is moot because Provider did not obtain preauthorization of the disputed services from the Carrier or an order from the MRD preauthorizing them, and (2) that Provider's request at issue in this case is a re-submission of the 2004 request for preauthorization made without supplying evidence of a substantial change in Claimant's condition as required by 28 TEX. ADMIN. CODE § 134.600(g)(4).

Regarding the first point, at the hearing Carrier properly acknowledged a long line of SOAH decisions holding that when a provider performs services after an MRD order, a retrospective review is appropriate.[2] Carrier argued that notwithstanding these earlier decisions, changes subsequent to

[2] For example, in SOAH Docket No. 453-97-2599.M2, ALJ Landeros wrote:

> Carrier moved to dismiss the case for mootness because the myelogram was performed while the appeal of the MRD was pending. Carrier argued the appeal meant the MRD decision was not a final Commission order authorizing the procedure. TEX. LAB. CODE ANN. § 413.014 requires the Commission to specify by rule those health care treatments and services which require express preauthorization by a carrier. A carrier is not liable for those specified treatments and services unless preauthorization is sought by the claimant or health care provider and either (i) obtained from the insurance carrier or (ii) ordered by the Commission. The language of Section 413.014 requires that preauthorization must be (i) sought and obtained or (ii) sought and ordered.
>
> A myelogram is treatment which is subject to preauthorization. In this case, the Carrier sought preauthorization and it was ordered by the Commission. Based on the MRD decision, Claimant was entitled to proceed with the myelogram while Carrier pursued its appeal of the MRD decision. In proceeding with the myelogram prior to the SOAH decision, the provider risked not mootness of the appeal, but a denial of reimbursement if Carrier

the SOAH decisions have now clarified that orders are binding pending appeal. Carrier argues that the MRD order in this case will not become final until Carrier's appeal is decided and certainly was not final before the 20 days for Carrier to request a hearing had passed, and that therefore Provider did not comply with TEX. LABOR CODE ANN. (Code) § 413.014(d), which provides

> The insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission.

Carrier's motion to dismiss for mootness is denied. Code §413.014(d) does not require the Commission order to have become "final" before Provider renders the preauthorized services. As ALJ Landeros wrote, Provider is entitled to rely on the order, but does so at its peril because Carrier may successfully appeal the order.

Carrier's second issue is Provider's failure to submit evidence of a substantial change in Claimant's condition after its September 2004 requests for preauthorization. While Carrier's statement of the facts is correct, dismissal is not the remedy. SOAH Rule 155.56(b) allows an ALJ to dismiss a proceeding for any of five reasons: lack of jurisdiction in the referring agency, lack of authorization for SOAH to conduct the proceeding, mootness of the case, failure to state a claim for which relief can be granted, and unnecessary duplication of proceedings. Provider's failure to document a change in Claimant's condition does not place the case into any of those five situations.

The requirement to submit evidence of a substantial change is procedural. As Carrier noted, 28 TAC § 134.600(g)(4) was amended in March 2004, with this explanation from TWCC:

> ''Comment: commenters recommended the rule should be explicit that it is improper for health care providers to resubmit requests that have been denied without documentation of a substantial change in the employee's condition whether or not there has been an IRO review. [. . .]
>
> Response: The commission agrees. Section (g)(4) as proposed and adopted clarifies, "a request for preauthorization for the same health care shall only be resubmitted when the

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won the appeal. Carrier's motion to dismiss is denied. (Decision and Order, 1998.)

requestor provides objective documentation to support that a substantial change in the employee's medical condition has occurred."[3]

Thus, while Carrier has shown that 28 TAC § 134.600(g)(4) requires providers to document change in a claimant's medical condition when they resubmit a request after an initial denial, it is equally true that the requirement is one of procedure that enables insurance carriers to determine more quickly how to respond to a subsequent resubmission. The rule only deems failure to document such changes "improper," and does not prescribe any remedy.

Nor does either party claim that the IRO's failure to treat resubmission requires remand. Instead, both parties tried the case on the theory that impliedly the MRD must have considered the 2005 request for preauthorization as a resubmission when it determined to send Provider's request to an IRO.[4] Therefore, Carrier's motion to dismiss this proceeding because of Provider's failure to document a change in Claimant's medical condition is denied. This decision treats the documentation of substantial change as an issue secondary to and part of the ultimate issue, medical necessity.

III. EVIDENCE AND ANALYSIS

Considering separately each service for which Provider sought preauthorization, this decision concludes that Carrier proved that neither were medically necessary for Claimant.

Carrier submitted no documents at the hearing. Provider submitted its Exhibits I and II, which were admitted. These two exhibits consist of information sent to the MDR and the MDR decision, plus notes on the psychological work-ups performed on Claimant.

James F. Hood, M.D., a board-certified orthopedist, testified for Carrier that Claimant's reported pain is inappropriate for her objective findings, which include in addition to her negative

[3] 29 Tex. Reg. 2355 (March 5, 2004).

[4] There is nothing in the record evidencing the MRD/IRO decision except the three pages of Provider's Ex. II.B., a fax cover sheet and two pages titled "Notice of Independent Review Decision" and dated May 26, 2005. Those pages together with a third page of the May 26 notice are also in SOAH's file in this docket, and official notice is hereby taken of that third page, which completes the communication from the IRO.

MRI and negative electromyelogram (EMG), no muscle spasm, no diminution in her reflexes, and no change in the measurements of her extremities. In Dr. Hood's opinion, biofeedback is only effective on patients who have muscle spasms. Dr. Hood stated that because Claimant's symptoms are subjective, an active physical program would be very much more effective than biofeedback. No studies establish efficacy of biofeedback in patients with"benign" objective findings, according to Dr. Hood, who also stated that Medicare will not cover biofeedback for psychosomatic pain. Dr. Hood did not directly address Provider's request for preauthorization of psychological counseling.

Only Carrier made a significant presentation concerning the medical necessity of biofeedback for Claimant. Dr. Hood's testimony was concise, clear, and uncontradicted. From it, one can only conclude that there is no proven or accepted connection between biofeedback and improvement of a psychosomatic condition such as Plaintiff's, whether that condition is labeled symptom magnification or pure fabrication. Biofeedback is not medically necessary for Claimant's compensable injury.

Regarding psychotherapy, Provider asserts that the documentary evidence shows that individual psychotherapy was necessary for Claimant, and points to an August 2004 psychological assessment.[5] That assessment notes Claimant's pain symptoms and that the psychological component has not been directly addressed with therapy. The assessment further observes that "the patient has not participated in conservative level psychotherapy treatment" and that such treatment should be requested "to see if an impact can be made upon her injury-related distress." The consultant also remarks that "the patient does not present with any major contraindications to treatment that would hinder her participation in individual therapy."

Against Provider's evidence stand two letters by the same reviewer, Christopher Garrison, M.D.[6] Dr. Garrison states that it is unclear to him why the request is being submitted (in March 2005) approximately six months after the consultation. He states that psychotherapy poses a risk of reinforcing Claimant's "pain behavior," a risk he terms " "highly probable," and concludes that Provider has not shown medical necessity of psychotherapy for Claimant, but rather that it is contraindicated.

[5] Provider Ex. I.G.

[6] Provider Ex. I.D.

Dr. Garrison is correct. Provider's Ex. II.C. contains the reports of the first five of Claimant's six psychotherapy sessions with Provider. From the absence of the sixth, the ALJ infers that it offered no improvement that would tend to prove that the service in fact helped Claimant. The only documentation Provider submitted concerning the period after the initial denial was two medical consultations between Claimant and Louise Lamarre, M.D., a chronic pain specialist. These two interviews occurred on January 17 and March 23, 2005. Neither of them reports any significant change in Claimant's condition compared with the previous evaluations. In fact, neither of the 2005 evaluations discuss a need for psychotherapy. Thus, Provider's only evidence supporting the need for psychotherapy was, at the time of the hearing, 13 months old. Dr. Garrison's evaluation of March 2005 stands as the preponderance of the credible evidence, and thus Carrier has shown that the requested psychotherapy sessions were not medically necessary for Claimant.

Because Carrier showed that neither requested service was or is, respectively, medically necessary for Claimant, reimbursement for the six psychotherapy sessions should be denied, and preauthorization for the biofeedback should be denied.

IV. FINDINGS OF FACT

1. ___ (Claimant) suffered a compensable, work-related injury to her lumbar spine on___.

2. Zurich American Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for her compensable injury.

3. After her compensable injury, Claimant received extensive chiropractic modalities, therapy, and pain medication, all of which proved to be unsuccessful in alleviating Claimant's pain.

4. Claimant had a negative MRI and EMG, but continued to have pain related to her lumbar spine.

5. Claimant was referred for psychological work-up with Provider, who in September 2004 requested preauthorization for six sessions of individual psychotherapy and six sessions of biofeedback.

6. Carrier, as the workers' compensation insurer for Claimant's employer, declined to reimburse for the individual psychotherapy and biofeedback.

7. Provider did not appeal Carrier's October 2004 denial to the Medical Review Division of the Texas Worker's Compensation Commission (MRD).

8. In March 2005 Provider submitted two separate requests to Carrier for preauthorization of the same services, both of which Carrier denied based upon medical necessity.

9. In April 2005, Provider requested medical dispute resolution by the MRD, which referred the matter to an Independent Review Organization (IRO).

10. In a decision dated May 26, 2005, the IRO designated by the MRD to hear Provider's appeal decided that the requested biofeedback and psychotherapy were medically necessary and should be preauthorized.

11. On June 7, 2005, Provider began a series of six psychological counseling sessions with Claimant.

12. On June 13, 2005, Carrier filed its request for a hearing before the State Office of Administrative Hearings (SOAH), and the case was referred to SOAH.

13. Claimant had no muscle spasm, no diminution in her reflexes, and no change in the measurements of her extremities.

14. Claimant's reports of persistent pain for more than a year after her injury have no basis in any physical clinical findings about her.

15. For chronic back pain, biofeedback is only effective on patients who have muscle spasms.

16. Biofeedback has not been shown to be effective in treating psychosomatic pain such as Claimant's.

17. No studies establish efficacy of biofeedback in chronic back pain patients with "benign" objective findings such as Claimant's.

18. Individual psychotherapy may reinforce the adverse behavioral response to pain of patients with chronic pain syndrome who do not have significant physical findings related to that pain, and is likely to do so in Claimant's case.

19. Other than Provider's own correspondence to the MRD, no healthcare provider has recommended psychotherapy for Claimant after August 25, 2004.

20. There is no evidence of any change in Claimant's condition after August 2004 that supports a need for individual psychotherapy.

21. Individual psychotherapy for her pain issues is contraindicated for patients such as Claimant.

V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Carrier has the burden of proof. 28 TEX. ADMIN. CODE §§ 148.21(h) and 133.308(w).

6. Carrier has shown by a preponderance of the evidence that the six sessions of individual psychotherapy provided to Claimant between June 7, 2005, and July 31, 2005, was not medically necessary for treatment of Claimant's compensable injury.

7. Carrier has shown by a preponderance of the evidence that biofeedback is not medically necessary for treatment of Claimant's compensable injury.

8. Carrier should not be ordered to reimburse Provider for the individual psychotherapy provided to Claimant between June 7, 2005, and July 31, 2005.

9. Preauthorization should not be ordered for biofeedback for Claimant.

ORDER

IT IS ORDERED that Zurich American Insurance Company is not required to reimburse Syzygy Associates, L.P. for the individual psychotherapy provided to Claimant between June 7, 2005, and July 31, 2005.

IT IS FURTHER ORDERED that the request of Syzygy Associates, L.P. for preauthorization for biofeedback for Claimant be, and the same is hereby, denied.

SIGNED October 28, 2005.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS